WHAT'S PAST IS PROLOGUE

A HISTORICAL-INSTITUTIONALIST ANALYSIS OF PUBLIC-PRIVATE CHANGE IN ONTARIO'S REHABILITATION HEALTH SECTOR, 1985-1999

by

Alina Gildiner

A thesis submitted in conformity with the requirements
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... WHAT'S PAST IS PROLOGUE, WHAT TO COME,
IN YOURS AND MY DISCHARGE.

William Shakespeare, *The Tempest,* Act II, Sc. i, lines 247-248

What's Past is Prologue: A Historical-Institutionalist Analysis of Public-Private Change in Ontario's Rehabilitation Health Sector, 1985-1999.
Ph.D., 2001
Alina Gildiner
Graduate Dept. of Health Administration
University of Toronto

Abstract

The dissertation addresses the privatization of rehabilitation services in Ontario over a 15-year period during which three ideologically distinct administrations held office in the province: the Peterson Liberals (1985-1990); the Rae NDP (1990-1995); and the Harris Conservatives (1995-1999). Its chief questions are: How is it that a clear, rapid, and virtually uncontested trajectory of privatization developed in a Canadian health care sector across three such ideologically distinct administrations? And what are the features of this privatization?

To address the first question, the author employs a historical-institutionalist conceptual framework to analyze the trajectory of policy change that occurred. She compares policy changes occurring over the course of the three administrations in the three ministries, and their corresponding communities, at whose intersection rehabilitation policy is set: the Ministry of Health, for public health care insurance; the Ministry of Finance, for automobile casualty insurance; and the Ministry of Labour, for workplace injury insurance.

With respect to the second question, she uses the Stoddart and Labelle (1985) framework of five axes of privatization (financing, management, administration, regulation, and ownership) to analyze changes in the public-private boundary for rehabilitation services. And she proposes the addition of a sixth axis: political privatization.

She draws her data almost exclusively from extensive documentation that exists in the public record, and analyzes it in accordance with these two frameworks.

Theoretically, the thesis is concerned with state retrenchment in public-policy arenas (the three insurance areas). The author concludes that the institutional organization of policy making in the rehabilitation health sector – in particular, its fragmentation – was a key factor in the trajectory of privatization that developed. She suggests that institutional organization of policy arenas may be a factor more generally in where and how retrenchment occurs. And she suggests a concept of "ricochet effects" to describe the unanticipated interaction effects in a policy arena characterized by such organizational fragmentation.

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Chapter One: Introduction

The Problem: One Policy Trajectory, Three Parties

By and large, Canadians think of their health care system, though threatened and beleaguered, as largely accessible to them on the basis of need rather than ability to pay. It is understandable they do so, given the language of the *Canada Health Act* (CHA) and the ways in which it has shaped public discourse. In fact, however, Canada's health care system is best conceived as a defined, stable public core surrounded by an amorphous and constantly varying public-private mix. The inner core of publicly insured services, made stable by the terms of the CHA,[1] consists only of hospital-based and physician-provided services. To whatever extent other services are made available under those conditions, they too are publicly insured. Thus, if the patient is hospitalized, pharmaceuticals, physical therapy, occupational therapy, speech pathology, social work, chronic care, and the like, are part of the public continuum of care. Otherwise, they are not, and it is up to each of the ten provinces and three territorities[2] to decide to what extent to fund non-hospital, non-physician health care services. What many Canadians think of as (and trust to be) a coherent set of integrated health care services is anything but that.

The federally-insured hub of hospital-based and physician-provided services is only partially distinguished by the fact that it is almost entirely publicly financed – approximately 95% for physician services, and 85-90% for hospital services (Canadian Institute for Health Information [CIHI]) 1999).[3] In addition, it is attached to high visibility, public accountability, legislative coherence under the CHA, and overwhelming popularity with the electorate. Canadians regard their health-care system not just as a signal public policy achievement but as a cornerstone of

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[1] This presumed protection is not absolute, however. Under Canada's constitution, health care is in provincial jurisdiction (with the exceptions of care for native and armed-forces communities). Thus, the federal government cannot say what the provinces must do. But a tradition of federal spending power in Canada has allowed the federal government to exert much sway. Under *the Canada Health Act*, which consolidated two earlier acts (the *Hospital Insurance and Diagnostic Services Act* of 1957 and the *Medical Care Insurance Act* of 1966, the federal government transfers money to the provinces for "medically necessary" hospital and physician services so long as they abide by five conditions: universality; comprehensiveness; portability; public administration; and accessibility. Should provinces not comply, the federal government's only recourse is to hold back a portion of these transfers; the Act does not make other legal sanctions possible. Furthermore, a succession of changed funding mechanisms since the late 1970s has diminished the value of these transfers, weakening the federal government's suasion and authority.

[2] As of 1 April 1999, Canada had three northern territories: Yukon, the Northwest Territories (NWT), and Nunavut. Throughout the period of this study, however, it had only Yukon and the NWT, Nunavut having been carved out of the latter.

[3] It is important also to note that, even though financing for these core services is almost entirely public, delivery and management are substantially private. For a comprehensive discussion of this, see Naylor (1986).

their national identity. The political costs of tampering here are substantial for any Canadian administration. Consequently, as Carolyn Tuohy (1999, p. 89) notes: "In the three decades after the establishment of the federal medicare program (which was fully in place by 1971), the Canadian health care system showed a remarkable structural and institutional stability."

It is certainly true that the core itself – and, perhaps more significantly, the framework of core versus peripheral sectors – has been stable. But what exists around the margins is the vast panoply of services needed to provide continuity of care in concert with physician and hospital services. Here, financing (and thus, to an unpredictable extent, access) varies from a public-private mix to almost entirely private. Furthermore, the admixtures of public and private roles are themselves volatile.

Thus, while core services may be characterized by high stability, continuity, visibility, and accountability, the opposite characteristics obtain to much outside the core. Rehabilitation services for the injured are a prime example of this dynamic in Canadian health care. How and why the dynamic has played out in Ontario's rehabilitation services sector, thereby redefining public and private roles, is the subject of the historical comparative-case study undertaken here.

Between 1985 and 1999, a series of policies[4] transformed Ontario's rehabilitation services, particularly those for out-patients, with virtually no public discussion or debate. Together, these policies formed a trajectory within which multiple public and private tiers of access were created. Considerable discrepancies in access to and quality of care became an important concern for patients, providers, payers, and other decisionmakers. Private responsibilities burgeoned, and along with them, so did private markets and private controls over decisionmaking. Public provision of services, public capacity to set goals or to monitor their achievement, and public accountability all began to decline in the rehabilitation health sector.

Despite the consistent direction of policy, however, the period of the changes comprised three different provincial governments that, between them, embrace the left-to-right spectrum of mainstream Canadian political parties. In each administration, the problems were framed differently, but the direction of change remained consistent. What might it be about this "marginal" or "non-core" sector in Canada's health care arrangements that helps to explain how

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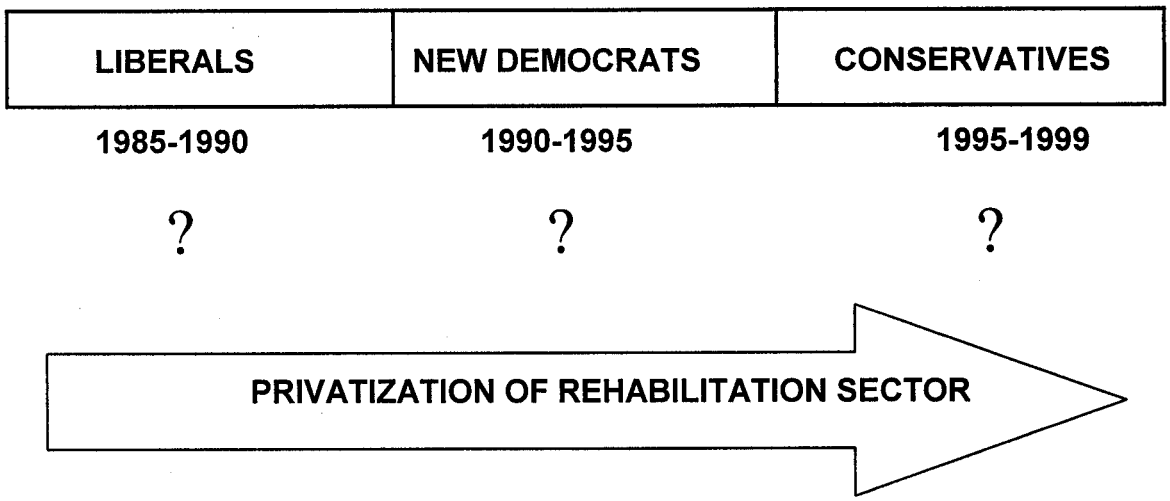
[4] The word "policy" is used in this work to mean a government's decisions about what its goals are or are not, and what it will or will not do to pursue them. See Howlett and Ramesh (1995). It may take the form of central control, or more or less stringent legislation, with or without regulations, or simply admonition and exhortation. It may also take the form of empowerment of other actors – commissions, committees, task forces, agencies, even private boards and corporations, and the like – to establish or pursue public policy goals.

it is that three such different governments, with different concerns and perspectives, in combination managed to produce a single trajectory towards the swift and relatively silent privatization of the rehabilitation health-care sector? This is a question both about the structure of the sector and about the process of policy change in it, and this study will argue that structure and process are closely linked. Relatedly, it will draw out the features of that privatization and their relationship both to structures and processes within them. Figure 1 represents the central puzzle graphically.

Additionally, the study goes one step beyond policy outcomes and their implications, and considers some of the outcomes for patients and providers that have occurred.

Figure 1: The Problem: Three Administrations, One Policy Trajectory



What Rehabilitation?

Rehabilitation is a term used to capture a broad array of interventions used in an even broader array of settings. In Ontario's Ministry of Health, for example, there is no division or branch devoted expressly to the planning, funding or administration of rehabilitation services. Rather, they are woven into almost each division and branch at the ministry, being provided in hospitals (virtually all of which in Ontario are globally funded by the institutions division of the Ministry of Health), in ministry-funded long-term care facilities, in private providers' offices (fee-based by licensing under the Ontario Health Insurance Plan), in home care (now an internal market under a community health division), and in an assortment of other public services, such as that for assistive devices. Furthermore, much – indeed, arguably most – rehabilitation in the province is funded increasingly not by the Ministry of Health but by accident casualty insurers.

In addition, the very concept of rehabilitation is ill-defined. A traditional health-care-based definition of rehabilitation is that it is "a progressive, dynamic, goal-oriented and time-limited process which enables an individual with an impairment and resulting disability to reach an optimal level of mental, physical, cognitive and/or social functioning.... to facilitate social re-adjustment and achievement of maximum possible independence" (Hundert & Assoc., 1993, p. 8). This is a very broad definition. It takes in a vast array of services, and it does not delimit the population to which it applies. This study will consider only those services provided to ameloriate the acquired functional limitations of working-aged individuals who have been injured as a result of external, accidental trauma, i.e., not those who have in-born genetic or congenital defects, or whose limitations result from disease and illness processes (such as neurological or cardiovascular conditions or accidents), or are acquired through non-accidental events (such as aging, addiction and the like).

Thus, rehabilitation is being delimited here to the following working definition:

Rehabilitation consists of those services whose goals are to maximize recovery of daily-living (self-care and work, paid or unpaid) function after accident injury from external trauma. These include providers of paramedical services, including licensed and regulated allied health professionals, such as physiotherapists, occupational therapists, chiropractors, massage therapists, and speech/language pathologists; the various non-professional aides who assist them (e.g., kinesiologists and exercise therapists, etc.); and the assorted other unregulated providers who have sprung up in more recent years, in response to legislative incentives, such as rehabilitation counsellors, rehabilitation consultants, and rehabilitation case managers. Vocational rehabilitation is not the primary focus of this report. Nonetheless, because of the way some of the data on rehabilitation in Ontario is maintained, it is virtually impossible to clearly separate paramedical from vocational rehabilitation.

Why Rehabilitation?

As noted at the outset, rehabilitation is one of several non-core health sectors in Canada's loosely configured health care system. So why focus on it? Three reasons are offered here: (1) it has substantial implications for the working-aged population; (2) as a policy arena, it is organized in Ontario, as in other jurisdictions, by the confluence of policy activity under several institutions, as will be discussed shortly, so its organization makes it a rich source of

information about how institutional features of the arena feed into public-private change particularly over time, which is a core question of this study; and (3) it offers potential theoretical lessons about public-private change more generally in health-care sectors, a question of broad theoretical concern.

It Has Serious Implications for the Working-Aged

The great majority – some 75 percent – of disabilities in industrialized countries have their onset during the prime working years of 18 to 54 and result from externally-imposed mechanical trauma, either accidental or cumulative; underlying disease and illness mostly account for disability in younger and older age cohorts (Berkowitz et al., 1991). In Ontario, it is this population that has been most affected by public-private change for rehabilitation services. A practice study by the College of Physiotherapists of Ontario (2000) indicated that the average age of patients using hospital out-patient and private-clinic community services was in the mid-50s, while the average age of those using hospital in-patient services (i.e., services in the stable inner core) and publicly-funded home care services was in the mid-60s.

For working-aged outpatients, both access to and quality of rehabilitation services will vary widely. If we imagine several individuals – all working aged, all with identical physical injuries and subjective complaints, all at the same stage of recovery, and all having received the same recommendations for rehabilitative treatment – we would be mistaken to think that their identical needs will result in identical care. The rehabilitation they receive will vary depending on the circumstances of their initial injuries and what legislated or contracted benefits apply to them. Individuals injured in motor vehicle accidents will receive one set of benefits, under automobile casualty insurance legislation. Those injured in workplace accidents will receive another, under workplace injury legislation. Those assaulted on the street or hurt in a recreational pursuit will have some services available under public health insurance. Some people will have benefits available under private extended health insurance or disability insurance, depending on their labour-market attachment or their willingness and ability to purchase individual coverage.

Because of the paucity of quantitative data that exists about utilization of out-patient and private-clinic services, it is difficult to know precisely how large this population of interest might be. The incidence of disability provides some broad indication of need, however, in spite of the fact that many individuals with disabilities will not require or benefit from rehabilitation

(Institute for Work and Health, 1995). The available data for the 1990s consistently show the reported incidence of disability for Canadians to be between 15% and 20% (Federal, Provincial and Territorial Advisory Committee, 1999; Crawford, 1998). Figures for Ontario are comparable (Lepofsky, 2000): 16% of the country's working-aged population, specifically, "were affected by disability at some point in 1993 or 1994" (Crawford, 1998, p. 10).

While some 15% of Canadians identified themselves as disabled in 1991, it is uncertain how many of these individuals have temporary as opposed to permanent, or total versus partial disabilities, or how many of them receive or are candidates for rehabilitation services. It is probable that many people who have, or have had, temporary disabilities might not self-identify on a survey as disabled. And there is likely to be substantial underreporting in the usual claims-filing channels because the growing number of self-employed and contractually employed, should they experience temporary or partial inability to work due to injury, have no reporting mechanism.

Clearly, the impacts of temporary or permanent-partial disability that might benefit from rehabilitation will be felt from individuals to organizations and to the broader economic and social communities. Thus, there is much value in identifying how policy change has shaped public and private responsibilities for this important cohort.

It Illuminates the Relationship of Policymaking Organization and Process

The variation in services available to the working-aged injured derives from the fragmented organization of policymaking for rehabilitation in Ontario. Far from the coherent organization of the sector's policy and operations that exists in some other jurisdictions – such as Germany (Breuer 1999) – Ontario's rehabilitation services sector is characterized by its fragmentation. This typifies not only the recipients of services – who are splintered into a number of "interest groups" or else are entirely disorganized – but the very institutions that make the most vital policy decisions, and the policy communities and networks[5] that they structure.

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[5] Coleman and Skogstad (1990) define a policy community as that group of actors who become involved in a policy focus (any activity that may be the object of policymaking); a policy network refers to the ways in which the members of the community are linked in the process of pursuing resolution of a given issue. A network is, therefore, a form of structure cutting across public and private players. The types described by Coleman and Skogstad include: pressure pluralist; clientele pluralist; parantela pluralist; concertation; corporatist; and state directed networks. These are differentiated on the basis of the relative autonomy and capacity of state versus societal actors. Because there is no discrete arena of policymaking for Ontario's rehabilitation health sector as a

Rehabilitation is not a discrete policy arena in Ontario, but forms obliquely at the confluence of policy decisions made in three areas[6]: (1) the Ministry of Health (MOH), which makes very limited policy specifically for rehabilitation, but weaves the services into virtually every program area; (2) the Ministry of Finance (MOF), which administers automobile casualty insurance legislation and has relatively recently begun to tackle rehabilitation issues; and the Ministry of Labour (MOL), primarily through its agency, the Workplace Safety and Insurance Board (WSIB, formerly the Workers' Compensation Board, or WCB), which has a defined rehabilitation policy.[7] During the period studied here, both automobile casualty insurance and workplace injury insurance each changed three times, with substantial revisions to rehabilitation benefits, and public-sector health policy underwent several important changes relevant to the sector

Few people would say that rehabilitation is not a health care issue, as well as an issue complexly evocative of the determinants of health (chiefly because of its relationship to labour-market and socioeconomic matters). Yet, within the institutional triumvirate described above, the Ministry of Health has played the least important role in shaping the out-patient rehabilitation sector since 1985. Indeed, it has no line budgets for out-patient rehabilitation. Rather, decisionmaking about these services is devolved to the level of individual hospitals, which determine how much of their global budgets to allocate to out-patient rehabilitation clinics. As for non-hospital rehabilitation facilities, or health centres that offer rehabilitation-related services, these do not require provincial licensure or accreditation, though individual

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whole, it becomes exceedingly difficult to characterize it. The communities and networks organized around rehabilitation under automobile, workplace, and health policy are very different.

[6] Other provincial ministries have also played, and still play, a role in post-accident rehabilitation, including the Ministry of Community and Social Services, and the Ministry of Education and Training. But these players do not make policy that affects access to the services that constitute the chief interest of this report; they are primarily involved with retraining. Both health insurance and disability insurance arrangements also affect access to rehabilitation services. But benefits under these are not publicly regulated or mandated; rather, they are negotiated under collective bargaining, or purchased by employers or individuals. By contrast, automobile casualty insurance is mandatory for all drivers, and workplace injury insurance is mandatory for many of workplaces in the province, and each contain regulatory provisions related to rehabilitation health services.

[7] Each of these three core institutions has undergone change, including name change, during the period of study. The Ministry of Financial Institutions under the Peterson administration amalgamated with Treasury and Economics during the Rae administration to become the Ministry of Finance. The Ministry of Health became the Ministry of Health and Long Term Care in the Harris administration. For the sake of simplicity, these will be referred to as the Ministry of Finance and the Ministry of Health throughout this study. The longstanding Workers' Compensation Board became the Workplace Safety and Insurance Board in 1998, and will be referred to as the WCB or the WSIB depending on the period discussed.

professionals may have public billing licenses or be accountable to self-regulating professional colleges.

Not coincidentally, the interests in the associated policy community are weakly organized. Chiropractors, physiotherapists, occupational therapists, massage therapists, and rehabilitation counsellors all function separately, and not infrequently are divided against each other rather than united as a coherent rehabilitation providers' community. (See, for example, the debates occurring around the *Regulated Health Professions Act*, discussed in chapter 4, in which several of these groups squabbled over overlapping scopes of practice.) Recipients are fragmented into automobile insurance claimants, injured workers, disabled social welfare recipients, the head injured, the spinal cord injured, and so forth. There are few institutional or programmatic channels through which their common interests either can be formulated or pursued.

The reasons for the fragmented organization of the sector have little to do with efficiency, either real or imagined. There is little that is functional or rational about this arrangement, which allows for considerable cost shifts to occur (Mustard, 1998) and for claimants to fall through its gaps and convolutions (Roeher Inst., 1992; Torjman, 1996; Govt. of Canada, 1996). Rather, the reasons stem from the historical establishment, occurring over many decades in the twentieth century, of the major institutions: workers' compensation, automobile casualty insurance, and Canada's health care system. This history, and its legacies, will be taken up in more detail in chapter two.

This arrangement of institutions remained a stable structure over the period of the three governments under study here. Even so, considerable volatility and change occurred in the sector along a trajectory towards privatization. A core part of the argument being developed here is that the stability, or rigidity, of the structural and institutional features of the sector is an important factor in understanding the development of that trajectory, which unfolded under the impetus of various new historical forces. As well, the formal separation of these three policy sectors, and the virtually independent development of rehabilitation-related policy in each, combined with their informal interconnection at the rehabilitation sector lying at their nexus to create "contingent" or unanticipated and unintended impacts of each for the others. Decisions made at one juncture by one player ricochet against the other players over time. Thus, an understanding of public-private change in the rehabilitation sector requires analyzing policy changes implemented in each area by the respective players and, particularly, analyzing the impacts of the players' policy decisions upon one another.

Rehabilitation is not entirely unique in the fragmentation that results from multiple payers. The same is true for long-term care services in Ontario, and for pharmaceuticals and dental coverage. But it is the only one of these non-core sectors for which benefits are explicitly publicly regulated under multiple public and private regulators. Thus, rehabilitation provides a clear basis for examining the relationship between policy change in a complex public-policy arena (which allows us to explore inter-institutional organization) and the development of a trajectory reshaping the public-private boundary in a sector over time.

It Offers Theoretical Purchase About Privatization of Health Care

Between 1978 and 1999, the private share of health care financing in Canada rose from 23.5% to 30.3%, while in Ontario it rose from 24.5% to 33.1% (CIHI, 1999). It is unclear, however, whether this increase in private spending represents a direct or intentional cost shift from the public to private sectors, or whether there are other mechanisms of privatization at work. As will be discussed in the literature review that follows shortly, most explanations of health-care privatization in general assume that the shift is a deliberate policy choice. But the case of Ontario's rehabilitation sector largely belies this explanation. Rather, it demonstrates the workings of a more long-term, historical dynamic that begins with an institutional framework that shapes potential (if not real) public and private roles, then arcs through the creation of a brand new demand-driven market for private services, which draws payers and providers into it, and eventually becomes largely privatized not only in its financing or provision but increasingly in its decision-making and goal-setting.

For students of welfare state dynamics, Ontario's rehabilitation health sector provides an example of how retrenchment may occur in health care, a welfare arena that some of the most key literature (Pierson, 1994; Tuohy, 1999) portrays as resistant to retrenchment once it has been established.

Literature Review: Parties, Institutions, Interests and Ideas

Given the puzzle posed in this study – the swift development of a clear privatizing trajectory in a health-care arena, over the course of three ideologically different governments – it makes sense to consider those bodies of literature that seek to explain the direction of policy trends over time. The literature that has been most concerned with this question is that on

institutionalism. Those of its theoretical and methodological contributions that are most promising for understanding the puzzle here will be discussed in some detail.

First, however, consideration is given to the "do parties matter" literature. Our puzzle suggests that, at least in this case, they mattered little. After all, privatization of rehabilitation was set in motion by a centrist Liberal government in the late 1980s, and gathered steam under the left-of-centre New Democratic Party administration of the early 1990s. By the time the neo-liberal[8] Progressive Conservatives were in office, consolidation of a substantially privatized sector was already occurring. What would the parties literature have to say of this?

Do Parties Matter?

Parties, and electoral choice amongst them, are a cornerstone of modern democracy. But do they – or to what extent do they – drive how policy unfolds? In this case, what did partisanship have to do with public-private change in the rehabilitation health sector?

Klingemann et al. (1994, p. 36) operationalize three indicators by which the impact of parties on policymaking can be measured: (1) agendas, or the extent to which "the variations in the overall agendas of the parties [campaigning in an election run-up]...forecast similar variations in policy priorities"; (2) mandates, or whether "parties that get into government after the election enact policies that conform more to their own election programs than to the programs of parties that do not get into government"; and (3) ideology, or the extent to which "parties in power follow more closely a policy reflecting long-standing ideology than one reflecting current programmatic emphases."

Quite quickly, however, the authors drop separate consideration of ideology and mesh its effects together with mandate, having found that it adds little purchase to explaining policy direction (which itself is defined only as expenditure decisions). It is a conclusion that belies the very foundation of why parties are presumed important in the first place, i.e., that they

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[8] The term "neo-liberal" is used in this study to denote an explicit agenda to decrease the role of public-sector instruments in economic activity, including in the traditional realms of social welfare policy (such as health, education, and housing), and to increase the role of private-sector market instruments. Exemplars of neo-liberal political leadership have been Margaret Thatcher in the United Kingdom and Ronald Reagan in the United States. Helen Milner and Robert Keohane (1996, p. 20), describe neo-liberal economic policies as "the combination of financial anti-inflation measures, trade and capital market liberalization as well as the reduction in government intervention domestically." Other writers, such as Brooke Jeffrey (1999), use the term "neo-conservative" to describe these governments. This, however, underemphasizes the vital role of the marketplace in these new policies, and risks confusion of market liberalism with social conservatism, which do not necessarily (or even traditionally) go together. For a thorough discussion of the differences between neo-liberalism, libertarianism, market liberalism, neo-conservatism and other related categories, see Moloney (1997).

embody and represent fundamental ideological cleavages in how citizens view what constitutes "the good life" in political terms and the role of the state in its pursuit. The more concrete and slice-in-time party-driven agendas (focal campaign issues) and winning parties' mandates are found to explain about 50% of the variance in policy decisions. But this still leaves 50% of decisions unexplained. And the definition Klingemann et al. choose for policy direction (budgetary expenditures) does not begin to capture the vast panoply of important policy directions, decisions and outcomes that have no immediate or obvious budgetary representation during a party's tenure.

In the case of Ontario's rehabilitation-related policy, as we shall see, agendas and mandates directly and obliquely pertinent to the arena – e.g., ideas about integrated disability and rehabilitation policy; plans to nationalize automobile insurance – made no difference to the overall direction that developed in the sector. The trajectory of public-private change in the sector, towards privatization, that occurred across the three administrations often was strikingly opposite to these ideas, and often unfolded in the absence of any explicit, coherent ideas about what a desirable direction for the province's rehabilitation health sector might be. This suggests that policy trends may not always derive from any direct, behaviourally driven decisionmaking process (whether to maximize self-interest, or to put into effect ideas about efficiency or about values), but may be driven instead by other forces.

Other writers in the tradition offer some corrective to this rather narrow view of the analytic importance of party ideologies by putting them into a broader context. Castles (1982, p. 88), for example, notes that party ideologies are not fixed, but are mutable over time:

> Politics clearly matter in the sense that party political structures institutionalize class and interest cleavages and make them continuingly policy-relevant. But the nature of such cleavages can and does change, and a much longer time perspective ... suggest(s) that these changes must eventally be reflected in new institutional structures, new ideologies and new policies.

And Rose (1980, p. 141) points out that the "differences in office between one party and another are less likely to arise from contrasting intentions than from the exigencies of government.... To recognize the importance of parties is not to argue that parties are all-important...." For example, examining the "convergence" on market models in northern

European health care reforms,[9] Jacobs (1998, p. 2) argues that the political ideology of the party in power must be factored together with "the nature of political institutions, and the structure of the pre-reform health system...in determining the values that would be favored" (p. 2).

Most recently, Fiona Ross (2000) built on these observations and sought to link them to the literature on welfare state retrenchment, particularly to Paul Pierson's (1994) argument that the politics of retrenchment are not simply the inverse of the politics of expansion: the rescinding of benefits that have been distributed (or are anticipated) is a fundamentally unique political exercise. Ross argues that while the ideological features of parties may appear consistent over time to the electorate, parties in fact may undergo "choice reversal," just as voters do, due to broader contextual cues. Thus, parties themselves may serve "as strategies in the retrenchment process by helping leaders diffuse responsibility for unpopular initatives" precisely because their ideologies are mutable but appear persistent (Ross 2000, p. 165). Ross uses the concept to understand why social-liberal parties, such as Tony Blair's U.K. New Labour Party and Bill Clinton's U.S. Democrats, have had an easier time imposing losses through policy than their right-wing predecessors did.

But for Ontarians, the puzzle remains: why did these phenomena not obtain for Ontario's NDP, which suffered greatly for its Social Contract (a policy that revoked aspects of public-service union agreements, configuring that revocation as a "lesser evil" than job losses) and which used its unwillingness to impose losses (even losses that would have been supported by rational-efficiency arguments) as a reason for not pursuing its mandate to replace private automobile insurance with a public plan? And why did neither the "Accord" (Liberal/NDP) government nor the Liberal majority or NDP majority governments, operating with constitutional parliamentary strength, pursue their own mandates for reforming the disability system, which would have had major implications for rationalizing rehabilitation and increasing public accountability for it?

In short, the literature on parties does little to help us understand the development of a single, privatizing trajectory in rehabilitation under the watch of three governments with different ideologies and mandates. Its most valuable contribution to the case here is the suggestion, in works such as Castles's, Rose's, Jacobs's, and Ross's, that parties' effects cannot

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[9] See the extensive discussions on this published by the OECD (1990), especially: A.J. Culyer, "Cost containment in Europe"; Alain C. Enthoven, "International comparisons of health care systems: What can

be easily isolated and, while sometimes necessary to an explanation for change, are not always even necessary, much less sufficient.

Institutionalism: The Relationship of Institutions, Interests, and Ideas, in Policy Change

As suggested above, the parties literature falls short as an explanation for trajectories of change over time that span the tenure of different parties in government. How to explain such trajectories in differing times and places, and especially how to understand the dynamics that animate them, has been the key issue for a body of literature collectively known as institutionalism.

For institutionalist scholars, three important explanatory variables have emerged: institutions, interests, and ideas, each of which has already been invoked in this discussion. What is problematic is construing their relationship to each other. In the institutionalist view, this is not for predictive purposes. Predictive science is only possible (or at least most valid and reliable) where variables can be isolated, measured, and held constant over time and place – that is, changes in one variable will result in predictable changes in another, regardless of when or where they occur. Institutionalism posits, by contrast, that in the social and political worlds, time and place are profoundly meaningful to an understanding of the forms that political life takes, of how they emerge and change, both diverging and converging. So these writers eschew what Theda Skocpol (1984, p.376) called "the dogma of universality" and seek instead "to make sense of historical patterns, using in the process whatever theoretical resources seem useful and valid" (Skocpol, 1985, p. 17).

Clearly, an understanding of the relationship between institutions, interests, and ideas is vital to the central puzzle in this study, and would offer much as an organizing conceptual framework for approaching that puzzle. The approaches within the institutionalist body of literature to an understanding of this relationship can be categorized, broadly, as two-fold: new institutionalism; and historical institutionalism. The ways in which each construes the relationships amongst the variables subtly changes their respective definitions of the variables themselves, especially institutions. Therefore, rather than attempting to define institutions, interests and ideas first, this

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Europeans learn from Americans?"; Jeremy W. Hurst, "Response to Enthoven," and Robert G. Evans, "Response to Enthoven"; and Bengt Jönsson, "What can Americans learn from Europeans?"

discussion will define them within the context of the two ways of understanding their relationship to each other.

New Institutionalism: A Triangle Relationship in Place and Time

All institutionalists share the premise that the organization of the state itself, particularly its autonomy from social interest groups and its capacity to act, is a critical variable in understanding policy change, and that this variable differs amongst state policy sectors. Hence, institutionalists tend to focus on policymaking in individual sectors and the "disaggregation of the state" is important to them precisely because of the variation that occurs (Coleman and Skogstad, 1990). But for one group of institutionalists, who are here called "new institutionalists," institutions function chiefly to constrain the independently-determined preferences of actors. For this reason, as Hall and Taylor (1996, p. 936, fn. 1) point out, "the 'new institutionalism'....and rational choice institutionalism overlap heavily and so we treat them together," as is done here as well.

An exemplar of this approach is Ellen Immergut (1992). In her study of why some European governments have been able to socialize medicine and others have not, Immergut argues that neither the ideas of policymakers nor the ideas and interests of physicians explain the differences amongst her three cases. Rather, she argues, the explanation lies in the design of political institutions. These she defines as "constitutional rules and electoral results that, respectively, establish procedure and affect partisan activity" (1992, p. 3), and the "veto points" they create for the progress of actors' ideas and interests of the actors, be they state or social actors. Specifically, she writes, "institutional mechanisms structure the decision process in a given polity, and by so doing, provide interest groups with different opportunities for influencing political decisions" (*ibid,* p. 66). Thus, actors formulate their goals – as ideas and interests – independently from institutions. The importance of institutions is that they affect actors' strategic calculations for attaining those goals, as well as their chances of doing so.

In this conception, institutions, interests and ideas exist in a state of constantly shifting balance relative to each other. Their relationship is triangular. Institutions are privileged to the extent that they establish structural constraints. Nonetheless, they are separate from preference formation. This is the view of the relationship between institutions, interests, and ideas that dominates in the rational-choice/new-institutionalist literature.

Such a view allows for considerable nuance with respect to how institutions affect interests and ideas. The variation is evident in the collection of sectoral policy studies brought together

by William Coleman and Grace Skogstad (1990), in which the central questions have to do with how structural characteristics of state-society relations vary across policy sectors. But the primary focus is on how these differences in sectoral organization affect the chances of success of different interests and ideas (again, those held by either state or societal players). Historical context is relevant because it allows for a "comparison of the membership and structure of a policy community over time (which) reveals information about changing patterns of power and influence" (Coleman, 1990, p. 113). Again, time and place are important because they create the conditions within which the triangular relationship amongst institutions, interests, and ideas is played out.

While the focus on the dynamics of policy communities that is at the core of these neo-institutionalist studies is certainly relevant to this study, it is less concerned with why and how patterned trajectories develop over time within policy arenas, which is the central question in this study. For this, the historical institutionalist literature is more helpful.

Historical Institutionalism: A Focusing Lens Over Place and Time

As we have seen, in the neo-institutional conception, institutions serve chiefly to constrain choice. Individuals or their aggregates – interest groups, representational parties, partisan governments, classes – remain the central change agents and their choices are formulated from amongst all the available options, as is the case in interest-based models (be they pluralist or class-based, functionalist or conflict-based, instrumentalist or structuralist). Time and place serve mostly as a means of tracking and isolating developments. As John Lavis (1998) points out, however, seeing political problems through the lens of interests will condition what is seen and how it is interpreted, not only yielding a result consistent with the premise that interests have primacy, but shaping the questions that get asked to demonstrate the conclusions.

Historical institutionalists shift the question from whose choices in a policy community are privileged to how decision making becomes patterned. Where neo-institutionalism privileges analysis of specific policy communities and networks – and in so doing treats institutions, interests and ideas in a more or less triangular relationship – historical institutionalism is concerned specifically with the dynamics of how policy patterns emerge over time in various jurisdictions. While it shares the neo-institutionalist definition of institutions as "the rules of the game," it focuses more intensively on institutions of the state. And it sees these, not chiefly in terms of the state's strength or weakness in imposing constraints on the interests and ideas of

actors (actors inside or outside the state), but "more macroscopically (as) the ways in which structures and activities of states unintentionally influence the formation of...ideas, and demands of various sectors of society" (Skocpol, 1985, p. 21).

In this conception, institutions acquire a dynamic capacity. The question now becomes how their influence operates to produce patterns over given times in given places – a question much like the one in this study. What is most fruitful and promising about the approach is that, while eschewing prediction, the focus on dynamics over time seeks to explain the probabilistic directions that have developed (or, alternatively, may develop or with more or less likelihood) in policy arenas. Practitioners of this approach seek to specify how change occurs. Why it occurs – a question that is rooted in theories ranging from functionalism to class conflict – is left implicit and variable; a perusal of many collections of historical institutionalist work demonstrates the variety of these ideas held by writers. The point is that these theories alone are not found adequate to explain the variation that occurs in policy decisions across time, place, and sectors. Historical institutionalism is fundamentally

> *problem oriented.* The primary aim is not to rework or reveal the inapplicability of an existing theoretical perspective, nor is it to generate an alternative paradigm to displace such a perspective. Rather the primary aim is to make sense of historical patterns, using in the process whatever theoretical resources seem useful and valid. (Skocpol, 1984, p. 17, italics original)

What matters is how the state becomes organized institutionally, and the ways that these institutions not only privilege some interests and ideas but pattern their emergence and their impacts (Weir et al., 1988).

In this way, institutions become the lens through which the ongoing play of interests and ideas, and their resolution into patterns, can be focussed. This is not because these three factors are separable from each other – they are not – but because institutions are the embodiment over time of interests and ideas. Implicit in Margaret Weir's (1992a, p. 200) statement that institutions affect "the development and flow of ideas by encouraging research and thinking about problems along specific lines" is a conceptualization of institutions as themselves a form of ideas made real. Ideas are not a monolithic category, she argues, but can be separated into two general sorts. The first is what she calls public philosophies – "broad concepts that are tied to values and moral principles" (*ibid,* p. 207); that is, what are frequently called ideologies. The

second she calls programmatic ideas – ideas about implementation – that are developed with direct reference to the means of public administration. Clearly, neither of these can be disentangled from interests. But more importantly, Weir argues, public philosophies have only limited capacity to influence policy unless they can be closely tied to programmatic ideas.

In other words, institutions may be seen as concretized forms of interests and ideas that took hold and created enduring impacts, or legacies, for subsequent interests and ideas. Institutions embody the resolution of prior conflicts about what is right or workable or desirable; they "are not created to constrain groups or societies in an effort to avoid suboptimal outcomes, but, rather, are the by-products of substantive conflicts over the distributions inherent in social outcomes" (Knight, 1992, p. 40). And what constitutes a desirable distribution is inextricably linked both to ideas and to interests. In this way, institutions provide a way of focussing the study of ideas and interests in the context of large social forces over time.

How institutional legacies establish policy paths and larger trajectories, and how institutional change and establishment occur, are the subjects of the following section.

Policy Legacies, Critical Junctures, and Contingency: The Dynamics of Institutional Change and Formation

If the neo-institutionalist perspective conceives of institutions as being like pylons on the policy road, around and through which actors negotiate their interests and ideas (the dynamic mechanisms for change), the historical institutionalist perspective sees institutions more like forces set in motion. It is the properties of the ways in which institutions organize decisionmaking that supply the dynamics for change. Conceived in such terms, institutional direction (the way in which it organizes decisionmaking) either will continue or will become diverted and changed by mechanisms conceptually related to those that apply to all objects in motion: inertia, momentum, and the application of new forces, which may create entirely new institutions.[10] The historical institutionalist literature posits the chief mechanisms for these policy dynamics to be policy legacies, critical junctures, and contingencies.

Policy Legacies

Legacies, which are also sometimes called policy feedbacks, are the ways in which existing state structures for policymaking – and it is important to bear in mind here that state structures organize social policymaking inputs as well, not just the activities of the state's actors – "exert considerable influence over the patterns and types of reform which are possible" (Myles and Pierson, 1997, p. 18). Or, as Weir et al. (1988, p. 17) describe them, "feedback effects of policies on subsequent politics reveals how changing policy agendas and alternative possible alliances emerge not only in response to new socioeconomic conditions but also on the basis of – or in reaction to – previous policy accomplishments." For this reason, as Pierson (1994) has argued convincingly, the retrenchment of state involvement in welfare arenas has been difficult to achieve, even by such powerful politicians as Margaret Thatcher and Ronald Reagan, where programmatic design has created powerful alliances in support of a continuing state role. But this does not mean change cannot occur, or even that it is inevitably slow moving. Recent literature has sought to refine conceptions of how policy legacies may either constrain change or channel it.

In the political world, the continuation of policy or institutional direction (i.e., the "object's" path, whether it is slow-moving or fast-moving, depending on its combination of inertia and momentum), may take two forms, according to James Mahoney (2000, p. 511). On the one hand, the institutional arrangement creates continual self-reproduction, maintaining the status quo. Mahoney describes this in terms of "self-reinforcing sequences," in which "inertia involves mechanisms that *reproduce* a particular institutional pattern over time" through policy feedback. (This is also known as "increasing returns.") And, on the other, the general direction may continue but, rather than being only self-reinforcing, it may establish a reactive sequence that results in incremental change.

Pierson (2000a) characterizes the change that occurs out of the combination of institutional inertia and momentum in slightly different terms. Generally, change is likely to be "big, slow-moving and invisible." But it may occur either as (1) causal chains, in which x triggers a,b, and then c, yielding y, expectedly or not; (2) incremental or cumulative processes, in which change "is continuous but extremely gradual"; or (3) threshold effects, in which incremental or cumultative

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[10] For full discussions of the conceptualization of institutions and change that informs this section, see Pierson (1993, 2000a, and 2000b), and Mahoney (2000).

forces do not have incremental effects, but build to a level of critical mass "which triggers major changes" (*ibid,* pp. 7-9).

Thus, policies are not only the end result of decision making processes, but become new input variables to subsequent decision making.

Critical Junctures

Notwithstanding that extant policy creates strong legacies for the boundaries of subsequent policy, how are we to understand the stark deflections in institutional and policy change that sometimes occur? This is an important question to this study, where it is being argued that rapid public-private change, in the direction of privatization, occurred.

This is where the application of entirely new forces external to the inertia or momentum of the institution become important. Hall and Taylor (1996) characterize these events as "a 'branching point' from which historical development moves into a new path," creating a new institutional direction or, indeed, new institutions. Called critical junctures by Mahoney, these forks in the policy road occur when two or more options for the resolution of a substantial policy problem become clearly viable to the players. Once one is chosen, however, it establishes new institutions – a new organizational structuring of the arena – with their own dynamic inertia and momentum. When this occurs, actors in the policy community, not unlike Robert Frost's young traveller, will find that "alternatives that were once quite plausible may become irretrievably lost" (Pierson & Skocpol, 2000, p. 10).

Contingency

Contingency refers to the ways in which unanticipated events are brought to bear on the policy making process. It is a way of accounting for the realities of political life, where policy arenas do not exist in a vacuum that can be held constant, but are continually and often unexpectedly affected by the broader context in which they operate. While legacies create what Weir (1992b, pp. 164-165) has called bounding, "Contingency means that decisions about policy…are often the product of circumstances that cannot be readily anticipated or controlled.... In some instances, contingent factors (reinforce) the direction in which interests and institutions (are) moving.... In other cases, contingent factors (create) new political meanings."

The intersection of contingency with a critical juncture can be key to outcomes, and to the establishment of new institutional formations and changes in institutional paths. This concept is shared by a number of writers who draw on the historical-institutionalist traditions: the interaction of institutionally established social class allegiances with unanticipated historical exigencies yields different governance structures (Barrington Moore Jr., 1966); emergent politics of race, the Civil Rights Movement, entwined with the development of employment policy in the United States, redefining the perception of problems, and therefore of solutions (Weir, 1992b); "windows of opportunity" open "accidentally" as a result of "events in the broader political arena," leading to the establishment of structures and institutions that, in turn, become important variables when the next window of opportunity opens (Tuohy, 1999). For these reasons, the timing and sequence of events is crucial to the concept of policy change and institutional dynamics: the same event will not lead to the same outcome in very place, at every time, because the mixture of extant institutions with current political pressures varies over time and place.

It is because of this interaction of the structure of state institutions with historical events – which may take the shapes of new interests and ideas, particularly about the political-economic order – that this study will provide a contextual background for the policy decisions that were made.

Historical Institutionalist Methods for Studying Historical Change

In keeping with historical institutionalists' views about how policy change unfolds, as has been discussed, process tracing is the analysis of historical material as sequential in meaningful ways. Chains of development are highlighted to establish the interconnectedness of key events in ways that illuminate the development of policy trajectories – their early critical junctures and contingencies, their feedbacks and legacies, and their ongoing contingencies and branchings. The point of view is broad enough to take into account multicausality and long enough to (a) make sufficient data available to generate variation in outcomes, while still (b) ascertaining temporal relationships amongst the variables, "that one precedes the other, or that the two occur at essentially the same time" (Pierson & Skocpol, 2000, p. 10), thereby providing theoretical purchase, and (c) making it more likely that period effects can be identified and accounted for. Thus, process tracing tracks "the development and paths to influence that ideas and material interests take within the institutional context of policy-making" (Weir, 1992a, p. 188).

Implications of the Historical Institutionalist Literature for the Case of Ontario's Rehabilitation Health Sector

The concepts of policy legacy, critical juncture, and contingency have particular promise for the analysis of Ontario's rehabilitation sector because of its fragmented organization amongst three ministries and their respective communities. As Weir (1992a, p. 192) writes, the interaction of "different domains of politics and policy" is important:

> To understand how a sequence develops requires examining not only the direct antecedents of innovation but also policies formally classified in other arenas, which may nonetheless shape the problem itself, thinking about the problem, or the politics of the issue. This calls for casting a broad eye over politics to understand how developments in different domains of politics and policy collide to create outcomes that cannot be readily anticipated or easily controlled by individual actors. Such collisions can become turning points in a sequence.

These relationships between different domains may sometimes be purely accidental, as has been discussed. But might not accidental or unanticipated interactions also arise precisely because of the way institutional relationships are organized? In the case of Ontario's rehabilitation sector, could the fragmentation of rehabilitation-relevant policymaking amongst three different policy domains have created unanticipated impacts – or ricochet effects – by each on the others? The literature suggests that this linkage of institutional organization to the development of critical junctures and the impact of contingencies is an underconceptualized and potentially important area.

The impact of fragmentation on welfare state retrenchment has been considered elsewhere in the literature, but primarily with respect to the impact of fragmentation in higher-order institutions, chiefly in division-of-power versus parliamentary systems, and unitary versus federal systems (Swank, 2001; Pierson and Skocpol, 2000). Nonetheless, their insights provide a lens through which to focus the possible impact of one of the salient features of rehabilitation policymaking in Ontario – its fragmentation – on the outcome of interest, public-private change. The literature supports the importance of transferring some of the insights gained from looking at higher, macro levels of institutions (such as constitutions and political systems) to meso levels, such as the the state's organization of the decisionmaking process through ministerial (and therefore policy community) arrangements.

Some examples of such an approach do exist in the literature. For example, Coleman et al. (1997), set out to test Pierson's (1994) hypothesis that retrenchment is difficult, if not impossible, due to the feedback effects of earlier, welfare-expansion policy. They found that, the more fragmented and pluralistic the policy community, the more retrenchment is likely to occur, especially under the spur of ideology. The more "vertically integrated" the community is, however, the less likely retrenchment is to occur.

In the rehabilitation sector, the broad community certainly is fragmented across the different ministries and by their respective policies. But my argument and questions here pertain less to the ways this fragmented community created weak linkages, and therefore weak resistance to retrenchment forces buffeting it (although there is some truth to this[11]), than to how this organization itself contributed to a sequence of events that affected public-private change. In this case, the three main ministries and their policy communities operate separately but they intersect at rehabilitation. So the rehabilitation health sector provides a case in which it is possible to see how contingency may be increased by the existence of multiple entry and exit points in the policy making process formed by institutional organization.[12]

Literature on the Public-Private Boundary in Health Care Arenas

The primary focus of this study is on policy process and its implications for how change occurred in the public-private boundary in a health care sector. Therefore, the literature reviewed thus far has been primarily that about policy process, especially in relation to puzzling out retrenchment or change in state welfare arenas. Nonetheless, it is also important to consider briefly the literature that defines the public-private boundary in health care arenas.

At its most basic, the public-private boundary is the demarcation between state and society jurisdictions or roles in an area. This sounds straight forward, but the reality is less so, because few policy arenas in western democracies are purely private or purely public. Rather, they exist on a spectrum in between, in a condition of variable instability that depends on a variety of dynamic factors, many of which have been dealt with in the literature review sections above. Furthermore, even within a single welfare policy arena, such as health care, different

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[11] This was an important factor in the privatization that occurred in Ontario's long-term care sector. See Patricia M. Baranek (2000).

[12] Doern and MacDonald (1999) also look at overlapping policy jurisdictions shaping a sector (trade). They do not really consider, however, the overlapping organization itself as a possible factor that creates opportunity for contingencies to arise.

components may lie at different points along the spectrum, and be shifting more or less quickly in either direction. How, then, should we determine whether public-private change is even occurring, or what it looks like?

It is widely acknowledged in most of the literature that change along the public-private continuum in contemporary welfare state arenas involves much more than change of economic ownership. Starr (1989) defines privatization as occurring along four axes: cessation or cutting back of government provision; transfer of public assets to private ownership; public financing of private services (e.g., by vouchers or contracting out); and deregulation of entry by private firms into formerly public activities. And Pierson (1994) expands it to mean any policy-directed shift toward residualizing the state's welfare role, thus refining the definition so as to be more specific to the analysis of late twentieth-century welfare state retrenchment. For students of complex welfare policy arenas, such as health care in Canada and in many welfare states, these views of the public-private boundary and its shifts need to be further refined and operationalized.

Saltman and von Otter (1992), and Deber et al. (1998), distinguish three axes as especially important to analyzing boundary shifts in mixed public-private health sectors: financing (where the money comes from); delivery (who provides the services); and allocation or funding (how the money gets to the provider). These axes, however, still leave implicit, or unexamined, matters such as administration, management, regulation, and decisionmaking about benefit distributions, all of which are important features of the public-private mix.

Greg Stoddart and Roberta Labelle's (1985) typology of privatization, however, offers an explicit and more comprehensive framework for understanding the public-private boundary in health care arenas and, therefore, the axes along which that boundary may shift. These are:

- financing, which describes where the money to pay for services comes from, distinguishing it from ownership;
- management, or operational decisionmaking;
- administration, or implementation of management decisions;
- regulation, or foundational rulemaking about entry to, exit from, and mandates of activities; and
- ownership, which remains relevant to many health care services in Canada.

Even so, a crucial aspect of change in public-private boundaries in contemporary welfare states is missing, and that is the issue of scope of conflict,[13] or decisionmaking about resource allocations. This is different than Stoddart and Labelle's concept of management, which has to do with day-to-day operational issues, rather than with decisionmaking about or oversight of contentious, conflictual matters. The concept of scope of conflict, therefore, will be added to Stoddart and Labelle's axes and called *political privatization*, operationalized as the effects of policy on:

- The power to make decisions about resource allocation (i.e., the structure of decisionmaking power about allocation of resources); and
- Decrease in public capacity to set policy agenda or implement/monitor actions.

Conceptual Framework for this Study: Institutions and Change in the Public-Private Mix

From the preceding discussions, the following conceptual framework has been drawn for this study:

- It begins with a conceptualization of rehabilitation in Ontario as being formed at the juncture of three arenas of jurisdiction – public health insurance; workplace injury insurance; and automobile casualty insurance – and takes this institutional organization as relevant to subsequent policy decision making, which in turn affects change along the public-private boundary axes, producing a trajectory.
- Within each decisionmaking/administrative period, there are three chief variables:
  - Institutions (which condition ideas and interests through an iterative process).
  - Policy Decisions (re: problems and solutions).
  - Implications/Outcomes (change along the public-private boundary axes).
- It uses the concepts of policy legacies, critical junctures, and contingency to analyze change over time in these arenas.

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[13] This is adapted from the work of E.E. Schattschneider (1964), who elaborated how the strong in a conflict seek to keep scope narrow so that their strength can more easily prevail, while the weak seek to broaden scope so as to gain adherents and, in their greater numbers, strength. Public democratic institutions, he wrote, are democratic to the extent that they serve to broaden scope of conflict.

- It looks for how the organization of the arena may have increased the possibilities that legacies in one area (e.g., automobile casualty insurance) created forms of contingency for the others, because of their uncoordinated and fragmented inter-effects in the rehabilitation sector.

Methods

Definitions and Delimitations

Rehabilitation already has been defined. To summarize briefly, rehabilitation in this study refers primarily to health services whose aim is to recover function lost by individuals due to accidental, exogenous trauma. (It may include, however, vocational rehabilitation services where these cannot be disentangled from health services because of the way that data is kept and because of the terms of different insurance policies that link health with vocational rehabilitation.) It focuses on policy affecting availability of these services to individuals in the working-aged population.

"Institutions" refers to the state's organization of policy decisionmaking in the rehabilitation sector, and the rules derived from it. Thus, it includes:

- Ministries, which are understood to organize policy communities and their decision making channels. The ministries under consideration here are the Ministry of Health; the Ministry of Finance; and the Ministry of Labour, particularly its Workers' Compensation Board/Workplace Safety and Insurance Board.
- Their rehabilitation-relevant policies, including
  - ➢ actions that imply direction (such as appointments of reporting commissions and committees, creation of subordinate institutions, such as agencies, boards of directors, and the like), and
  - ➢ those actions that implement direction (such as acts and regulations).

Within Health, these included policies affecting the public supply of out-patient rehabilitation services. (Home Care services are not included because no data exist about rehabilitation versus nursing or homemaking services.[14]). Within the Ministry of Finance,

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[14] Conversation with research coordinator at HCERC, University of Toronto, January 2000. Furthermore, the proportion of out-patient rehabilitation services provided under Home Care for the population of interest is very small compared to that provided under the delimited policy areas. Similarly, while the Ministry of Education/and Training, and the Ministry of Community and Social Services have also played important roles in rehabilitation

policies include those pertaining to automobile accident casualty insurance. And within the Ministry of Labour, they include those of the Workers' Compensation Board/Workplace Safety and Insurance Board.

Case Selection

Like most historical-institutionalist studies, this one begins with a case that poses a puzzle, rather than beginning with theory and on its basis selecting a case. The starting point of the Liberal period of 1985-1990 has been selected for two reasons. Firstly, a review of the literature about rehabilitation in Ontario indicates that this is the period in which discrepancies between public and private access to services first became tentatively identified as a problem area for some injury populations, especially the brain injured (Ministry of Health, 1987; Social Assistance Review Com., 1988), although not yet as a more widespread problem. Also, it was in the wake of the Liberals' two 1990 bills (substantially changing both the automobile and workers' compensation legislations), that these discrepancies were noted to become greater and more problematic (Institute for Work and Health, 1995, 1996), so the development of these Acts is important. The second reason for selecting this starting point is that it marked the onset of a period of unusual political instability in the province (White, 1998), during which three ideologically distinct parties succeeded each other. So it makes it possible to consider, and compare, them as three historically sequential cases over which a policy sequence, path or trajectory developed (increasing privatization of the rehabilitation sector).

It ends with 1999 simply because this is the year that marked the end of the first Progressive Conservative administration under Premier Mike Harris – the second is mid-stream at the time of writing – and this makes it possible to complete the comparison of the three successive administrations.

Data Collection and Analysis: Documents and Process Tracing

Data used for this study are almost exclusively documents, both primary and secondary, drawn from:

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services in the past (especially the latter's Vocational Rehabilitation Services division) these have greatly diminished. For the sake of clarity, focus is maintained on the three major institutional players.

- Hansard records of Legislative House proceedings, and of Standing Committee Debates relevant to the policies examined.
- Reports of committees, commissions, and task forces struck to examine the policy issues.
- Provincial *Public Accounts* (budgets and financial statements).
- Statistical and Annual Reports issued by relevant ministries, agencies, and boards (e.g., the Ministry of Health, the Ontario Insurance Commission, the Workers' Compensation Board).
- Non-government stakeholder reports (e.g., the Insurance Bureau of Canada)
- Government press releases, statements, and speeches.
- Bills, Acts, and Regulations
- Secondary historical accounts and analyses, including those appearing in popular and trade periodicals.

Where significant gaps arose from the documents that had to be answered to meet the objectives of this study, key informants were sought out. These were very limited in number. Two semi-structured, open-ended interviews were conducted early in the research, not so much to answer the chief questions posed by it as to gain exploratory input confirming the salience of the questions and approach. During the course of research, one other individual was contacted by electronic mail (e-mail), and was asked a brief number of specific questions that could not be answered using only the available, written documentation. The reason for this primarily document-based approach was that the questions posed did not pertain to how the players perceived or understood the variables of importance to have operated or what motivated their own actions. Rather, the questions sought to determine what the record itself indicated about how the institutional organization of rehabilitation policymaking may have interacted with policy outcomes in ways that explain the path or trajectory that developed. Since such a rich documentary record of the institutions and the steps and outcomes exists, it was decided to let this record stand for itself rather than introduce the retrospective analyses of individual players.

The conceptual framework was used to organize data according to their relevance to the key variables in the framework: institutional parameters, decisionmaking processes, public-private change implications of policy decisions, and legacies. The documents were read specifically for what they said about these variables, and data from them then were electronically stored and organized using the Papyrus© bibliographic database (version 7.0.16a), which allows for multiple keyword coding of entries, making it possible to group data readily into categories.

The analytic process conforms to the conceptual framework: each substantive chapter deals with one of the three administrative periods. (Although there were two Liberal governments between 1985 and 1990, they are treated as one here because of the short time frame and the consistency, from one to the next, in leadership. Salient differences between them, such as the fact that the 1985-87 Liberal government was an informal coalition with the NDP while the '87-'90 administration was a majority government, are addressed in the text.) Within these, the policy trajectory is traced through the three institutional arenas. Legacies from the previous period are analyzed for their current institutional configurations (including how they structure interests and ideas and decisionmaking processes, i.e., the path extant at the time). New policy decisions are analyzed for their relationship to these legacies (i.e., for their path dynamics). And, finally, implications of policy path development and trajectory during the period for public-private change are analyzed.

This organization of the data, arranged to make it possible to discern linkages from period to period and inter-institutionally, is itself part of the methodological strategy, process tracing, which already has been discussed.

From Policy Outcomes to Outcomes for Patients and Providers

As much as possible within the context of its questions and methodology, an effort was made to extent the study from policy outcomes to some cursory results from the field. The motivation for this evaluative component came partially from the question: is there any evidence that privatization has occurred with respect to such evaluative variables as patient access or provider or payer behaviours? Motivation arose, too, from the writer's experiences in the field, as a clinical physiotherapist in both the public and private sectors, as an occupational injuries consultant in a large Toronto-area hospital, and as a rehabilitation consultant for a private company providing case management services mostly to those injured in automobile accidents. Also, perhaps the nature of policy studies in a Department of Health Administration is bound to be slightly different than it would be in a Department of Political Science.

Even so, the primary approach was a policy studies one, and not an evaluative one.

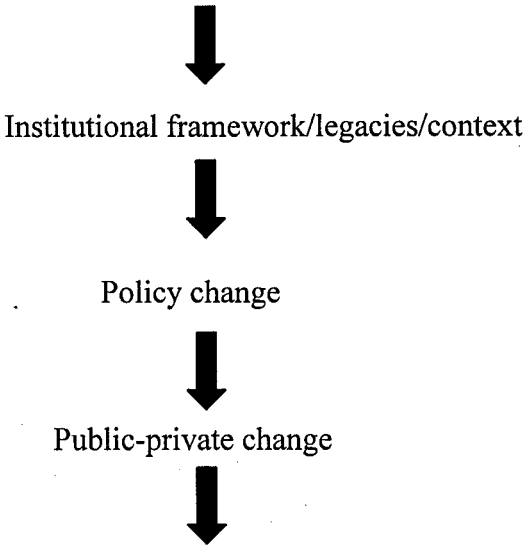
Overview of the Study

The remainder of this study charts the course of a privatizing trajectory in Ontario's rehabilitation health sector using the above conceptual framework and methods. Chapter Two

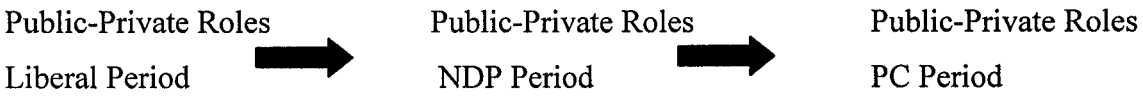
lays the background by chronicling the establishment, over the first 70 years of the twentieth century, of the institutional framework within which the trajectory developed, and argues that elements of this history constituted critical junctures. The following three substantive chapters take each of the three successive governing administrations as their cases: Chapter Three analyses the period 1985 to 1990, when the Peterson Liberals held office, and the balance of public and private roles in the sector first began to shift under the impetus of policy change. Chapter Four considers 1990 to 1995, when the balance shifted further still towards privatization during the Rae NDP administration. And Chapter Five scrutinizes the consolidation of privatization in Ontario's out-patient rehabilitation health sector as a new reality in the province's revamped health care economy under the Harris Progressive Conservatives.

Each of these substantive chapters is structured similarly, so that it is possible to track the policy trajectory developing through them, looking for feedback effects; for forms of contingency that arise inter-institutionally amongst them, as well as that emerge from forces in the broader social, political and economic settings; and for new critical junctures. First, the legacies of the previous period and extant institutions, particularly with respect to their impacts on interests, ideas and the distribution of policymaking power, are considered. This is followed by a section on the broader social and political-economic context operative during the case. Then come sections on rehabilitation-relevant policies introduced by each of the three decisionmaking arenas (health, auto, and workers' insurance), within the contexts of the previous legacies and the overarching environment of the period. And finally comes an analysis of the implications of these policies, which emerged out of an institutional framework operating at a given time and place, for public-private change along the axes that have been delineated, with particular attention to the emergence of a sixth axis of "political privatization."

Thus, each substantive chapter makes it possible to assess how politics shape policy, which in turns shapes future politics:



And the succession of cases makes it possible to assess the process of a trajectory developing over time, between policy making institutions, and across governing administrations:



Finally, Chapter Six draws conclusions about the development of the privatizing trajectory in the rehabilitation health sector, and its relationship to the institutional organization of policymaking for it. As well, it suggests the implications of this historical trend for future policymakers and for students of the politics of public-private change in health care systems.

Chapter Two: Historical Background to the Case

Strictly speaking, the three institutional frameworks of interest – the public health care insurance arena, the private automobile casualty insurance arena, and the workplace injury insurance arena – developed in the following historical order: the provincial *Workers' Compensation Act, 1914*; the provincial *Insurance Act, 1980*, which occurred in the wake of industry changes that had been occurring since the 1950s; and the federal *Canada Health Act, 1984*, which consolidated the *Hospital Insurance and Diagnostic Services Act, 1957* (HIDS), to which all provinces had subscribed by 1968, and the *Medical Care Act, 1968* (Medicare) to which all had subscribed by 1971.

Through the course of this study, however, they are treated in the order of health, automobile casualty insurance, and workplace injury insurance because: (a) the impact of policy on health care services is the focus of the study, so an effort is made first to understand the context formed by the public health insurance system for the rehabilitation sector; and (b) automobile casualty insurance emerges as the policy arena in which the first major trajectory changes are seen; and (c) workplace injury insurance changes provide the final, major policy change of interest during the period of study.

Also, this chapter provides background and does not seek to elucidate the historical relationships that may have existed between the three developing arenas. Indeed, one of the conclusions of this study is that there was little overlap between them in these early stages, a situation that subsequently changed with important consequences for the rehabilitation sector.

Therefore, this historical background will treat the policy arenas in the same order in which they are treated through the rest of this analysis rather than in strict chronological order. Its purpose is to provide the reader with an understanding of the institutional framework that developed for the sector, and to introduce the major players.

Rehabilitation in Canada's Emerging Public Health Care System

Defining its Institutional Place

Rehabilitation made for some curious bedfellows during the early planning stages of what was to become Canada's federal health care system. Debate about such a strategy had opened up in Canada during the Depression years of the 1930s. It was not until after World War Two, however, that the major policies shaping the federal system came into being – HIDS in 1957, and Medicare in 1968. Over the intervening years, the positions of several of the major players

– federal and provincial governments; labour groups; the Canadian Medical Association (CMA), which had formed in 1867; and the commercial insurance industry, particularly the life and health industry – would shift several times as historical circumstances changed.[1]

In 1943, however, reporting to the federal House of Commons Committee on Social Security, they were fleetingly in synch (Taylor, 1987): the CMA stressed in its brief that any national health insurance system should include rehabilitation services as part of its necessary core features; the Canadian Life Insurance Officers' Association encouraged "the inauguration of a comprehensive and efficient health and rehabilitation service" (*ibid,* p. 31); and the Trades and Labour Congress advocated "a close tie-up with the newly enacted unemployment insurance plan and provision of sickness cash benefits" (*ibid*, p. 32). In 1954, Malcolm G. Taylor, in his *Confidential Report on Health Insurance for the Ontario Government,* strongly recommended that hospital insurance not be introduced alone, but be part of a comprehensive system that included rehabilitation. Not suprisingly, given that disability had been found to strike low-income workers disproportionately, in 1957 the Canadian Congress of Labour (which had amalgamated with the Trades and Labour Council the previous year) submitted a brief urging a plan that would cover preventive, diagnostic, curative and rehabilitation services. And the federal government's national health grants program, which had begun in 1948, was expanded in 1953 to include medical rehabilitation.

Any one of these recommendations would have established an entirely different course for the future development of rehabilitation policies than eventually unfolded. So these early years, during which only hospital-based and physician-provided services became publicly insured, constitute a critical juncture in the history of rehabilitation within the Canadian health care system. The extent to which hospitals and physicians came to dominate the system and to be its gatekeepers was not always so paradigmatic as it is today, as the following exchange, which occurred in 1934 before the Standing Committee on Economics, makes clear:

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[1] In 1934, for example, the Canadian Medical Association's Committee on Economics, anticipating that a federal plan would make use of the CMA-operated "Blues" insurance plans, released a report arguing that any federal insurance plan should ensure that only a single insurer existed for all health care services, to avoid the sorts of conflicts between medical practitioners and insurance carriers that bedevilled several European plans. With respect to the development of a federal arrangement, while HIDS, Medicare, and the *Canada Health Act* of 1984 formed its institutional backbone, provincial acts had played a seminal role in spurring development of the system. Particularly in the vanguard had been Saskatchewan's Cooperative Commonwealth Federation (CCF) – precursor to the New Democratic Party (NDP) – governments, which led the way with the *Saskatchewan Hospital Services Plan* of 1946 (with debate dating back to the 1920s), and then with the *Saskatchewan Medical Care Insurance Act*

> George Fulford (Ontario, Liberal – Leeds) pointed out that the plans for public insurance at the time "made no provision for 'osteopaths, chiropractors, and masseurs. After all,' he added, 'in a modern community they do form in so far as the layman is concerned, an important group and perform a useful service."
>
> Dr. J.J. Heagerty, Chair of the federal government's Advisory Committee on Health Insurance, replied: "The doctor has the privilege of utilizing the services of the masseur, the osteopath and the chiropractor and any other service that he thinks his patient needs. That, I think, covers all these other questions."
>
> Fulford responded: "I hoped if the medical profession became all powerful that they would not outlaw the so-called drugless practitioner."
>
> Dr. Heagerty stated that each province could make its own decision about the matter, depending on how it chose to define the term "general practitioner."
>
> Hughes Cleaver (Ont., Liberal – Halton): "Do I take it from that answer, Dr Heagerty, that a person who is ill will not be able to have the services of a chiropractor under this Act until the general practitioner recommends that he requires those services?"
>
> When Heagerty confirmed this, Cleaver commented, "That would appear to be highly dangerous." (Naylor, 1986, pp. 113-114)

Thus, rather than being integrated into a comprehensive system, as it might have been under these alternate proposals,[2] the rehabilitation sector became institutionalized in two ways: within the core sectors, it would be at the discretion of hospitals and physicians, who would budget for it or requisition it as they saw fit; and outside the core, rehabilitation would be provided or not in a patchwork fashion, depending on payment.

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of 1961, the first universal medicare care insurance act anywhere in North America. For a thorough history of the creation of Canada's health care system, see Taylor (1987).

[2] This is not to suggest whether it was right or wrong, appropriate or inappropriate to exclude non-physician services, as came to be the case. Rather, it is to highlight the political nature of the development of health professions, including those involved in rehabilitation practices. Three decades after this exchange had occurred, during the 1965 Royal Commission on Health Services (the Hall Commission), chiropractic practice was considered dubious (Boase, 1982).

Rehabilitation Interests Within Public Health Care Institutions

The development just described was not incongruent with that of rehabilitation providers themselves, who had for some time hitched their wagons to the rising stars of hospitals and physicians in Canadian history.

Rehabilitation took two different historical courses in the United States and the United Kingdom. As with so much, Canada's history lies somewhere between the two, although much closer to the UK through most of the early years of the 20th century. In the United States (Gritzer and Arluke, 1980), physical therapy originated as a subset of physicians who believed that externally-applied physical and electrical agents were more "natural" and effective than the more physically invasive emphases of much medicine. These "physical therapy physicians" trained and supervised assistants, who carried out the actual interventions while the physicians made diagnoses and treatment plans. Like their colleagues, they focussed on acute care and it was not until the late 1940s, in the aftermath of World War II, that rehabilitation *per se* developed as a specialty. By then, the physical therapy physicians had been renamed physiatrists, and their assistants had become the physical therapists.

In the UK, however, physiotherapy developed from a group of nurse-masseuses early in the 20th century (Miles-Tapping 1989; Williams and Gelmon, 1982). Emigrating to Canada, they chose to place themselves under the supervision of physicians, who were themselves then being challenged by osteopaths and chiropractors in the early years of the development of medical dominance. Placing themselves under such supervision was the physiotherapists' bid to gain professional legitimacy in an arena where considerable struggle for power was occurring. HIDS, Medicare, and finally the *Canada Health Act* of 1984 all consolidated the structure of professional power in the Canadian health care system, placing hospitals and physicians at its apex. Under the CHA, the only rehabilitation service mentioned is physiotherapy, and it is insured only to the extent that it is provided in hospitals.[3]

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[3] HIDS (1957) had insured in-patient but not out-patient physiotherapy. The federal Minister of Health and Welfare said, however, that out-patient services would be included in federal cost-sharing if provinces wished to define out-patient centres as "facilities" under the agreement. Ontario's Ministry of Health was agreeable to this. But, worried that hospitals would not be able to meet demand, the Ministry invited private practice physiotherapists to join the Ontario Health Insurance Plan (OHIP) and submit accounts at 70% of the current fee, with no extra billing allowed (Boase, 1982.) The CHA (Section 2) specifically insurers both in-patient and out-patient physiotherapy in hospitals (Government of Canada, 1984).

Exclusion of chiropractors from the development of a public health care system[4] had long been a thorn in the side of the profession. Ontario's first chiropractic college opened in 1909 in Sault Ste. Marie, a small city in the north of the province, and closed just four years later. A second opened in 1914 in Hamilton, moving to Toronto, the province's capital city, in 1919 and closing in 1923. A third had opened, also in Toronto, in 1920 but closed in 1926. In the 1910s, the Hodgins Commission on Ontario Medical Education "dealt a devastating blow to chiropractic" (Vear et al. 1997, p. 57) by giving the medical profession control over university and hospital training of health practitioners. By the time the legislative framework of the Canadian health care system was put in place, chiropractic was excluded from a central role within the core insured services. In Ontario, the province chose to give chiropractors limited billing privileges under the insurance plan in 1970,[5] an action that "was crucial to the survival of the discipline" (Boase, 1985, p. 35).

Although the CHA had restricted physiotherapy insurability to services provided in hospitals, this meant that, for all intents and purposes, the practice was publicly insured, because of the extent to which physiotherapy had developed under the aegis of medicine. While osteopaths would be almost eradicated in Canada, and chiropractors did not begin to gain legitimacy or full professional status until late in the century,[6] physiotherapists enjoyed legitimacy precisely because of the sponsorship they received from physicians through the early century and the First World War. Thus, the profession reaped both the costs (restricted autonomy) and the benefits (legitimacy and access to patients) – what Carole Miles-Tapping

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[4] Medicare provided a framework for provinces to enter a cost-sharing agreement with the federal government. Ontario entered when it passed the *Ontario Health Services Act* of 1968-1969. This Act did not include coverage of chiropractic services, "but by regulation of the Lieutenant-Governor-in-Council, chiropractors were admitted to the plan on July 1, 1970" (Boase, 1982, p. 335).

[5] At the time, it was anticipated that this would cost the province some $7 million annually. Between 1972 and 1981, however, the actual cost to OHIP was $219,910,175, for which there was no federal cost sharing at all (*ibid,* p. 341). This represented 2.4% of OHIP's funds for the year, "the largest practitioner cost [to the plan], excluding physicians" (*ibid,* p. 337).

[6] In spite of their successful lobbying power (see Boase, 1982 and 1985) and growing professionalization, by the late 1990s the debate continued in Ontario about whether to allow chiropractic training to occur within a university (Harvey, 1999). To this day, the practice continues to be taught in a private chiropractic college in Ontario. The profession's goals as of the early 1970s included OHIP privileges, access to hospital X-ray and laboratory facilities, reciprocal referral with MDs, legal permission to call themselves doctors, training within a university faculty, and self regulation (Boase, 1982). As of the time of writing, they had attained three: OHIP billing; the title of "doctor"; and self regulation.

(1989) calls the "sponsorship and sacrifice" – of being subsumed within the developing "core services" of Canadian health care.[7]

It remained, however, a small profession until its ranks began to swell in the 1940s and 1950s, in response to the Second World War, the Korean War, and the polio epidemics of those years. University programs to train physiotherapists and further establish their professional legitimacy expanded greatly through the 1960s and 1970s.[8] Demand increased still further through the 1980s, spurred by the rising "fitness boom" and its associated injuries, rising accident incidence, and burgeoning post-trauma survival rates achieved by improved medical technology. By the mid-1980s, there was perceived to be a shortage of all rehabilitation professionals throughout Ontario, as across Canada and, indeed, around the world.[9]

The vast majority of Ontario physiotherapists worked, however, in the public sector, where 2,456 out of 3,266 (75%) did even as late as 1989. Approximately 60% of the total worked in general hospitals, home care, the WCB hospital, or community health centres, where they would have been accessible to the patient population of interest in this study. Only 21% worked in private practice or industry (Miles-Tapping, 1989).[10] Less than a decade later, the proportions of private to public physiotherapists had pretty much reversed (Alliance of Physiotherapy Regulatory Boards, 1990-1997). No new physiotherapy billing licenses had been granted under OHIP since 1965 (Boase, 1982), so this dramatic shift could only have been spurred by confidence that income would be forthcoming from elsewhere.

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[7] See also Joan Boase (1982) for a discussion of how "chiropractors and physiotherapists .... occupy positions vis-à-vis the provincial medical insurance plan opposite to those which their relationships with the medical profession would suggest." I.e., close affiliation with medicine has long been correlated with low billing privileges for physiotherapists; relatively the opposite relationship obtains for chiropractors. According to Boase, it becomes "apparent that a close and legitimate association with the medical profession is not necessarily of benefit in the pursuit of professional recognition" (p. 332)

[8] The first university program in physiotherapy was established at the University of Toronto in 1929, followed by one at McGill University in 1943. The Universities of Alberta and Montreal followed suit with programs in physio- and occupational therapy in 1954; the Universities of Manitoba and British Columbia, Dalhousie University, Queen's University, the University of Saskatchewan, Laval, and the University of Western Ontario all added programs in the 1960s; and McMaster University did in 1970. Amongst them, in 1982, they graduated 497 therapists across the country. In 1981, there were 6,000 registered therapists in Canada, 220,000 registered nurses, and 45,000 MDs (Williams and Gelmon, 1982).

[9] See, for example: Ontario Ministry of Health (1989), and Ontario Workers' Compensation Board, and Medical Rehabilitation Strategy Feasibility Study Working Group (1988).

[10] The remaining 15% of publicly employed therapists worked in settings such as chronic care, the Arthritis Society, pediatric facilities, and psychiatric hospitals. The remaining 4% of the total worked in educational institutions, government and other official settings.

What is relevant to the issue at hand in this history of professionalization amongst rehabilitation providers is the "disconnect" that developed between rehabilitation therapy providers and the legislative frameworks outside the Ministry of Health under which they came increasingly to work. Evolving within the aegis of physician-directed and hospital-based institutional frameworks, several types of rehabilitation providers (such as physiotherapists and other hospital-based professionals) developed a set of precepts about their work that was largely non-entrepreneurial and patient-focussed, evident in their very definitions of the goals of rehabilitation and in the ways they were trained and their approaches to practice. All of these would be challenged by the policy changes in the final decade of the century.

Commercial Insurance

Frameworks for Private Insurance Players in Rehabilitation

While decisions were being made about rehabilitation within the public health insurance system, other events were occurring that created additional frameworks for the sector, particularly the development of a commercial insurance industry for life and health, disability, and casualty insurance. The conditions of the HIDS, Medicare and Canada Health Acts all had relegated the role of private health insurance strictly to a supplementary rather than parallel (or competing) tier: that is, publicly insured services – those that were hospital-based or physician-provided – could not be duplicated under private insurance.[11] This had been possible because, at the time that HIDS and Medicare were enacted, the private insurance industry was still relatively young and did not present formidable interest-group opposition to the development of a public system (Taylor, 1987). Not only was the industry small, but so was the population, relative to the substantial numbers that are optimal for insurance risk pools. [12] Unlike what

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[11] It is not illegal for physician and hospital services to be provided privately in Canada. Provinces that allow this, however, are faced with reduced fiscal transfers for health from the federal government. Even with recent changes to the federal funding formula, which have substantially reduced these transfers, this provision has remained a strong deterent. And, at the time discussed in this section, when 50-50 cost-sharing arrangements existed, it was a much stronger deterent.

[12] For a discussion of the advantages and disadvantages to commerical insurers of offering health-insurance "products," and the criteria required for their success, see Deber et al. (1999a, 199b). Few provincial jurisdictions offer populations large enough for reliable insurance risk pooling. This is why many insurers, for property and casualty as for health, are large international and multinational corporations. Nonetheless, substantial regional populations would still be required simply to justify managerial and administrative costs for them. This may also explain why it would have been easier for New Zealand to implement a fully national and fully integrated accident

occurred in the United States, therefore, the development of workplace benefits in Canada comprised supplementary services – such as private hospital rooms, or pharmaceuticals, dentistry, psychology, and vision-care services provided outside hospitals – and so did not presage the development of what Beth Stevens (1988) calls a "private welfare state."

Disability insurance – both short-term and long-term – is, like health insurance, generally offered through the workplace, although it may also be purchased privately. Intended primarily to provide income benefits to workers who have sustained temporary or permanent disabilities, it has relevance for rehabilitation because of the incentives it creates for employers and insurers to reduce claim durations by returning individuals to the workplace.

Neither health insurance nor disability insurance, however, are publicly mandated. Although the industry for their provision is regulated, the terms of coverage are strictly contractual, negotiated by management, labour, or individual purchasers and insurers, and the extent of coverage depends on the private contract. Thus, benefits under these plans do not constitute public policy, although interactions between this private industry and the public health care system clearly are important and have been extensively examined, especially where technological change or fiscal constraint have moved services out of the aegis of hospitals and physicians (Deber et al., 1995, 1999a, and 199b).

To the contrary, however, the role of property and casualty insurers has been far more obscure. Yet, with respect to rehabilitation, that role is publicly mandated through strictly regulated benefits, making rehabilitation an area of specific public-policy concern under it. And the casualty insurance industry has become a key player in the rehabilitation sector, as will be seen through the course of this study.

Pains, Gains, and Automobiles

The rise of the motor vehicle as a primary means of transportation, and the development of a sizeable, economically powerful commercial property and casualty insurance industry along with it, was a contingency in relation to the concurrent development of the rehabilitation health sector, which was occurring largely within the framework of hospitals and under the sponsorship of medicine. Between 1941 and 1981, the Canadian population increased from 11.5 million to nearly 23 million (approximately 115%) and the Ontario population from nearly

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insurance scheme in 1972 (Palmer, 1994), i.e., commercial insurance for product lines such as casualty insurance alone would not be highly profitable.

4 million to nearly 9 million (132%). Meanwhile, motor vehicle registrations in Ontario alone rose from 739,194 (19.5% of the population) to 5,057,801 (57% of the population) over the same 40 years, an increase of about 580% in registrations (Statistics Canada, Cansim Series T147-194, and D462156).

By the time motor vehicle accident insurance became compulsory for Ontario drivers in March 1980, a sizeable and growing market existed here and across the country, a market that had not existed when policymakers first began to contemplate a national health care program. With its growth, and that of road transportation systems and markets, came a rise in accidents. Across Canada, the numbers of people injured in motor vehicle accidents rose nearly 750% from 31 thousand in 1941 to more than 260 thousand in 1981(Statistics Canada, Cansim Series T271-284, and Transport Canada Road Safety Statistics, TP3322), the same period of time over which rehabilitation became increasingly professionalized and available in the public health care system.

Sir William Beveridge, father of the United Kingdom's social security system, had said in 1942 that, "If a workman loses his leg in an accident, his needs are the same whether the accident occurred in a factory or in the street." Thus, he had advocated a universal accident insurance scheme that would

> guarantee...all victims of personal injury, irrespective of its type or origin, the same benefits and the same level of protection under conditions that are identical for all. (Miller, 1985, pp. 194-195)

But, in Ontario (and in much of North America) concurrent developments in workplace injury and public health insurance had already fractured the arena of disability insurance, which is frequently yoked to rehabilitation provisions. In Ontario, motor vehicle accident injury claimants resorted to the courts (i.e., tort) for restitution of both economic losses, such as income and uninsured medical or rehabilitation care, and non-economic losses, such as pain and suffering. Very limited no-fault accident benefits had been added to insurance in Ontario in 1969, becoming compulsory for insurance holders in 1972 – though insurance itself remained optional until March of 1980, in the wake of the *Insurance Act, 1980.* Public policy interests in

casualty insurance, in the form of regulated benefits for the injured, remained minimal well into the early 1980s, allowing legal decisionmaking to dominate outcomes.[13]

Between 1969, when minimal no-fault (i.e., statutory) benefits were first added to the tort system, and 1990, when the threshold no-fault system was introduced (to be discussed in the next chapter), medical/rehabilitation and long-term care benefits were minimal in relation to potential costs: $5,000 for medical/rehabilitation, with no additional care benefits, until 1978; and, after that year until 1990, $25,000 total for a maximum of four years for all types of medical/rehabilitation/care benefits combined. Clearly, the injured either could wait for their settlements and then purchase (or repay) care, or they would have to be receiving it elsewhere, such as through the public health-care sector.

Indeed, the existence of an OHIP right of subrogation[14] against casualty insurers is a tacit acknowledgement of the extent to which the public system was relied upon. Such a right of subrogation (or levy) was first considered in the early 1970s, when both the Insurance Bureau of Canada and the Ministry of Health proposed formulas for calculation of recovery rights (Insurance Bureau of Canada, 2000a). The two were unable to agree on a formula, and the plan was put aside until December 1978, when a levy of approximately 2% of written third-party liability premiums was established. It could increase to 2.5% under the terms of the agreement, but renegotiation would be necessary should it exceed that. (The levy stayed at 2% from 1978-1983,when it rose to 2.2%, and then to 2.4% in 1984, at which it remained until 1990 when, as we shall see, it was eliminated altogether.) Payment was made monthly on a collective industry basis, which is known as "bulk subrogation." Though insurers' participation was voluntary, most participated.

For much of its life over these years, the agreement was a bone of contention between the two parties: the private casualty insurance industry, and the public health care insurance plan.[15]

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[13] In Canada, the federal government's interest in financial institutions relates primarily to the economic stability of its four traditional pillars (chartered banks, life insurers, trust and mortgage loan companies, and investment dealers). Public policy aspects of insurance, however, relating to income, health and disability benefits, are in the jurisdiction of provincial governments.

[14] This allows the provincial health care insurance plan (OHIP) to charge a levy to private insurers in order to reclaim public costs for treating privately insured MVA-injured individuals.

[15] For example: "In 1983, it became apparent that OHIP was pursuing recovery against insurers where an uninsured motorist was involved. IBC believed that uninsured motorists were covered under the Subrogation Agreement and in 1984 recommended that Insurers not pay OHIP. Meetings revealed that OHIP was considering taking proceedings against a number of companies not to mention other concerns OHIP had with the Agreement. As expected, the issue was resolved in the courts in Connolly v. Royal Insurance Canada. The Superintendent of

It was one aspect of the extent to which their separate development had not precluded an interdependence between private casualty insurance and public health insurance.

Industrialization and Workers' Compensation

The Development of No-Fault Insurance for Workplace Injuries

Workers' compensation is and always has been a no-fault insurance scheme. Essentially, the right of injured workers to press legal suit against their employers was exchanged for their uncontested right to receive benefits for injuries clearly resulting from conditions of employment. Whether this was (and is) to the greater, lesser, or mutual benefit of workers or employers depends on many factors: how generous the courts would be in comparison; how substantial employers' statutory obligations are; how easy it is to access benefits in comparison to obtaining court awards; who ultimately bears the financial cost[16]; and so on. Theorists may convincingly argue that development of workers' compensation was of primary benefit to employers during a period of rapid and frequently hazardous industrialization, because it eradicated unpredictable court costs and shifted control over exposures from the public courts to the agents of private employers – even where public regulations, mandates and agencies are involved, they provide greater access for direct employer input than the courts do (Bellamy, 1997). Nonetheless, however, historical evidence strongly indicates that implementation of workers' compensation policies by states was not uncontested; other options were vehemently debated and ultimately discarded, and so the development of these policies and institutions constituted a critical juncture.

In Ontario up until 1886, an institutional history of fault-based tort provided the only recourse, and a fundamental assumption operating in the courts was that workers voluntarily and rationally contracted to assume risk in exchange for wages (Maton, 1991). Thus, to win in

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Insurance for the Province of Ontario held that OHIP was entitled to subrogate for uninsured motorists and that such claims were not covered by the Agreement" (Insurance Bureau of Canada, 2000a, p. 6).

[16] Even in jurisdictions where only employers contribute directly to WCB schemes, studies have demonstrated that costs are passed almost entirely on to employees in the form of wage losses and to consumers in the form of costs. See Fishback and Kantor (1995), Stephens (1995), Moore and Viscusi (1990), and Maton (1991). (Obviously, however, this is a form of amortization over past and future wages of employees other than beneficiaries. Immediate costs, which can be large enough to bankrupt small businesses, must be borne by the employer.) According to Maton (1991), the major features of Ontario's first *Workers' Compensation Act* of 1914, which remained unchanged until 1969, were that: it fixed costs and reduced their uncertainty, while at the same time making it possible to pass them on to consumers and workers; it collectivized employers through collective insurance (and thus collectivized them politically to seek influence over the Board), while it individuated workers

court, the worker had to show that the risk leading to the specific injury was greater than that considered a "normal" part of the job (i.e., had not already been recompensed), that neither the worker nor any co-worker was responsible for the increased risk, and that the employer could have done something about the risk but did not, i.e., had been negligent. Predictably, workers (at least, those who could pursue tort suits) seldom won; their growing cynicism, especially in the face of increasing industrialization and industrial accidents,[17] was a contributor to growing unrest.

But in 1886, amendments were introduced to Ontario's employer liability laws that "did two critical things: they reduced the scope of the employers' three defences in the courts, and introduced the juridical structures necessary for the increased influence of juries in the courts" (Maton, p. 46). These institutional changes meant that liability became easier to demonstrate and workers now sat on juries making the distributional decisions. Court awards began to rise.[18] When workers' compensation came to be debated in Ontario, with a bill eventually passed in 1914 and enacted the following year, it was strongly opposed by labour organizations, who would have preferred further institutional changes to the tort system, making it more favourable towards injured workers.[19] So, while theory may have predicted the adoption of workers' compensation schemes across the industrializing world in the late 19th and early 20th centuries,[20]

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by individual claims system; and it substantially limited the rising costs to employers that had been occurring under tort changes after 1886.

[17] "(M)ore American workers were killed or wounded on the railroads than were killed in the world wars. The monthly average of railroad workers killed from 1888 to 1908 was 328, and this was only ten percent of 35,000 killed and 536,000 injured in American industry each year. It was estimated that 70 percent of industrial accidents were related to working conditions or to employer negligence" (Schmidt, 1980, p. 47).

[18] Nonetheless, they remained considerably constrained: an average of 43% of families of U.S. workers killed on the job received no compensation; of those who did, compensation typically was about 56% of the workers' earnings in one year (Fishback and Kantor, 1995). In addition, court processes were (as they still are) notoriously slow: of accidents occurred in 1903 that that received any court award at all, 16% received them in the year of occurrence, 37% the next year, 20% in the third, 14% in the fourth, and 16% in the fifth year or later (Castrovinci, 1976).

[19] The first North American workers' compensation act was passed in Illinois in 1912, also after a protracted political battle. Organized labour opposed it. Amongst its reasons was that stage-legislated welfare would weaken allegiance to unions, and there was enough labour unity and strength that earlier passage of the act in 1905, when it was first debated, had to be abandoned. A cleavage in the labour ranks developed, however, when a labour member of the state Commission supported compensation by saying that tort favoured those workers with the resources to acquire good legal representation. This cleavage was crucial to eventual passage of Illinois's bill. See Fishback and Kantor 1995, and Castrovinci 1976.

Also, for a fascinating account of how similar early-20th century labour dynamics and anxieties (especially about the role of the state) affected development of health policy in the United States, contributing unpredictably and perversely to the growth of a "private welfare state" for health care, see Beth Stevens (1984 and 1988).

[20] Germany had led the way, under Chancellor Otto von Bismarck, in 1884, with Poland following suit the same year. These were not initiatives of social democracy or incipient communism in the region. Bismarckian

their development constituted a critical juncture, particularly in polities where considerable contestation occurred, such as Ontario.

Rehabilitation Under Workers' Compensation in Ontario

Through much of its life workers' compensation in Ontario had virtually nothing at all to do with rehabilitation, in spite of the extent to which medical and vocational rehabilitation are today such contentious aspects of the plan. Its chief goal had not been to re-establish broken or interrupted links with the labour market. Rather, it had been to make reparation, pure and simple, for narrowly-defined economic losses resulting from death, temporary disability, permanent partial disability, or permanent total disability. The idea of using rehabilitation as a means to minimize disability, or redress long-term losses, did not become an issue for Ontario's compensation board until the early 1970s, when increased benefits began to create ongoing, long-term potential cost exposures for payers.

At the time of enactment of Ontario's first workers' compensation act, medical aid was available to claimants only where it was "the only means of avoiding heavy payment for permanent disability" (*Workers' Compensation Act, 1915,* Sec. 15). Coverage of medical, surgical and nursing aid became rights under all compensable injuries in 1917; payment for dental services and appliances was added in 1932; and for drugless practitioners, such as chiropractors and physiotherapists, in 1937. At the time, however, as we have seen, drugless practitioners acted mostly in the treatment of acute illness; the development of rehabilitation per se – as post-acute minimization of long-term functional losses – was still in its infancy. When Ontario's Workmen's Compensation Board opened its first rehabilitation clinic in downtown Toronto in 1932, it was staffed by "a Doctor who had carried on physiotherapy work in the city for a number of years....(and) a trained aide" (Workmen's Compensation Board, 1932, p.8).[21]

The Ontario's workers' compensation system developed (and currently has) two classification categories under which paramedical rehabilitation[22] falls: rehabilitation services

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social insurance, of which workers' compensation became one part, was envisioned by the chancellor as a means of stemming the rising tide of worker unrest and socialism in Germany, against which laws had been passed in the 1870s, to give the state power against it by transforming the state into a "welfare state." See Haverkate 1985. Czechoslovakia and Austria adopted schemes in 1887 and, by 1900, 11 European nations had established similar programs. England had enacted one in 1897. In North America, Illinois first entertained the idea in 1905, enacting legislation in 1912; by the 1930s, the majority of US states and Canadian provinces had proclaimed similar laws.

[21] See also Workers' Compensation Board (July, 1991).

[22] What is meant by paramedical rehabilitation here is the services of allied health professionals, who are regulated in Ontario under the Regulated Health Professions Act, such as physiotherapists, occupational therapists,

delivered prior to a claimant's referral for vocational services; and rehabilitation services delivered at the same time as vocational services. Vocational rehabilitation itself did not become part of the Board's mission until the 1940s, when it was first introduced, and then the 1950s, when it grew during a period of rapid post-war economic expansion. While the Downsview Rehabilitation Centre (DRC), established in 1958 on 65 acres in north Toronto, could accommodate 500 live-in patients, and so seemed quite substantial, it must be remembered that this served the entire province at a time of significant industrial and manufacturing growth.

In fact, Board resources for developing and enforcing rehabilitation policy – resources both in terms of funding and personnel – were slim at the time. It was not until the Starr Report of 1973 that the Board experienced a significant expansion of vocational rehabilitation responsibilities and capacities, creating "massive increases in resources allocated to vocational rehabilitation" (Maton, 1991, p.124). A series of reports made to the Board in the early 1980s,[23] eventually led to several important changes to the *Workers' Compensation Act* under Bill 101 in June 1984. Amongst these were increased temporary disability benefits. Even though rehabilitation and job reinstatement continued to be discretionary under Bill 101, the higher benefit levels increased incentives to seek rehabilitation of claimants, a link in the sequential chain of development that would have repercussions in the next iteration of policy.

In the course of this history, Ontario's WCB developed its own databanks for tracking rehabilitation information, and its own decisionmaking institutions for providing input to legislative mandates pertaining to rehabilitation and their interpretation. These are quite different from those that developed in the other two related policy streams. For example, the Board's management and dispute-resolution structures are entirely separate from those within

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chiropractors, speech-language pathologists, and massage therapists. The field also includes, however, vocational counsellors, rehabilitation consultants, case managers, and kinesiologists. Some of these, e.g., rehabilitation consultants and case managers, may also be regulated health professionals, who may or may not have received specific training (e.g., as kinesiologists or social workers). They may also have membership in the Canadian Association of Rehabilitation Professionals, but they are not regulated.

[23] The most significant of these was Paul Weiler (1980) (generally known as the first Weiler Report). The Association of Injured Workers Groups released a white paper on the report the following year. And, in 1982, the Ministry of Labour called hearings on both the Weiler Report and the White Paper before the Standing Committee on Resources Development, which submitted its results in 1983. Weiler also submitted a subsequent report (1983) to then-governing Progressive Conservative government's (under "red Tory" premier Bill Davis) Minister of Labour, Robert Elgie. Elgie was appointed Chairman of the Workers Compensation Board in 1985, under the Peterson Liberal administration.

the automobile insurance industry. And both, in turn, have no counterpart in the Ministry of Health's rehabilitation activities.

Conclusion: A Sleepy Sector

Gradually, over the course of the 20th century, overlapping historical processes put in place the three arenas of policy players that had a potential stake in rehabilitation health services. For a long time, rehabilitation was not a highly politicized issue. For one thing, it did not really develop as a professional field until later in the century. In its early years its focus was largely on assisting or substituting for other acute-care practitioners. When it eventually did develop as a field of treatment for post-acute and chronic conditions, it did so primarily under the aegis of medical sponsorship, and its practitioners remained closely allied to physicians, the places where they worked, and the institutionalized "culture" of medically necessary health care in Canada.

As well, legislated mandates for its provision under workers' compensation and private insurance legislation were minimal. Under private health insurance, it was of little concern once Canada's publicly insured services were established, given that rehabilitation was so linked to the supervision of physicians and their usual workplaces, primarily hospitals. As for automobile casualty insurance, it was not even compulsory in Ontario until 1980, and no-fault benefits (including rehabilitation) were minimal.

By the mid-1980s, rehabilitation was barely a blip on anyone's policy radar screen. How, then, did this sleepy little, disaggregated health-care sector, in which some 2,800 physiotherapists (almost all in the public sector) and 1,300 chiropractors were practising by 1985 (Ministry of Health, 1993a), become transformed into a private economy through which nearly $1 billion of automobile insurance money alone would flow just fifteen years later?[24] The next chapter examines how the process got under way within the institutional frameworks that had been laid down.

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[24] The source for this figure is the policy division of the Insurance Bureau of Canada.

Chapter Three: The Peterson Liberals, 1985-1990

Rehabilitation Policy Legacies for the Liberals: Pluripotentiality

A fundamental tenet of historical institutionalism is that policy decisions (and non-decisions[1]) are formed within the context of the legacies of previous decisions. Such legacies themselves form institutions in the two ways described earlier: (1) in the state's organization of decisionmaking processes, and players; and (2) in the rules established by policy of any sort. As such, institutions become tightly yoked to interests and ideas. Nonetheless, this is not to say that historical institutionalism views these three variables as equivalent. Whatever their original foundational dynamics, institutions become the environment within which interests and ideas form and act, live or die, do or do not in turn change their environment.

Institutions

By the mid-1980s, the legacies of the developments discussed in the previous chapter had rendered Ontario's rehabilitation health sector pluripotential (to borrow a concept) with respect to public and private roles within it. Its framework contained the germ of possibly substantial private roles and responsibilities in financing as well as delivery: employers had exchanged legal liability for no-fault benefit obligations, and the WCB had gradually increased its rehabilitation activities; and casualty insurance had established a niche exchanging risk assumption for profit potentials in a growing market. But the germ remained nascent and largely undeveloped: WCB turned primarily to public sector providers in hospitals and physicians' offices to treat its claimants, reimbursing the public system on a case-by-case basis; and the insurance industry's regulated exposures for rehabilitation costs, paid either to claimants or to OHIP, were minimal. Almost all rehabilitation delivery, and much of its financing, occurred within the confines of the public system,[2] where institutional arrangements and policy history had placed them.

All the same, the institutional organization that had developed – the ministerial triad – created the possibility of conflict, cost shifts, and unforeseen, unintended interactions amongst them. And the rules that had been established through policy – the framework for employer and

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[1] A "non-decision" is the decision (explicit or implicit) to do nothing about a recognized public problem (Howlett and Ramesh, 1995, p. 83).

[2] This will be discussed further in the sections on demand and supply under Ministry of Health activities later in this chapter.

insurer responsibilities – created a relatively open-ended backdrop for public and private responsibilities and rights, and all the prospects for conflict therein. Would or should greater financial duties accrue to private payers? Who would retain the levers of control over these, if they did? Or would the status quo persevere?

The institutional legacies of the preceding decades had established a fairly rigid, if fragmented, organization of the relevant decisionmaking ministries, alongside a legislative and regulatory regime for public and private roles and responsibilities that made them certain in general terms but contestable on specifics. This is entirely different than the legacies in the core sectors, where more coherent organizational structures, and more rigidly defined obligations, obtained.

Interests

Extant policy meant that the interests of many non-physician rehabilitation providers remained closely yoked to the public system. Physical and occupational therapists required physician referral, sponsorship and at least nominal supervision under the law, the former being regulated under the *Drugless Practitioners Act* of 1925 and the latter being totally unregulated. The majority of their activities were conducted in hospitals, as the examination of demand and supply below will demonstrate. Few avenues of lucrative payment existed for their services outside the public system, since the only other potential payers – private health insurers,[3] casualty insurers, and employers under the Workers' Compensation Act – enjoyed limited exposures for rehabilitation services under legislation. While chiropractors virtually all operated in private practices, they were largely dependent on OHIP billing for their remuneration.[4]

Changes to WC legislation under the 1984 Bill 101 had only just begun to increase further employers' fiscal incentives to fund private rehabilitation providers, and the Board's capacity to use these. But increasing costs always mean increasing interests in controlling them, by

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[3] A review of data from the Canadian Life and Health Insurance Association (CLHIA) indicates that this group of carriers funds rehabilitation to a limited extent, relative to the other major payers. Also, this funding is not a matter of public policy, but of contractual agreements between employers and workers for extended health benefits.

[4] Unfortunately, detailed data do not exist for chiropractors' billing practices until the late 1990s, when the Canadian Chiropractic Association established a databank. Nonetheless, nearly 40% of practitioners' income in provinces with public insurance for chiropractic services (Ontario, Manitoba, Saskatchewan, Alberta, and British Columbia) came from provincial plans in 1995-1996 (Kopansky-Giles and Papadopoulos, 1997). Given that this was under conditions of private funding growth for rehabilitation services in Ontario during the period, it is reasonable to deduce that a substantial proportion of income prior to 1985 in Ontario also was derived publicly.

funders, users, and suppliers alike. Bill 101 also had created the institutional arenas for possible resolution of these new inherent conflicts: the Workers' Compensation Appeals Tribunal, the Offices of the Worker and Employer Advisers (also recommended by Weiler), and the new Board of Directors, which would be the overarching policymaking institution for the WCB. Though putatively balanced in employer and employee representation at their outset – except for the Board of Directors, which was tripartite (employers, employees, state) but had more substantial employer representation from the outset (Maton, 1991, p. 209) – these new institutional changes at the level of organization also had created new levers for contesting decisionmaking power and capacity. And these are, fundamentally, interests.

Ideas

History until this point had established two important ideas about rehabilitation: Firstly, services were to operate within the context of medical and health care, sharing the goals of patient-centred practice and the alleviation of suffering from the perspective of health status. Secondly, tort legacies in the areas of workplace and vehicular injury had established a tradition of regarding these classes of injuries within the context of private, contractual relationships for the purposes of determining liability. The idea that employers should pay for injuries incurred by those they hired, or that casualty risk insurance rightfully belonged in the marketplace, not only acquired institutionalized forms (both organizational and in policy) but became entrenched in ways that would have profound impacts on how policy problems and their solutions would be conceived of in their next iterations – the subject of the rest of this chapter.

Broader Contexts and Contingencies

This study takes seriously Margaret Weir's (1992a) injunction to cast "a broad eye over politics," taking in "different domains of politics and policy." A premise of this study is that the institutional organization of the rehabilitation health policy sector establishes relationships (i.e., amongst the ministerial triad) that provide some boundaries within which to look for contingent impacts. It is also crucial to the historical institutionalist perspective, however, to consider potential influences from the underlying political-social and economic climates of any given period. It is from within these that the most urgent, generalized exigencies for the state are likely to arise.

Ontario's Political-Social Environment, 1985-1990

Ontario had been the preserve of the Progressive Conservative Party for 42 years, culminating in the 15-year dynasty of Premier William Grenville Davis. Bill Davis exemplified the "Red Tory" era of Ontario politics, a period marked by conciliatory politics and the growth of a substantial public-sector "service state" (White, 1985). In the United States and England, more libertarian and neo-liberal forms of conservatism were on the ascendancy under the administrations of Ronald Reagan and Margaret Thatcher, forms that Ontario would not embrace until the mid-1990s (Jeffrey, 1999).[5]

Davis's successor in the 1985 election, Frank Miller, was a more aggressively right-wing politician, and less an old-style Ontario Red Tory. His party's minority victory ended quickly, however, in a vote of non-confidence and the accession of the opposition-party Liberals to government. It was a victory for the Liberals that would not have been possible had the New Democrats not agreed to vote alongside them, an agreement predicated entirely on an informal Accord document drawn up by the two parties. The Accord gave the Liberals a minority government, but tied them to a policy agenda drawn up largely by the NDP, which would hold until 1987, when an election would be called. The document consisted of a letter of agreement signed by the two party leaders, David Peterson for the Liberals and Bob Rae for the NDP, and three documents setting out an agenda for legislative reform and implementation of other policy actions. Amongst these were the establishment of a Select Committee "to investigate the commercialization of health and social services in Ontario," and workers' compensation reform (Ehring and Roberts, 1993, p. 377). Clearly, both were meaningful, or could be, with respect to rehabilitation services.

Indeed, one important institutional undertaking that did not fit into the triumvirate of ministries dominating rehabilitation policy and that had much potential importance for rehabilitation arose during the Accord period. In 1986, the minority government, with the active support of the NDP, established the Social Assistance Review Committee (SARC) to review poverty issues in the province. It held 23 public hearings in 14 communities, receiving more

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[5] At the same time, it is worth nothing that the tides had begun to turn subtly in Ontario in the mid-1970s, after the worldwide economic shocks of the 1973 "oil crisis" that many see as having marked the end of the most expansionary period of the post-war welfare state. In 1975, when the NDP had formed the opposition in Ontario for the first time, it went against the party's Keynesian economic traditions by agreeing with the Progressive Conservatives and the Liberals that restraint on public social spending should be pursued. See Ehring and Roberts (1993).

than 1,500 submissions and briefs before reporting in 1988. Amongst these was an NDP caucus report, *Toward a New Ontario*, that called for change in a number of social policy areas, as well as the implementation of universal accident and illness insurance, which had always been in the jurisdiction of the ministries of health, finance (or financial institutions, as was then the case), and labour. Though reporting to the Ministry of Community and Social Services, SARC took broad aim. Its final recommendations included that, "All relevant government ministries should further develop and expand the delivery of integrated services that would enable people with disabilities to maximize their potential for independent community living, including employment" (Social Assistance Review Committee, 1988, p. 118).

Yet at the very same time, as we shall see, development of policies was underway that would increase the responsibilities of private insurers and employers for rehabilitation initiatives. This is the first example in the period of how existing institutions structured what actually occurred. The report called for coordination amongst multiple institutions and policy jurisdictions. But the report was pure public philosophy, to borrow from Weir. Its ideas were utterly uncoupled from the existing institutional and programmatic frameworks already in place and entrenched, and were simultaneously working on related policies that would pull them in a different direction. Indeed, the very language of the SARC report – to "enable people with disabilities" to engage in "independent community living" – is indicative of an ambiguity about public versus private interest in rehabilitation issues that has a long history. There is a persistent murkiness in the the public debates and documents about what forms of disability are being discussed: permanent or temporary disabilities are not clearly distinguished; nor are in-born and disease-related disabilities from those arising in injuries or accidents. Without it ever being made explicit, a difference had arisen de facto, out of the history of legislative frameworks earlier in the century. (In Ontario, as elsewhere in the English-speaking world, it likely also dated back to a still-longer history rooted in the English Poor Law traditions, which relegated permanent and in-born or illness-related disabilities to the domain of the state, while keeping temporary or injury- and accident-related disabilities tightly linked to the private labour market [Stone, 1984].[6])

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[6] In this way, state welfare for certain types of disabilities in Canada, as in the United States, has become "residualized" to the most marginalized disabled, i.e., the permanently disabled. This is not historically the case in all western jurisdictions, as Appendix A describes.

In the midst of a "crisis," which was perceived to exist in both the auto and workplace accident insurance arenas, and with a majority government in place, it was not only more expedient to act quickly within the existing frameworks, but the frameworks themselves wound up driving the agenda. The fragmentation of policy institutions in the rehabilitation sector precluded the implementation of ideas such as SARC's, which would have required substantial institutional upheaval.

The Accord period ended with a Liberal majority in 1987, Peterson reaping the benefits of public visibility of Accord initiatives, even though these had been negotiated by the NDP. Just two years into the majority mandate, however, Peterson would call yet another election, very likely because the Liberals could see economic storm clouds gathering on the horizon and wanted to expand their time-line for power while prospects still looked rosy. The Liberals could see the boom coming to an end before it could be seen by the voters, who were still riding what felt like an expansionary wave.

Economic and Labour-Market Environment

After slipping into a serious recession in 1982, Ontario's economy began to rebound in 1985 and posted healthy annual growth rates of four and five per cent each year up until 1989 (White, 1998). Provincial revenue rose by more than 60%, the majority of the increase coming from personal income taxes (Treasury and Economics, 1984-85). But the recovery was not simply a return to things as they had been before the downturn. It was occurring in the context of a changing economic environment for the province, which itself reflected global economic changes.

Nineteen eighty-five, which marked the end of Ontario's long history of political stability and its entry into a period of volatility, was also the year that Brian Mulroney's Progressive Conservative federal government "catapulted" Canada-U.S. free trade "(f)rom being a deeply buried public issue for at least half a century ... to the head of Canada's political agenda" (Williams, 1990, p. 16). Completed just two years later, in 1987, and ratified in 1989, the *Canada-US Free Trade Agreement* (FTA) was fundamentally a conflict between nationalism – particularly, for Canada, as focussed on "distinctiveness of the sociocultural milieu" (*ibid,* p. 18), which for a majority of Canadians is itself focussed on dominant institutions such as publicly administered and insured health care – and continentalism, particularly the dominance of private market-driven approaches in the United States, including within matters of public policy (such as private administration and management of workers' compensation and

Medicare, and the like). Within Ontario itself, trade had been re-routed increasingly from Europe and the British Isles to the United States over several decades until, by the early 1990s, U.S. markets absorbed more than 60% of all of Ontario's trade (White, 1985). These changes in the broader economy formed a vital context within which other policy changes occurred. In an increasingly continentalized (and globalized) economy, smart players would be alert to the potential opening of new types of market opportunities.

On a related front, the industrial and manufacturing base that had fuelled Ontario's growth in the post-war period gave way to a burgeoning service sector that by the mid-1980s accounted for 70% of the provincial economy (Ehring and Roberts, 1993). Much of the job growth that took place during the decade, including the years of the "mini-boom," occurred in small business and self-employment (Lowe et al., 1999).

Thus, legislative and policy activities that occurred in arenas affecting rehabilitation – including automobile insurance and workers' compensation labour – were occurring in the context of significant upheaval on their own terrains, namely finance and economy, and labour. How rehabilitation benefits might affect business and labour interests in a rapidly changing economy was a key concern in the legislative debates about casualty and workers' compensation insurance that occurred in the late 1980s.

The Ministry Of Health, 1985-1990

Health Sector Legacies for Rehabilitation

The Ministry of Health had at the time – and still has – no line budget for rehabilitation services. Instead, the services were woven into almost every program and numerous activities. This may reflect the somewhat elusive nature or definition of rehabilitation itself, and its utilization in many different health-care areas. It is also, however, a likely reflection of the relatively low status of rehabilitation within the Canadian health-care system, stemming less from a decision at any historical point that it was unimportant than from a long trajectory of policymaking in the creation of the Canadian system. Indeed, as we have seen, in the early stages of the system's development, rehabilitation was considered a key element. But the policy process crystallized into a step-wise approach, and history intervened in ways that meant we never got past the first two steps, hospital and diagnostic services, and physician services (Taylor, 1987). While those first two steps occurred in the context of an expanding post-war

welfare state, what would have been the succeeding steps dissipated in the context of altogether different forces.

But the completion of the early stages of Canada's health care system created more than a backdrop for what did or did not unfold next. The institutions created became an integral force themselves in shaping further developments because, as Weir (1992a, p. 200) points out, institutions affect "the development and flow of ideas by encouraging research and thinking about problems along specific lines." They do so via mechanisms such as their own programmatic features, which concentrate interests via the agencies, councils and committees they generate, all of which shape the development of ideas about policy problems and solutions, from formation to implementation (Weir, 1992b; Pierson, 1994). Capacity at each of these institutional and sub-institutional levels, then, becomes a crucial feature. For it is quite possible for institutions to establish, intentionally or not, mechanisms without teeth, or with just a few dull ones.

Much of what the Ministry of Health did during the period of 1985 to 1990, with respect to rehabilitation policy and institutional legacy, could be characterized as "disease-group" formation, which is by definition fragmentary. In 1987, the ministry established the Acquired Brain Injury Centre for Ontario at Chedoke-McMaster Hospitals, and, together with the Ministry of Community and Social Services, the Provincial Acquired Brain Injury Advisory Committee. In addition, it established the Joint Working Group on Rehabilitation Human Resources, whose findings included that the numbers of trained personnel were inadequate to meet needs at the time. Thus, the policy community that existed around rehabilitation issues, specifically from a health (rather than private insurance) perspective, was a highly fragmented one, with no coherent institutionalized core and few institutional channels through which to work policy.

Population-specific, disease-focussed interest groups can be very powerful, as those for breast cancer or for North Americans with HIV attest. But their power is shaped by the extent to which their public philosophies can be linked to what Weir calls programmatic ideas. In the case of cancer, for example, programmatic ideas, public philosophies, and administrative capacities are all linked and strengthened through the existence of research centres and service technologies that developed under the dominance of "core" principles in the system, i.e., the primacy of medical and hospital interventions. While some aspects of rehabilitation, such as neurological and neuromuscular research, for example, participate in this core, many

rehabilitation services do not, especially those for musculoskeletal and soft-tissue injury, which form the majority of injuries in people utilizing rehabilitation services. Public philosophies about them – for example, the goal of maximum potential recovery of community-based independence and function -- remain uncoupled from strong programmatic (implementation) ideas, which are fractured by the fractured nature of the funding and delivery system for rehabilitation amongst an incoherent group of organizing institutions and decisionmakers. Implementation and administration in the rehabilitation sector are not only incoherent, but large chunks are organized to reflect very different organizing philosophies, particularly goals of rapid return to the labour market, rather than maximizaton of independent function. When the Acquired Brain Damage Committee reported in 1987 on the extent of incidence of traumatic brain injury and the difficulties in receiving post-acute care, the policy implications ramified through multiple programs and ministries that had virtually no discernible institutional linkages amongst them.

The Ministry of Health had no coherent approach to rehabilitation largely because rehabilitation services were perceived to be taken care of already within the hospital system, as a reading of the debates around the auto insurance and workers' compensation bills makes clear. As well, the Ministry took no opportunities to establish institutional links with other ministries formulating rehabilitation-related policy. One recommendation of the Ontario Task Force on Vocational Rehabilitation in 1987, with Labour as the lead ministry, was that, where local community hospitals able to provide vocationally-oriented assessments and interventions did not exist, "Minister of Labour should work closely with the Minister of Health to assist actively in the establishment of" such community-based services (Ontario Task Force on Vocational Rehabilitation, 1987, p. 60). There is no record of any such ministerial collaboration. Instead, a private market developed to fill the gaps, shaping interests very differently, and around different goals and philosophies, than would have been the case had collaboration occurred, bringing health-sector perspectives to labour- and insurance-sector initiatives.

Finally, the Ministry of Health was engaged at the time in promoting a public philosophy of turning away from institutional services and towards community-based (or de-institutionalized) ones. In the 1990 election lead-up, the Liberal health care platform decried the lack of community-based care alternatives in the province (Ministry of Health, Speaker's Bureau, 1990). It offered the 1988 Ministry of Health re-organization into three major programmatic

divisions (Institutional Health, Health Benefits, and Community and Personal Health) as evidence of its change initiatives.

Yet, on closer examination, what is evident is that the changes were cosmetic, with no impact on underlying institutional organization of and capacity for power. At the budgetary level, where an important reflection of capacity is to be seen, Institutional Health consumed 53% of the ministry's budget in 1985-86, 52.3% in 1987-88, and 55.7% in 1989-90 (Treasury and Economics). Mental Health and Community and Public Health, the pre-1988 programmatic divisions that would capture some aspects of community-level rehabilitation activities, received a combined total of 11% of the ministry's total expenditures in 1985-86, and 8.6% in 1987-88. In 1989-90, the new Community and Personal Health program, offered as evidence of programmatic change, received only 8.3%.

Problems and Decisions: Information, Supply and Demand

Rehabilitation did not emerge as a policy problem for the Ministry of Health during this period. Nor did any of the Ministry's decisions set out to affect it directly. Nonetheless, the institutional legacies described above would be meaningful for the rehabilitation sector, particularly as they shaped three parameters that would be important for future policy iterations: information about the sector; and supply and demand within it. Since these are bound up with each other, they will be discussed collectively here.

One of the problems arising from the legacies of incoherent rehabilitation policy within the Ministry of Health is the current stunning dearth of information about the sector. It can only be surmised from directories of hospitals in the province which of them had out-patient rehabilitation departments, or even have them now. The Ontario Hospital Association, which itself recently launched a rehabilitation study section, cannot say. As one chief financial officer of a major, Toronto-area teaching hospital put it, funding of rehabilitation depends on "what the hospitals decide to spend." Typically, hospitals' operating plans do not include specific allocations for rehabilitation.[7] With global budgets constrained by cutbacks and rising costs of technology and professional services, out-patient rehabilitation in hospitals has been reduced (College of Physiotherapists of Ontario, 2000). Nor is it possible to say how much of the ministry's home care program budget, which rose from $104.5 million in 1984-85 to $305.3

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[7] Personal telephone communication.

million in 1989-90 (Treasury and Economics), was spent on rehabilitation activities.[8] Nobody knows how many private clinics offering rehabilitation services existed in the province between 1985 and 1990, or knows what those services were, much less how much they cost, to whom they were delivered, and who paid for them. Fifteen years and many rehabilitation policies later, coherent and reliable databases still do not exist. The information is in scattered bits and pieces and would require several major primary data collection efforts to assemble.

Evaluation of the available data[9] strongly suggests, however, that supply of rehabilitation services in Ontario during the years 1985 to 1990 was largely publicly funded, provided either in acute general settings or by professionals able to bill OHIP. The figures also suggest, however, that demand was growing, and may have been straining public availability; in 1989, the Ministry of Health reported that there was a shortage of all rehabilitation professionals at both a provincial and national level (Ministry of Health, 1989). In spite of a growing trend for physiotherapists to be employed in the private sector, some 75% of all physiotherapists were employed in general hospitals in the late 1980s, and 18% in the private sector. (These do not add to 100% since some therapists worked elsewhere in the public sector, such as home care, mental-health hospitals, schools, and the like.) By 1997, private practice "employment locations" for physiotherapists would constitute 40% of the total, while public-sector ones would constitute 29% (Alliance of Physiotherapy Regulatory Boards, 1990-1997).

As well as quasi-medical rehabilitation services, such as physiotherapy, occupational therapy, speech pathology, and chiropractic, available through various Ministry of Health programs, vocational rehabilitation services could be found elsewhere in the public sector and in not-for-profit agencies. Between 1984-85 and 1989-90, Community and Social Service's (ComSoc) spending on workshops, training and rehabilitative services for the disabled rose from $30.9 million to $39.1 million. Speaking at a Canadian Bar Association seminar in 1986, lawyer Charles Scott Ritchie told his colleagues they could find "a wide range of programs for people with physical, mental and emotional handicaps...as long as (the goal is to) assist with a return to employment," through ComSoc's Vocational Rehabilitation Services (VRS), with "no maximum amount for which the claimant is eligible" (Ritchie, 1986).

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[8] Personal telephone communication with the research coordinator, Home Care Evaluation and Research Centre, University of Toronto, January 2000.

[9] See Treasury and Economics (*Public Accounts*) in combination with supply and demand data in: Ministry of Health and Program Information Division (1987); Tasca et al. (1994); and the Ministry of Health's *Ontario Hospital Statistics* (which are available only until 1991, when funding constraints ended their publication).

It was not an easy system to navigate, and it is doubtless that many of those with acquired traumatic injuries who hoped to return to productive working lives fell through its cracks. But there seem to have been several public layers set up to try to catch them, or at least to break the fall. There is nothing in the documentary history to suggest that anyone thought supply in the usual ways would not keep up with demand, so long as additional training occurred. But demand increased steadily through the late 1980s. At that time, it was being driven largely by increases in incidence of accidental injury, and advances in medical technology that made it more likely the injured would survive their acute traumas – after which many would require rehabilitation (Tasca et al., 1994). Supply remained largely public, however.

The balance of supply of rehabilitaton services through the Ministry of Health, against demands for them, was already precarious. Anything that substantially increased demand would tip that balance over. And that is precisely what the Ministry of Financial Institutions' Bill 68 would do.

The Ministry Of Financial Institutions And Automobile Legislation

Finance/Auto Legacies for Rehabiltiation

Chapter two described the ways in which casualty insurance came to have a greater actual and potential role in the rehabilitation sector. All the same, by the mid-1980s its active role remained relatively constrained by two factors: firstly, a broader policy history had relegated rehabilitation services primarily to activities within the jurisdiction of the Ministry of Health, where they largely had been delegated further down the line to hospital decisionmakers; and, secondly, the automobile insurance legislation and regulations themselves mandated very limited industry exposure for rehabilitation services.

In spite of these constraints, however, history had laid the foundation for one crucial legacy: the combination of casualty with property insurance for drivers. When such insurance became compulsory, it became a public policy issue. And it meant that at least some capacity for decisionmaking about health was placed outside the health-care arena. Even though the realities of the day circumscribed the extent to which anyone was interested in exercising this capacity, the policy made it latent. Related to this was the normative implication of private casualty insurance: that automobile insurers *should* assume the costs of the injury risk costs they barter in became a legacy of the the fact that they *did* assume them.

The creation of an industry – especially one with a growing and lucrative market – entrenched interests in, at the very least, its economic preservation. At the same time, its activities acquired a quality of moral correctness and imperative.

Policy Problems

The Ministry of Financial Institutions was new on the policymaking scene, having just been created out of the Ministry of Consumer and Commercial Relations' Division of Financial Institutions, when minister Murray Elston introduced its first major act, Bill 68, *An Act to amend certain Acts respecting Insurance*, on 23 October 1989. Popularly known as the OMPP, the Ontario Motorists' Protection Plan, it was the Liberal government's response to a general insurance liability crisis that had "struck Ontario hard" in mid-decade (O'Donnell, 1991, p. 3).[10] Between 1982 and 1987, automobile insurance premiums had increased in Ontario by some 65%. A freeze at about 5% was in place at the time of the 1987 election campaign but was soon due to expire, and insurers were saying that, when it did, rates would have to rise by 30 to 35 per cent again. Automobile insurance was a major issue in the campaign, particularly between the major combatants, the NDP and the Liberals. The NDP was promising to introduce public automobile insurance to create efficiencies. Out on the campaign trail three days before the September election, Liberal leader David Peterson announced that he had "a very specific plan" to deal with the crisis (Ehring and Roberts, 1993, p. 260). Peterson was comfortably ahead in the polls and the comment likely made little difference to the election outcome. But it did make his government accountable for producing the touted plan.

In fact, it had no such thing at the time, as soon became luminously clear (Hansard, Standing Com. on Gen.Govt., Feb. 8, 1990). But the young Ministry of Financial Institutions did have at its disposal the results of several studies it had commissioned. Almost immediately on the ministry's creation by Order in Council in April 1986, Minister Elston established the Task Force on Insurance, led by economist David Slater. Its policy concerns were mandated as economic, in the interest of "market stability (for all insurance products, not just auto), policy holder protection and a climate of economic opportunity for insurance companies" (McNaught, 1993, p. 6), a mandate that itself institutionally shaped possible solutions. Reporting the same year, the task force recommended adoption of pure no-fault automobile insurance (i.e., there

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[10] The orthodox explanation for the liability crisis was rising tort costs. See Glasbeek (1991-1992), however, for a radically different explanation of the crisis.

would be no recourse whatsoever to court suits, i.e., tort). The scale of Ontario's already-established private insurance system – some 40,000 employees in a "market … with more than 100 companies generating in excess of $3 billion a year in direct premium income" (Hansard, St. Com. on Gen. Govt., Feb. 3, 1990, p. g-8) – also led him to recommend that it remain in private hands.

As a second-choice alternative, the task force proposed a threshold no-fault scheme, such as that which existed in several U.S. jurisdictions, notably Michigan. Here, tort would be accessible only to those who crossed over a "threshold" of extremely serious injury, as-yet undefined. It was noted that the problem with such a system, which basically extended the no-fault principles already in place, was that benefits erode over time. Identifying this as the reason that the extant legislation had not been effective over the long term, Slater predicted that raising the levels would create some short-term relief but this also would erode over time.

The Slater report's recommendations bore similarities to the eventual Bill 68 (O'Donnell, 1991; McNaught, 1995), suggesting that the ministry leaned towards it. (And, in spite of its youth, the ministry had power: Minister Elston was also vice-chair of the Management Board Secretariat, co-chair of the Policies and Priorities Board, Minister of Treasury and Economics, and Deputy Premier.) But the Slater task force was open to criticism because automobile insurance had not been its primary focus. So the year after the report was released, the Ministry established the Inquiry into Motor Vehicle Accident Compensation in Ontario, chaired by the Honourable Mr. Justice Coulter A. Osborne. With a mandate to consider automobile insurance specifically, and with a justice perspective predominating over an economic one, Justice Osborne's 1988 report came to an altogether different conclusion than had Slater's: full tort access should be retained *and* no-fault benefits greatly increased, in order to reduce incentives to sue while maintaining the legal right (Osborne, 1988).

At the same time that the Osborne Inquiry was reporting, in 1988, the Automobile Insurance Board, established by the Ministry to consider the crisis but also as an ongoing institution, was conducting its own hearings. Its focus was rating practices, and its chief recommendation was to remove low-risk group advantages, such as those for women and seniors. Realizing that this would be a political albatross, the ministry asked the board to consider three alternative schemes, one of which was threshold no-fault. Like the Osborne Inquiry, the AIB rejected the option. The board was soon dissolved (Hansard, Legislative Debates, Dec. 4, 1989).

Policy Decisions

BILL 68, THE ONTARIO MOTORIST PROTECTION PLAN

So now the ministry had input from three perspectives around strongest, most resourced members of its policy community, insurers, brokers and lawyers, were organized: general industry principles and viability; automobile insurance justice; and industry rating practice effects. What it settled on, in Bill 68, was a threshold no-fault system of the sort suggested by Dr. Slater. Much reduced access to tort (barred by a threshold defining serious injury) was to be balanced by increased access to no-fault benefits, particularly rehabilitation benefits in the company of income benefits during time lost from work.

The fairness and economic impact of substantial reductions in tort access was the most hotly contested issue during the eight months the bill was heard and debated before the Standing Committee on General Government. The one thing that got lost in the debate, however, was the impact the bill would have on health-care services, particularly rehabilitation, the availability of which was the most fundamental, untested, and implicit assumption throughout the hearings. How the problem had been framed (as tort costs) and the solution sought (through the institutional framework of the Ministry of Financial Institutions and the community it shaped), made its health considerations appear secondary in the eyes of the players, even when they were offering health care as the *quid pro quo*.

It was an idea largely shaped by the balance of powers amongst the interests involved, itself reflected in the institutional framework. As Rick Ferraro, the minister's parliamentary assistant, himself said, the ministry knew very little about automobile insurance when it was thrust into planning and developing major policy about it (Hansard, St. Com. Gen. Govt., Feb. 6, 1990). While the ministry certainly had the power, especially within the context of the government's large majority, to push through its legislation, it lacked the history or capacity to have developed the legislation with substantial autonomy. Indeed, though the substance of Bill 68 was congruent with the Slater task force's findings, it had even older and highly congruent antecedents in industry proposals. When the industry's trade body, the Insurance Bureau of Canada (IBC), had appeared before the Automobile Insurance Board's hearings in 1988, it had represented a threshold no-fault system as its third choice, after pure no-fault and a "Choice" model. (Under the last, drivers could purchase either unlimited tort access or high first-party no-fault statutory benefits.) Yet only shortly before, the IBC had submitted a fully formulated plan to Justice Osborne's commission, advocating a threshold no-fault system that it called

"Smart No-Fault," which was itself like the industry's 1973 "Variplan" proposal for a threshold no-fault system. What became Bill 68 was "very similar indeed" to both these plans (O'Donnell, 1991, p. 6). It increased insurers' responsibility to finance rehabilitation, and greatly increased their incentives to do so (because of higher benefit levels, which applied until the claimant's file could be closed), but it also greatly decreased their tort exposures, which had been their initial goal.[11]

The cost of legal fees to the casualty insurance industry in 1988 was estimated at roughly $500 million (Hans., St. Com. Gen. Govt., Jan. 15, 1990), which helps to explain why the legal community had, along with the insurance industry, a highly concentrated interest. Bill 68 promised $85 million more annually in rehabilitation benefits, as estimated by insurers (*ibid,* Jan. 16, 1990). It is unclear how this figure was deduced, but it is clear that the insurance industry representatives believed that being directly responsible for rehabilitation and related benefits, and thus having some control over their allocation, would be less costly than letting the courts decide allocation. Thus, to increase insurers' private financing responsibilities also created incentives and possibilities for them to control or manage allocation in the rehabilitation sector, a factor that itself became a legacy for future policy iterations.

"While we prefer total no-fault," said a panel of senior executives from the Dominion of Canada General Insurance Co.,

> We do accept Bill 68 as a reasonable compromise as in our opinion it will do many things. It will constrain present but also future costs; (it) will be more cost-effective; ... (and) there will be more fairness ....
> ....we believe society will be better served by offering all accident victims immediate access to extensive no-fault benefits. However, those...have significant costs attached and we believe the appropriate quid pro quo for these enhanced benefits is the abolition of the right to tort actions. This will produce a reasonable tradeoff between costs and rapidly available benefits. (*ibid,* Jan. 25, 1990, p. g-624)

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[11] The relationship between tort access limitations (the "threshold") and no-fault benefits is at the heart of bill 68 and all the other changes to automobile insurance that occurred during the period of study. As well, access to no-fault benefits for income loss, which then become linked to access to rehabilitation services, are based on a "test of disability." Appendix B charts the changes that occurred in these perameters under the different automobile casualty insurance bills discussed in this study, and makes it possible to compare them.

Far from seeking simply to shift costs from tort to rehabilitation, insurers and the ministry were assuming that rehabilitation expenditures would remain roughly unchanged after implementation. Out of 39 cabinet documents compiled during the drafting period, 24 were produced by a single actuary from one firm, Eckler Partners. Speaking before the Standing Committee, Colleen Parrish, Director of the Ministry of Financial Institutions' Policy and Planning Branch, said,

> The assumptions made about medical long-term care [sic] and rehabilitation by Eckler Partners [actuaries] were that the frequency or the number of claims for these kinds of benefits will not continue to trend upwards. Essentially, the introduction of a primarily no-fault system with enriched benefits will not make much of a difference to the behaviour of claimants.... (the actuary reporting) found, in his view, that utilization would not significantly change.

Two other cabinet documents, analysed by two other consulting firms, used different assumptions and came to different conclusions, in both cases, that rehabilitation claims and demand would increase. But, Parrish continued,

> To some degree it is a question of judgement as to what evidence is most likely to be like Ontario in a new system of insurance. (*ibid,* Feb. 8, 1990, p. g-910)

The continued existence of a publicly funded health care system that included rehabilitation, adequate to meet the increased demands under Bill 68, was the fundamental assumption behind the assumption that medical and rehabilitation benefits would not increase appreciably. The occasional participant pointed out that not all rehabilitation services were publicly available and others pointed out that the new bill would strain existing public resources. Under it, insurers had to either return a claimant to work or demonstrate that return to some sort of suitable work was possible within three years, otherwise they might be exposed to payment of a lifetime income benefit for permanent disability. Rehabilitation became a vital means by which to either effect actual return to work, or at least to create a document trail that all efforts had been made and the client could return to some form of suitable work but was non-compliant.

The close linkage of return-to-work with medical and rehabilitation provision that occurred under Bill 68, with the onus being on providers to supply the documentation for benefit decisions, signalled the extent to which the institutional framework of policymaking reshaped

ideas about rehabilitation. The goal of maximal independent function that had long been the credo of rehabilitation providers, was replaced by the goal of labour-market function to a minimum acceptable level as decreed by the legislation. It also had implications for traditional caregiver-patient relationships, which were reshaped by financial-sector legislation. Dr. Andrew Pipe, of the Medical-Legal Society of Ottawa-Carleton, said it would create incentives to "doctor shop," conduct extensive testing and referral, and the like (*ibid,* Feb. 7, 1990). Orthopaedic surgeon Dr. Hamilton Hall, founding president of the Canadian Back Institute, a growing chain of private physiotherapy-focussed clinics (that would eventually be sold to a large US managed health company), stood to profit from increased insurer incentives to provide rehabilitation. Yet speaking before the Standing Committee, he said that the terms of the legislation would encourage providers to provide whatever the legislation made payable, and added candidly, "I am not sure that in terms of actual rehabilitation benefit for dollar, you are going to gain. You will spend more (but) I am not sure you are going to get a great deal more for your money" (*ibid,* Feb. 8, 1990, p. g-16). It is a revealing statement of the anticipated impact of Bill 68 on demand in the rehabilitation sector.

Health care providers who spoke at the committee hearings divided into two broad camps, with respect to their views on public and private impacts. There were those who focussed on the degree to which the bill would create demand that the public sector could not meet. And there were those who focussed on the extent to which the pressure created by increased demand would have to be funneled into a private market, where quality of care would be difficult to monitor. Nobody considered the issue of potential impact of a growing private market on publicly available rehabilitation, when the fragmented structure of funding and services that had been established by institutional history and organization met new demands. It would not be until the late 1990s that there was an attempt to establish fledgling institutions to address the disarray and the quality concerns that attached to a mushrooming private sector in rehabilitation.

At the same time that Bill 68 created the conditions for driving up rehabilitation demand, which its proponents expected would be met by public health insurance – the casualty insurer was second payer to any other insurance available – it also withdrew resources from the public system. The Bill removed OHIP's bulk subrogation agreement with the insurance industry, an agreement

> which provides that the insurance companies (collectively) will compensate O.H.I.P. according to an established formula rather than

> O.H.I.P. asserting its subrogated claim as a result of each motor vehicle accident in which insured services are rendered. (Ritchie, 1986, p. 7)

There is no way of telling to what extent the formula captured real costs to OHIP. At the hearings, the Ontario Safety League's president stated that,

> there are about 6,000 people on any given day in hospital receiving treatment as a result of vehicle accidents. That is thirty 200-bed hospitals' worth. (Hans., St. Com. Gen. Govt., Jan. 15, 1990, p. g-230).

In his report, Justice Osborne had written that the formula on which the bulk agreement was based was a considerable under-representation of actual OHIP costs, particularly as technology and injury incidence and outcomes changed. Nonetheless, at the time, the subrogation agreement's value to OHIP was approximately $48 million (Hans., Leg. Debates, Nov. 15, 1989).

In addition, Bill 68 shifted costs onto the labour sector. For the nearly three million Ontario employees who had long- or short-term disability benefits, it required their union-negotiated extended benefits (including sick-leave income) to be first payers before the automobile insurer. Perhaps more significantly, Bill 68 made the provision that a worker injured in an automobile accident would no longer be able to choose either workers' compensation no-fault benefits or pursue tort; he or she would have recourse only to the former. It was estimated that this would result in costs of anywhere between $25 and $60 annually to the Board, employers, and employees. As first payer, WCB had no subrogated rights to recover costs.

And finally, Bill 68 removed the provincial government's 3% tax on automobile insurance premiums, which generated approximately $95 million in general revenues at the time (*ibid),* a provision that would have greater implications under conditions of economic recession than it did for the government of the late 1980s boom years.

Thus, funds were diverted from the collective, public pools of insured health care and taxation, and redirected to individual drivers and insurers, chiefly on the assumption that alternative systems, including public ones, would continue to provide the services anyway. As an alternative, representatives from the Chedoke-McMaster Hospitals' Rehabilitation and Chronic Care Programs suggested that OHIP subrogation be increased, rather than eliminated, specifically to support the rehabilitation services necessary for the MVA-injured, particularly as mandated under the new legislation. This would achieve a pooling of resources for rehabilitation services. In addition, it would have required subrogated costs to be directed to

rehabilitation, rather than simply subsumed in hospitals' global budgets. But health care implications had been largely unconsidered (even deliberately minimized) in the bill's development, even as health care provisions were being used to support its primary aim of reducing tort exposure.

The Ministry of Labour and Workers' Compensation

Labour/Compensation Legacies for Rehabilitation

As with casualty insurance, one of the chief (even paradigmatic) legacies of workers' compensation history was that it had placed the onus of responsibility for workplace injury on private payers, and had segregated a class of health problems on the basis of how they were acquired. But the obligations to rehabilitate continued to be relatively minor under the legislation, only beginning to expand in the 1970s. Bill 101, enacted in 1985 by the outgoing Conservative administration, particularly had increased rehabilitation provisions under the Act, simultaneously increasing both the Board's need to find ways of meeting them and its ability to do so through private practitioners.

Both the incentives and capacities that these legacies created would feed into the next round of policy decisions.

Policy Problems

At the Ministry of Labour and its policy community, as at the Ministry of Financial Institutions and its, decisionmakers were reconsidering the role of rehabilitation. Just as tort was seen to be the problem by casualty insurers, permanent partial disability awards were the problem in the eyes of the employers, and the Board, which was not established as a collective insurer (in the sense of pooling risk) but as a regulatory agency that both made, managed and administered policy for collecting compensation payments from employers and distributing them to injured workers. Compensation in the form of permanent partial disability awards, which would continue to apply even if the individual returned to work, had been the dominant distributive mechanism since the late 1960s. By the late 1970s, however, employers were becoming disenchanted with it, feeling that it was unfair for them to continue paying for an injury even after return to work had been achieved.

They began to consider a return to the pre-1960s system of variable benefits (rather than fixed benefits, based on a set value assigned to the injured body part). Also known as a "wage

loss" system, variable benefits are tied less to the injury than to the amount of wages the worker is losing while away from or limited in work. The way to keep them low was to use rehabilitation either to minimize wage loss or to demonstrate that it was unnecessarily incurred. When employment levels are high, losses are low, because there is a greater prospect of an injured worker re-entering the labour market. So managing return to work through rehabilitation and labour-market conditions become two important variables. Not surprisingly, the appeal of a wage-loss system was lesser in the early 1980s, during the recession, than during the mini-boom in the second half of the decade.

A wage-loss system also redefines the role of rehabilitation. Rather than being chiefly a means of improving health and function, it becomes a tool for labour-market re-entry. Benefits shifted from being a form of achieving compensatory justice (however flawed) and became stop-gap income during recovery efforts spearheaded by rehabilitation, i.e., compensation became more narrowly defined and re-coupled with the labour market, from which it had been de-coupled while a justice issue.

The question of how best to achieve management of costs through rehabilitation is central to a wage-loss system. Prior to Bill 162, which was enacted in 1990, the legislation in force was Bill 101. Though wage-loss had been debated in the lead-up, it was not included in that bill, most likely because of the labour market conditions that prevailed. Bill 101 had, however, established strong rehabilitation provisions. In combination with the weak labour market and the fixed-cost system, compensation costs and the Board's unfunded liability had risen dramatically.[12]

But other conditions in Bill 101 had changed the organization of interests in the community. The bill had created a Board of Directors (BoD) within the Board (WCB) that assumed responsibility for overall policy direction of the Board. It comprised employers, workers, and bureaucrats, but employer representatives outnumbered those from labour (Maton 1991). And Bill 101 also created the Workers' Compensation Appeals Tribunal (WCAT), an external, independent final-level appeals tribunal, with equal representation of employers nad workers. Between 1985 and 1987, WCAT had made several major decisions seen to favour workers. (By 1989, when Bill 162 hearings began, there was a two-year long line of claimants waiting to be heard by the tribunal [Hans., St. Com. Res. Dev., July 11, 1989].)

Decisions

ORGANIZATIONAL CHANGE: POWER SHIFTS

The BoD (headed up by Drs. Robert Elgie and Alan Wolfson, who were also the chief executives of the WCB) began to use its discretionary powers to re-interpret a key section of the legislation so as to limit compensation exposures by stopping benefits as soon as the worker was demonstrated, through rehabilitation, to be capable of some type of work, whether return to real work had been effected or not. This reinterpretation of legislation also signalled the growing discretionary power of the BoD and its members. The 1987 report of the Ontario Task Force on Vocational Rehabilitation (known as the Minna-Majesky report, after its co-authors, one a Liberal and the other an NDP MPP – a legacy of the Accord period), had recommended that the BoD be expanded by one injured worker and one vocational rehabilitation practitioner, thereby potentially expanding the scope of conflict – instead, the BoD was restructured so as to contract the scope.

In addition, the BoD responded by establishing a WCAT Review Advisory Committee, with the power to override WCAT decisions. Thus, the institutions created under Bill 101, became changed in their permeability to stakeholder interests, with relatively weaker institutional representation of workers. In addition, employers were better organized and had stronger institutionalized links than workers did at the time, the latter's chief organization having been rooted in unions, which were on the decline, and through parties such as the NDP, which had been much weakened in the 1987 election.

POLICY CHANGE: THE NEW REHABILITATION STRATEGY AND BILL 162

At the same time, in 1986, the Board also began the exercise of developing a new, formal Rehabilitation Strategy, which decentralized rehabilitation administration to regional offices (goal-setting remained centralized). It initiated twelve community-based pilot projects, called Community Clincs, for early rehabilitation on a fee-for-service basis, after a survey of stakeholders that found "a great deal of interest in participating in the new service delivery system on the part of hospitals and physiotherapy services, as well as some private clinics" (WCB and Med. Rehab. Strategy Feasibility Group, 1988, p. 3). The Ministry of Health's Deputy Minister and Assistant Deputy Minister of Institutional Health gave their blessings to

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[12] See Ontario, Workers' Compensation Board, *Annual Reports*, for the years 1984 through 1990. Also: Maton (1991).

the plan. There was general concern amongst stakeholders that there were not enough paramedical professionals, especially physiotherapists, although many physios and OTs expressed interest in adding part-time work to their schedules, and licensed professionals could be assisted by unlicensed workers. This gave rise to some concern about the potential for problems in monitoring quality and consistency of services, and there was confusion about "the fact that the WCB will not be directly operating any of the facilities providing medical rehabilitation services to injured workers....and (about) a failure to differentiate between the medical and vocational rehabilitation strategies" (*ibid,* p. 3). But the plan was put in place.

Under the new Strategy, administration of Community Clinics (CCs), administration of rehabilitation efforts (and much of the data retention about rehabilitation practices), would be independent of the WCB and not publicly accountable. Notwithstanding the inclusion of some community-based hospitals in the system, many of the CCs were private, for-profit enterprises, in keeping with a Board policy, developed in late 1987-early 1988, to contract with private agencies for rehabilitation, counselling and placement services as an "attempt to disarticulate its assessment and rehabilitation functions by privatizing the delivery of services" (Maton, 1991, p. 227). The Board retained some capacity to intervene actively in the rehabilitation of individual claims, through on-staff vocational rehabilitation counsellors who managed recalcitrant cases. But the provision of services moved from the old model of the Board's own Downsview Rehabilitation Centre, to largely private community-based clinics.

As well as the Rehabilitation Strategy in 1987, the following year the Board introduced rules that employers would 50-50 cost share in all on-the-job training placements, and vocational rehabilitaton costs would be included in an employer's accident cost statement. This increased competition to keep costs down by whatever means possible. So too did the expansion of experience rating, under which individual firms in an employment-sector category are assessed to receive either rebates or penalties on the basis of their performance relative to other employers in the category. Thus, rather than encouraging industry-wide strategies for injury reduction and rehabilitation, it encouraged privatization of strategies to the enterprise level, further narrowing scope of conflict.

The organization of BoD power, which privileged employers, had made it more possible to implement the return to a wage loss system, which worker groups opposed but employers supported. Such a system, however, requires constant monitoring of the temporarily disabled claimant "in order to know when they became fit to work, what kind of work they were capable

of performing, whether they were honestly attempting to find employment, and whether they in fact had found work" (*ibid,* p. 102). For the most part, however, the WCB did not have the capacity to perform these tasks internally. Nor was there really a profession that existed to perform the tasks for the Board. Physicians opposed their new role under the proposed bill as certifiers of disability, even though the OMA subsequently would produce a position paper on the topic in an effort to prepare its members for conditions under both Bill 162 and Bill 68, the new auto legislation (OMA, 1994). The reintroduction of a wage-loss system was strengthened by its development hand-in-hand with the Community Clinic (and associated Regional Evaluation Centres program), in congruence with the idea that rehabilitation would have return to work as its pre-eminent goal (in a descending hierarchy from time-of-loss job to anything else). By the middle of the 1990s, the growing market of RTW assessment and other services for implementing rehabilitation-related regulations, was able to better supplement the wage-loss system.

These policy changes, unilaterally devised and implemented by the Board, particularly by the Board of Directors, were already in place when Bill 162 was formulated and came to debate. Indeed, they structured the options so that the bill became primarily a means of legislating what was already underway. The consultation process during drafting of the bill gave evidence to the weakness of some members of the policy community that existed. The Minister's office published a list of labour organizations it said it had consulted. More than 50% of those on the list, however, said they had never been consulted, or said that the minister had simply mentioned the upcoming bill in conversation, or that he had talked to them about its implementation – but never that he had asked for consultative input (Hans., St. Com. Res. Dev., July 11 and 14 Nov., 1989).

Contrary to the Minna-Majesky Task Force's recommendation that rehabilitation be defined as "the process of restoration, to (the worker's) fullest physical, mental, social, vocational and economic independence to the maximum possible extent" (*ibid,* Oct. 20, 1988, p. 5092) – a recommendation that decoupled the individual worker from the specific requirements of the time-of-injury job – the BoD's earlier reinterpretation of the previous act, then legislated in Bill 162, made the aim of rehabilitation, not optimal labour-market re-entry, including possible training, but demonstration of capacity to perform any work for which the worker was reasonably suited already.

Finally, Bill 162 formally subordinated the WCAT to the Board of Directors. And, in the year of its enactment, 1990 (after a year and a half of debates – at the end of which, the majority government was able to push through closure before clause-by-clause reading of the rehabilitation section even began), the BoD made full expansion of experience rating, which had previously been voluntary, mandatory.

Summary of the Liberal Period: Momentum Gathers

Here was a policy issue, "the question of rehabilitation," that had no discrete policy framework for itself yet had been hotly "debated in this province for at least four years," since 1985 (Hans., St. Com. Res. Dev., June 15, 1989, p. r-21). Rather, what is striking in the documentary history is the institutionalized fragmentation of the sector's policy decisionmaking framework. There is literature that considers the implications of fragmentation within policy communities, under the framework of single policymaking institutions, on public-private boundaries and on policymaking in general (Coleman and Skogstad, 1990; Coleman et al., 1999; Baranek, 2000). And there is some literature that tackles arenas with overlapping jurisdictions, but does not examine the impact of this organization closely (Doern and MacDonald, 1999). But there is little of which I am aware that considers the implications of the fragmentation of the institutional organization itself, i.e., the institutionalized inter-ministerial arrangements in a single policy arena.

Fragmentation of the "rehabilitation system," to speak very loosely (as it clearly was not a coherent system), is a fundamental component of how policy unfolded in 1985-1990, and of the trajectory that the sector's governing policy formed over time. This is because it meant that the different parts could have unanticipated impacts on each other – for example, by increasing the opportunities to make faulty assumptions about each other, such as the universality and comprehensiveness of the publicly funded health care system, or by recasting the environment in which each of the other institutions operates. Many of the consequences along the way would be unanticipated and unintended, but would establish policy legacies and inputs for future decisionmakers. Much later in the policy story, the demand-driven privatization that created a private marketplace under Bill 68 was a factor in decisions made eight years later under Bill 99, the Workers' Safety and Insurance Act. And the development of different rehabilitation approaches, and fees, under different institutional payers and structures reorganized professional interests.

The situation reinforces the structural aspects of policymaking in public-private change in welfare provisions. The rehabilitation sector had accumulated a set of institutions – chiefly, the three main ministries involved in policymaking, but also their sub-institutions in the state – that had been structured by very different ideas and interests about rightful public and private responsibilities for provision, rights to control of allocations, and appropriate administration. They each pulled rehabilitation in different directions across the public-private boundary along the axes of change defined by Stoddart and Labelle in 1985: privatization of ownership, of financing, of regulation, of management, and of administration. In addition, interwoven with each of these, is an aspect of private-public change that Stoddart and Labelle (1985, p. 2) recognized as critical, but did not expand much upon at the time:

> The nature of *control* of resource allocation decisions...is much more complex and is at the heart of the privatization debate. Although ownership in a market system accords the owners of enterprises control over production processes, all health care systems are mixtures of 'command' and 'market' mechanisms, thereby fragmenting control and rendering issues of who controls which activities of paramount importance.
>
> Control may be exercised in mixed private/public systems through the activities of management (both for-profit and not-for-profit), financing (both raising revenue and remunerating providers), regulation, and (to a lesser extent) administration, in addition to that of ownership. When individuals, associations or bureaucrats speak of privatization in Canadian health care, they are referring to a not always well-defined notion of an increased role for the private sector in one or more of these activities. [italics in original]

Administration may be the least obviously significant of these, but is important nonetheless because it may signal changes in infrastructure to other players in the system, thus constituting "symbolic signalling" of new ideologies, constraints and possibilities within it.

The political and policymaking framework for rehabilitation during 1985-1990 was a set of institutions that had fragmented the potential, if not the full financial, responsibility for rehabilitation policy over the course of their development. During the Liberal period nothing changed about that overarching institutional framework. Indeed, it became more deeply

entrenched as expenditure obligations and resource controls shifted within it. It is, perhaps, unlikely that anything could have changed given:

- the entrenchment over time of major social structures, such as the insurance industry, and of institutions, including the ministries and agencies involved; and
- the sense of crisis that drove the amendments that occurred in both Bills 68 and 162.

Implementation of the sort of integration that would have been required by the ideas about rehabilitation (inchoate as they were in general, although those about income benefits were much more developed) in the SARC's *Transitions* report would have required massive institutional reshuffling. This was an undertaking highly unlikely in the midst of a crisis for the solution of which an institutional framework already appeared to exist. And it was unlikely in the context of a majority Liberal government that was trying to keep the confidence of the large business community after jeopardizing it during the Accord period.[13] The overarching institutional framework, with rehabilitation-related policymaking occurring in three almost entirely unlinked ministries, constrained what was conceivable as well as what was doable.

The historical roots of the fragmented framework were very likely embedded in much higher-level institutional developments that maintained individuals' ties to the labour market (Stone, 1984). Employers and then insurers were given the responsibility to compensate when those ties were broken by accidental injury. Those responsibilities (and the political conflicts and nuances attending them) grew incrementally to include not just compensation but return-to-work initiatives and, eventually, prevention. For the most part, however, these had developed in the context of an expanding public health-care system. As long as the requirements under the Acts did not exceed what the public system offered, then rehabilitation financing was not a major part of employers' and insurers' concerns. But any major change in either legislated requirements (and therefore demand) or public availability (supply) would tip the balance. And, when rehabilitation responsibilities shifted increasingly to private payers (insurers and employers) it required a redefinition of rehabilitation from the terms of the health care system to terms compatible with return to work goals.

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[13] The 1985 election reduced the Progressive Conservative representation in the legislature dramatically (White, 1998). Such a large Liberal majority must have represented a formerly PC vote that the Liberals would have been concerned to keep.

Changes Along the Public-Private Axes

How did the policies and Acts discussed affect public-private changes on the axes defined by Stoddard and Labelle? The following five sub-sections consider the axes that Stoddart and Labelle laid out, and the sixth considers the addition of an axis called "political privatization."

PRIVATIZATION OF FINANCING

This axis may include privatization by attrition combined with demand-driven privatization. Bill 68 had the capacity to constitute the early stages of demand-driven privatization. In addition, it shifted resources into private insurance industry hands, from public systems (OHIP, taxation). And it greatly increased responsibilities for financing of rehabilitation services by automobile insurers; indeed, this was the bill's cornerstone (even if it was not believed at the time that it would cost much). Such a programmatic change meant both that demand could (and very likely would) rise; the point of the bill, at least in principle, was precisely to increase demand for rehabilitation. Changing financing conditions mean that incentives for distributing those resources change, from meeting something defined as public goals, to meeting profit-making goals. As the state's role diminishes,

> Cross-subsidization of benefits and the preservation of professional discretion are increasingly squeezed out of privately financed systems, but these elements are key to the maintenance of systems of public finance. Public and private finance, then, involve fundamentally different sets of incentives, and turning to one versus the other shifts not only the means but the ends of the welfare state in the health care arena. (Tuohy, 1999, p. 262)

The willing assumption of increased financing responsibilities, of the sort automobile insurers made with Bill 68, also meant that private insurers would have the potential for exercising greater control over allocations, certainly greater than if allocations were made by courts. It was a precondition for any future forms of care management.

Within the context of mixed public-private systems, what matters, as Stoddart and Labelle (1985) have said, are the subtle shifts in responsibilities and controls. A bill may increase financing obligations in the private sector (thus leading to financial privatization) but at the same time decrease the sector's discretionary power over disbursement of the finances. Or, such power may be increased in the course of legislative battles and the battles to interpret legislation (as occurred in the lead-up to Bill 162). Time would tell whether and how the payers

under Bills 68 and 162 would win or exercise those controls, and it will be an important question to ask in the succeeding chapters. If it is true that privatization may begin with privatization of financing and proceed to forms of privatizing control, then what we should see is an initial, and probably sharp, escalation in costs followed by subsequent declines, particularly steep with any future legislative changes that increase prospects for control.

In spite of the claims that Bill 162 was intended to rectify fairness issues by providing greater opportunity for injured workers to return to work, there was a sharp decline in WCB claims and vocational rehabilitation costs and referrals after its introduction.

Privatization of Management

Bill 162 and Bill 68 shifted management decisions from broader courts of appeal (such as the Workers' Compensation Appeal Tribunal or the civil courts) to more central decisionmakers who, though agents of the state, were substantially permeable to the most powerful of organized social interests, in these cases employers and casualty insurers.

The rehabilitation strategy interwoven with Bill 162 introduced contracting out, with the board establishing features of the contracts (i.e., for the Community Clinics program and the Regional Evaluation Centres). While it would be possible to find out how much the Board spent on rehabilitation in the future, it would no longer be possible to know how much services cost to deliver, for that would be proprietary information.

> Politicians are regularly criticized if the number of public employees has increased while they have been in office. They are virtually never criticized if the number of employees working for agencies under contract...has increased dramatically.... Contracting, up to a point, thus hides the growth of government from public scrutiny. (Smith and Lipsky, 1992, p. 249)

Whether contracting represents state growth is a debatable matter. Less debatable is that it hides details of expenditure, removing government-funded activity from public accountability, and, in the case of for-profit agencies, privatizes efficiencies for the benefit of shareholders rather than plowing them back into the activities (or redistributing them otherwise).

Bill 68, in increasing financing responsibilities for rehabilitation, shifted information more deeply into the proprietary sector. If it did coincide with demand-driven, or other forms of privatization, then it would be increasingly difficult for future efforts to investigate effects, or make new decisions about policy.

Privatization of Administration

Increasing privatization of financing is very likely highly correlated with increased private administration, as those who have funding responsibility have increased incentives to assume control of them. The administrative reorganization of the WCB is indicative of this – employers gained a greater hand (though nothing compared to what would be the case under the next iteration of the Act) in the establishment of the executive Board of Directors as a final arbiter of decisions in allocating benefits, and the BoD was more highly permeable to employers than the Workers Compensation Appeals Tribunal had been.

The growth of experience rating that accompanied Bill 162, combined with the re-instatement provisions and the linkage of rehabilitation benefits to return to work, increased firm-level competition and the incentives for private firms to assume firm-level control over expenditures. The expansion of experience rating and the charging of accidents to individual employers was a major administrative shift towards privatization, not because administrative functions themselves were privatized but because the strategy turned employers within a rating category into competitors rather than collaborators for the purposes of reducing or managing workplace injury.

Privatization of Regulation

Deregulation generally means increased ease of entry for the private sector in an activity, or decreased mandated requirements for the public sector in it. The public-private boundary did not change appreciably on this axis in the cases discussed thus far.

Privatization of Ownership

Unlike medical services, which mostly are privately owned in the Canadian health care system, rehabilitation services have straddled the public-private divide, and many have been provided by public hospitals. Changes in demand, however, have the potential either to shift ownership from the public to the higher-paying private sectors, or to create an expansion in one where the other cannot meet the increased demand, and the Ministry of Finance's Bill 68 contained incentives for vastly increased demand, which would become a legacy that reshaped the provider community and fed into subsequent rounds of policymaking.

The development of the WCB's Rehabilitation Strategy and Community Clinics Program also shifted ownership of rehabilitation resources to the private sector, through not only

decentralization of provision (which could have been achieved via the suggestion to have multiple small WCB-operated facilities) but through deliberate privatization of it.

Political Privatization

While Stoddart and Labelle's axes are helpful, they have a limited capacity at a conceptual level to capture some of the most significant public-private changes in the rehabilitation sector that can be seen to begin during the Liberal period. These have to do with what Paul Starr (1989, p. 42) has called a reordering of claims. Much economic discussion of privatization, Starr writes,

> misses the special claims of the public sphere in a democratic society-claims for greater disclosure of information, which should improve the social capacity to make choices, and for rights of participation and discussion, which permit the discovery and formation of preferences that are more consistent with long-term societal interests.

This aspect of public-private change will be discussed here as "political privatization." The case of rehabilitation, beginning in the Liberal period, provides an example of how policymaking state institutions and legislative frameworks supported such an ordering and reordering of claims in ways that, piece by piece, diminished what Schattschneider (1964) elaborated as scope of conflict.

The role of the courts is a very ambiguous one when it comes to public-private issues. On the one hand, they require private resources on the part of the plaintiff, while mediation/arbitration through government agencies does not. The PC critic decried Bill 68 precisely because it shifted decisionmaking from an individual sphere under tort, to a public one, under no-fault. On the other hand, however, access to courts is a form of broadened scope of conflict in which the decisionmaking process occurs either by jury (individuals constituted as public citizens and peers) or a judge who would be censured if found directly influenced by organized interests. By contrast, in mediation and arbitration under no-fault benefits, the weight of judgement is more open to influence, through the capacities of the agencies and of the social groups linked to them. It is entirely possible for state institutions to narrow the scope of conflict. Without institutionalized, corporatist-type representation, or other forms of social alliance, the most powerful groups are more likely to exert the most control, that is, they narrow, or privatize, the potential scope of conflict.

With respect to rehabilitation resource control in the case of Ontario during 1985-1990, the reorganization of the WCB's Board of Directors and Appeals Tribunal under Bill 162 constituted such a narrowing of institutionalized scope of conflict. Bill 68 did not achieve something similar, but it established the conditions under which future achievement of it certainly would be desirable.

The inter-employer competition for rehabilitation success (or claim denial) generated by experience rating and reinterpretation of legislation, also is a form of politcal privatization: it narrows scope of conflict in decisionmaking about management of rehabilitation. Bill 162 was an example of how the incentives created under the increased requirements of Bill 101 would lead to a search for private means of controlling private payments rather than an explicit shift to public sources. That is, a payer exposed to higher costs might do one of two things: say that those responsibilities are rightfully someone else's; or accept the responsibilities and then find ways to minimize access to them.

Finally, and very importantly, the changes along the axes of financing, ownership, management, and administration all created the potential for privatizing information, without which it would become enormously unwieldly for coherent rehabilitaton sector-wide policy reform to occur – a legacy that came to haunt future researchers and decisionmakers.

Chapter Four: The Rae NDP, 1990-1995

Rehabilitation Policy Legacies Facing the NDP: An Emerging Private Market

The policy legacies in Ontario's rehabilitation sector at the outset of the New Democratic Party's provincial administration, in September 1990, consisted of decisionmaking structures and legislative frameworks – institutions – that infused the development of interests and ideas throughout the policy community, creating the environments in which they either flourished or did not (and thereby recreating the environment again). These institutions, and the interests and ideas enmeshed with them, were a mixture of old and new, relatively stable and clearly dynamic, rapidly and slowly changing. This introductory section of the current chapter examines how the legacies of the preceding Liberal administration established institutions in which were embedded interests and ideas in the rehabilitation sector, especially with respect to public versus private roles, as they appeared at the start of the Rae administration. Subsequent sections analyze the new policy and legislative decisions made within the context of these legacies during the Rae administration of September 1990 to June 1995, again focussing on those made within the ministries having jurisdiction over automobile insurance legislation, workplace injury legislation, and health policy.

Institutions and the Persistence of Fragmentation

The most enduring and critical structural feature for decisionmaking in Ontario's rehabilitation sector was the fragmentation of jurisdiction in it, which dated back to historical junctures of power formation and institution building during industrial and economic developments earlier in the 20th century. Stalwart and entrenched as this structure was, the Liberal period had constituted a potential critical juncture challenging it. A parliamentary government with a substantial majority, in a time of relative prosperity and with the support of numerous reports calling for rationalization of disability-related institutions, including one report it had fashioned itself with the help of its opposition (the report of the Social Assistance Review Commission), facing major crises in two important public policy areas (automobile insurance and workers' compensation reform), was in the right place and at the right time to challenge the structural features of the rehabilitation health sector.

Admittedly, a problem in the rehabilitation sector *per se* had not been identified – yet – but a problem in the structural features central to it had been: several reports had been explicit about

the lack of institutional integration and its detriments. The Liberal government made a non-decision with regard to this problem, however, and focussed instead on policy options that left key structures intact. In the face of a coming economic downturn, and within the context of an entrenched structure that would be exceedingly difficult to change, it likely was easier to turn to options that did not address the structure itself but shifted roles and responsibilities within it, as occurred under workers' compensation and, to a larger extent, under automobile insurance. Such institutional mechanisms of creating greater responsibilities, and especially incentives, for rehabilitation service provision under these two acts created the conditions for demand-driven growth of a privately-funded and privately-delivered market, a significant policy legacy. At the same time, the institutional fragmentation of such a market had implications for future decisionmakers because it rendered increasing amounts of information proprietary.

Finally, again at the level of macro institutions, constitutional relegation of health to provincial jurisdiction means that the conditions of the *Canada Health Act* provide only a floor of common services across the country. Provinces are free to establish the ceiling on what they will fund within their public insurance plans; the remainder is funded privately, to whatever extent that there are willing and able payers.[1] And,

> because each province sets its own health-care agenda, there are few nationwide trends [in private-sector development]. As a result, in Ontario there are private rehabilitation clinics; in British Columbia private magnetic resonance imaging (MRI) clinics are increasing; and in Alberta a new private mental health clinic recently opened its doors. (Dalglish, 1994, p. 44)

The question that such a statement raises is, why does privatization occur in different health care sectors across jurisdictions? The previous chapter suggests that an important feature in accounting for provincial variation may well be how institutional organization and policy legacies vary from jurisdiction to jurisdiction.

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[1] Other than compulsory automobile casualty insurance, all other private payment is voluntary and market rules determine price. For many services, there appears to be an assumption that they can be included in private insurance plans, particularly through employee benefits. But market rules mean that some costly procedures simply will not be covered for the majority of people, especially in a labour market characterized by decreasing traditional employment. As one insurance executive said, "I don't think it would be sensible to assume that what is deinsured [from provincial plans] would be picked up by employers" (Deber et al., 1999b, p. 546)

In Ontario, rehabilitation-related policy decisionmaking was deeply fragmented, creating gaps in information and increasing the likelihood that decisions in one area could have unanticipated effects on another that was linked to it in an unacknowledged way (as health, automobile, and workplace injury insurances were to each other through rehabilitation). Equally deep-seated policy legacies had fragmented the roles and responsibilities of public and private players over time. When these factors converged with policy crises in automobile and workplace injury insurance in the late 1980s, they had resulted in policy decisions that created the expansion of a demand-driven private market before there was any clear evidence that public rehabilitation services were constricting. That is, demand increased before public supply decreased.

In this way, the legacies of policy in the late 1980s in Ontario's rehabilitation sector made it at least a partial exception to current theorizing that privatization in Canada's health care sectors is explained by the movement of formerly "core" services into the community, where they are met by forces ranging from fiscal constraint to globalization. Events during the Liberal period, when rehabilitation-relevant policymaking gathered new momentum, indicate that meso-institutional features of state organization are a critical factor, alongside macro-institutional features such as the Canada Health Act, in privatization of health sectors.

Interests Under New Market Incentives

The creation and expansion of a demand-driven market in private rehabilitation services gathered momentum in the wake of the policy changes in both automobile and workplace accident insurance. There had been few, if any, organized interests to challenge it at the time. Service providers would be benefited clearly by it, at least in the short term, since they could command higher prices in a low-supply private market. Private payers did not anticipate the extent to which costs could or would escalate. Service recipients were not a mobilized community. And public health administrators appear to have been largely uninvolved (viz. the lack of Ministry of Health input to the development of the Workers' Compensation Board's rehabilitation strategy and Bill 162). But within a few years, the impact of the changes on interests was becoming more apparent. Dalglish (1994, p. 45) cites

> the case of Columbia Health Care's new neuro-rehabilitation centre in Toronto. The impetus for the facility's startup earlier this year was Ontario's new no-fault auto insurance legislation.... (which) made

> motorists who suffer head injuries eligible for up to $1 million in private-care rehabilitation paid for by their insurance companies. As a result, Columbia, a private health-care company, approached Queen Elizabeth Hospital in Toronto, which specializes in head injuries, with a proposal to build a $2-million rehabilitation facility.

Access to service programs would depend on payment, said Bill Brown, president of Columbia at the time, agreeing that

> a housewife...who suffers brain injury in a fall at home is left out in the cold—except in the unlikely event that she has private insurance—because provincial health-care insurance does not pay for [this level of] rehabilitation. "Your treatment depends on the politics of how you were injured," says Brown. (*ibid*)

By 1994, Columbia Health Care, whose parent company is in the United States (Medline, 1997), had sixteen rehabilitation centres in Ontario. The home-grown Canadian Back Institute, which would be bought eventually by the US-based Select Medical, had 19 Ontario locations and was expanding across the country. And International Managed Health Care, owned by Liberty Mutual, a subsidiary of the US-based Liberty Health, which had bought out another home-grown company (Premier Treatment and Health Management Centre, which opened directly in the wake of Bill 68, the new threshold/no-fault auto legislation), had four clinics in Toronto and was about to open two more (Chamberlain, 1994).

Rehabilitation had provided one of the most dynamic openings for the private sector in the Canadian health care economy, which overall was "in for a very substantial restructuring," in the words of Warren Jestin, chief economist with the Bank of Nova Scotia. "That process is being portrayed as a threat that will cause dislocation and pain but, in reality,... is creating enormous opportunities for the private sector" (Dalglish, 1994, p. 44). Rehabilitation's special role in the process was discussed in messianic terms by Brian Johnston (1994, p. 26), "I once questioned the value of rehabilitation," said Mr. Johnston, a senior executive with Liberty International, which was at the forefront of US insurers' entry into the Canadian rehabilitation markets,

> but I have changed – not because I have seen the light, but because I've seen the whole train barrelling through a tunnel of sharply rising health care costs and down a track of sweeping social and economic change.

> Rehabilitation is aboard that train....
> This prompted me to look at 'rehab' ... in a completely different light.
> I found something I didn't see before... a business sector with terrific growth potential.

Both the advent of threshold no-fault automobile insurance (with its greater potential cost exposures), and the growth of outsourcing at the Workers' Compensation Board (spurred by the new rehabilitation strategy, which could not be met by in-house capacity) at the end of the 1980s, in the face of public services inadequate to meet the new demands,[2] were speeding along what Johnston enthusiastically hailed as " the birth of a new post-OHIP society" (*ibid*).

Ideas: The Post-OHIP Society

The very concept of a "new post-OHIP society" is worth considering. If the OHIP society was bound up with foundational ideas about the relationship of health care provision to need, and the "pre-OHIP society" was something to which we could not or would not wish to return,[3] then what would be the precepts of the "post-OHIP society"? How and by whom would health service goals be defined conceptually or their best pursuit envisioned, much less implemented?

The changes under automobile and workplace accident legislation introduced in Bills 68 and 162 entwined with ideas about how to answer these questions, at least insofar as they pertain to rehabilitation. The increasing linkage of services with access to income benefits – the chief motivator of rehabilitation service provision under both of the new acts – was a critical policy legacy of the period. It is not possible to disentangle the growth of a private rehabilitation market in Ontario from the institutional frameworks that shaped it, the interests entwined with it, or the ways in which those factors shaped perceptions of and ideas about the services.

As long as rehabilitation had remained largely decoupled from income benefits and defined primarily as a needs-based health care service, it had come under the purview of health programs in the context of an expanding welfare state. Income protection benefits provided under provincial programs and policies, such as workers' compensation, automobile insurance, and disability welfare, as well as national programs such as disability pensions, had all operated

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[2] See Hans., St. Com. on Finance and Economic Affairs, Feb. 2, 9, and 16, 1993.

[3] Few would champion the conditions of pre-welfare state health care provision in Canada, not least amongst them being physicians, who benefited from the expansion of guaranteed, fee-for-service remuneration (Naylor, 1986).

largely separately from rehabilitation provisions. But the expansion of rehabilitation benefits under Bills 68 (automobile casualty) and 162 (workers' compensation) both yoked it tightly to income benefits, and opened new concerns about how to define and pursue rehabilitation.

While the policies were Ontario's, they dovetailed with much broader trends in the field, such as the burgeoning literature on the importance of early, active intervention and rapid return to regular activities (Lindstrom et al., 1992; Lancourt and Kettelhut, 1992; Waddell, 1993). For the most part, these were ideas about approaches to rehabilitation of the working-aged injured that hospital-based rehabilitation services had not been established to deliver. Nor did the OHIP fee schedule for out-patient services[4] support the labour-intensive assessment and treatment activities, such as functional abilities evaluation or worksite analysis, job modification and work hardening programs, not to mention the detailed documentation and reporting, that the new rehabilitation goals required.

The remainder of this chapter first briefly describes the changing, broader economic and political environment of Ontario during the early 1990s. It then considers how the rehabilitation-relevant policy legacies discussed above, in institutions and the interests and ideas intricately interwoven with them, both affected and were transformed by new policy decisions during the Rae administration – building on the trajectory of public-private change in the rehabilitation sector.

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[4] The OHIP schedule for fee-for-service physiotherapy has been $12.20 per visit, including initial assessment, since 1990 (Source: OHIP Claims Office, Toronto). It remains at that level at the time of writing and there are no known plans for changing it (2001). Immediately prior to the schedule set in 1990, the fee was $11.50/visit (Source: Proprietor, Main and Gerrard Physiotherapy, Toronto. An OHIP clinic proprietor was consulted as neither the OHIP claims office nor the Ontario Physiotherapy Association had this information). The fee schedule for chiropractors is lower: $11.75 for the initial assessment and $9.65/subsequent visit, up to a total of $220/year since 1989; the previous schedule had been $11.25 per initial visit and $9.45/follow-up, to a total of $150/year. Every registered chiropractor in the province has billing privileges, however, while only approximately 90 physiotherapy facilities are licensed to bill across the province, and no new billing privileges have been granted since 1965. Indeed, several have become inoperative, and regional disparaties are a problem (College of Physiotherapists of Ontario, 2000). Also, chiropractors have been able to extra bill since 1970, while physiotherapists never have been able to do so.

Broader Contexts and Contingencies

Ontario's Political-Social Environment, 1990-1995: From Protest to Splutter[5]

Premier Peterson gave no reason when he called an election for early September, 1990, with two years still to go in his mandate. Most likely, the call was motivated by the goal to consolidate an even longer mandate before being swamped by the economic downturn that Treasurer Robert Nixon saw looming in the distance, or before the downturn became apparent to voters (Ehring and Roberts, 1993). But the Liberals' confidence in an easy victory was overly sanguine: in a broader context, within which public interest groups were coming to play an unprecedented role in Canadian electoral politics (Pross, 1992), the incumbent government was unprepared for the impact of the alliance that had formed been the Ontario Public Service Employees' Union, the Ontario Medical Association, and the Ontario Secondary School Teachers' Federation. This unlikely partnership (particularly with respect to the OMA) had in common little more at the time than unhappiness with the governing party. Together, "the money they spent on the campaign equalled the budgets of any of the political parties, and all their resources went to undermine the Liberals" (Ehring and Roberts, 1993, p. 268). Nor did the Liberals anticipate the weary skepticism the election call would provoke in voters being called back to the polls for the third time in five years.

In the meantime, the New Democratic Party, equally certain that the incumbents would be re-elected, never bothered to assemble a transition team and campaigned on an aggressive opposition or protest platform, one of its chief planks being public, "driver-owned" automobile insurance.[6] The NDP surely was no less surprised than Peterson himself when it won a majority government, with 74 of 130 seats, a dramatic increase from merely 19 seats in the '87 election.[7] At 37.6 per cent of the popular vote, it may have been the first time that a majority government in Ontario had won with less than 40 per cent. Still, it was a substantial increase from the 22 per cent of the province-wide vote that the party's predecessor, the Cooperative Commonwealth Federation (CCF), had enjoyed between 1934 and 1961, and the 26 per cent that its successor, the NDP, had from then until the 1990 election.

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[5] With all due respect to Bob Rae (1996).

[6] Other major planks were increased corporate and upper-income taxes, lowered taxes for other groups, and strategically increased public spending (e.g., in environmental and preventive health).

[7] The Liberals were reduced to 36 seats from their prevous 95, and the PCs rose from 16 to 20 seats.

Ontario's flirtation with a nominally social-democratic government may have seemed strange given the growth of neo-liberal anti-statism that was occurring far and wide, as will be discussed in the following section. For a number of reasons, however, the honeymoon was short lived – which is perhaps less of a wonder than that it occurred in the first place. Shortly into Rae's mandate, the economic stormclouds that had been gathering were directly overhead, raining recession onto the province. Treasurer Floyd Laughren's first budget of 1991, in the wake of which the provincial deficit ballooned to $9.7 billion, was not only seriously flawed from within, by miscalculations based on anticipated high revenues, but hamstrung from without. The party had inherited a $700 million deficit from the Liberals. But within months of the election, before its first budget was even formulated or any spending decisions made, the deficit rose to $2.5 billion under the pressure of the declining economy. The tax points the federal government had transferred to the provinces in 1977 were not worth much in the context of a severe downturn: even with them, tax revenues dropped by more than $3 billion in 1991-92; and, at the same time, a decline of $2.7 billion in federal cash transfers was anticipated for 1992-93 (Lankin and Ministry of Health, 1992). Of the nearly $10 billion to which the deficit grew after the 1991 budget, only $640 million represented new spending (Ehring and Roberts, 1993, p. 304). The rest represented ongoing funding commitments and high deficit financing costs in the face of substantially decreased revenues and severe constraint. Where programmatic spending was concerned, it was less a matter of implementing new spending than refusing to cut extant spending. And even there, the party quickly rescinded.

By the 1993 budget, with the recession dragging on and the deficit now at $17 billion, the government announced large public sector layoffs. And, in the same year, it introduced its contentious Social Contract. Although this policy, which imposed involuntary wage reductions through enforced unpaid days off for public sector employees, could be seen as an effort to minimize layoffs – and although the government enacted Bill 40,which banned replacement workers and created new, union-favourable organizing laws, in the same year – the Social Contract invoked the wrath of unions, which saw it as an abdication of negotiated contracts. And it provoked the cynicism of many long-time party supporters, who saw it as an abandonment of NDP principles and alliances (*ibid;* and Hargrove and Gerrard, 1994).[8]

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[8] A more sympathetic account of the Social Contract is to be found in White, 1998.

Some observers expected that "most rank-and-file labor support will find its way back to the (NDP), since neither the Liberals nor the Conservatives have what could be considered a pro-labor agenda" (U.S. Dept. of Labor and Foreign Labor Trends Program, 1996), but time would tell a different story. While the overall electoral support of the NDP dropped from 24% of eligible voters (37.6% of actual voters) in 1990 to 13% (20.5%) in 1995, the decline specifically in lower-middle-income, lower-income, and industrial ridings was particularly striking (Hale, 1997).

The 55% of decided-voter support Rae had enjoyed prior to the '91 budget shrank to 34% after it and 23% by 1993. Much more significantly, his about-faces on policy had created internal rifts in his own government and party. His reversal on public automobile insurance, which had been a major campaign plank, was a crucial example, as will be discussed in the section on automobile insurance policy later in this chapter. Perhaps one of the most important legacies of the Rae government for Ontario politics was the advantages that its real and perceived failures afforded the province's Progressive Conservative Party.

In 1990, the same year Ontarians, in the midst of a period of unusual electoral volatility for the province, voted the NDP into office, the PCs chose Mike Harris as their party leader. The choice marked a turn in the party's history. Long known for its "Red Toryism," the party's roots reached back to 19th century English Tory traditions, which championed traditional social class relationships and responsibilities over the individualistic market relationships and self-reliance championed by the British Liberals and a growing middle class. Now, however, a marked transition occurred in the PC party ideology towards a late-20th century form of market-based neo-liberalism. Indeed, the changes in the party's own system of selecting a leader itself echoed these broader social currents. As Brooke Jeffrey (1999, pp. 155-156) points out, Harris's leadership victory owed much to a new selection process that changed from the traditional party convention, in which old alliances tended to dominate, to a one-member/one-vote system, which "meant Harris could appeal to the extreme right of the party, the 'conservative' component of the 'progressive conservative' coalition. It also meant that, when he won, Harris owed nothing to the party elites or the old guard." Harris spent the years 1990-95, "essentially rebuilding the party in his image."

Ontario's political party institutions were in a state of tumult: from the New Democrats to the Progressive Conservatives, traditional alliances and policies were being revamped, as exemplified not only by the changes in PC leadership just discussed but, very dramatically, in

the rifts that Rae's Social Contract opened with public sector unions. The province was not alone, of course, in the upheavals occurring in traditional "left-right" politics. Testimony to this was borne by events around the world (the collapse of the Berlin Wall in 1989 and of the Soviet Union in 1991), on the North American continent (the *Free Trade Agreement* of 1989 between Canada and the United States was quickly, and just as contentiously, followed by the *North American Free Trade Agreement*, NAFTA, bringing in Mexico, in 1994), and across the country, as will be discussed briefly below.

While it is far beyond the scope of this study to examine these in any detail, they are a critical contextual background against which policies relevant to all health care sectors occurred. One of the most significant political science debates of the late 20th century has been the changing roles of the state and the market in welfare provisions. These macro-level, structural changes in state and market institutions and relationships are felt even in relatively obscure corners, such as Ontario's rehabilitation sector, in which the creation of opportunities for new markets in a "new post-OHIP society" – i.e., post-state welfare society – was eagerly anticipated as "a business opportunity for the insurance industry at large" (Johnston, 1994, p. 26).[9]

Growth Of Canadian Neo-Liberalism

As Martin Barkin, Ontario's deputy minister of health in the early 1990s, pointed out, the provincial government was making important "value" decisions about where to allocate (and whether to keep allocating) its resources in the face of fiscal constraint, and in the midst of a time when "'(s)mall' government has become popular, and a wave to sever government from service delivery has swept many western democracies" (Barkin, 1992, p. 6). Others, too, have commented on the degree to which American anti-government and pro-individual ideas or values poured over the border into Canada, either as a side-effect of changing institutions (such as the *Charter of Rights and Freedoms* introduced in 1983) or by a form of cultural osmosis, perhaps hastened by the growing economic linkages. There is "a powerful North American ethos, driven by attitudes in the United States," wrote labour leader Buzz Hargrove and Leo

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[9] The changing face of the insurance industry and its relationship to health care in Canada has not been nearly so closely examined as that in the United States (e.g., Paul Starr, 1982), although it deserves to be. The issue of expansion into, and creation of, new health markets in a post-welfare state society recalls the debates of early theorists on changes in the post-war welfare state, such as O'Connor (1973) and Offe (1984). While giving some credence to O'Connor's functionalist account of state retrenchment occurring basically to make way for new forms of capital interests, they also support the structural arguments of Offe, i.e., that state realignments do not respond specifically to accommodate group interests but to accommodate change in overarching economic relations (e.g., shifts from industrialization to corporatization to globalization).

Gerard in 1994, "that taxes are simply money taken away from people.... That attitude spills over into Canada" (Hargrove and Gerard, 1994).

The question that needs to be asked, and that some writers have asked (Jeffrey, 1999), is why Canadians embraced both neo-liberal (market-based) and neo-conservative (e.g., "family values"-based) agendas so much later than did either Americans or Britons, who had gone through their respective Reagan and Thatcher "revolutions" a decade earlier. Canada had had the Progressive Conservatives in federal office under Brian Mulroney, an admirer of both Thatcher and Reagan, from 1984 to 1993. Neo-liberal inroads were both delayed and different in Canada, due to a combination of factors ranging from economic and trade restructuring, to political culture and institutions (such as deference to an idea of good government, hand-in-hand with Westminster-style parliamentary democracy and a Red Tory British legacy that spawned both the Progressive Conservatives and the New Democratic Party), to the endless scandals that attached to Mulroney and his cadre (*ibid,* pp. 44-51). Political cynicism and fatigue in the wake of Mulroney's governments and a succession of constitutional debates, in combination with economic realignments, including the relative growth of provincial and decline of federal economic power, which exacerbated regional differences, created the bedrock for the growth of populist politics in Canada, both of the neo-conservative and neo-liberal strains.

In the west of the country, primarily in Alberta and British Columbia, the populist Reform Party was born in 1986, as a regional-interest rejection of centralized powers. Just seven years later, in 1993, it went to Ottawa as the official federal opposition to Liberal prime minister Jean Chretien, with more votes from unionized workers than the unions' traditional party ally, the NDP, got. Founding leader Preston Manning described the Reform party's "social conservatism (as) a combination of Rambo and Mother Teresa" (*ibid,* p. 331). Also in 1993, Ralph Klein became Alberta's premier "on an aggressive platform of cutting back the role of government" and "get(ting) the government out of the business of being in business" (*ibid,* pp. 111 and 123). Widespread privatization had begun immediately after Klein's election and, even as the province slid into recessionary times in 1994, Klein held taxes down and increased user fees and premiums substantially. The same year, while Bob Rae's NDP staggered about the ring, Ontario's Progressive Conservatives, under Mike Harris, published "Common Sense Revolution" (Progressive Conservative Party, 1994). The party's platform for the 1995 summer election, it opened with the statement that: "The people of Ontario have a message for their

politicians – government isn't working anymore. The system is broken" (*ibid*, p. 4). Its five planks were: Lowering Your Taxes; Less Government Spending; Removing Barriers to Growth; Doing Better for Less; and A Balanced Budget Plan.

In Ottawa, the Liberal Party, under Chretien, returned to federal office in November 1993 facing a budget deficit of some $40 billion, widespread unemployment, and a prevailing mood of mistrust in public office. During the nine years of Brian Mulroney's tenure as Prime Minister, ten cabinet ministers had stepped down in scandal. When the Liberals resumed office, one of their first actions was to reduce the size of cabinet, which became dominated by "the party's pro-business wing (which) has firm control over the key economic portfolios" (Caragata and Fulton, 1993, p. 8). In effect, it was Canada's first "downsized" federal government, and it was an important sign of the times.

Economic And Labour Market Environment: A Refashioned Public Purse

By 1993, Ontario's economy growth was back in the positive growth range, although it would hover only between 1 and 2% until 1997. Nonetheless, unemployment remained high, so recovery was not readily apparent to much of the working population. "In 1991 net job loses in the province would cumulate at greater rates than had been seen since the 1930s" (White, 1998, p. 135). By 1992 and '93, unemployment hovered at about 10.8%, dropping to 9.6% in 1994, and 8.7% in 1995 (Statistics Canada, Cansim database). Ontario urban hubs, such as the regions around Toronto and Ottawa, experienced amongst the largest impacts of growing urban poverty in Canadian cities, which soared 34% in the early 1990s (Picard, 2000).

A crucial factor in these upheavals was the boost that restructuring of the province's economy, from goods production to service provision, was given by the 1989 *Free Trade Agreement* and accelerating economic globalization. The "little boom" of the late '80s "would have busted, regardless of who or what was in office at Queen's Park [in 1990]. Output, employment, and government revenues would have fallen, social assistance costs would have risen quite sharply, without changes in any policies. As Thomas Courchene and Colin Telmer have explained..., if Mike Harris had 'won the 1990 election (instead of the 1995 election), he would never have been able to implement *The Common Sense Revolution*" (White, 1998, p. 223).

Of the 226,000 jobs lost in Ontario between March 1990 and March 1991, 220,000 of them were in manufacturing (Ehring and Roberts, 1993). Of these, 65% were expected to be permanent losses, as compared to the 24% of layoffs that became permanent losses in the recession of 1981-82 (Lankin and Ministry of Health, 1992). In 1987, 75% of Ontario's businesses had fewer than 20 employees (Hans., St. Com. Gen. Govt., Jan. 16, 1990). By 1993, the figure was 95% (Hans., St. Com. Fin. & Economic Affairs, Jan. 28, 1993). Own-account, self-employed workers (OASE, i.e., freelancers, consultants, and contract workers) rose steadily through the period, growing 4% annually across Canada, compared with 0.5% growth for employees. Between the mid-1970s and 1990, there had been considerable growth of small-business employment, outpacing that of the OASE category. But the trend inverted in the 1990s and escalated rapidly. By 1994, "one in three labour force participants were either working in part-time or temporary jobs, held more than one job, or were own-account self-employed, up from 28 per cent five years earlier" (Lowe et al., 1999, pp. 5-6).

Perhaps not coincidentally, persons covered by individual (i.e., not small- or large-group employment-based) private extended health insurance soared in Ontario from 28,996 in 1990 to 230,369 in 1995, an 800% increase. Under individual policies for personal accidents, persons covered rose 35%. Meanwhile, those covered for extended health benefits under group plans (i.e., employment-based ones) dropped 0.4% (Canadian Life and Health Insurance Assoc.).[10]

Not at all coincidentally, restructuring of the labour market and economy had led to a decline in union membership of some 6% between 1982 and 1990. By the early 1990s, "Organized labour estimated it had to sign up 35,000 new members a year just to stay even with plant shutdowns, but was only managing about half that number" (Ehring and Roberts, 1993, p. 327). While some studies (Rose and Chaison, 1996) consider the Canadian union movement to have been strong and growing through these years, others[11] interpret the data to support the

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[10] These CLHIA reports also indicate more long-term trends in group-based coverage for disability benefits. Persons covered for short-term disability, i.e., for work interruptions of less than 12 months, fell from 801,436 in 1985 to 674,103 and 525,167, respectively, in 1990 and 1995, an overall decline of more than 34%. Those covered for long-term disability rose from 1.5 million to 2 million to 2.2 million during the same period. It is uncertain why this "product" trend occurred, or how it might have been related to changing provisions for disability provisions under other policies.

[11] United States Dept. of Labor and Foreign Labor Trends Program (1996): "Except for the two more recent recessionary periods [i.e., early 1980s and early 1990s], union membership has been rising in Canada. However, the labor force has grown at a rate exceeding that in union membership and this has resulted in a decline in the proportion of union members in the labor force.... Since 1978, the continuous labor force growth at a rate above that in union membership has resulted in a longer-term decline in the proportion of union members in the labor force."

contention that unionization declined during the period, although not as much as in the United States.

The government sought some good will, to offset the negative effects of these larger factors and of its high-visibility Social Contract, with new labour legislation, including changes to the Workers' Compensation Act (which will be discussed in detail in a later section in this chapter) and the enactment of Bill 40, the Labour Law Reform Bill, in January 1993, which forbade replacement workers ("scabs") and strengthened unionization. Nonethless, these seemed fragile in the face of the major structural dislocations occurring at the time.

As though its economic, labour market and political woes were not bad enough, the Rae NDP government of the early 1990s was also dealing with the impact of reductions in federal transfer payments. Although it was the provinces that had asked originally for tax credits in partial lieu of cash transfers, in order to gain greater autonomy from the federal government and increase provincial control over health spending (Ruggie, 1996, pp. 101-102), a wish granted to them with the Established Programs Financing Act of 1977, tax points did them little good in the midst of a recession. And in 1977 they had not foreseen the federal Conservative (Mulroney) government's constraining and then freezing them in the 1980s, with support in the early '90s from the Chretien Liberals. While federal Health Minister Diane Marleau was "doing what she has done since the federal budget announced steep cuts in Ottawa's funding for health care: insisting that the pillars of medicare can remain untouched even as the structure of the system undergoes wholesale renovation," Ontario's provincial Minister of Health, Ruth Grier, was saying the federal budget would cost the province $1 billion in 1995 – in addition to the $2.7 billion reductions of '92-'95. "Just when we thought we had got to the point that we could look at some expansions," Grier lamented, "we're back on our heels saying, 'Where do we find another billion dollars?'" (Caragata, 1995, p. 14).

The Ministry Of Health

Health Sector Legacies for Rehabilitation

Within the specific configuration of Ontario's public health care institutions (i.e., the formal organization of the public interest in health care), the legacies of how they framed interests and ideas continued to shape rehabilitation in the face of changing demands. First and foremost amongst these was the lack of formal programmatic channels for rehabilitation-relevant policy

making or resource allocation. Even in the face of growing pressures on community-based rehabilitation services, the Ministry had responded within the confines of established channels, by investing in hospital-based services. The funding for these, in turn, continued to be at the discretion of the hospitals themselves. No policymaking branch existed in the Ministry for rehabilitation, and no specific rehabilitation programs through which to channel funding or develop do-able goals existed. The capacity to provide community-based services through extant programs, such as transfer payments to non-institutional practitioners under the Health Insurance Program, was held down by ongoing restrictions of OHIP billing licenses for rehabilitation professionals, and low public fee schedules for community-based provision where it did exist.

Early into the turn of the new decade, the problems of access to rehabilitation that had been created in the wakes of Bills 68 and 162 expanded rapidly. "In the past several years," said a speaker before the Standing Committee on Finance and Economic Affairs, as it deliberated the further changes to automobile insurance that will be reviewed later in this chapter,

> a large [private rehabilitation] industry has developed in absence of standards or regulations. The government of Ontario must provide leadership in the development of standards and qualifications regulating this industry.... part of the problem is that, depending on how you were injured, the kinds of rehabilitation you're entitled to, financially anyhow, become very different. (Hans., St. Com. Fin. & Eco., Feb. 9, 1993, 1010-1020 hrs.)

The most salient factors in determining access to services were no longer need and public supply, but whether the accident had occurred in a motor vehicle, at work, or elsewhere, and whether the individual was insured for the particular conditions in which injuries had been sustained. What treatment was available depended increasingly on who was paying for it, and how much coverage was available. By mid-decade, every health planning region of the province was reporting that two-tier development for rehabilitation had become a significant problem, as had lack of data about public and private services being offered or sold (Manganelli and Ministry of Health, 1994).

The developments divided the interests of several parties – or, more accurately, they created new and separate interests among the various payers (public and private) and among providers

with new capacities to tailor their services to different payers. Different players, in turn, had differing ideas about rehabilitation. Both interests and ideas had been, and continued to be, focussed through institutional lenses, as is evident in how views of rehabilitation goals began to shift during this period under the impetus of changing policies: In Ontario's hospital-based in- and out-patient environments, rehabilitation services were dominated by goals of symptom reduction and optimal functional independence, the definitional legacies of particular historical developments for the professional practitioners and of the institutional framing for the health care system. Elsewhere, however, a distinction was developing as changing regulatory frameworks under casualty and workplace injury insurance made "productivity enhancement" and return to work the "highest priority" goals for rehabilitation outside hospitals (Twelves, 1990).

This section of the chapter is specifically about the public payer for rehabilitation services, the Ministry of Health. In the midst of the larger changes occurring, in the broader environment and within its own institutional parameters, how did the Ministry understand the challenges or problems being raised and how did it decide to meet, or not to meet, them?

Policy Problems and Preferred Solutions: Agendas, Definitions, And Options

Agenda setting for health policy in the Rae administration was driven, by and large, by the dual pressures of dwindling revenues – themselves driven not just by a recessionary economy, but a fundamentally changing one, alongside changed federal inputs – in the face of expanding delivery costs. To consider what to do, Rae turned to the Premier's Council on Health, Wellbeing, and Social Justice, which he had created out of Peterson's former Premier's Council on Health Strategy (Signal, 1994).

The "vision" statement it produced, of hand-over-heart goals such as longer life, greater health, and deeper happiness for all Ontarians, was to be expected. More specifically, it set out a policy of saving public health care, at least in the province, by redirecting money away from hospitals and physicians (the only aspects of the system insured under the *Canada Health Act*), and towards "stronger program and funding priorities in the areas of health promotion, disease prevention and community health" (Lankin and Ministry of Health, p. 5). Yet it had no institutional or programmatic channels for doing so. To redirect increasingly scarce funds away from hospitals and physicians could not have been conceived of as easy. Their allocation to these services enjoyed institutionalized protection under the CHA, which had created two

powerful policy legacies: the privileging of hospital and physician groups; and intense voter support for the status quo. (Arguably, many Canadians did not know that these were the only services for which public insurability was guaranteed. Expansionary times, when many services were indeed offered within hospitals, including rehabilitation services, had led many Canadians to believe that insured services represented the general public availability of a continuum of health care services.)

By the early 1990s, however, there was a growing body of literature that identified the limited focus on hospital-based and physician-provided services precisely as the problem. There was a widespread sense that, under the frameworks that had become institutionalized in the Act, Canadian governments had overinvested in these types of care and could afford to cut back on them (Deber and Rondeau, 1990; Ministry of Health, 1994a, 1994b). The problem for the Ontario's Ministry of Health became how to preserve the principles of Canadian medicare while revamping the provincial system to meet its newly defined public interests in community-based care.

The new interests that the ministry defined for itself, which would also be alternatives or optional solutions to the problem of core-focussed funding, were issue-specific. The "new strategies" and "new priorities" that the ministry set out relatively early in its planning stages, included a range of concerns, from specific illnesses (such as diabetes and AIDS) to specific populations (women, children, and aboriginals), to behaviours (tobacco use), and to service delivery issues, amongst them rehabilitation. "A number of recent developments (e.g., auto insurance and Workers' Compensation Board reform) have increased pressures on the rehabilitation system," said a Ministry document (Ministry of Health, 1992, p. 23). The Rae administration's first Minister of Health, Frances Lankin, stressed its commitment to addressing the problem in rehabilitation services in a number of her early communications on hospital downsizing. "(D)emands for rehabilitation services are growing," she noted. "The ministry will therefore develop a systematic approach to the planning, development and co-ordination of rehab [sic] services" (Lankin and Ministry of Health, 1992, p. 9). In an address to senior citizens, she defined the expansion of rehabilitation as "particularly important," placing it first in a list of priorities. But while Lankin talked about specific intiatives for addressing other problem areas, when it came to rehabiliation she said only: "I cannot yet provide you with plans. But I can assure you that I am in general accord with the way the Seniors Panel and many other participants addressed the issue of rehabilitation" (*ibid*, p. 105) in their submissions to the Premier's Council.

One indication of the lack of rehabilitation planning in the province was the amount that OHIP was spending on out-of-province rehabilitation services: Early in its administration, the Rae government had expressed a health policy goal of re-investing money being spent on care in the United States on developing new programs in Ontario. In 1993-94, the Ministry of Health paid approximately $35 million for in-province care of those with acquired brain injuries (ABI; one of the few communities about which data was gathered because of the establishment of a provincial Advisory Committee and ABI Centre in 1987). An additional $27 million was spent for ABI treatment of about 100 patients receiving care in the United States (Manganelli and Ministry of Health, 1994), where private rehabilitation facilities for this population were (and are) widespread, flourishing, largely private insurance-funded businesses.

Another indication of the changing need for community-based, rather than hospital-based, rehabilitation is that hospital admission of patient populations in need of rehabilitation services was declining. Between 1982 and 1992, admissions for mechanical neck and back pain had dropped 52% in Ontario, declining "more rapidly than the rate for all conditions taken together" (Lavis et al., 1998a, p. 29), and as many as 30% fewer admissions were made in 1993 than in 1989 for traumatic brain injury (Manganelli and Ministry of Health, 1994). In neither case is there any reason to believe that incidence was declining.

It is clear from the available documents that the ministry had identified rehabilitation as an important problem area in the early 1990s, one linked to policy decisions being made in other jurisdictions as well as to its own institutional organization and priorities. How it would – or could – deal with this, however, would be a test of the impact of those legacies on its ability to redefine and pursue its new goals.

Policy Decisions

Two major policy thrusts implemented by the Rae administration's Ministry of Health in pursuit of its goals would have implications for public-private change in the rehabilitation sector. The first had to do with programs already in place, namely hospital downsizing (primarily bed closures and funding restrictions) and expansion of government-funded community programs such as long-term care and Community Health Organizations. The second had to do with the NDP government's handling of regulatory frameworks for controlling expansion of services beyond these established programs, these frameworks being the Independent Health Facilities Act and the Regulated Health Professions Act.

Hospital and Programmatic Changes

The Ministry proclaimed its intention to pursue hospital downsizing in the wake of reports by the Premier's Council on Health Strategy, and the Council on Health, Well-Being and Social Justice. Along with other studies, reports and commissions, the Ministry's statement (Ministry of Health, 1994b) recommended that increasing the supply of MDs and hospital beds, especially in already over-serviced areas, would not make Ontarians healthier and would result instead in misallocations from other more beneficial programs. Hospital-based services were seen to be overly expensive ways of treating many problems that technology had made increasingly treatable outside hospitals, and between 1985 and 1990 the growth in physicians had outstripped that of the general population.

The government set about rectifying some of these outcomes, which it had come to see as problematic. Between 1990 and 1995, about 8,500 beds were taken out of service in Ontario (Steed, 1995), the vast majority of them after 1991, causing a decline of approximately 5% in inpatient services (Armstrong, 1995). (As it was, 1990-91 saw about 47,819 acute care beds in operation in the province, down from a high of 54,142 just two years before [Ministry of Health, *Ontario Hospital Statistics*]). The Metropolitan Toronto area alone lost approximately 3,500 beds between 1987-88 and 1993-94; at the same time, use of outpatient clinics rose by about 13% (Crawford et al., 1995).

Some programmatic planning was put in place to offset the impact of this extensive downsizing. With respect to the implications for rehabilitation, the Ministry of Health announced that it intended to "develop a systematic approach to the planning, development and co-ordination of rehab services" (Lankin and Ministry of Health, 1992, p. 9). A group was formed within the Ministry to

> put together a broad-strokes multi-year strategy for guiding policy development and functional planning, which was approved by senior management in early 1993. The same group, with the assistance of an external expert advisory committee, set about to develop a sort of "recipe for change" using devices such as working groups, focus groups, regional consultations, etc. Other sectors, such as private insurance, the Institute for Work and Health, and the Workers' Compensation Board/Workplace Safety and Insurance Board, were involved in this process. (Confidential e-mail communication, September 2000)

The process did not culminate in a plan, however, until four years later, in 1997, at which time the next administration was already in place, with the Progressive Conservatives having taken office under the leadership of Mike Harris. By then, the new government had already brought in yet another automobile insurance act, set about a full-scale restructuring of the hospital sector, and was working on a new workers' injury act that would radically alter the approach to rehabilitation in that arena.

As its term in office turned the half-way mark and began to draw towards a close, the Rae administration trumpeted the extent to which it had achieved its goals of reorienting the province's health care programs and resources towards the community. It noted, for instance, that the Long Term Care and Community/Public Health programs had had the most substantial spending increases between 1992-'93 and '93-'94 of, respectively, 6.7% and 8.2% (Ministry of Health, 1994b). But when total combined spending for these two programs amounts to 15% of an $18 billion health budget (11% for Long Term Care and only 4% for Community/Public Health), serving a population at the time of approximately 10 million people, then the spending increases do not seem like a major reorganization of programmatic priorities relative to hospital downsizing. Rehabilitation for the temporarily injured working-aged population does not occur in long-term care settings. It occurs in community and public health clinics, in out-patient departments, and in private-practice community practitioners' offices, for which funding may be either private or public (generally through OHIP payments to practitioners).

Out-patient rehabilitation departments were not specifically funded by the ministry. Allocations to them were decided upon by individual hospitals; with global budgets being reduced, it is unlikely that hospitals were choosing to direct their resources towards out-patient rehabilitation.[12] As for public payments to private-practice rehabilitation practitioners, the ministry had negotiated agreements with chiropractors and physiotherapists (amongst other providers such as optometrists, dentists, and podiatrists) that resulted in decreased payments of 4.4% during the period of the Social Contract (Ministry of Health, 1994a), which had begun in 1993 .

An 8.2% increase in the Community/Public Health Program would have meant approximately $600,000, spread across multiple services. The ministry had added six new Community Health Centres (CHCs) in the province, and was planning five more. (CHCs are

community-governed practices with multidisciplinary primary care teams, intended particularly to deliver care to hard-to-reach populations.) These initiatives, however laudable, barely made a dent in how the province's health care system was organized. Even doubling the number of CHCs in the province still meant that only about 4% of patients received health care in them, the remainder continuing to access it through the usual fee-for-service channels. The impact of this change would scarcely have been felt by comparison with that of no growth in hospital funding – no growth being the same as attrition (Pierson, 1994), as costs were shifted out of the public system due to shorter hospital stays, fewer admissions, more day surgery, and the like – and approximately 4% decreases in OHIP spending between 1992-93 and 1993-94. The province would have had to do a great deal more in the way of reorienting resources to the community than the relatively minor budgetary changes it made if it was to balance this out and maintain a public interest, backed by resources, in the changing health care landscape.

By the final year of the Rae administration's tenure, in 1995, plans continued for a revitalized rehabilitation sector to offset the impact of hospital restructuring. At least, they existed on paper and for the Metropolitan Toronto area. "A new organization dedicated to excellence in service, teaching, and research of rehabililtation" and affiliated to the University of Toronto was envisioned by the Metropolitan Toronto District Health Council (Crawford et al., 1995, p. 23). It would be responsible for: coordinating a Metro-wide network of rehabilitation service delivery through an integrated patient registry and referral system; coordination of overall planning of rehabilitation and roles of the various professionals involved; and enhancement of excellence throughout the network. "All rehabilitation services will have an increased emphasis on outpatient rehabilitation and there will be an expanded availability of community-based rehabilitation services" (*ibid,* p. 24).

Grand and admirable as the plans were, while they were being laid real changes were occurring within the confines of very different institutional and programmatic channels. In the words of one disappointed insider, "There was no rehabilitation office per se, which I think speaks volumes on how high a priority it ever really enjoyed" (confidential e-mail communication, Sept. 2000). Far from the coordinated, integrated, smooth continuum of rehabilitation services of the "visioning" exercises, the reality was a hodge-podge in serious disarray. The administration's hospital restructuring efforts, though they made much sense, had

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[12] Like many questions raised by an examination of these changes, that of how out-patient rehabilitation

been hampered by lack of resources available or allocated to shoring up the community services through which health care needs would be met. A Patient Care Hotline that was established to field consumer response reported that one of the issues that came up repeatedly was the lack of public rehabilitation services available and the increase in their privatization (Armstrong, 1995). Eleven per cent of callers complained that they had to provide rehabilitation-related care for their hospitalized loved ones, either by militating to get them rehabilitation care in the first place (after long delays), or by physically getting the patients to rehabilitation themselves, in the absence of porters and orderlies being available, and even by performing rehabilitation interventions themselves, on initial instruction from rehabilitation staff. After discharge from hospitals, more individuals were having to pay for rehabilitation services. And those who had not been hospitalized bore the full costs of whatever interventions they received, either paying out of pocket or through their extended benefits insurance carriers (if they were fortunate enough to have one through group or individual policies), because they were unable to access the scant public ambulatory services that existed.

Thus, the Ministry of Health, against the grain of all its espoused intentions, had made programmatic and funding changes that pushed rehabilitation services further into the arms of the private sector, for better or for worse. Efforts at least to coordinate its goals with those of private payers (particularly casualty and workers' compensation insurers) may have helped to allay these events, perhaps sufficiently to maintain and carry the ministry's interests in rehabilitation through the economic crisis And some efforts were made, particularly to participate in changes occurring under automobile insurance. But "even MoH senior management weren't interested in the impact of auto insurance reform on the public healthcare system or didn't fully grasp it enough to make representation to the Ministry of Finance on Ministry of Health concerns" – deputy minister Michael Decter at one point told rehabilitation planning staff that the issue "didn't have much scope for Health" (confidential e-mail communication, Sept. 2000). Doubtless, the way the ministry's interests had been framed by an entrenched legacy of hospital-based and physician-rendered services had wrought its effects. Even as some bureaucrats were championing the need to re-order priorities, including those for rehabilitation, others saw no need.

NEW REGULATORY FRAMEWORKS: THE REGULATED HEALTH PROFESSIONS ACT

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departments were affected is one that cannot be answered without extensive primary data collection.

While programmatic restructuring was feeble at best, and greatly unbalanced against hospital restructuring and budgetary reductions – the 1993 provincial budget announced $4 billion in cuts, $1.1 billion of them to come from Health – the Ministry also made legislative changes that it hoped would help to bolster community services. These too had implications for rehabilitation, although not altogether of the sort the Ministry anticipated or championed.

The *Regulated Health Professions Act* (RHPA) received royal assent in November 1991, though it was not proclaimed until the end of 1993 and not implemented until 1994-95. These final stages were the tail end of a process that actually had its inception in 1982, during the final years of Bill Davis's "Red Tory" government. A Health Professions Legislative Review committee was established at that time to prepare draft legislation respecting which health professions should be regulated, to update the *Health Disciplines* and *Drugless Practitioners' Acts*, to devise a new structure for governing the growing non-physician health professions (Ontario, Health Professions Legislation Review, 1989), and to settle "turf disputes" (Hans., St. Com. Soc. Dev., Aug. 6, 1991, p. s-243). (These had to do with inter-professional conflicts about matters such as need for physician referral, and protection and definition of professional titles and scopes of practice.) Of 75 professions that requested to become self-regulating under the new act, it was announced on 3 April 1986, during the minority Liberal administration, that 24 would have it granted.

This was one policy change that had the support of successive governments. The Rae NDP administration saw it as a means by which to establish a regulatory framework for quality assurance and accountability as it tried to shepherd the health care system through substantial reorientation away from hospital-based and physician-provided services. As well, it would "better enable the public to exercise freedom of choice of health care providers within a range of safe options" (Ministry of Health, 1993b) by granting more professions primary care status (i.e., by relinquishing the requirement for physician referral). Under the RHPA, several rehabilitation professions were changed in ways that would have implications for their further professionalization and legitimacy in the private sector. Chiropractors could call themselves doctors and make diagnoses; physiotherapists gained primary care status, no longer needing medical referrals under the law, and had their controlled acts expanded to include spinal manipulations (a change in scope the chiropractors had fought); and occupational therapists became self regulating, after having been unregulated. These regulatory changes had sustantial meaning for professionals poised on the brink of expanding their markets.

New Regulatory Frameworks: The Independent Health Facilities Act

The Rae administration missed an opportunity to use an existing regulatory framework to help tackle its problems in the rehabilitation sector, though it had been developed for other purposes. The *Independent Health Facilities Act* (IHFA) was in fact a legacy of the Liberal administration, having been enacted in April 1990 to:

> control the unplanned proliferation of health clinics in the community offering specialized services often seen as competing with public hospitals, and to provide mechanisms to ensure that standards and quality care are maintained in these clinics. (Sharpe, 1991, p. 39)

It restricted ownership to providers themselves, so as to prevent entrepreneurial investors from creating market distortions in access and quality, as legislators believed was occurring problematically in the United States (Barkin, 1992). As well, under the regulatory requirements for independent facility licensing, the private, for-profit sector would be able "to compete for facility ownership (although a preference for non-profit ownership must be given) and to manage facilities," but it would have to comply with strict controls on ownership, quality-assurance frameworks, and restrictions on both share and license transfers as well as on conditions of licensing (MacMillan and Barnes, 1991, p. 60). Chiefly, the regulatory restrictions were intended to ensure that medical and diagnostic services offered by the clinics did not compete with services in the public sector for public financing (i.e., did not create public subsidization of private health care).

Though originally intended for freestanding clinics providing interventions such as abortions and cataract surgery, the act underwent acrimonious debate in 1989 when the government moved to expand its aegis to include diagnostic facilities, especially those offering radiology services.[13] This greatly expanded its aegis, so that by the time of its enactment, the IHFA applied to 25 extant treatment clinics and another 1,400 extant diagnostic facilities (MacMillan and Barnes, 1991). Its potential implications for community-based health care were much broader, however. Because it established a regulatory framework, and a reimbursement mechanism for community-based providers' overhead facility costs, the IHFA provided an

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[13] A review of the Hansard debate records before the Standing Committee on Social Development in October and November 1989 indicates that almost all brief submissions were from this professional community. Also see Rhodes (1989).

institutional framework that could have been interpreted to include a broader variety of types of community-based facilities, including rehabilitation.

When the IHFA was first enacted, community-based rehabilitation had not been identified as a problem area in the changing health care system. But by the early 1990s, it certainly had been, with the proliferation of private clinics seen as the source of growing access and quality-assurance problems. The Ministry of Health during the NDP government might have used the act as a means of asserting public interest over the burgeoning rehabilitation market's operations. Virtually all the criteria for determining its applicability to freestanding clinics, by which they became eligible for public funding, would have applied to rehabilitation services (Demers, 1991). Bringing facilities under the aegis of the act would have been one response to the recent developments, which were seen as problematic by the ministry. (And, as we shall see in the next chapter on the Harris PC administration, not bringing them under it scarcely allayed foreign, for-profit, corporate investment in them, which the NDP originally feared the act would augment.)

Indeed, the Ministry of Health did briefly consider the possibility of bringing private rehabilitation facilities under the *Independent Health Professions Act*. The decision was

> contemplated within the context of the Physiotherapy Review initiated by the Provider Services Branch in...1994.... (and) was precipitated largely by concerns over access to service, quality, the advent of new health disciplines legislation ..., cost of service, emerging auto insurance legislative changes, etc. While the notion of bringing private clinics like physio under IHFA was discussed as one possible solution to some of the issues, consensus was never reached on some of the more fundamental ones and...the Review was (not) ever completed in terms of a final report with recommendations coming forward. (Confidential e-mail communication, Sept. 2000)

Once again, the Ministry of Health pursued a non-decision in the face of acknowledged and growing problems in the rehabilitation sector.

The Ministry Of Financial Institutions / Finance, and Automobile Legislation

Ministry of Finance and Auto Insurance Legacies for Rehabilitation

In the spring of 1990, not long after the implementation of Bill 68 (the Ontario Motorist Protection Plan), a spokesman for the Insurance Brokers' Association of Ontario proclaimed, no doubt with relief: "If this works...auto insurance will be off the political agenda for a long time" (Loosemore, 1990, p. 7). By that November the 20th, however, it was back on the agenda. Delivering his first throne speech, Premier Rae announced: "After a period of discussion, we will introduce, in the spring, a bill to reorganize the delivery of car insurance to the driving public" (Hans., Leg. House, Oct. 5, 1992, p. 2346).

Bill 68 had set out to address the problem of uncontrollable insurance rates, driven by tort costs. The introduction of a threshold no-fault system under the bill ostensibly was designed to control premium increases by increasing benefits, thereby reducing far more expensive court costs. Much of the debate in support of the bill emphasized that its passage would keep rate increases down to about 8% in urban areas and zero in rural areas, instead of the 35% the industry claimed they otherwise would need to rise at the time of Bill 68's first reading (Hans., Leg. House, Oct. 23, 1989, p. 3175).[14] This was somewhat misleading, as the official increases requested by the industry and agreed to by the government, in the wake of the bill's passage, were much greater.[15]

The solution to the rate crisis of the 1980s – higher benefits, particularly for rehabilitation – constituted the legacy that eventually would transmute into the next problem, even while it left rate increases at roughly the same levels as before the bill had been introduced (though less than the industry had claimed they would have to rise otherwise). The bill increased private provision of rehabilitation services because of the demand that it created. One clinic, for example, reported a 40% increase in revenue quickly after its implementation (Welsh, 1994a). Bill 68 had initiated "a shift in the cost of health care from, in many respects, the public sector

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[14] The promise of 8% urban and zero rural rate hikes "helped [Minister of Financial Institutions Murray] Elston sell the plan to the province's nearly six million licensed drivers" (Lilley, 1990, p. 10).

[15] In the Greater Toronto-Hamilton-Wentworth area (where the majority of the province's population lives, and where industrialization is heaviest), approximately 40% of drivers saw increases between 4-8%, 38% saw 8-15% rises, and 11.2% saw more than 15%. Outside that region, 40% had increases up to 8%, and 7.2% had larger increases (Hans., Leg. House, May 14, 1990, p. 1189). (These figures to not add up to 100%; the remainder experienced either no increase or decreases.) Furthermore, increases were only stabilized at the agreed-upon rates for about two years; beginning in 1993, across-the-board rises began again (McNaught, 1995).

to the private sector.... Now, there's nothing necessarily wrong with that," said a spokesperson for one group of property-casualty insurers, "but it is starting to transfer a cost to the driving public.... health care costs [are] going from the public sector, in terms of what we classically think of as OHIP, into an automobile insurance product, the implications of which need to be thought about" (Hans., St. Com. Fin. & Eco., Feb. 4, 1993, 1710-1720 hrs.).

The early stages of the transformation that policy change had set in motion in the sector were evident in several ways:

- Financing and ownership were increasingly privatized (as a relative proportion of the overall sector activities) due to the "influx of funds into rehabilitation that followed implementation of the Ontario Motorist Protection Plan...(and) many entrepreneurs got into the business of treatment accident victims" (Welsh, 1994a, p. 16).[16] Not only did the OMPP, Bill 68, increase available financing for rehabilitation, but the increased demand driven by its incentive structures drove up the price paid by auto insurers compared to that paid by OHIP or under workers' compensation.
- Where traditional private rehabilitation clinics had been practitioner-owned solo or small-group practices (chiefly owned by physiotherapists, but sometimes by physicians billing through the OHIP G-code[17]), now incorporated groups of physicians, lawyers and insurance brokers joined the market.[18] As well, the insurance industry itself made its initial forays into delivery of rehabilitation services in Ontario. Liberty International Canada, a unit of the the U.S.-based Liberty Mutual Insurance Group, became the first when it purchased a majority share of Toronto-based Premier Treatment and Health Management Centre in 1993, changing its name to International Managed Health Care the following year. At the time, there were three IMHC clinics in Toronto and Liberty, confident of ongoing market growth, planned to expand across the province.

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[16] No researcher yet has undertaken the primary data collection task of charting the numbers and ownership of private rehabilitation clinics in Ontario, much less of the different services they offer. As one interviewee said, these varied rapidly over the 1990s, responding to market incentives created by changing legislated requirements and interpretations of the legislation.

[17] Code G467 allowed physicians to bill for physiotherapy services provided under their direction. These did not have to be provided by a licensed physiotherapist since the RHPA granted title protection for "physiotherapist" and "physical therapist" but no protection for the activities themselves. Anyone could say they performed physical therapy, though not that they were a physio- or physical therapist.

[18] Amongst the 31 limited partners in FIT for Work, a multidisciplinary clinic that opened directly in response to Bill 68, were Bernard Gluckstein, a personal injuries lawyer, and "the clinic's biggest investor with a 10% stake...(and) KRG Management Inc. ... (whose) holdings include KRG Insurance Brokers Inc." (Lilley, 1990, p. 10).

- The nature of services also began to change, as providers responded increasingly to market incentives created by what the legislation, a moving target, made payable.
- Delivery of services began to shift subtly, with the first, early developments of preferred provider networks for physiotherapy services (Canada News Wire, 1998).
- And resource allocation approaches also underwent change with the introduction of early prospective payments. These had been spurred initially by development of the Workers' Compensation Board's Community Clinic program, which made payment on the basis of treatment "packages" for injured workers at various stages of recovery. Several private rehabilitaton providers took the initiative to develop similar approaches to manage care under categories of intervention, such as for chronic pain management or return-to-work/work-hardening.[19]

The chief legacies of Bill 68 were two-fold. First, the creation of a service or product market parallel to the public one had a substantial impact on the interests of stakeholders. As has been discussed, it created inroads for new investment opportunities in the midst of an economy changing rapidly into a services-based one, in which health care was considered a prime area for potential expansion. It gave rehabilitation providers new market leverage they had not previously enjoyed, because demand for them now far exceeded their supply: Within months of the bill's proclamation, the expansion of large-scale rehabilitation businesses, such as FIT for Work, "already have started the escalation of prices.... (because they) strain an already short supply of skilled staff" (Lilley, 1990, p. 10).[20]

Bill 68 had created a burgeoning market for a relatively new type of private rehabilitation provider, case managers (Klich, 2000), who sometimes were internal insurance industry

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[19] These had taken on special importance because of "deeming" under the workers' compensation Bill 162: injured workers had to be rehabilitated to a point at which they were deemed capable of re-entering the labour market, whether a job existed or not; demonstration of this, sufficient to withstand potential dispute resolution, required extensive documentation of work capacity in tailored programs. Under the auto insurance Bill 68, insurers were responsible for income benefits during rehabilitation efforrts for up to three years after the onset of disability. If, at the end of that time, the injury, which could be physical, psychological or mental, still "continuously prevents the insured from engaging in any occupation or employment for which he or she is reasonably suited by education, training or experience," [s.12(1),(5)], the insurer was liable for lifetime income payments. Thus, demonstrating the ability of a claimant to perform work became as important under Bill 68 as it had under workers' compensation. See also Swinimer (1994).

[20] One way that clinics circumvented this problem was through "deskilling," by hiring lower-paid, unregulated kinesiologists and physical education graduates to perform interventions under the higher-paid supervision of chiropractors, physicians, or physiotherapists.

employees[21] and sometimes were externally hired on a case basis, in both instances creating new conflicts.[22] Also called rehabilitation counsellors or rehabilitaton consultants, these new providers might be members of regulated colleges (e.g., physiotherapists and occupational therapists who had been hired in this new capacity) or graduates of the few community college programs for rehabilitation counsellors that existed in Ontario. Or they might be neither, in which case they were entirely unregulated and unaccredited, a situation that began to be defined as problematic during this period (Hans., St. Com. Res. Dev., Aug. 29, 1994).

While the creation of this market parallel to the public one eroded public rehabilitation services by draining away qualified staff, the public sector never declared an interest in retaining them. There was virtually no indication at the time that the Ministry of Health recognized that public availability of rehabilitation services was declining, or was threatened by the creation of the new private market. While the ministry had proclaimed rehabilitation a "priority" area, its interests as declared by institutionalized programs was limited to rehabilitation-service in-patient beds, in acute and specialized hospitals, and to home care services. Most of the rehabilitation performed for the working-aged temporarily injured, however, is provided on an ambulatory, out-patient basis, either in hospital clinics or in freestanding facilities. The ministry took no programmatic interest in hospital clinics, leaving them up to the decisionmaking power of individual hospitals. And its only programmatic interest in the freestanding clinics is through OHIP payments, which it had limited, leaving the majority of their financing to come from private sources. It declared virtually no interest in their administrative or managerial accountability to the public sector with respect to service delivery standards. Thus the first legacy of Bill 68 had been its transformation of interests in the rehabilitation sector.

Its second chief legacy, arising from the first, was the way in which it shifted policy levers over a health care sector away from the jurisdiction of the Ministry of Health. It transformed a health-care policy issue increasingly into a non-health care policy one, even though it required even more health care inputs (i.e., resources). The implications of this for the interests of the Ministry of Health grew through this early period and came slightly more to the fore in the build-up to the Rae administration's new automobile insurance policy, Bill 164, the major

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[21] "We recognize that, within an environment of no-fault insurance, it is incumbent upon us as insurers to provide the best possible management of the rehabilitation needs of our insureds. At the request of the auto insurers in Ontario, the Insurance Institute of Ontario has established a certificate program to educate claims staff to a level of certified insurance rehabilitation coordinators" (Hans., St. Com. Fin. & Eco., Feb. 4, 1993, 1010-1020 hrs.).

[22] *Ibid*, 1440-1450 hrs.

policy decision that will be discussed later in this section, after discussion of the problems it set out (overtly and covertly) to tackle.

Policy Problems and Preferred Solutions

By and large, casualty insurers saw few problems with Bill 68 in its early days; indeed, automobile insurance profits rose to $1-billion during the first six quarters after its implementation, peaking in 1991 (Hans., Leg. House, Sept. 30, 1992, p. 2262; McNaught, 1995). The growth in rehabilitation costs, which rose by approximately 150% between 1990 and 1991 (pre- and post-OMPP) was perceived as somewhat problematic. But these costs remained small relative to the total costs of compensation (i.e., including income benefits), and the insurers remained sanguine about the new legislation for about two years. Also, amongst the driving public at large, an Insight Canada Research poll released in 1992 found that 81% of Ontarians were either very or somewhat satisfied with their car insurance policies (Hans., Leg. House, Oct. 1, 1992, p. 2293).

What brought automobile insurance legislation back to the table at the very outset of the Rae administration, was the government's own commitment to the issue. One "quite widely known proposal" in the NDP's Agenda for People, its campaign platform going into the 1990 election, "did seem to summarize (the platform's) symbolic thrust – for both new NDP voters and more traditional stalwart supporters alike: the promise of public...automobile insurance" (White, 1998, p. 218). In his throne speech of 20 November 1990, Rae promised to make good on his campaign promise to create a "driver-owned" automobile insurance plan.

Yet in September 1991, one year after taking office, the government announced it would not be proceeding with public automobile insurance after all, precipitating deep rifts within its own ranks.[23] The reason it gave was that, in the midst of the worst throes of the recession, it could not afford to pursue the undertaking. (Further details about this decision will be discussed below. At this point, a review of the problem definitions is the focus.) Nonetheless, the government believed that there were real problems in the system that needed to be tackled, chief

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[23] In particular, it alienated Premier Rae from Peter Kormos, who had been the NDP auto insurance critic during the fierce debates over Bill 68. But it was far more widely contentious, given that Rae had made numerous comments about the issue over his years as the party leader and during his formal opposition to the preceding Liberal government. He had made it a leading issue in both the 1987 and 1990 campaigns. See party stalwart Mel Swart's brief to the Standing Committee on Finance and Economics (Hans., St. Com. Fin. & Eco., Jan. 27, 1993) for an indication of the response of some insiders to its rescinding.

amongst them that "the OMPP no-fault benefit schedule is significantly deficient...it leaves out significant numbers of people, individuals, groups and classes of people almost totally from effective coverage and representation" (Hans., Leg. House, Sept. 30, 1992, p. 2262). Some observers believed that the administration's primary problem was the need "to save some political face" (*ibid*, Oct. 1, 1992, p. 2293), after having reneged on a public insurance plan. It is certainly true that the executive's backtracking on such a high-profile campaign promise, made on the heels of the NDP caucus's bitter battle against Bill 68, was, ironically, akin to the promise of a solution to the liability crisis that had cornered the Peterson government: it had to be seen to do something. Even if the solution it offered was different than the original one proposed, it would have been untenable to say: well, we made a mistake, there was no problem after all. Or, worse still, to say: Bill 68 took care of it.

Aside from political interpretations, however, it is also the case that the NDP had been arguing for several years, since before forming the government, that it was opposed to the *status quo* in automobile insurance. Its past stance had been to prefer a publicly run system that also maintained full tort access alongside generous no-fault benefits. (Justice Osborne had recommended these latter two parameters, but the retention of the private industry.) Being publicly run would produce efficiencies by cutting out the "middle-man's" profits and reducing administrative costs, and these savings could be used to provide the generous benefits, which in turn would minimize tort suits even though these would remain available as a form of justice.

This was not, however, the course the administration's policy decisions took when it finally set out to tackle automobile casualty insurance, which it had said for so long it wished to do.

Decisions

The Rae government made two significant decisions in approaching automobile casualty policy. The first was to abandon its long-trumpeted plan of public insurance, and the second was to implement a new bill instead. Bill 164, the *Insurance Statute Law Amendment Act, 1993*, was designed to make up for the abandonment of public insurance, and to demonstrate the administration's commitment to having insurers satisfy public interests by increasing insurers' obligations for statutory benefits.

PUTTING ASIDE PUBLIC INSURANCE

In 1991,[24] the property and casualty insurance industry investment in the province of Ontario represented some $9 billion. The industry, which employed approximately 47,200 people in the province (about half of them as insurance companies' employees, and the other half as independent agents, brokers and adjusters), wrote $7.3 billion in property and casualty (P&C) premiums, half of the entire country's. Sixty per cent of that derived specifically from automobile insurance (as opposed to other properties, damage to which also could entail personal injuries).

Such substantial economic activity made the insurance industry a formidable adversary to theNDP's ambitions to nationalize the industry, which would have entailed substantial initial costs. Estimates of how many jobs would have been lost in the course of consolidating (or amalgamating) the industry varied wildly, from the broad range of 5,000 to 14,000 jobs (about 60% of them part-time) estimated by the Insurance Bureau of Canada to be threatened by nationalization (White, 1998), to the staggering "projected displacement of 22,000 jobs" declared by the Thunder Bay Chamber of Commerce (Hans., St. Com. Fin. & Eco., Feb. 1, 1993, 1340-1350 hrs.). It was similarly uncertain what additional one-time start-up costs there would be. Estimates of these ranged from $1.5-$2 billion (*ibid,* Oct. 1, 1992) to $4 billion (Glasbeek, 1991-1992), though the latter included approximately $3.5 billion that the IBC claimed the industry should be compensated under the free trade agreement, which stated that any direct or indirect expropriation of a business demanded compensation. (It is possible that the industry would have had a weak case, since the Supreme Court had "suggested that there is no inherent right for private actors to sell liability insurance" [Glasbeek, 1991, p. 76]).

Others have speculated that Rae may have chosen to abandon public automobile insurance because, once in power, the government underwent a process of "policy learning" and realized that it was an untenable option (Lascher, 1999). And still others have speculated that the decision was motivated by Rae's efforts, in the midst of a changing economy, to maintain the goodwill of the business sector (Ehring and Roberts, 1993). What is most relevant to rehabilitation about the decision not to nationalize the industry, however, is that it left the government with few other levers for addressing its problems in the area. Having decided to abandon a public system, its options for managing the problems facing it – both as it had itself

defined them rationally, i..e, inequities, and as they stood in the wake of the abandoned promise, i.e., loss of credibility – appeared only to be found in, first, adjusting the statutory benefits and, second, otherwise being seen to "discipline" the insurance industry. (As part of this disciplinary strategy in lieu of nationalizing the industry, the government already had reinstated the 3% tax on premiums in 1992, creating $120 million in provincial revenue [Hans., St. Com. Fin. & Eco., Feb. 2, 1993, 1110-1120 hrs.)

Another option may have been to separate property insurance from casualty and personal injury compensation and benefits altogether. Indeed, a Roeher Institute report from the period notes that:

> As the debate rages between those who favour no-fault and those who do not, much of the discussion centres on who should run auto insurance -- government or the insurance industry -- when the more important issue might be whether there should be auto insurance at all with respect to personal injury compensation. (Roeher Inst., 1992)

This was not an option, however, that the government ever entertained, judging by the publicly available documents. To do so would have entailed reorganizing the entire disability income and benefits structures in place. This idea continued to be championed by a number of proponents throughout the early 1990s, including the NDP itself. (Linked to its changes in workers' compensation, which will be discussed in the next section, was a plan to establish a Royal Commission to review this issue.) And still another option may have been to regulate the other inputs on the property side of property and casualty insurance (including the unregulated repair and towing industries, as well as operating costs), which amounted to the majority of total product costs and, therefore, the majority of premiums.[25] This would have given the government time to develop an approach to the much larger issues of disability benefits, including rehabilitation and labour-market reintegration, in which it had declared an interest while, at the same time, tackling the issue of inefficiencies in the insurance industry.

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[24] Numeric data in this paragraph are from the presentation of the Insurance Bureau of Canada to the Standing Committee on Finance and Economic Affairs, on Bill 164, on Jan. 26, 1993.

[25] See the presentation of William M. Mercer Ltd., actuaries for the Ministry of Financial Institutions, to the Standing Committee on Jan. 26, 2993. Also that of People Against the Insurance Nightmare (PAIN) on Feb. 4, 1993: "brokers' commissions are in the area of 15-17% of total expenditures; insurers' profits in the area of 10%; administrative overhead adds another 10%; about 60% of what's left goes to property damage claims; and personal injury consumes a total of about 20-30% of the entire disposition" (1650-1700 hrs.). (An insurance industry

The Rae administration, however, had conflated whether the industry was publicly or privately administered with the fairness of the balance between tort and benefits when it argued that a publicly administered system would make possible both higher benefits and unrestricted tort access. This was largely a rhetorical device. It is possible, in economic terms, that the savings garnered by (a) unified public administration, which would reduce administrative overhead in the industry, and (b) monopsony power, which would give the single government payer greater leverage in negotiating fees with providers (as is the case in publicly insured health care) could have been used to offset tort costs fully.

This, however, is not necessarily the case. Indeed, it has not been tried in any other jurisdiction. Most casualty and accident insurance systems operate tort and benefits as opposite ends of a see-saw. If they were both down at the same time, unpredictable costs would be entirely shifted onto the claimant. If they were both up, equally unpredictable costs would reside with the insurer. New Zealand's pre-1992-reform Accident Compensation Corporation (a comprehensive accident benefits system that made no distinctions based on mechanism of injury, even including medical misadventure) made available generous benefits, integrated with the health care system (integrating rehabilitation with them was always problematic). But it was entirely no-fault, that is, no tort whatsoever was allowed (as opposed to the "threshold no-fault" system in Ontario, which allows a combination of tort and no-fault benefits). British Columbia's publicly administered automobile insurance, at the time of the debate, allowed tort access but limited benefits considerably, to a level slightly greater than had existed in pre-OMPP Ontario and much lower than existed after the OMPP. Quebec's publicly administered automobile insurance provided generous benefits, but no tort access for economic loss, although drivers could purchase entirely separate, private "top-up" policies that did allow tort.

Bill 164, the Insurance Statute Law Amendment Act, 1993

The new legislation received royal assent in late July, 1993. While the government trumpeted it as a combination of the best of both tort access and no-fault benefits, it was in fact an uneasy marriage of minimally increased tort and substantially increased benefits, as follows:

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representative speaking immediately after PAIN countered this claim, saying that total operating costs were in the range of 22-30%, not the 35% suggested by PAIN's numbers).

- Income benefits rose to a maximum of $1,000 per week (from the previous limit of $600), which would cover some 97 per cent of the work force at the time. The test of disability (i.e., the basis for access to income benefits) no longer applied for three years, but only for two, after which a lifetime Loss of Earning Capacity Benefit could be assessed. In other words, the insurer now had two years instead of three to rehabilitate the claimant; otherwise it would face long-term cost exposures.
- Under the bill and its regulations, rehabilitation benefits rose to $1 million, separate from the unlimited lifetime long-term care benefits. They were to include all "reasonable measures to, (a) reduce or eliminate the effects of any disability resulting from an injury; and (b) facilitate an injured person's reintegration into his or her family, the labour market and the rest of society" (S.O. Chapter 10, Part I, Sec. 26). Rehabilitation benefits were to apply not only to those with physical injuries, but those with mental and psycho-social sequelae after car accidents.
- Very importantly, no longer were rehabilitation benefits to be on an indemnity basis, but on an entitlement basis, i.e., they became directly billable to the insurer as soon as the provider(s) deemed them necessary, rather than being reimbursed after the fact, transferring immediate decisionmaking power to claimants and their caregivers.

The increase in long-term exposures greatly spurred insurers' incentives to rehabilitate claimants within the two-year window, while the increase in short-term exposures spurred their incentives to find ways to manage the costs as much as possible. To offset the increased benefits, Bill 164 entirely eliminated the "threshold" that had existed under OMPP, which had allowed tort suits for economic loss under certain conditions. Under Bill 164, no economic-loss tort was possible, but tort access for non-economic loss increased.

Insurers were not pleased with these increased exposures, as a reading of the lengthy Hansard debate record makes clear. By 1993, when the new NDP legislation was imminent, their profits had started to decline while costs rose once again (Ontario Insurance Commission, 1993/94), and they were not so sanguine as they had been for the first two years after the implementation of the Liberals' Bill 68. At the time of the Bill 164 hearings, insurers had coalesced, as an interest group within the broader community, around an argument that now medical and rehabilitation costs were problematic. (This was an agenda that would feed into the next iteration of the legislation under the Harris government, as well.) While the government's actuaries and an alternative actuarial study both assumed that Bill 164 would result in a 20%

increase in medical-rehabilitation costs, most of it incurred soon after implementation and then tapering off, the industry commissioned its own actuarial study, which found that there would be a 90% increase, spread uniformly throughout the term of disability (Hans., St. Com. Fin. & Eco., Jan. 26, 1993).

The strength of insurers' articulated interests and viewpoints was matched primarily by that of the Ministry of Finance's representatives. The scope of conflict was not broadened a great deal beyond these parameters during the hearings. One supporter of the government's increased rehabilitation benefits, Dr. David W. Slater (who had chaired the Slater Commission in the prelude to Bill 68), wondered about whether "relationships to other programs, such as Workers' Compensation and OHIP, (have) been worked out" (*ibid,* Feb. 3, 1993, 1010-1020 hrs.). And one Ministry of Health insider says,

> I do remember many discussions on this issue with the Ministry of Finance. I think they understood the wisdom of proceeding on such things as standards, funding guidelines, etc., in tandem with the Ministry of Health, even with Health taking the lead as it should. But none of the senior people at the Ministry of Health showed much interest even in our own emerging plan, which really was a multi-sectoral one. So I suppose I can't really blame Finance for proceeding on their own, given the lack of leadership at Health. (Confidential e-mail correspondence.)

As well, relatively few providers presented at the hearings for Bill 164. (This supports Schattschneider's [1964] claim that the "losers" in a conflict will try to broaden its scope. In the lead-up to Bill 68, those who stood to lose the most were the lawyers and claimants who wished to maintain tort access. In the lead-up to Bill 164, however, it was the insurers and brokers who stood to lose the most and who thus represented the vast preponderance of presenters.) Of those providers who did present, their chief concern was about quality of care standards, which they said were compromised by the emergence of different tiers or streams that were developing for access because of the multiple payer system. By this point, OHIP was still reimbursing non-hospital based physiotherapy at a $12.20 per visit, and the Workers' Compensation Board paid OHIP rates for routine treatment, and a $49 per diem under its Community Clinics Program, which required several hours of daily clinic attendance (Sinclair et al., 1997). The president of International Managed Health, the chain of rehabilitation clinics owned by Liberty Canada, said

the following year that "International treats a few Workers' Compensation Board cases but not many because the rates are too low" (Chamberlain, 1994, p. D1).

Not surprisingly, then, providers supported increased obligations for private rehabilitation provision in the most lucrative of those streams, automobile casualty insurance. Between 1990 and 1995, the property and casualty industry's spending on combined medical and vocational rehabilitation rose from about $50 million to about $400 million, most of the increase occurring under the impetus of Bill 68, which was the dominant legislation throughout the period, as Bill 164 did not come into force until 1 January 1994.

One of the issues that had begun to emerge around Bill 164 was that of who would get to interpret what constituted "reasonable" rehabilitation (Hans., St. Com. Fin. & Eco., Jan. 28, 1993). That is, there was an emerging issue of managerial control (which we will see was much more explicit in the debate that occurred during this period about workers' compensation benefits). Nonetheless, in spite of insurer opposition, Bill 164 left it in the hands of providers to determine what was reasonable treatment, and in that of insurers to pay for it. Indeed, it made this a public statutory entitlement, rather than simply a benefit under a private contractual arrangement (McNaught, 1993). Where a dispute arose, cases would be referred to a new dispute resolution system composed of approximately 100 Designated Assessment Centres (DACs), the majority of which were privately owned by providers, to determine the reasonableness of treatment plans.

The Ministry of Labour, and Workers' Compensation

Labour/Compensation Legacies for Rehabilitation

The expanded private rehabilitation market that now existed was chiefly a legacy of Bill 68, the automobile casualty insurance, but also partially of Bills 101 (1984) and 162 (1989), which had created greater incentives for employers to ensure rehabilitation of injured workers. The expansion of experience rating under Bill 162 had introduced employers to the imperative of managing their own claims, and had significantly changed their interests by making them singly rather than collectively liable. Intended to decrease "free riding," there is no telling whether experience rating actually achieved this. But it did suggest to employers that they would be wise to seek out new strategies for internally controlling exposures and increasing their prospects for rebates under the program. Some no doubt turned to rehabilitation measures, such

as establishing physical demands analysis projects to increase opportunities for modified work programs, or hiring ergonomists and others who could advise on injury prevention strategies, or developing internal modified work and injury-management programs, as Ontario Hydro and the City of Toronto had. And others may have turned to ways that made it possible to keep costs in-house, rather than have them go through the Board.[26]

As well, the Board's Community Clinics Program had introduced a prospective payment-type system into rehabilitation services. As Tuohy (1999) writes, looking at U.S. examples, introduction of prospective payment systems by one group of payers creates incentives for providers to recoup losses by shifting costs to other payers, who in turn respond by establishing mergers that give them enough power to control providers (i.e., monopoly and oligopoly, the free-market versions of monopsony power). Whether this would happen in Ontario, it was not yet possible to tell, but certainly prospective payments may have been one reason that WCB costs began to decline in the early 1990s and this would have encouraged providers to look to other payers, such as casualty insurers.

Shortly into the early 1990s, the ratio of lost-time to no-lost-time claims began to reverse. The Board itself has not ascertained whether this was because employers were not reporting injuries, because fewer injuries were occuring, or because employers were stepping in with private-sector services for rehabilitation rather than risking surcharges under experience rating and additional administrative costs. All of these are possible outcomes of Bill 162. And all are potential ways in which the legislation "privatized the issue," as one Board executive says (confidential interview).

The important thing, with respect to the public-private change trajectory taking shape, is that experience rating under Bill 162 had "meant that each employer would be increasingly responsible for the costs of his own workers' injuries" (Maton, 1991). Whether this was good or bad is a normative judgment that cannot be linked to outcomes (such as quality of or access to rehabilitation) for lack of coherent evidence. But it clearly established a direction towards privatization (or enterprise-level internalization of costs) through the incentives it created.

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[26] One study (Kralj, 1994) found that must cost containment activity under the board's experiencing rating programs focussed on "activities such as claims monitoring, appeals and SIEF [Second Injury and Enhancement Fund, in which employers get relief for claims they say had pre-existing injury components]," while a much smaller role was being played by provision of rehabilitation and retraining services.

Policy Problems

As they had with automobile insurance, the NDP came to office with an explicit intention to reform workers' compensation policy. In the midst of the recession and in the wake of Bill 162 (it is not possible to tell which was the more salient factor), unemployment amongst those on compensation stood at about 80% compared to 30-40% in the late 1980s, prior to the introduction of the new dual-award system and the expansion of experience rating. Also as with automobile casualty insurance, the NDP sought both to rectify the impacts of previous legislation and to leave its most fundamental conditions intact. In this case, the conditions were those of experience rating, and the impacts were those of worsening unemployment, poverty, and fears of loss of control over decisionmaking under experience rating. (See various presentations that occurred before the Standing Committee on Resource Development on September 8, 1994.) Both sides of the argument focussed their concerns on how to interpret and deal with the growing unfunded liability, which became framed as the single most important policy problem facing workers' compensation legislation.

From 1990 to 1993, the board's unfunded liability had risen from $9 billion to $11.5 billion dollars (Workplace Safety and Insurance Board, 1999a). In the midst of a recession, the increase received much anxious attention and disapproval. For employers, the growth of the unfunded liability was the most pressing issue that had to be dealt with. In addition, they expressed their concerns that any further loss of their control over decision making in benefits and expenditures – e.g., by a rolling back of experience rating – would only continue to drive the liability levels upwards.

Interpretation of the liabilty was a contentious issue. Some, especially those representing labour, saw it as resulting from a changing economy and a declining number of companies being enrolled with the Board because of it. (See, for example, the Injured Workers' Consultants submission to the hearings on September 7, 1994). Others saw the liability as being driven by reckless board decisionmaking in favour of profligate spending on benefits, as an exchange between the Progressive Conservatives' Elizabeth Witmer and then-Minister of Labour Bob Mackenzie during the Rae government's tenure exemplifies (Hans., Leg. House, Oct. 30, 1991).

Still others saw the unfunded liability as a manufactured crisis, a mythical monster created out of skewed definitions. Perhaps the most succinct expression of this perspective on a

complicated matter was that put forward by the London and District Labour Council representative at the draft legislation hearings:

> The unfunded liability situation at WCB has actually improved in the last 10 years. The liability, when expressed as a funding ratio of assets to liabilities, has gone from 32% to 37%..../ If I had a $100,000 mortage and $37,000 in the bank, I think I'd feel quite comfortable. I think most people would feel quite comfortable. (Hans., St. Com. Res. Dev., Aug. 29, 1994, 1000-1010 hrs.)[27]

The government itself, however, came down in the middle between these perspectives. It explicitly concurred that the unfunded liability was indeed a problem and it promised to find a way to control and reduce it. But it also saw secure access to benefits as a significant problem that needed to be tackled concurrently. (See Premier Rae's speech to the House, on October 26, 1993.) The question was: how could it tackle both?

As tort and benefits were in see-saw balance under casualty insurance, experience rating and other control mechanisms were considered to be in see-saw balance with benefits under workplace injury insurance (where tort is not an option in Ontario). Workers and their representatives argued that the board's aegis should be broadened to bring in new revenues (and account for the changing labour market) and that experience rating should be eliminated, or at least tightly monitored. This, they said, would off-set strengthened rehabilitation and re-employment requirements, thereby both reducing the liability and increasing the coverage. The Office of the Worker Adviser's submission noted that "there was an off-balance in experience rating of $187 million in 1993; $187 million more awarded in rebates than charged by surcharge. That figure, just for example, would more than pay for the ... additional benefits to injured workers" (Hans., St. Com. Res. Dev., Sept. 8, 1994, 1200-1210 hrs.). On the other hand, employers and their representatives argued that experience rating should be maintained and broadened, as a positive incentive, and rehabilitation expenditures should be brought under tighter control.

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[27] See also the submission by Reuben Roth to the Standing Committee on Resources Development, August 24, 1994.

Policy Decisions

BILL 165, THE WORKERS' COMPENSATION AND OCCUPATIONAL HEALTH AND SAFETY AMENDMENT ACT, 1994

Introduced on 18 May 1994, Bill 165 sought to firmly establish rehabilitation as the primary meaning and purpose, alongside compensation, of the *Workers' Compensation Act*. To that end, it both increased the Board's capacity to get involved in vocational rehabilitation and the statutory requirements that it do so.

Section 9 of the Bill introduced many amendments to the rehabilitation section of the Act (Sec. 53). It amended it to require the board to contact the injured worker promptly, and immediately thereafter the employer, to identify possible need of vocational rehabilitation (VR) services. It required the board to provide these services to both the worker and the employer, whenever the board considered it appropriate to do so, and gave the board's VR workers the right to enter the worksite in order to determine appropriate modifications and rehabilitation planning, a right of decisionmaking that employers had fought against. The section also put a new duty of cooperation on the employer with respect to all VR services, which included recommendations for interventions. And while making it possible for employers to request return-to-work related information from health providers, as they and their supporters, including Progressive Conservative members of the house, had sought, Bill 165 stipulated that the ultimate decision was bound by the employee's consent and evidence that any prescribed requirements had been met..

All told, Section 9 of the new Act greatly expanded the Board's legislated obligations to intervene and provide vocational rehabilitation services, rather than to leave them at the discretion of the employer, and its capacity to do so. Its obligations on the employer to comply were a reversal from the previous provisions that a worker had to notify the board if re-employment provisions were not being met through rehabilitation, modified work, and the like.

These changes had less to do with the amounts of benefits than with the centrality of rehabilitation and reinstatement. To give the requirements stronger teeth, the Bill incorporated enterprise-level prevention, rehabilitation, and re-employment strategies into determination of rebates and surcharges under experience rating. In effect, this "best practices" approach gave the board power to enquire of employers what they were doing to these ends and to use the information for fiscal sticks and carrots. Although the legislation retained experience rating, to employers' relief, these new provisions introduced new public controls over how it could be

used by employers, much against their protests (Bill 165, Sec. 29 amendments to Sec. 103.1 of *Workers' Compensation Act*).

How to handle disputes over access to benefits, particularly with relation to the role of the Workers' Compensation Appeals Tribunal, had also been a point of contention in the lead-up to Bill 165. The Liberal opposition, the third-party PCs, and employers all sought to make the Tribunal increasingly subordinate to Board policies and legislative interpretations, out of a growing concern at the time that the Tribunal would begin to permit claims for occupational stress (Hans., St. Com. Res. Dev., Sept. 28, 1994; Shortt, 1995). Ultimately, the NDP majority in the house overrode this opposition, and Bill 165 maintained the Tribunal's quasi-judicial status as it had existed under Bill 162, which had created it, maintaining its ability to interpret the legislation differently than did the Board of Directors, a sorely contentious point at the time. Relatedly, while mediation had been voluntary under Bill 162, Bill 165 made it possible for any of the three parties (employee, employer, or board) to intiate it and, once initiated, it had to be provided by an impartial third party (Sec. 22) rather than by the board itself.

Concurrently, Bill 164 disbanded the former Board of Directors (BoD) and created a transition one with a future mandate for strict bipartism. The new BoD was to be made up of four directors representative of workers; four representative of employers; two vice-chairs (one from each of employers and workers); and two directors representative of the public, nominated on the joint recommendation of worker and employer members. The new BoD would be at arm's length from the Board, as opposed to the former arrangements, under which the senior officers of the BoD could be the same as those under the Board. In the new structure, administrative and policy setting functions were to be strictly divided between, respectively, the Workers' Compensation Board and its Board of Directors (Sec. 23).

Finally, concurrent with Bill 165, the government announced that it would establish a royal commission to examine the relationship between workers' compensation and other income maintenance and disability support systems. (See parliamentary assistant Sharon Murdock's address to the house on the day that Bill 165 received third reading, Dec. 5, 1994.) At long last, it was taking steps towards the universal disability system it had been talking of since the mid-1980s. Indeed, Odoardo Di Santo, Chair of the Board, had written in 1992, before his appointment, that three steps had to be taken towards consideration of an alternative way of supporting and rehabiltiating disabled working-aged people (Di Santo, 1992). The first step, he said, was to deal with the Board's problems in the areas of service delivery, rehabilitation, and

reemployment. The second would be to re-examine the ongoing role of the WCB as a specific body, since it had become increasingly dificult to disentangle its role from that of other public and private social security systems. And the third would be to have a sustained public discussion about a universal system.

In retrospect, Bill 165 appears to have been the first step, and establishment of the royal commission a tentative move towards the second and third steps. The commission was to report by the end of 1995. But an election intervened in June, just six months after Bill 165 had gone into effect.

Summary And Conclusions

By the end of the NDP's 1990-1995 tenure in office, the relegation of rehabilitation services had been increasingly yoked with income benefits, control over which lay in non-health purview. A combination of privileging of hospital-based and physician-provided services under health, increased demand under casualty insurance, and an increased employment focus under workers' compensation had moved the bulk of expenditures and controls for rehabilitation almost entirely out of the direct health-policy sphere. The situation was a complete reversal from what it had been ten years before, in 1985. As such, the movement of rebilitation increasingly into the purview of finance and labour policy changed the powers of the three main institutional players and their corresponding communities with respect to this area of health expenditures. It made rehabilitation an area of the Canadian health care system that was moving increasingly towards the American model of market mechanisms, or at least had made the sector much more congruent with such an approach.

In the long term, would the increase in market mechanisms lead to losses of professional autonomy similar to what had occurred for physicians in the United States (Tuohy, 1999; Starr, 1982)? It was not entirely possible to tell yet. Providers appeared not to have lost any ground during much of this period, particularly because of changes under casualty insurance. But it is foolish to disregard more long-term relationships between interests and policy change, which undoubtedly brings new battles to the fore. The *Regulated Health Professionals Act* had increased rehabilitation professionals' ability to move into the private sector. The market in services had grown, and relatively new interests, such as case management companies, had emerged. Benefits had increased under automobile insurance, and rehabilitation requirements

had increased under workers' compensation. These changes would all create new interests in time.

Changes Along The Public-Private Axes

Privatization of Financing

The most significant increases in private financing of rehabilitation services occurred under automobile casualty insurance. In addition, there was an increase in private financing of vocational rehabilitation (a category that includes all payments made while a claimant receives vocational rehabilitation, including those for medical-rehabilitation), even though payments strictly in the health-care categories fell.

Ontarians were also financing rehabilitation services out of pocket or through their extended health plans. From 1985 to 1995, inclusive, the percentage change in the share of private payments for services that included physiotherapy and chiropractic was 4.06%. Between 1990 to 1995, it rose an additional 3% -- greater rates of increase than were seen for dentistry or vision care, both of which also fall outside "core services." (Adapted from Canadian Institute for Health Information, 1999, Table D.2.6.1.)

As a point of comparison, we may consider the increase in these private expenditures as opposed to that for drugs or other institutions (such as long-term and chronic care). Spending on non-physician professional services, including dental and vision care as well as rehabilitation services, rose from $1.3 billion in 1985 to approximately $3.2 billion in 1995 (in constant dollars). Admittedly, the majority of these would be for dental and vision care, data for which are collected together with rehabilitation services by the Canadian Institute for Health Information. But we have seen that rates of increase were greatest for the rehabilitation category. Private spending on drugs during the period, rose from a little below $1 billion to a little over $2.5 billion. And private spending on other institutions rose from a little less than $500 million to just under $1 billion (*ibid*). Figure 2 (attached at the end) provides a graphic illustration.

Privatization of Management

Changes under both automobile casualty insurance and workplace injury insurance crystallized agendas around management issues. Some public capacity to manage cases was increased through the WCB's vocational rehabilitation provisions. But very powerful incentives

also were created and maintained for employers to develop internal case management expertise. Under automobile insurance, there was no substantial increase in private management control. But the most important change along this axis had to do with how both new Acts changed the agendas for both insurers and employres to gain new managerial control, which was an outcome of the financing changes.

Privatization of Administration

As management strategies had been privatized by experience rating, so too had some aspects of administration been, since employers, by keeping claims out of the Board's scope, would have had to take on administration of injuries internally.

Privatization of Regulation

As during the Liberal administration, none of the Acts brought in by the NDP government could be said to have substantially deregulated the rehabilitation sector, although the movement of practices out of the aegis of the Ministry of Health created the prospect of a vast new area of practice that was unregulated from a health perspective.

Privatization of Ownership

Once again, the overall implications of policy change during this period increased private ownership of rehabilitation services. Importantly, it had begun to increase private corporate ownership, rather than the "mom-and-pop" competitive market that had existed earlier. During this time, Ontario's rehabilitation sector began to see the emergence of early corporatization, making it arguably the first sector of direct health care provision (that is, including assessment and treatment) that had.[28]

Political Privatization

The privatization that was occurring in ownership, financing, management and rehabilitation, all created further huge losses of publicly available information and public accountability. More importantly, they spurred incentives to gain greater control over decisionmaking, which would be played out in the next iterations of legislation.

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[28] For discussions of corporatization, see Starr (1982 and 1985) and Fried et al. (1987).

Chapter Five: The Harris Progressive Conservatives, 1995 to 1999

Rehabilitation Legacies for the PCs: Plus Ça Change...

By the mid-1990s, even rehabilitation providers themselves, who stood to gain from the "very dynamic marketplace out there" (Hans., Leg. House, June 17, 1996, 2000-2010 hrs.) were worrying that "the explosive growth in the number of rehab clinics" and the lack of coherent regulation in the sector had "led to unnecessary treatment, prolonging illness and increasing costs" (Hans., St. Com. Fin. & Eco., Feb. 21, 1996, 1110-1120 hrs.).[1] As well, the disaggregation and increasing proprietarization of information, as of policy, was making it difficult to understand outcomes or set goals (Campolieti and Lavis, 1998).

The changes that had been occurring since the mid-1980s exemplified the extent to which the organization of institutions, and the disorganization of decisionmaking within that structure, had shaped both more of the same (the now increasingly entrenched legacy of fragmentation), and unexpected change (the dynamic responses to old structures under new pressures).

This chapter, the third and closing act of our empirical case history, unfolds as did the previous two. First, we take stock of where we are now, of the legacies in the rehabilitation sector that attend a new administration, and particularly of how those legacies shape public and private roles. Then, we explore how these legacies became framed as new problems and solutions by the three major institutional players, and what new decisions arose from them. Finally, we consider the implications of these decisions for further change in, and entrenchment of, public and private roles, responsibilities and capacities along the public-private axes of interest here.

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[1] The speaker here, at the hearings for reform of workers' compensation, is Tony Melles, CEO of CBI Physiotherapy, Rehabilitation & Sports Injury Centres. Melles, a physiotherapist, was one of the founding principals of the Canadian Back Institute, which was started up by Dr. Hamilton Hall, an orthopaedic surgeon in Toronto, in the 1970s. In 1997 CBI merged with Select Medical, a private US company, started by a physical therapist, which has since also purchased NovaCare Rehabilitation in a series of mergers. CBI currently consists of 81 clinics, mostly in Canada but with a handful also abroad (< http://www.cbi.ca/default2.cfm>). As of February 2001, Select Medical Corporation was described in its website as "a national network of specialized, acute healthcare facilities and services including long-term acute care hospitals, inpatient and outpatient rehabilitation, and contract therapy services. Select currently operates 51 hospitals and 676 outpatient clinics throughout the United States and Canada. Select is a privately held corporation, well-capitalized through both venture capital and bank credit facility financing. Select's current operating revenues exceed $700 million annually" (<http://www.selectmedicalcorp.com/synopsis.htm>).

Institutions

With respect to organizational institutions in the rehabilitation sector, the NDP government had changed very little. It was not for lack of intent or interest: since the md-1980s, extensive reorganization of disability systems (which are the shell within which much rehabilitation occurs) had been a party goal. But the administration moved so slowly, for better or for worse, and for a variety of reasons from economic to internal,[2] that it had only begun to put in place an institutional mechanism – the royal commission – for exploring system change, much less implementing it, by the time the next election was upon it.

Instead, Rae's government had done what the Peterson Liberals before it did: use the existing institutional framework as a template for resolving new problems, even though it explicitly mistrusted the framework. If it could not implement public automobile insurance, then it would instead increase the regulated fiscal responsibilities for rehabilitation and other benefits of the competitive private players. If rationalization of disability systems was its long-term goal, then it would instead begin by increasing employers' responsibilities for implementing return-to-work programs. If a rehabilitation strategy to deal with the growing out-patient and community sector was necessary in the Ministry of Health, there would nonetheless still be no programmatic structures for it to flow through other than those for individual hospital decisionmaking.

The unintended effect of these decisions was a radical refocussing of interests in response to private payers' growing responsibilities and capacities.

Interests

Table 1 provides a graphic account of what physiotherapists could expect to earn from the three major payers by the mid-1990s.

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[2] See, as well, Baranek (2000) for a discussion of how this aspect of the Rae NDP government played out in Ontario's long-term care sector.

Table 1: Physiotherapy fees under the three major payers, Ontario, mid-1990s

Activity	Initial Assessment ($) (and report)	Treatment ($)
OHIP Fee Schedule*	12.20	12.20[3]
Ave. Auto Claims*	75.00 (140)	30-45
Workers' Comp.**		
"Usual Care"	12.20	12.20
"Community Clinic Program"	49.00 per diem	49.00 per diem

* Source: Ontario Health Insurance Plan
** Source: Sinclair et al. (1997)

Clearly, "It is unlikely that clinic owners would provide the more resource-intensive CC program at the lower per visit rate" (Sinclair et al., 1997, p. 2921). That is, service delivery would be differentiated depending on the payer, affecting both patients' treatments and providers' incentives. As well, both the low cap on OHIP payment for physiotherapy services and the per diem rate for the CC program potentially created incentives for providers to minimize service. Anecdotally, it became not unusual to see private clinics with gyms occupied by CC attendees performing "supervised" exercise programs (supervised by lower-paid kinesiologists, for example), while the automobile-injured received more resource-intensive one-on-one treatment with licensed physiotherapists.

The dynamic was similar to what Tuohy (1999) describes happening on a much broader scale in US Medicare payments: the development of a "logic of entrepreneurialism" in which the goals of management for profit in an increasingly complicated system of payment converged with the goals of professionalism in health care. But what was the evidence that such a realignment of interests was emerging as a legacy of the legislative changes that had occurred in the rehabilitation sector and the multi-payer marketplace they had fostered? Perhaps the most important evidence is in the way that the rehabilitation health services sector had begun to be reorganized as a market, from small, competitive businesses to large corporate interests. This, too, is what Liberty's Brian Johnston (1994) had meant by the "post-OHIP society": a transformation of the market from individual health professionals – "craftspeople," as it were –

[3] The original OHIP billing fee for community-based physiotherapists in the mid-1960s had been $5, which was the same as the standard fee rate in the private sector at the time. (Source: Mary Sauriol, Proprietor, Physiotherapy Associates, Toronto; past director, Private Practice Group, Ontario Physiotherapy Association. Telephone conversation.)

to a new business model, increasingly fashioned after the managed-care models in the United States. Indeed, mergers with and acquisitions by US care management and delivery interests accelerated through the mid-1990s.

In December 1995, Sun Healthcare of New Mexico acquired a 76% interest in Columbia Health Care, a group of 16 physiotherapy clinics in Ontario, for an estimated $12 million, planning "to expand its rehabilitation business in Canada" (Crosbie, Jan. 31, 1996, p. 8). By May 1997, when it was announced that Sun was now planning to sell Columbia Health Care, in order to focus on its nursing-home businesses, Columbia had become a group of 31 rehabilitation facilities across Canada.[4]

As noted above (fn. 79), the Canadian Back Institute, which was founded in the 1970s by Dr. Hamilton Hall, an orthopaedic surgeon in Toronto, merged in 1997 with Select Medical, a private US company. And, in the same year, Liberty Mutual expanded its interests in the area of rehabilitation. In November 1993, Liberty Mutual International Canada Holdings Ltd., a subsidiary of Liberty Health in the United States, had purchased a controlling interest in Premier Treatment and Health Management Centre, a group of three multi-disciplinary rehabilitation treatment facilities in Toronto. After changing the company's name to International Managed Health Care, Liberty Mutual was "set to implement a new business plan that calls for the building and acquisition of new facilities to make its services more accessible by expanding not only in Ontario, but across Canada" (Welsh, 1994b, p. 32). And, by 1997, Liberty Mutual also had purchased the non-profit Ontario Blue Cross and had "studied extensively Canada's non-profit workers' compensation system...(which) critics say...indicates a wish by Liberty to take it over as well" (Medline, 1997, p. B7).

While the core services of the Canadian health care system remained a relatively unassailable institutional citadel against private incursions, both insurers and care managers saw the "biggest economic incentive" in the new return-to-work rehabilitation environment and in disability management (Yellin, 1996, p. 7). With the emergence of these new interests, others in the changing environment began to look for ways to "afford some protection to practitioners who did not wish to be enveloped by the large American HMOs, but who were committed to providing a superior service to insurers." In 1992, Toronto physiotherapist Brenda Rusnak

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[4] On its sale, Columbia was split into Canadian eastern and western divisions. The eastern division is owned and operated by Ron Tall, a Torontonian acting with US venture capital funding. The company is now poised for further expansion. In the west, it is owned and operated by Tom Saunders out of Calgary, Alberta.

organized a group of practitioners into a preferred-provider network, whose services she marketed to payers. By 1998, the group, called ACTIVE Health Management, expanded to include other types of rehabilitation service providers (Canada News Wire, 1998). In northern Ontario, a rehabilitation consulting company that had opened in 1991, in the wake of auto and workers' compensation insurance reforms, had expanded to 18 cross-Canada locations and more than $10 million in annual revenues by 1998. Its three main purchasers were automobile insurers, employers, and long-term disability insurers seeking to minimize costs (Mills, 1998). Physicians, too, began to increase their investments in physiotherapy and rehabilitation practices, and then "stream" their patients into different treatment venues on the basis of what the highest available payment was (Hans., St. Com. Fin. & Eco., Feb. 26, 1996), a self-referral practice that constituted one of the problems needing to be solved in the next iteration of automobile insurance.

These unfolding interests, responding as they did both to the longstanding structures for private roles in the sector and to the more recent legislative changes that had opened new opportunities within them, were both congruent and incongruent with some of the dominant ideas about health care generally, and disability and rehabilitation issues specifically, circulating at the time.

Ideas

Ideas about rehabilitation specifically focussed on a growing sense of urgency about system "integration."[5] The way that the *Canada Health Act*, and the legacies leading up to it, had fragmented the country's health care system into core and non-core services, combined with the shift of services into the community as a result of changing health care technologies, had rendered rehabilitation services, amongst others, increasingly difficult to access without private resources (Deber et al, 1998). At the provincial level, concerns were being expressed by the Metropolitan Toronto District Health Council, as will be discussed in the following section on policy under the Ministry of Health. And even at the federal level, consideration was being given to how to integrate disability-related policy, not only to resolve inequities in income benefits but in rehabilitation access (Government of Canada and Task Force on Disability Issues, 1996).

Yet ideas of integration, propounded by public-sector actors,[6] were coming increasingly face to face with broader ideas about what should be the rightful role of the public sector altogether in the health care economy. On the face of it, the recession in the early 1990s may be seen as having driven the growing sense of crisis and constraint in Ontario's (as in Canada's) health care system, the sense that new sources of financing for it had to be found, particularly private sources (Canadian Medical Association, 1995). Yet, a much more profound recession, crisis and constraint – the depression of the 1920s and '30s – had led to a new, expanded role for the public sector. Similarly, the push to reform health care systems (largely through the introduction of public-private competition and related ideas) that occurred across western economies during the late 1980s and early 1990s (Saltman and Von Otter, 1992, 1995), had not been a dominant idea in response to the worldwide recession of the 1970s either, even though by then health care systems were a substantial welfare-state expense.

Asking, during a conference held in Toronto in early 1997,[7] why health care system reform had become a major issue across the world of welfare states, Yale University professor of politics and public policy, Theodore Marmor, answered that the reasons were threefold. Firstly, medical financing had become an increasingly uncontrollable part of many governments' budgets. Second, its cost growth outstripped the capacity for continued funding growth of mature welfare states. And, finally, there had been a "wearing down" of the post-war consensus about the welfare state. In Marmor's view, the "rhetoric of markets and management" – fuelled by changing interests in an increasingly globalizing economy in which players sought new production and consumption market opportunities – had become a potent "persuasive definition," by which redefining the problems as free-market constraints (especially constraints on "consumer choice") and public-sector inefficiencies gave the appearance of taking the problems away.

So, on the one hand, a broader set of ideas about transfering responsibility from the state to the individual and to the community (i.e., to the market), which were themselves inseparable from historical changes in the political economy, was being offered as a solution to governments

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[5] Integration was a topic of interest at a 1996 conference, Business and Health Care: A Work and Health Perspective, coordinated by the province's Institute for Work and Health and McMaster University's Centre for Health Economics and Policy Analysis, and held at the Royal York Hotel in Toronto, Ontario, on May 1-2.

[6] Integration is also a topic of interest amongst private-sector actors in health care, e.g., amongst health management and administration organizations. But in Canada at the time, public-sector actors led the discourse.

seeking to control health care costs. And, at the same time, public-sector actors at the national and provincial levels were considering what their role might be in system integration. How did these play out in policy for Ontario's rehabilitation services within the new Progressive Conservative administration under Premier Mike Harris?

Broader Contexts And Contingencies

Political-Social Context In Ontario

In June 1995, Ontarians elected their first expressly neo-liberal government, that is, their first government explicitly committed to reducing the role of the public sector. Having chosen MPP Mike Harris as party leader in 1990, the provincial Progressive Conservative party launched its election campaign platform in May 1994. Called Common Sense Revolution, it announced that, "The political system itself stands in the way of making many of the changes we need right now. Our political system has become a captive to big special interests" (Progressive Conservative Party (Ontario), 1994). As a remedy, the party proposed several major campaign planks:

- to lower taxes by 30%;
- to decrease government spending by 20%; and
- to implement "Removal of Barriers" to business, including (a) abolition of the Business Health Tax, a payroll tax that existed for health financing (worth about $400 million at the time), to be replaced by the "Fair Share" plan, which shifted the tax onto individual income; and (b) reduction of income benefits paid by employers under workers' compensation by 5% (or about $100 million).

Reductions in government spending were to come from several sources, including:

- decreasing the provincial public service by 15%, or 13,000 people, i.e., back to the size it was in 1985;
- reducing the number of MPPs from 130 to 99 by making riding boundaries for provincial elections the same as those used for federal elections;
- reducing welfare payments;

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[7] Examining Fundamental Values: The future of health policy and health care. A conference organized by the Ethics Centre, Ryerson Polytechnic University, Toronto, Ontario, January 10-11, 1997.

- and redesigning education funding, including the partial de-regulation of post-secondary tuition fees.

Eager to assuage voters' concerns about their health care system, the Common Sense Revolution platform emphasized that spending reductions would not occur in the area of health, and "Under this plan, there will be NO new user fees" (*ibid,* p6).

After winning the election with 44.8% of the popular vote, and 63% of the parliamentary seats, the new government moved swiftly to implement its agenda. By June 27, 1997, exactly two years after having been sworn in, it had passed 81 pieces of legislation (Mackie, 1997). It then took a summer recess and returned to pass another 31 in the 51 days that the house sat before its next recess in mid-December – a new law every 48 hours (Urquhart, 1997).

One of its earliest and most important acts was Bill 26, the *Savings and Restructuring Act* of November 1995. Known informally as the Omnibus Bill, because of its broad sweep, Bill 26 paved the way for numerous initiatives and powers, including the province's power to unilaterally close hospitals and, towards this, to establish the Health Services Restructuring Commission, which will be discussed in the following section on changes within the public health sector.

Early on, the administration had established a sub-committee on Restructuring and Local Services, mandated to find "ways to reduce (the) size and cost of all governments" over which the province had jurisdiction – i.e., provincial and municipal levels – and to increase business opportunities in the private sector (Campbell, 1996). Its preference for the private over public sector, to the greatest extent possible, also was heralded by the August 1996 creation of the new Cabinet Committee on Privatization. On the committee sat a new Minister without Portfolio with Responsibility for Privatization, Rob Sampson, and several of the most powerful members of cabinet: the Deputy Premier and Minister of Finance (Ernie Eves), who chaired the committee; the chair of Management Board; and the Minister of Labour. The broader climate of ideas about market superiority in all areas of the economy, including the traditional preserves of the welfare state, such as health, had penetrated Ontario politics. Although the Progressive Conservatives' platform, Common Sense Revolution, vowed to maintain health care spending and impose no new user fees in the sector, the commitment to maintain spending at the same level, in the context of a growing population and even minor inflation, would constitute what Paul Pierson (1994) has called "implicit privatization" or decrementalism.[8]

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[8] As well, new user fees did soon appear, e.g., for seniors' out-patient medications.

The administration's approach to financing the three cornerstone welfare programs in its jurisdiction – health, welfare, and education (a fourth, unemployment insurance, is under federal jurisdiction in Canada) – was shaped by its own ideology, but was given greater legitimacy and lesser accountability by the federal government's decision to reduce transfer payments to the provinces. In his March 1995 budget speech, federal finance minister Paul Martin had announced his government's intention to "redesign the very role and structure of government itself" through $29 billion in spending cuts over three years, for various branches of government, including 19% cuts for all federal departments and the elimination of 45,000 federal public-sector jobs. Seven billion dollars of the spending reductions would be achieved through a major programmatic change: the elimination of the previous funding formulas for fiscal transfers to the provinces in support of health, welfare and education programs, and the introduction of block funding under the Canada Health and Social Transfer (CHST). Under the new formula, which would represent a loss in transfers of $3.6 billion for Ontario between 1996 and 1998, it would be entirely up to provinces to determine how to allocate the resources amongst the three competing arenas.[9]

The federal government had not been alone in its hopes to reform disability policy in the mid-1990s. One of Harris's election platforms had been an Ontarians with Disabilities Act, which would have oiled the wheels for return-to-work initiatives, reinforcing them as a fairly uniform mandate across policy arenas, supported by a provincial interest, and thus making them perhaps easier to link with rehabilitation health services for a broader array of recipients (i.e., not just those to whom automobile and workplace injury insurance applied). But aspects of the business community were strongly opposed to such an Act. While agreeing, for example, that incentives might be needed for business to integrate the disabled – such as public education about disability, technical assistance to business, and tax incentives – what was not needed was

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[9] A number of the programmatic and funding changes introduced by the finance minister in 1995 bear a strong resemblance to recommendations made to him the previous year by the International Monetary Fund. The IMF had then urged the minister to replace the former Canada Assistance Plan with block funding and to reduce both health and education funding that existed under the Established Program Funding program. It also recommended changes in seniors' pensions, unemployment insurance, and transfers for social housing, all of which did indeed occur in the 1995 budget. See Canadian Consortium for International Social Development (1999). The congruity between the IMF's recommendations and the federal government's actions, as between the federal Liberals' actions and the provincial Conservatives', suggests the extent to which broad readjustments in the global economy, and the politics attending it, superceded national and provincial politics, as well as individual parties' ideologies.

"heavy-handed regulations" (Canadian Federation of Independent Business, 1998). An Ontarians with Disabilities Act was not passed during the Conservatives' first administration.[10]

Economic And Labour Market Environment

By 1995, Ontario's economy already had begun to recover from the recession of the early years in the decade. But the labour market recovery coincided with the beginnings of income-security and social program reforms described above. And much of the job growth that occurred in the mid-1990s, even as the economy grew and unemployment declined, was in jobs that paid minimum wage, or were temporary or contractual and did not pay benefits (Canadian Centre for Policy Alternatives and Choices, 1998). In Ontario, as elsewhere in the country, poverty rose, particularly in the large cities (Picard, 2000). Toronto, the province's and the country's largest city, climbed in the nation's urban-poverty rankings from 15th-poorest to 6th-poorest, at the height of the province's economic resurgence (Gadd, 1998). By 1998, the poverty rate in the country stood at 16.4%, 1.4% down from what it had been during the worst of the recession of the '90s and still a good 3% above what it had been a decade earlier; some 10% of Canadians relied on either unemployment insurance or welfare for income (Rae, 1998); and many more depended on various social-transfer programs to keep from slipping into poverty (Myles and Pierson, 1997). In 1997, transfers "constituted 57 percent of the income of families in the bottom income group - in large part because of the insecurity of the labour market and its inability to pay a living wage for many families, especially those with children to support" and because of reductions in unemployment insurance and welfare payments (Battle, 1999, p. 5).[11]

Increasing numbers of working-aged Ontarians found themselves, in the new economy, without the benefits and employment standards, including occupational health and safety standards, that accrued to more standard work arrangements: "eligibilty for firm-level benefits...(is) tied to minimum service requirements. The same applies for weekly hours, whereby part-time workers who do not meet a predetermined number of weekly hours are

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[10] Nor has it been thus far in its second administration, which was elected with a majority in December 1999.

[11] More than half of low-income families that year were "headed by people who worked in the paid labour force but remained poor because they earned low wages and/or could find only seasonal or part-time work. The heads of one in five low-income families worked full-time, and one in three were employed part-time.... (These families) saw their average income benefits from social programs fall by roughly the same amount as their earnings increased; transfer payments fell by around 3.1 percent or around $320 in 1997. So their total income actually declined slightly, to just $17,559 in 1997" (Battle, 1999, p. 5).

excluded from benefits" (Lowe et al, 1999, p. 24). The trend towards small-business employment had accelerated from the mid-1970s until 1990 greater than the trend toward own-account self-employment (OASE, i.e., freelancers, consultants, and contract workers). But in the 1990s, this trend had inverted itself, so that by 1998, 11.7% of total employment was in the OASE category – more than one out of every ten employed individuals.

In Ontario, purchase of individual health and disability insurance between 1985 and 1999 displayed the trends seen in the following table:

Table 2: Number of persons covered by non-group private health insurance benefits in Ontario, 1985-1999, incl. dependants

Product	1985	1990	1995	1999
Income	139,848	220,007	226,852	270,478
Extended health	14,202	28,996	230,369	181,754
Personal Accident	147,469	164,081	222,016	207,133

Source: Canadian Life and Health Insurance Association

What can we make of these trends? It is difficult to be certain without a good deal more data for comparison and analysis of movement between the individual and group coverage categories, especially for small-group and individual coverage. On the face of it, however, not only was the market for private insurance clearly growing – though an analysis of it in relation to the entire labour market would shed much greater perspective on this[12] – but the declines in health and accident insurance between 1995 and 1999, especially in the face of still-growing income insurance (i.e., declines in the former cannot readily be attributed to return to more standard forms of group insurance), suggest that more individuals are making the decision to assume the potential economic risks of illness and injury.[13]

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[12] To provide some perspective, at the 1990 hearings for the Liberals' auto legislation changes, the executive director of the Canadian Federation of Independent Business said that, "some 173,000 Ontarians hold individual disability policies. These would be held primarily by owner-managers and the self-employed. Allowing for the possibility that some small business people have arranged small group plans, there is still a significant shortfall in coverage for our sector" (Hans., St. Com. Gen. Govt., Jan. 16, 1990, p. g-298).

[13] What about those fortunate enough to be able to buy into a small-group private plan? The following example of benefits in a small-group plan in 1995 for a relatively high income earning group (rehabilitation consultants in downtown Toronto, earning approximately $60,000 - $80,000/year) is illustrative, and comes from the writer's experience: 100% of eligible employees had to participate for the plan to be available; employees paid individually; disability income benefits were set at 66.7% of monthly earnings to a maximum of $1500/month (i.e., $18,000/yr.); and medical-rehabilitation benefits were set at a limit of $350 per year per specialty.

Now we turn our attention to how policy changes in the three dominant policy sectors were affecting public and private responsibilities for those risks with respect to rehabilitation availability and provision.

Ministry Of Health

Legacies for Rehab

Table 3 below provides a synopsis of the availability of physiotherapy between 1990 and 1997. (Physiotherapy is singled out because it is the rehabilitation profession whose history most easily demonstrates shifts between the public and private sectors. This in turn is because of the legacies of the *Canada Health Act* and of the tradition of therapists working under the aegis of physicians and within hospitals.)

Table 3: Number of physiotherapists and their employment settings, Ontario, 1990-1997

	1990	1994	1995	1996	1997	% change 1990-97
Active physios	3670	4894	4685	4727	4766	+ 30
In general hospitals	45.4%	35%	38%	36%	32%	- 21
In long-term care / homecare	18.8%	11.9%	12.4%	13.6%	12%	- 36
In private practice	24%	27%	29%	40%	45%	+ 87
In "other"*	0.01%	1.5%	1.8%	3.3%	4.3%	+ 43000

Source: Alliance of Physiotherapy Regulatory Boards, 1990-1997

* The "other" category captures numerous settings, including consulting firms and agencies, insurance carriers, and rehabilitation counselling. It is not possible to break out details.

And what of those individuals in the new "self-employed" economy who must purchase individual insurance? In New York State in the year 2000, a self-employed freelance writer paid $US400/month for sole coverage with modest benefits (Kelly, 2000). The growth of the market for small-group and individual insurance coverage in Ontario and Canada is a topic that has, as yet, received little attention. In the United States, there is evidence that rising costs of HMO coverage for employment-based groups – a cost that it is now thought by some to have been kept artificially low in order to spur confidence in the industry and was rising steeply by the late 1990s – are leading employers, especially small ones, simply to drop coverage for workers. This would force people out into the individual-policy market. Because of the high costs here, only those who are or have been sickest would tend to

It should be borne in mind that these changes occurred in the context of a population that grew from about 10 million to approximately 10.8 million. The leaps in private practice and practice in "other" settings occurred alongside substantial declines in general hospital practice and declines as well in community settings with public input – long-term care and homecare – into which "reinvestment" supposedly was being made. The availability of publicly funded rehabilitation services in the community had declined as a legacy of earlier reforms. And the incentives for physiotherapists to provide OHIP-funded services were not only stymied by the ministry's ongoing refusal to grant new licenses, but by the fee schedule of $12.20 per patient visit it had left unchanged since 1989 (OHIP). With the purchase of a facility bearing an OHIP license costing approximately $500,000 in 1996 (Hans., St. Com. Fin. & Eco., Feb. 22, 1996, 1750-1800 hrs), physiotherapists in possession of them would have been encouraged to increase volumes and minimize treatment time and intensity of service for OHIP patients. Most likely, those patients who could afford it may have been encouraged to "go down the hall" where, for a few out-of-pocket dollars, they could receive faster and better service.

By 1996, a review of physiotherapy services in Ontario (conducted jointly by the Ministry of Health, the Ontario Physiotherapy Association, the Schedule 5 Physiotherapy Association,[14] and the Ontario Medical Association) found that the entire province, and especially rural regions, were substantially underserviced with respect to publicly funded physiotherapy, citing the extent to which hospital cutbacks under the Rae administration had led to the closure and downsizing of many rehabilitation departments (Ontario Physiotherapy Association, 2000). As a corollary, it would not have been surprising to find growth not only in private physiotherapy practice, as we have seen, but in the practices of chiropractors, massage therapists, kinesiologists and others who provided substitutive services in the private sector.

Problems and Preferred Solutions

Publicly, the ministry during the first Harris administration defined its health care system problems as, chiefly, twofold: firstly, a financing "crisis," wrought by the changes in federal financing and the broader economic conditions described above; and, relatedly, a need to rationalize hospital and physician services, its most costly expenses. Internally, however, it was

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purchase insurance, driving premium costs higher, but insurers would seek to underwrite only the healthiest individuals, creating an adverse selection spiral (Fisher, 1998).

[14] Schedule 5 of the Ontario Health Insurance Plan applies to OHIP-licensed physiotherapy facilities.

not without awareness of similar problems specifically in the rehabilitation sector that had evolved in recent years.

In 1993, the ministry had begun work on multi-year strategizing for rehabilitation services in the province, as discussed in the previous chapter. A report by the Metropolitan Toronto District Health Council two years later supported the direction, stressing the need for substantial reorganization of the sector, calling for "an increased emphasis on outpatient rehabilitation and...expanded availability of community-based rehabilitation services" (Crawford et al, 1995, p. 24).[15] And an October 1996 rehabilitation strategy plan, fuelled by the ministry's planning group and by recent reports from the province's Institute for Work and Health (Institute for Work and Health, 1995, and 1996), laid out the key issues in the sector as being "service fragmentation, cost control and inequitable access," as well as a lack of information and planning tools that could help to solve them (Ministry of Health, 1996). Goals of the plan were defined as being an "integrated, affordable system," which had been made more urgently needed by hospital restructuring, increasing rehabilitation costs, uncertain access and quality, considerable historical public policy investment, and recent automobile and workers' compensation reforms. The rehabilitation strategy group recommended that the ministry's Senior Management Committee approve the overall direction and approach, as well as the proposed strategy of striking a partnership amongst key payers. And it recommended that this partnership be given the capacity to develop adequate tools to implement its directions. The draft strategy never went any further, its trail running cold in 1996.

The legacies of past programmatic structures, which did not include a focus on or channels for rehabilitation policymaking and, especially, policy implementation, particularly in the out-patient sector, stood in the way and the plan fizzled out on the back burner. Institutionally, at the level both of its organization and its resources, the ministry was focussed on hospital and physician services, and remained so through the early years of the first Harris administration, as we shall see in the discussion below about the Health Services Restructuring Commission. Other than the small handful of people who had been involved in developing it, and they had virtually no capacity to implement it alone, nobody at the Ministry of Health showed much

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[15] The MTDHC reported that: "Many of the PSG [Patient Service Group] Task Forces identified lack of access to rehabilitation services and the existence of significant unmet and unrecognized needs for rehaiblitation.... evidence of a substantial unmet need for rehaiblitation services.... Rehabilitaton should be an integral component of the full spectrum of healths ervices," including inpatient, outpatient and/or in-home care" (Crawford et al., 1995, p. 71).

interest in the nascent plan for rehabilitation services. As for the broader rehabilitation community, it was so fractured, and had so few programmatic channels through which to operate itself and was generally so under-resourced itself, that no pressure came from it to move the plan forward.[16]

Decisions

With respect to the rehabilitation sector, particularly those services for out-patients, non-decisions had prevailed once again. But this did not mean that other ministry decisions had no implications for the sector: they did. The most significant of these was the creation of the Health Services Restructuring Commission.

HSRC (The Health Services Restructuring Commission)

Bill 26, which had proposed the creation of the HSRC, received royal assent at the end of January 1996. By 28 February, Dr. Duncan Sinclair, dean of medicine at Queen's University, had been named as chair, and a mandate had been released. The commission's jurisdiction was to include: making restructuring decisions regarding hospitals, including their closures, amalgamations, program transfers, or any other necessary actions with respect to facilities and programs; making recommendations to the Minister of Health about how to improve efficiency and effectiveness; and making recommendations for required community reinvestments in order to create the comprehensive, integrated system that formed the ultimate goal (Health Services Restructuring Commission, 1997a).

The Commission saw its work as being to deal with the impact of the declining use of-inpatient services (approximately 1/3 of inpatient beds had been closed since the early 1990s) and the corresponding shift in care to community, non-hospital settings. But the extent of its institutionalized powers – to make orders regarding hospitals, but only recommendations regarding community-based services – hobbled its capacity in respect of the long-term, system-wide goal. Reporting specifically on rehabilitation in April 1998, the commission noted that the sector was "characterized by...service fragmentation, lack of cost control and inequitable access to services." Its recommendations included not only that in-patient utilization assumptions should remain the same (except for increases of approximately 25% for cardiac and trauma rehabilitation – striking in the context of system-wide general reductions), but also that local

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[16] Confidential e-mail communication, Sept. 2000.

rehabilitation networks be established. This was to be done with the involvement of the private sector, which had become extensively involved in the sector, and with "some level of funding support by the Ministry of Health," in order to coordinate services and to make them publicly accountable (Health Services Restructuring Commission, April 1998, pp. 61 & 71).

In March 1997, the commission had described a grand vision of an integrated system that "allow(ed) organizations to meet the total health needs of a defined, rostered population" providing "the full spectrum of health services needed to promote health and provide health care for Ontario's population" (HSRC, 1997a, p. 4; HSRC, 1997b, p. 3). In June of the same year, it had recommended closing 25 out of 80 Ontario hospital sites, operated by a total of 68 hospital corporations, and turning four others into ambulatory care centres (Coutts, 1997). By November, it had actually cut hospital costs by approximately $800 million ($470 million from closing 11 metropolitan Toronto-area hospitals) and had recommended $400 million of reinvestments in community-based services (Chamberlain, 1997). Yet by early 1998, a physician and health services analyst was saying that, "The government created the Health Services Restructuring Commission, but it hasn't restructured health services, all it's done is go in and chop hospitals and not do anything for the rest of the system" (Coutts, 1998).

Funding Allocations Decisions

One of the most important resource allocation decisions made during this period resulted from two other matters. Firstly, the ministry abandoned efforts to tackle primary care reform, which it had tried to pursue in order to change from high-cost fee-for-service arrangements to, it was hoped, lower-cost capitated group practices – a policy much opposed by the Ontario Medical Association as a standard for all family practitioners. Secondly, it had hamstrung the HSRC's capacity to implement any restructuring other than hospital closures; any other system-wide restructuring could only be recommended. And, though the commission strongly recommended regionalization and rostering for all services, hospital and non-hospital alike, the Ministry made a non-decision about proceeding with these. So, while battling physicians about primary care on one front, it was dealing with much bad press about hospital closures on another.

In this context, it struck an agreement with the Ontario Medical Association in May 1997 to provide a 1.5% annual increase in the pool of money available to physicians. In addition, the

agreement with physicians eliminated clawbacks on billing that the Rae government had implemented, and stipulated that the increase would be based not on how much physicians had earned the previous year but on how much they had billed (i.e., the larger amount).

While the agreement may have been a bid to mollify both angry physicians and a worried public, the resources for it could only have come out of a relatively static pool of funding. Although the government claimed to have increased spending, that is, to have enlarged the overall pool, there is evidence that what appeared on the budgetary books as increases were in fact simply a change in accounting practices, from cash accounting (money counted when spent) to accrual accounting (money counted when announced). Thus, announcements of severance costs, benefits owed to departing workers, counselling and retraining fees, communications and public relations, legal fees, consulting, and auditing fees – all of them steeply increased in the wake of hospital restructuring – became included in budgetary health spending (Toronto Star, Editorial, 1999; Mackie, 1998).

The agreement with the OMA would likely have put additional pressures on other programs funded by the ministry, including community services and hospitals, where decisions about public financing of rehabilitation services (and others) were being made. Although the ministry did change its name to the Ministry of Health and Long-Term Care, and did make budgetary allocations for long-term care – which the HSRC had singled out, along with rehabilitation, as being especially problematic – there is little to suggest any significant new allocations for rehabilitation. To the contrary, the allocative decisions made would have decreased what was available.

Hospital Rehabilitation Service Decisions

No coherent data exist about out-patient rehabilitation service decisions made at the hospital level – a level of decision making for the sector that was a legacy of past policies. Early evidence suggests, however, that during this period a trend began of hospitals outsourcing these services. This not only raises questions about accountability for access to and quality of publicly funded services, but it also raises questions about legality and professional ethics.

An initial screening survey distributed to 115 outpatient physiotherapy facilities in the Greater Toronto Area[17] set out to determine what changes were occurring in them, particularly

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[17] The GTA refers to an economic region covering some 7,200 square kilometres (3,000 square kilometres), in which approximately 4.5 million people lived in 1996, nearly half of them in Toronto itself. Between 1991 and 1996, the region's population grew by 9%, mostly in the suburban areas. (Sources: Greater Toronto Service Board

with respect to outsourcing decisions (Craning et al., 2000). (Outsourcing was defined in the study as contracting out services, either to external managers or to privately-owned providers.) With a response rate of 77%, the authors found that 67% of hospitals either already had implemented outsourcing of outpatient physiotherapy services or were considering doing so. This was reported to have led to reductions of approximately 30% in publicly funded physiotherapy services by 1997. Sixty per cent of respondents said that outsourcing had first been proposed in their facilities in 1996-97, and 35% in 1998-1999; the remaining 5% had first considered it in 1994-1995. All reported that the chief promoters of and decisionmakers about outsourcing were hospital administrators. Only six hospitals actually had implemented the decision, but another 31 were still in the process of considering it at the time of the survey. (The remainder who had considered it had set aside the idea for the time being.)

A paper released by the Ontario Physiotherapy Association calls these "private clinics in public hospitals" (Ontario Physiotherapy Association, 2000, p. 5). On the face of it, this activity seems to contravene legal conditions for hospitals. But the hospitals have argued that the legislation is open to interpretation and, more importantly, no legal investigation or interpretation has been undertaken to make a decision about whether the practice does indeed contravene the *Canada Health Act* (which specifically insures outpatient physiotherapy services provided in hospitals), the *Ontario Public Hospitals Act* or the *Ontario Health Insurance Act.*

These activities also have implications for professional ethics, chiefly with respect to self-referral and referral for profit, activities that are frowned upon by most professional colleges. The OPA paper noted that there was evidence that hospitals with both public and private outpatient rehabilitation facilities had been "streaming" patients towards their private clinics if they had the coverage or were willing to pay out of pocket. The incentives for these patients was shorter waiting times than in the public stream. Such streaming explicitly contravenes *the Ontario Health Insurance Act*, the paper pointed out. Another tactic that concerned the OPA was the prospect that hospital administrations would have incentives to direct their staff physicians to refer their patients specifically to the organization's private clinic, which would be regarded as "self-referral" or "referral for profit" by the College of Physicians and Surgeons of Ontario. Similarly, staff physiotherapists seeing inpatients might be directed to encourage their patients

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website, < http://www.gtsb.on.ca/Public/gta.htm>; and Human Resources Development Canada website, <http://www.on.hrdc-drhc.gc.ca/english/lmi/eaid/ore/cen96/to/>). The City of Toronto used to be one of 5

to attend the hospital-based private facilities post-discharge, contravening their regulatory college's ethics code.

This concept of "renting" out rehabilitation departments to external managers and providers, for for-profit purposes, raises the question: why would hospitals not say they are doing the same with their surgeries, or nursing stations, or other outpatient clinics? The most likely answer is that those services have been made much more politically accountable by institutional frameworks, and the politics of privatizing them in this way would invoke a fierce and potentially costly electoral backlash. In short, hospitals are doing it with outpatient rehabilitation departments because they can, and doing so frees up internal resources for allocation elsewhere while shifting costs to the private sector. Their interpretations of the relevant Acts seem flimsy, prima facie, and unlikely to bear much scrutiny. But nor are they likely to receive much scrutiny, given the legacies of the rehabilitation sector.[18]

The Ministry Of Finance And Automobile Insurance

Legacies for Rehabilitation

By 1996, changes under the automobile insurance act had spurred the growth of an unwieldy rehabiliation marketplace, the boundaries and complexities of which eluded most of its participants. It is not possible to separate the extent to which the results were due to automobile insurance alone, as opposed to workers' compensation insurance changes and the shifting public rehabilitation sector, but many observers attributed both the dynamism and confusion in the marketplace primarily to the auto legislation revisions that had occurred in 1990 and 1994. Individuals within the field whose business it was to understand the sector were unable to grasp all its tentacles: "Rehabilitation services in Ontario are changing significantly," wrote two authors in 1996,[19] "but no single person or organization has a clear, over-all picture of the scope of these changes, their speed, or even their importance.... Even the principal payers do not have

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municipalities under one regional governing authority known as Metropolitan Toronto from 1954 to 1997, when they all were amalgamated into a single municipality during the first Harris administration.

[18] Anecdotally, there are reports that physicians at hospitals that have outsourced their physiotherapy services are finding that the hospital's clinics are allocating most of their time to automobile and workplace insurance claimants, leaving very little space for OHIP patients. As a consequence, physicians are referring these patients instead to chiropractors, whose servics are at least partially covered by OHIP and whose waiting times are shorter. (Confidental discussion, March 2000.)

[19] One of the authors, Paul Holyoke, had also co-authored the provincial Institute for Work and Health's two Rehabilitation Services Inventory & Quality Project reports; in addition, Mr. Holyoke was at the time, and

consistent information. All this (makes) it difficult, if not impossible, to understand the state of these services in Ontario" (Kinzie and Holyoke, 1996, p. 42).

One of the fastest growing fields in the rehabilitation market was that of case managers and rehabilitation consultants or counsellors. By 1997, there were 1,400 rehabilitation consultants accredited in Ontario through the Canadian Association of Rehabilitation Professionals (CARP; telephone communication). Their backgrounds ranged from medicine to chiropractic to physical and occupational therapy, from social work to psychology.

Prior to 1990, however, the field was relatively small in Canada (although much larger in the United States). By the mid-1990s, there were nearly 90 accredited Masters and PhD programs for rehabilitaton counsellors in the United States, while in Ontario the field remained almost entirely unaccredited and unregulated (Hans., St. Com. Res. Dev., Aug. 29, 1994). The growth of private payers' responsibilities after 1990 had spurred payers to look to individuals who could help them to manage their cost exposures. Not trained themselves to understand health care language or to communicate with the myriad caregivers who might now be involved in a claimant's case – from physicians to therapists to psychologists and ergonomists – automobile insurance adjusters began to hire consultants to help them negotiate and establish case management plans. The consultant would meet regularly with the claimant, his caregivers and his employer (if one was available), to determine what steps were being taken for the claimant's rehabilitation or were not being taken and perhaps should be, to explain benefits provisions to the claimant and his caregivers, to recommend and explain interventions to the adjuster, and to oversee, monitor and report on progress or lack of it, for the purposes of funding and claims management decisions being made by the insurer.[20]

Because there were no legislated requirements that consultants be accredited, either through CARP or through the United States' Commission of Rehabilitation Counselor Certification – which had for some time offered a Canadian certified rehabilitation counsellor (CCRC) designation (Hans., St. Com. Res. Dev., Aug. 12, 1997) – there is no telling how many individuals were operating at the time as rehabilitation consultants in Ontario. The CARP figure is surely an underestimation, though how much of one is unknown. It is highly probable, however, that the growth in "other" employment settings for physiotherapists, noted above,

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continues to be, General Counsel for the Workers' Compensation Board (now the Workers' Safety and Insurance Board).

[20] The writer worked as a rehabilitation consultant for a private Toronto company from 1991 to 1996.

reflected at least in part the movement of physios into this new field, where their skills at understanding, planning and overseeing rehabilitation could be put to more lucrative use by them than was possible in most clinical practice settings.

Problems

PREMIUMS AND THE MEDICAL-REHABILITATION / TORT BALANCE: ASKEW AGAIN

Introducing second reading of Bill 59, the *Automobile Insurance Rate Stability Act*, on 13 February 1996, Rob Sampson, parliamentary assistant to Ernie Eves, the Minister of Finance,[21] defined the problem as a combination of inadequate recognition of not-at-fault drivers' right to legal recourse against at-fault drivers, and overly generous benefits. Now rehabilitation was not the panacea for rising costs, but the cause of them, and benefits needed to be rebalanced with tort access.

After stabilizing at a rate of increase of a few percentage points in the wake of the initial introduction of threshold no-fault insurance, automobile premiums began to climb again. In 1994, they rose an average of 10%, and by September 1995, it was an average of 11.3% (Hans., St. Com. Fin. & Eco., Feb. 19 and June 13, 1996). Even though expanded benefits had been sought by insurance interests, as preferable to more unpredictable and presumably more costly tort expenses, insurers now claimed that they could "actuarially identify medical and rehabilitation and attendant care costs as the most expensive and unstable components of the automobile insurance system" (Bill 59 Fees & Protocol Committee and Ministry of Finance, 1997, p. 6). The increased benefit provisions under the NDP's Bill 164 were cited as the source of premium escalations, which had begun virtually with the announcement of the legislation. This is because premiums are based not on actual expenditure experiences currently or in the recent past, but on actuarial predictions of anticipated exposure under legislative requirements for the future.

The problem, as defined by the insurance industry, is a fascinating example of how the story of a policy problem gets told. (This is not to suggest that there was no problem; only that any story can be told from several perspectives, and much of any policy battle – certainly much of what makes it interesting for students of policy – is about whose perspective will prevail, not

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[21] The Ministry of Financial Institutions, formed during the Peterson administration out of a former division within the Ministry of Consumer and Commercial Relations, had then been merged with Treasury and Economics during the Rae administration to become the Ministry of Finance. By the Harris period, it was a powerful ministry, and Minister Eves was also the province's Deputy Premier.

about the "cold, hard facts.") A careful analysis of the numbers provided in the Ontario Insurance Commission's *Annual Reports* (1993-94 and 1995-96) indicates that average loss costs (the amounts paid out per claim[22]) per vehicle rose only $6.03 between 1993, under the Liberals' OMPP, and 1995, under the NDP's Bill 164. Yet medical-rehabilitation costs rose 20% between 1994 and 1995. On the face of it, this suggests that, while medical-rehabilitation costs had risen substantially, costs must have been dropping somewhere else in the overall equation. There is no telling whether or how any relationship exists between these variables. But the representation of a system with out-of-control costs was only half the full story.[23]

Fraud

In the mid-1990s, multiple articles began to appear in popular and professional periodicals about the fraudulent abuse of medical-rehabilitation benefits under automobile insurance, citing it as the reason behind the rapid escalation of premium costs.[24] According to parliamentary assistant Rob Sampson, fraud accounted for anywhere between 10-30% of all claims costs in 1995, although other reports put it in the range of 10-15% (Dunlop, 1995a, and 1996a).

What was meant by fraud was a range of behaviours from "people who merely exaggerate their accident related injuries to those who falsely represent injuries or attribute to the accident pre-existing or subsequent, unrelated medical conditions" (Dunlop, 1996a, p. 38). To categorize all of these as fraud, which generally requires willful deceit deliberately intended to mislead another for one's own illicit gain, is akin to calling every anxious parent who brings a child with sniffles to the doctor, every patient who exhibits any hypochondriasis, every person worried that this current pain is a recurrence of that old problem, a fraud. If all of these behaviours together were called fraud, and if they actually were distributed along a bell curve (with deliberate deceit

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[22] Furthermore, these loss costs include what is put into reserves. Out of written premiums, a portion is invested, a portion is paid directly for actual claims, and a portion is reserved for potential payments, depending on actuarial analysis of what potential exposures might be under legislation. But these reserves, which are an accounting tool, confound analysis of the industry's operations, since they make "loss costs" higher than actual claims payments by an unknown amount. See Hans., Leg. House, March 22, 1990, pp. 112-113.

[23] The years 1994 to 1998 were, in fact, high profit years for Ontario's automobile insurance industry (Canada, Dept. of Finance, 2000), notwithstanding the impact of Bill 164. The Ontario Insurance Commission's statement that rising medical-rehabilitation costs and declining premiums between them "squeezed profits in the industry" (Ontario Insurance Commission, 1993/94, p. 6) also puts a particular lens on how the insurance industry works. It is typical in Ontario, as it is worldwide, for the casualty insurer to pay out in claims as much or more than it takes in in premiums. Profit comes, instead, from investment income generated. To put things in perspective, no P&C exited the Ontario market during the 1990s (Canada, Dept. of Finance, 2000).

[24] See: Star (1994); Daw (1995a, 1995b, 1995c); Dunlop (1995a, 1995b, 1996a, 1996b); Sears (1995a, 1995b, 1997); and Baer, 1997).

being at one end, a range of exaggerated and anxious behaviours driven by anger, adversarialism and fear of income loss, in the middle, and the mildest sort of exaggeration at the other end), then outright fraud would have accounted for much less than one per cent of all claims costs. Nonetheless, it became an important basis for framing a problem the only solution to which, it was argued, was to reduce benefits and to give insurers greater legislated powers to control access to them, effectively to acquire more of a gatekeeping function for medical and rehabilitation benefits.

How much of the fraud that did occur was attributable to providers as opposed to claimants was another problem. Providers were suspected chiefly of committing fraud in the form of directing patients to receive prolonged and unnecessary treatment at facilities in which the providers have a financial interest. The United States Congress had passed legislation in 1992 prohibiting self-referral for Medicare and Medicaid patients. In Ontario, however, "Extensive soul-searching by the [College of Physicians and Surgeons] resulted in a policy that allows doctors to engage in self-referral if they disclose their financial interest to the patient and college. There is no legislative prohibition against the practice" (Baer, 1997, p. 255). At the same time, insurers and insurance brokers also had begun to invest in rehabilitation clinics, as had lawyers (Lilley, 1990; Rusnak, 1994).

Decisions

Draft Legislation: Automobile Insurance Back on the Blocks

On 12 December 1995, Mario Sergio, a Liberal member of the house, moved first reading of Bill 29, An Act to provide for Fair Automobile Insurance Practices. Two days later, finance minister Ernie Eves moved to refer the entire matter of automobile insurance to the standing committee on finance and economic affairs, indicating that the ministry would file documentation and draft legislation for it to review and report on. Parliamentary Assistant Rob Sampson was given the lead, and the committee convened for eight days in February 1996.

In contrast to the hearings for the previous two iterations of the legislation, particularly the first (Bill 68), a great many rehabilitation providers made submissions to the committee – an indication of the extent to which their interests had become concentrated by automobile legislation. Tellingly, their submissions were mixed in ways that suggested the extent to which their professional and entrepreneurial interests had become entwined as well. Some decried the extent to which "unnecessary treatment, prolonging illness and increasing costs" had become a

problem in the field, and called for regulation of private providers, separate from professional college regulation (Hans., St. Com. Fin. & Eco., Feb. 21, 1996, 1110-1120 hrs). It is not unimaginable that some of these providers may have been motivated by their need to compete, and perhaps be undercut, in a field that had come to look somewhat like that of medicine at the turn of the 19th century, when physicians and street-peddlars in potions competed for what the market would bear. Their concerns were more about accreditation and regulation than about levels of benefits under the legislation – the draft legislation proposed that medical-rehabilitation benefits be reduced from a lifetime limit of $1 million no-fault under Bill 164 to $1 million only in the event of catastrophic injury and, otherwise a lifetime limit of $75,000 "in excess of the OHIP coverage" (Hans., St. Com. Fin. & Eco., Feb. 19, 1996, 0950-1000 hrs.) [25] Perhaps more significantly, any disbursements would be subject to the insurer's agreement to the treatment plan.

Many providers agreed that even lower levels of medical-rehabilitation benefits would still be adequate in the majority of cases, but their chief concerns were twofold. Firstly, they argued that insurers' right to refuse treatment plans pending independent assessment at a Designated Assessment Centre would unfairly restrict and delay access to services, and would put this allocative power in the hands of unqualified individuals with conflicting interests. Representatives of the Ontario Brain Injury Association (amongst others) pointed out that, even under the putatively generous benefits of Bill 164, people were being denied professionally recommended rehabilitation interventions (Hans., St. Com. Fin. & Eco., Feb. 21, 1996). And secondly, the definition of catastrophic injury was so restrictive that many individuals whose injuries would be classified as non-catastrophic (e.g., mild and moderate brain injury), but were still much more limiting and long-lasting than average musculoskeletal injuries, would receive inadequate benefits and fall out of the labour market and into the public social security net. (The definition of catastrophic injury that was finally decided upon is described in Appendix C. The appendix also provides a comparison of Bill 59's final benefit provisions with those recommended in the Insurance Bureau of Canada's proposal submitted to the Ministry of Finance in 1995.)

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[25] This wording concurs with the legislation having made insurers second payers after all other available insurance, and subsequently opened up a "gray area" of interpretation, in which insurers argued that it was the public sector's responsibility to ensure that it provided adequate rehabilitation services for injured individuals. (Personal experience.)

Insurers were relatively uniform in their presentations, arguing that rates would have to climb between 35 and 40% over the next five years if there were not major changes to the legislation, particularly in the areas of medical-rehabilitation and income benefits. With respect to medical-rehabilitation benefits, they said that fraud and excess usage were being encouraged by the "availability of the richest set of benefits in North America for injuries sustained in an auto accident regardless of fault" (Hans., St. Com. Fin. & Eco., Feb. 19, 1996). And with respect to income benefits, coverage up to a maximum $1,000/week under Bill 164 (depending on the claimant's pre-accident earnings) meant that individuals in lower income brackets nonetheless were forced to contribute to a pool making the upper levels possible. (This is because premiums for statutory coverage are not based on income level. Therefore, rates are set actuarially on the basis of the highest expenditures that are anticipated given the coverage.) For this reason, the insurance industry argued that the high income benefits were unfair to lower-earning individuals and should be reduced so that the maximum would cover only up to about 50% of the labour force – a way of framing the problem that was advantageous to them.

Bill 59, the Automobile Insurance Rate Stability Act

The new legislation restructured automobile insurance benefits in ways that affected the role and nature of rehabilitation, access to rehabilitation services, incentives or disincentives to seek and provide them, and other forms of controlling rehabilitation benefits. Each of these will be dealt with in turn.

The role and nature of rehabilitation

Regulations accompanying the bill (Statutory Accident Benefits Schedule, Ontario Regulation 403/96), define disability, for the purposes of income benefits, as "a substantial inability to perform the essential tasks" of whatever employment the claimant had spent more than 26 weeks performing in the year prior to the accident. (Individuals with fewer than 26 work weeks, or who were attending school, were eligible for low no-income benefits.) (Part II, Sec. 4.) Rehabilitation consists of measures employed to reduce disability in order to make it possible for the person to be demonstrated capable of "engag(ing) in employment that is as similar as possible to employment in which he or she engaged before the accident" (Part V, Sec. 15).

In the hearings, providers and claimants had repeatedly brought up the ongoing conflict between rehabilitation being, on the one hand, meant to shorten the disability period during

which the weekly benefits are payable by demonstrating that the claimant was functionally capable of meeting a substantial portion of his previous employment's demands (whether it still existed or not, and regardless of ongoing levels of pain or discomfort) and, on the other, being meant to reduce and eliminate disability resulting from the injury as much as possible (Hans., St. Com. on Fin. & Eco. Affairs, Feb. 19 and 26, 1996). They argued that a person meeting the first goal may well still fall out of the insurance net and into the public welfare net easily, and one meeting the second would be less likely to do so. Insurers, however, felt strongly that the latter goal constituted an entitlement, and "the insurance principle of indemnity is to return the claimant to the same position they were in before the accident, to the extent that money can, no better and no worse," but never unequivocally defined what "the same position" constituted, leaving it open to interpretation (*ibid,* Feb. 19, 1996).

Access to rehabilitation

One of the most important changes introduced by Bill 59 was the introduction of insurers' capacity to refuse treatment plans:

> Bill 59 requires insurer approval before implementing treatment plans, in lieu of the previous 'medical certificate'. In the United States, this is referred to as managed health care. However, in Ontario, its purpose is to mitigate against conflict of interest and control rising costs.[26] (Direnfield, 1996)

Previously, physicians, chiropractors, physiotherapists and psychologists had been able to initiate and continue treatment they considered necessary. The insurer, however, could request to see a treatment plan or seek an independent medical examination and could begin a dispute process, but was required to continue paying for treatment pending its resolution. By contrast, Bill 59 made all physiotherapy and chiropractic treatment, beyond the first 15 sessions, subject to approval by the adjuster. In order to refuse further treatments, however, the insurer was required to make referral to a Designated Assessment Centre (DAC). DACs had first been implemented in 1994, when 757 assessments were performed by them. By the end of 1995, they were performing a total of 4,727 assessments annually (Ontario Insurance Commission, 1995/96).

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[26] This actually is the purpose of managed care wherever it is employed.

The only indicator available about the extent to which insurers might have been disputing and, thereafter refusing, treatment under Bill 59 is the number of referrals to DACs and their outcomes. Table 4 presents figures from 1998 to 1999. These provide an indication of the degree to which DAC activity (and the majority of DACs are private facilities) increased, and of the decisions being made by them:

Table 4: Designated Assessment Centres, Activity, 1998 and 1999

	1998 Calendar Year		1999 Calendar Year	
	Under Bill 59	**Under Bill 164**	**Under Bill 59**	**Under Bill 164**
Medical-Rehabilitation Benefit Referrals Made	6,057	7,457	6,952	7,447
Assessements Done	4,772 (79%)	5,995 (80%)	5,301 (77%)	5,746 (77%)
Recommended Treatment Accepted	723 (15%)	266 (22%)	813 (15%)	123 (28%)
Recommended Treatment Rejected	1,452 (30%)	1,802 (30%)	1,712 (32%)	108 (24%)
Alternative Provided	2,597 (54%)	3,204 (53%)	2,776 (52%)	2,990 (52%)
Disability Benefit Referrals Made	1,885	2,413	2,495	2,577
Assessments Done	1,516 (80%)	1,976 (82%)	2,034 (82%)	2,105 (82%)
Meets SABS Disability Test	267 (18%)	402 (20%)	392 (19%)	414 (20%)
Does Not Meet SABS Disability Test	1,249 (81%)	1,575 (80)	1,642 (81%)	1,691 (80%)

Source: Financial Services Commission of Ontario, Designated Assessment Centres Activity Reports

As can be seen, the volume of assessments rose nearly 10% in one year alone. At assessment costs of up to as much as $3,500 for complicated cases (Daw, 1997) – the average cost in 1998 was $2,467 (Buist, 2000) – and with the volume of activity noted in the table, DAC referrals represented a substantial volume of business for these mostly private facilities. And designated assessments are thought to represent only a fraction of the total number of independent provider assessments purchased by insurers (*ibid*). Such assessments, therefore, would have constituted a large amount of the resources being calculated as part of medical-rehabilitation benefits.

Also, the cap on non-catastrophic medical and rehabilitation benefits would have had an effect on access to them in some cases. As one presenter at the hearings pointed out, the majority of claimants never approach the limits on benefits (Hans., St. Com. on Fin. & Eco. Affairs, Feb. 20, 1996). Average claims costs in 1994 were a little over $20,000 (Baer, 1997). So the limits really only applied to those with the most serious impairments and sequelae who nonetheless did not meet the definition of catastrophic injury. Given that the average cost of rehabilitation for brain injury was $75,000 to $80,000 in the mid-1990s, it meant that an unquantified number of claimants would not be fully covered, since benefit limits were not indexed. Reduced benefit caps, combined with tighter restrictions on catastrophic injury, could make a big different to costs for very serious, though not catastrophic, and costly injuries.

Incentives and Disincentives for Rehabilitation

Not only were insurers' obligations reduced and their control over meeting them increased, but their incentives to provide rehabilitation (in order to be able to cease making income benefit payments) were also reduced.

In 1990, when the Liberals had proposed an income benefit maximum of $450 per week, the Progressive Conservatives had considerated it "desperately unfair to most families" (Hans., St. Com. Gen. Govt., Jan. 8, 1990, p. g-14), and had joined ranks with the NDP to have the amount raised to $600 under the OMPP (Bill 68). Another of the PCs' criticisms of the OMPP, during the 1990 hearings, was that it would encourage insurers to "cherry pick" clients who had access to other income maintenance programs.

Yet $450 was the maximum they established under their own Bill 59 in the 1996 economy, with the option for drivers to purchase "top up" coverage to a potential maximum of 80% of previous net income, and it was made secondary to any other collateral benefits the insured had

available. That maximum would cover approximately 50% of the workforce "and when collateral benefits are considered, a large majority of the working population will have full income replacement protection without needing to buy additional coverage," and the other 50% would have the choice to purchase more.[27] In addition, income benefits (beyond what was available from collateral benefits) only had to be paid, as already noted, for two years post-accident if the individual could not perform a substantial amount of his pre-accident employment functions; after that, they would only be paid if the individual remained completely disabled from performing "any employment for which he or she is reasonably suited by education, training or experience" (SABS, Part II, Sec. 5). By comparison, the NDP's Bill 164 had set three years as the initial income benefit period, had established long-term economic loss awards, and had set an income benefit maximum that automatically covered the great majority of Ontarians of working age.

Other controls for rehabilitation

Bill 59 gave the Ministry of Finance authority to strike two temporary sub-institutions – the Auto Task Force on Accreditation, and the Bill 59 Fees and Protocols Committee – in an effort to address, respectively, the proliferation of an unregulated market, where quality could not be monitored or assured, and the inordinately high fees insurers had argued were driving up premiums. (Though these fees themselves were a result of the competitive market that had been created by the multi-payer system wrought by the fragmented legislative frameworks, in which providers charged whatever the market would bear given the variable demands that legislation in the three areas created. As the payer with the most stringently regulated statutory obligations for rehabilitating claimants, automobile casualty insurers understandably had become the payer of choice for many providers.)

The Task Force on Accreditation set out to do its work with a mandate that provided no legal power for it or for the Ministry to implement any decisions, because of the extent to which doing so would infringe the jurisdiction of the Ministry of Health and the professional regulatory colleges under its *Regulated Health Professions Act.* And it was faced with a Herculean task because of the disaggregation of data that had developed in Ontario's

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[27] Between 1997 and 1999, an average of 107,000 "written exposures" were purchased, for written premiums averaging $27 million. Against these, there was an average of 1,300 claims made annually, with average annual claims costs of $18.5 million. (Source: Insurance Bureau of Canada, Policy Branch, telephone communication.)

rehabilitation services market and the proprietary nature of much of the information. As one member put it:

> We don't know the number of vendors. We don't know the nature and mix of those vendors, or the ownership... .We don't have a registry or an inventory. These places don't have to be licensed, so they come and they go, their businesses are in place or out of place, there are consortiums, there are all kinds of things that have emerged depending on what is getting paid for. Not only do we not know who the vendors are, we don't really know ... what the product lines are that they sell.... the menu of these things varies ...depending on who's shopping for something (i.e., depending on how different policies set out medical- and vocational-rehabilitation priorities).... (Because) of this fragmentation, this multiple payer (structure)...none of the payers really have information from each other on who's buying what and what problems or concerns they might have, and there's no data system, there's no inventory. (Confidential interview, Feb. 1999)

The task force submitted an interim report in April 1998 (Auto Insurance Task Force on Accreditation, 1998). One of its chief conclusions was that that a coherent database was more urgently needed than an accreditation system, and it recommended that such a database be created and then be administered by an *independent* (italicized in the report) third party, with the information in it made widely available to all stakeholders. The task force also recommended that a "forum" for various stakeholders be created to deal with recurring issues on an ongoing basis. And finally, it recommended that the Ministry of Finance coordinate these efforts together with the Ministry of Health and the Workplace Safety and Insurance Board (the former WCB), so that the database would be truly coherent. Until these efforts were put in place, it suggested, piecemeal legislative changes could only be stop-gap efforts at taking control over, or protecting public-policy interest in, rehabilitation health services.

Accreditation, the report said, was not the best place to start. Firstly, an accreditaiton system could only apply to multidisciplinary providers, since individual providers already were regulated by colleges or were graduates of accredited programs. (Therefore, the Ministry of Finance and insurers would be accrediting on the basis of their own outcome measures, rather than on the basis of extant professional and educational standards.) And the market in

multidisciplinary centres had become virtually impossible to define, describe, or even fully identify because of the fragmented, proprietary, and frequently simply unavailable information about them. In addition, the task force pointed out that most accreditation models (which it had set out to study) are designed to increase quality and client-centredness, and do not traditionally have cost monitoring or cost stability as their outcome objectives. "There is no demonstrated direct relationship," the report concluded, "between existing accreditation systems and cost stability" (*ibid,* p. 19).

The Bill 59 Fees and Protocol Committee was not having much better luck on its front. The Committee's draft report of April 1997 noted that, "While the schedule of benefits does limit indemnity to reasonable and necessary intervention, the system does not permit insurers to simply refuse claimed benefits on the basis that they are not covered" (i.e., to "de-list" certain unnamed interventions altogether). The Committee considered this situation to be a "structural inequality" in the legislation (Bill 59 Fees & Protocol Committee and Ministry of Finance, 1997, pp. 7-8). The report expresses the insurers' frustration at not having been able to negotiate fee agreements with many provider groups, as the government had requested they do by the end of 1996. (On the other hand, representatives of both the medical community and the Ontario Psychological Association denied ever having held negotiations with the Committee [Daw, 1997].)

Nonetheless, in November 1997, the Ontario Insurance Commission issued a bulletin (Ontario Insurance Commission, 1997) announcing that the industry had successfully negotiated fees with the Ontario Physiotherapy Association. These had been set at a range of $95-$120/hr. for direct one-on-one treatment time (including report writing, treatment plan preparation, and inter-professional and insurer consultations); and $23.75-$30 per 15 minutes of treatment time thereafter. By comparison with the fees negotiated the following year for physiotherapy under workers' compensation – $18 per asssessment or treatment – and with OHIP's ongoing fee of $12.20, auto insurance fees remained generous. Whether they are appropriately or inappropriately generous, given the quality of treatment MVA claimants receive from therapists (especially in comparison with treatment provided to workers' compensation and OHIP patients, as we have seen many providers and analysts suggested was the case), is beyond the scope of this study. What is less uncertain, however, is the likelihood that these fees would skew the market in physiotherapy services, pulling the best practitioners (or at least the most ambitious

ones) out of the public or even the WCB spheres and into that for motor vehicle accidents, thereby diminishing their availability to these other types of patients.

Recognizing public cross-subsidies

Finally, on 1 November 1996, Bill 59 reinstated the OHIP bulk subrogation rights that had been removed in 1990. The levy was set at a fixed, un-indexed amount of $80 million per year. This represents approximately two per cent of written premiums at the time, or a little less (Lascher, 1999; Ontario Insurance Commission Annual Reports). Per vehicle, it represents approximately $12.60. To put this in some comparative national perspective, in 1996 Alberta introduced a levy of 4.4% of direct written premiums that was yielded more than $50 million by the year 2000. (Alberta's total population is a little more than one-quarter of Ontario's.) Per vehicle levies range from $14.51 in Newfoundland to $54.69 in New Brunswick (Insurance Bureau of Canada, 2000a). At the lowest of these, Ontario's levy would have amounted to over $92 million in 1996.

Regrettably, it is not possible to tell whether the $80 million paid to OHIP does or does not pay the costs of motor vehicle accident victims treated with public funds, or even whether any of it ends up allocated to public rehabilitation services. As in the past, however, the levy is received as a bulk payment by the Ministry of Health, and how and to whom it is then allocated, or with what implications for public rehabilitation providers, is not known. What is likely, however, is that in the new climate that has been created since the levy was removed in 1990, when doing so signalled the insurance industry's assumption of rehabilitation responsibilities, its reinstatement will open a new area of contestation. With their rehabilitation exposures having turned out to be much greater than they originally had anticipated, insurers will seek to use the levy payment as the basis for arguing that the public sector is shirking its obligations to use it to provide services to motor vehicle accident claimants. In the meantime, public sector provision of rehabilitation services has shrunk, partially in response to the private market that had been created.[28]

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[28] While anecdotal in nature, there is some evidence that this contestation is occurring. (Telephone conversation, Allianz Insurance ombudsman, summer 1998).

WORKERS' COMPENSATION

Legacies for the Rehabilitation Sector

One of the most important legacies under workers' compensation insurance from the late 1980s and early 1990s was the rehabilitation strategy employed, primarily the Community Clinic Programs (CCP). The intent of the CCP was to provide such high-quality and speedy rehabilitation interventions, that, even if the costs of doing so were high, overall costs associated with lost-time injuries would be reduced. Its chief legacy, however, turned out to be the dart it aimed at earlier, popular notions of rapid clinical intervention for rehabilitation. As such, it contributed to the evolving redefinition of much rehabilitation, which we have seen under automobile insurance as well, from a medical model to a case-management model.

While it had indeed turned out to be the case that the Board's expenditures did begin to decrease after about 1993, it was not possible to credit the CCP for the success. Initially, injured workers had been admitted to the CPP immediately, on the premise that early intervention was best. But a study in the program's early years found that there were no differences in outcomes between early and later attenders. Then, in 1997, a subsequent, rigorous study that became widely disseminated (Sinclair et al., 1997), concluded that the program, under which so many resources were spent, led to no overall significant differences in functional status, health-related quality-of-life, and pain measures between clinic-attenders and clinic-non-attenders. The most significant difference was in costs: attenders cost approximately twice as much as non-attenders. In fact, the thing that made attenders and non-attenders alike – that they were claimants involved in a frequently adversarial process – may have been more significant with respect to the outcome measures (return to work, total costs, functional and self-rated pain, and self-rated quality of life status) than whether they did or did not attend the CCP, thereby skewing the results. Nonetheless, the quasi-medical-model interventions that had been so core to much of rehabilitation's professional history were under friendly fire – the very program the Board had established in keeping with the model was undermining it.

A related and perhaps more important legacy of earlier workers' compensation policy was the institutional structure of an internal board of directors with the capacity to interpret legislation and set policy for rehabilitation. There is no comparable institution under either automobile insurance or public-sector health care. Not only was the board of directors able to act unilaterally to limit access to the community clinic programs (as it did when conditions for admission were revised in late 1995, when it was found that early or later admission made no

difference), but internal policymaking capacity also allowed it to change other practices that help to account for the decline in the board's expenditures during the 1990s. Partly this was due to a decline in health care expenditures, which fell from a high of $270 million in 1993 to $242 million in 1997. Physiotherapy expenditures declined from nearly $14 million to $10.5 million over this period, chiropractic services from $7.8 to $6.9 million, and independent evaluation costs from nearly $6 million to approximately $4 million. One of the most substantial declines in the Board's annual health care expenditures came in the area of hospital in-patient expenditures which dropped from a high of $51million in 1991 precipitously to $40.4 million by 1992, and steadily to $31.4 million in 1997, probably reflecting the decreasing availability of hospital beds and changing admissions practices.[29]

But these figures tell only a very small part of the story. More significant was the diminishing number of lost-time claims allowed, and the also-diminishing number of those that were referred to vocational rehabilitation. (The board had more than 400 internal vocational rehabilitation workers by 1997, but about 70% of all VR expenditures were for private-service contracts [Hans., St. Com. Res. Dev., May 5, 1997.]) The declining number of VR referrals was a matter of internal policy and decisionmaking, since referrals were made by claims adjusters; and the decline in lost-time claims may well have been, as many critics claimed, a legacy of the experience rating program (another internal policy decision). It will be recalled that the WCB classified payments as health-care only if the individual was not receiving vocational rehabilitation (VR), and that all those in VR had their benefit costs bundled together (income, medical-rehabilitation, and vocational-rehabilitation benefits), and many of these individuals attended the Community Clinic Program, although it was possible to enter the CCP well before VR activation. Table 5 indicates changes in lost-time claims, CCP attendance, and vocational rehabilitation activity and costs through the early and mid-1990s, when these indicated legacies of Bills 162 and 165 (and the internal Board policy accompanying them), until the point at which the first Harris administration changed the legislation:

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[29] Data breakouts in this paragraph were provided by the Workplace Safety and Insurance Board, legal services.

Table 5: Lost-time claims, Community Clinic Program attendance, and vocational rehabilitation activities and expenditures, Workers' Compensation Board, Ontario, 1992-1997

	1992	1993	1994	1995	1996	1997	% Change
Allowed LT claims	141,360	129,836	129,488	121,935	107,123	95,282	- 32.6
CCP attendance*			19,457		5,022		- 74
Referred to VR (% of total)	21,165 (15%)	17,333 (13%)	16,294 (13%)	15,112 (12%)	12,092 (11%)	6,876 (7%)	- 67.5
Activated VR (% of total)	17,499 (12%)	13,874 (11%)	12,776 (10%)	12,045 (10%)	10,052 (9%)	5,749 (6%)	- 67
Rehab. program expenditures, $mill.**	561	465	417	456	386	326	- 42

Source: WSIB, Quarterly Report on Vocational Rehabilitation, January 1998
Except: * Institute for Work and Health;
** WCB Annual Reports

The figures indicate a substantial turn-around in the rehabilitation strategy that was undertaken in the mid-1990s – that is, the decline in its usage.

It is not known with any absolute certainty whether the substantial decline in lost-time injuries during the 1990s represented decreasing injury rates or changing employer reporting and internal case-management practices. (The Institute for Work and Health currently is investigating these and other explanations for the decline.) At the subsequent hearings for legislative change, however, a number of practitioners indicated that employers were already directly contracting with private providers to treat employees (Hans., St. Com. Res. Dev., Aug. 11, 1997), rather than going through the board's programs, in order both to avoid the WCB's administrative assessments and to boost their prospects for rebates under the experience rating programs, another important legacy under workplace injury insurance. By 1997, NEER (the New Employer Experience Rating program) rebates to employers exceeded penalties (surcharges) to them by about $350 million, short-term disability benefits to workers by about by $350 million, and health care expenses for injured workers by $91 million. Four years earlier, in 1993, rebates had exceeded surcharges by $187 million (Ontario Network of Injured Workers Groups and Toronto Injured Workers' Advocacy Group/Union of Injured Workers,

1999). Enterprises either had become excellent at preventing injury, or they had learned quickly about managing it through channels not visible (or accountable) at the public level.

The Liberals' Bill 162 had made rehabilitation and return to work more the Workers' Compensation Board's business than it had ever been before, and the NDP's Bill 165 had increased its legislated responsibility, and internal capacity, to provide rehabilitation. But other institutional legacies – experience rating, and internal policymaking structures and capacity through the Board of Directors – were much more powerful legacies in shaping where, how, whether, and what rehabilitation would be provided.

Problems and Preferred Solutions: Responsibility and Control

The problem framing that became central to policy changes in the workers' compensation arena in the late 1990s revolved around the question of what should be the responsibility of the Board, and therefore within its sphere of control, and what should not be. It was an issue that had come to be augmented by what Marmor had called the "persuasive definition" that non-governmental actors were better at controlling costs.

In fact, this framing had its roots earlier in the decade. At the time of the hearings for the NDP's Bill 165, the Board of Trade of Metropolitan Toronto synopsized what would become the central issues for the next round of policymaking:

> WCB has to be manageable; it has to be built on a shared worker responsibility, worker-employer responsibility; the management of the system has to be with as little WCB intervention in the workplace as possible, and all of this has got to happen within a financial responsibility framework. (Hans., St. Com. Res. Dev., Aug. 23, 1994)

Workers, on the other hand, had argued that the board should maintain a strong role in overseeing plans for rehabilitaton, along with the input of workers and caregivers, and that the only role for employers was to comply with appropriate plans for rehabilitation management, not to set them. As we have seen, Bill 165 strengthened the board's obligations and involvement but maintained institutional structures that created strong incentives and capacities for employers to develop internal case management and administrative strategies, as well as for them to push for greater control over these.[30]

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[30] Board administrative costs, paid for through employers' premium rates, were approximately 15% at the time, the fourth-highest in the country (Hans., Leg. House, June 14, 1994). For comparative purposes, administrative

Although the board's unfunded liability already had declined considerably under the provisions of Bill 165 and the policy activities of the board during the mid-1990s – from a high of $11.5 billion in 1993 to $8 billion by 1997 (WSIB, 1999a) – a specific core feature of problem framing continued to be the issue of the liability. (During the debates, the figure most commonly used was the 1994 one of $11 billion.) How to construe the real meaning of the liability was one of the central "stories" told at the time about policy problems in the arena, and it was hotly contested. Those who said it was not a critical issue pointed not only to the declining liability but to the Board's profit of over $500 million in 1995 (Hans., St. Com. Res. Dev., June 25, 1997). They argued that the liability was an actuarial sleight of hand, being used by employers to frighten the public with images of debt, mismanagement, and profligacy (Hans., St. Com. Res. Dev., May 5, 1997). On the other hand were those who perceived, and represented, it as precisely that worrisome image: a massive long-term debt that constrained business competitiveness in the province and had to be eradicated as quickly as possible.

As well as the liability being an albatross around the neck of the board itself, it was regarded as an impediment to future, long-term changes that some saw as economically desirable. In January 1996, Cam Jackson (Minister without Portfolio, Responsible for Workers' Compensation Reform) issued a discussion paper inviting proposals for reform of the workers' compensation system entitled "New Direction for Workers' Compensation Reform." Within three months, both the Insurance Bureau of Canada (the association for property and casualty insurers) and Liberty Canada (a private health insurance and management company, with head offices in the United States, where Liberty was the largest provider of private-sector workers' compensation) had submitted proposals for private-sector involvement in workplace injury insurance, which by tradition long had been a public-sector activity in Ontario (Liberty Canada, 1996; Insurance Bureau of Canada, 1996). Both cited the unfunded liability and the high payroll assessment rates as problematic. (In Ontario, the assessement rate at the time was a little over 3%, compared to 2.6% elsewhere in Canada. By comparison, in Germany, where a consolidated funding system exists that pools all resources for treatment and rehabilitation in the event of accidents, regardless of cause, and is both publicly administered and provided,

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costs under automobile insurance in Ontario in 1990 were approximately 21%. In California, which has private workers' compensation insurance, administrative costs in the late 1990s were34% (Ontario Network of Injured Workers Groups and Toronto Injured Workers' Advocacy Group/Union of Injured Workers, 1999).

employer assessment rates were approximately 1.4% [Breuer, 1999]. In the United States in 1997, rates were about 4% [Hans. St. Com. Res. Dev., Aug. 11, 1997]).[31]

The IBC report stipulated that:

> Before the private sector would be prepared to take over delivery of the necessary services, companies would like to see some fundamental changes made. For example, the IBC wants benefit levels reduced to a more reasonable level. In addition, private sector companies have called for the Ontario government to gain more control of rehabilitation costs and establish loss prevention programs. (Saylor, 1996)

Whatever was the "truth" about the unfunded liability, assessment rates and rehabiliation costs – the above demonstrating that truth and perspective are difficult to disentangle – a sense of imperative to bring both the unfunded liability and benefits exposures down not only farther but much faster prevailed and became the visible engine of problem-framing, and solution proposals, at this time. Which perspectives prevailed would play out in the decisions made.

Decisions

As with the Liberals' Bill 162 and the NDP's Bill 165, changes to workers' compensation policy during the Harris administration began well before legislation was drafted, debated, or passed, because of its insitutional structures. This was seen not only in the changes to rehabilitation under the community clinic and vocational rehabilitation programs, as discussed above, but in another institutional change within the board that realigned decisionmaking powers. This was the removal of the requirement for full bipartism on the board of directors (BoD), the policymaking institution within the WCB, early in the new provincial administration. Its composition soon became primarily business representatives.

Also, during the period leading up to Bill 99, the Board had begun to contract out 100% of its vocational rehabilitation services, and not just the 70% that it had contracted previously (Hans., St. Com. Res. Dev., May 5, 1997). The decision to do so was made in the context of

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[31] New Zealand's universal accident insurance, prior to the 1992 reforms, covered all forms of accident regardless of where or how they occurred (except for motor vehicle accidents) and regardless of whether the individual was employed. The cost was about $1 per day per New Zealander, with about 7% going to administrative overhead (Palmer, 1994). The average payroll assessment paid into the scheme by employers was 2.33% in 1987 and covered 100% of the population. In the same year, in Ontario, it was 2.88%, and covered

knowing that changes to automobile casualty legislation had left a lot of "hungry" providers in the marketplace, as one WCB insider put it (confidential interview, March 1999).

Bill 99: The Workplace Safety and Insurance Act

The twin engines of Bill 99, which came into effect in January 1998, were benefit reductions and devolution of rehabilitation case management, in the form of return to work (RTW) strategies, to the enterprise level. Indeed, rehabilitation is not even mentioned in the act (which has no separate regulations for benefits, except for pension benefits); it is left largely implicit in the RTW thrust of the legislation. The economic value of the benefit reductions overall – which affected not only income benefits, which declined from 90% to 85% of net income, but medical- and vocational-rehabilitation and pension benefits as well as the decrease in attendant administrative costs – was estimated to be approximately $15 billion in savings to employers. (This reduction was projected over the 17 years to the target date of 2014 for elimination of the unfunded liability [Hans., Leg. House, May 1, 1997].) It is unknown how much of these savings, which represent costs that formerly had been publicly transparent and accountable, was transferred to private expenditures for services. But the bill had substantial implications for rehabilitation, which will be discussed, again, in terms of its nature and role, access to it, incentives and disincentives to seek it, and other controls. First, however, the chief provisions of the act are outlined, as background for the subsequent discussion of their implications:

- The employer must notify the board of an injury incident within 3 days only if "the accident necessitates health care or results in the worker not being able to earn full wages." (Part 3, Sec. 21(1)). I.e., so long as the worker does not attend a physician's office and continues to be paid normally, no claim needs to be filed. The worker may choose to file a claim within six months (22(2)), but must initiate this him- or herself.
- The worker can make an initial choice of health professional, i.e., a member of a regulated college, but the board "may approve arrangements for his or her health care," leaving this open to board policy. And the claimant must participate in the health care that the board determines is appropriate or face loss of benefits. Either the board or the employer can request the claimant to be examined by a professional selected and paid for by them. (Part IV.)

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approximately 70% of the working-aged population only, and only for workplace accidents (Hans., Leg. House, Oct. 26, 1988, p. 5255).

- It is up to the employer and employee to determine and provide suitable employment "that, when possible, restores the worker's pre-injury earnings," and that "does not cause the employer undue hardship." Re-employment requirements obtain not only to workers who had been employed for at least one year, as in the past, but also only to employers with more than 20 employees. They are obligated to provide the board only with that information that "the Board may request." The board "may contact the employer and the worker to monitor their progress." (The use of "may" rather than "shall" in legislation is important.) Either party can notify the board if a dispute arises, at which point the board will attempt mediation and, if that fails, make a decision itself internally. (Part V.)
- The jurisdiction of the Appeals Tribunal does not extend to injury, disease prevention or health examinations. All board decisions and actions are final. (Part XI)

In addition, the board of directors was to be composed of a chair appointed by the Lieutenant Governor, a president also appointed, and three to seven members "as the Lieutenant Governor in Council considers appropriate" (Part XII). While this did not pertain directly to rehabilitation matters, it does fortify and institutionalize the realignment of policy decisionmaking powers, which has relevance for them.

Role and nature of rehabilitation

Where the NDP's Bill 165 had set out a "purpose clause" for the legislation, making the WCB's purpose threefold – compensation, rehabilitation, and re-employment – Bill 99 set out the new board's goals to be prevention and "return to work." The responsibility for both was removed from a health-care aegis to a labour-market one, a process that had been underway for some time as has been argued throughout this analysis. Previously, the goals of the legislation had implied a process that had shaped the players' activities: the board was notified of injury; health-care and rehabilitation providers made determinations about disability and necessary care; employers complied (within their duties to do so, which applied if they had more than 20 employees, for a restricted period of time); and the board both monitored progress and participated in delivery. The new goals changed that implicit process: return-to-work determinations would be made at the level of the enterprise; caregivers would provide information as necessary, and provide interventions either at the discretion of the employer or at the insistence of the worker; and the board's Labour Market Re-Entry program would become involved only if it was requested to do so by either the employer or employee. Amongst them,

they signalled a decrease in the board's involvement in, or monitoring of, both health rehabilitation and vocational rehabilitation, and an increase in employers' levers for control, either by arranging post-injury rehabilitation independently (privately) or by arranging (again independently) for their prevention.

In 1997, there were 424 vocational rehabilitation employees at the board. Under Bill 99, the department was phased out, with some of the workers re-assigned internally, and the new Labour Market Re-Entry program instituted. The plan was to hire approximately 300 nurse case managers for the program.[32] Most RTW activity would fall outside the aegis of the program, and under that of the new "self-reliance" approach at the level of the enterprise.

The nature and role of rehabilitation are included within prevention activities. On the face of it, rehabilitation and prevention are oxymorons: by definition, the former occurs after the fact of injury and the former before it. But in the field, rehabilitation professionals are often involved in prevention measures – performing physical demands analyses of jobs and functional abilities evaluations of the individuals performing them; assessing enterprises' injury experiences and designing ways of reducing; and so on. So the provisions of the legislation for prevention activities have potentially important implications for shaping provider interests. These functions, too, had undergone a process of declining public capacity and increasing devolution to the private enterprise level during the lead-up to Bill 99 and within its contents: an early act of the new government had been its closure of the province's Workplace Health and Safety Agency. This Agency had been established by the NDP government as a bipartite injury prevention institution. Thus " health and safety programs and training will be entirely employer controlled," except in the case of the relatively small number of Ontario workers – one-third – who worked in unionized settings, where labour-management prevention strategies are most likely to exist (Hans., Leg. House, May 1, 1997; and Ontario Network of Injured Workers Groups et al., 1999).[33]

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[32] By 1999, there were a little more than 200 nurse case managers at the board (WSIB, 1999b). This was about half the number of vocational rehabilitation counsellors it had had two years earlier.

[33] As well, Bill 99 eliminated the Occupational Diseases Panel (an arm's-length body that established disease prevention guidelines for workplaces), and internalized its activities to the board.

Access to rehabilitation

Previously, any physician who saw a patient could activate a claim for benefits, or the employer could. Under Bill 99, however, it became up to the employee to acquire the forms from the employer, and complete and submit them (Part III, Sec. 21), placing the onus for claims-seeking on the worker. At the same time, workers who might feel intimidated[34] or lacked language skills, were no longer able to turn as readily to the Office of the Worker Adviser, whose budget was reduced by approximately 30% (Hans., Leg. House, May 5, 1997) . Fewer, then, would know what rehabilitation resources were or were not available to them.

The onus for providing rehabilitation and return-to-work planning effectively was devolved to the employer. The board's capacity to track interventions exists only when it has become involved. Otherwise, the employer, employee, and caregivers are all under no obligation to report any rehabilitation or return-to-work activities occurring in a claim.

Where disputes about access to rehabilitation or other benefits arose, the bill stipulated that mediation and final decisionmaking were to be performed by the board itself, with limited recourse to the Appeals Tribunal, which was in any case compelled to conform to board policy (Sec. 117(2)). Mediation would be performed by a three-member team, including the nurse case manager (herself a board employee), the claim adjudicator, and an employer representative:

> Within this team approach, the nurse case manager may find himself or herself at a disadvantage relative to the other team members who might be focused instead on a quick return-to-work strategy to avoid WCB payments rather than on quality-of-life and health issues. However, the nurse case manager will not have the legislative mandate to effectively argue and carry out the rehabilitative strategy. (Hans., St. Com. Res. Dev., August 11, 1997)

Thus, employers' increasing control over access to rehabilitation was consolidated: it ranged from initial decision making in the process to the final authority of the Board of Directors, which had ceased to be a bipartite institution. And employees' control over that access was diminished: first, by the new barriers to claims seeking; and finally by the fact that their sole potential advocates in mediation were employees of a board committed to decreasing its costs and bound by legislation that made it more a final that a first recourse. The capacities

of their two most important former institutional advocates – the independent Office of the Worker Adviser, and the Appeals Tribunal – had been curtailed.

Incentives and disincentives for rehabilitation

The reduction and de-indexation of income benefits would not only increase workers' incentives to return to work quickly, but would reduce employers' incentives to provide rehabilitation, since this potential cost exposure was modified. This would be compounded further by an additional factor: the decreased re-instatement obligations, which now applied not only where the employee had been with the company for at least one year, but where the workplace had more than 20 employees. In the context of a labour market restructuring towards small business, this was a boon to small firms that feared the cost exposures of statutory obligations, if a bane for their injured employees.

Finally, the maintenance of experience rating programs under Bill 99, in concurrence with the recommendations of employers and against those of employees, maintained a policy the legacies of which for rehabilitation are not known, but which provides a strong incentive to internalize (privatize) both the costs of rehabilitation and decisionmaking about it to the enterprise level. As has been noted, it is not possible, given current data, to tell whether the declining number of claims in the 1990s truly were due to improved prevention and management strategies being employed at the enterprise level, although that had been the purpose of experience rating. But some strength is provided to the argument that they were not by the fact that occupational fatalities rose between 1997 and 1998 (Ontario Network of Injured Workers Groups et al., 1999), even as soft-tissue claims dropped. This was a trend that had been noted in the early 1990s, after the introduction of experience rating (Hans. St. Com. Res. Dev., Aug. 24, 1994).[35]

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[34] The hearings contained many anecdotal accounts of workers fearful of losing their jobs if they pursued a compensation claim.

[35] Similarly, in the early 1990s, an "article... appeared in the Journal of Occupational Health and Safety in Australia and New Zealand where the author studied statistics following the introduction of a merit rating program in the province of Victoria. As it turned out, the number of claims was reduced significantly; however, the decrease came in minor injuries. There was no corresponding decrease in more serious injuries or fatalities, which, at least for this author, allowed him to conclude that there hadn't really been any improvement in health and safety conditions but simply tighter claims management to screen out more minor injuries" (Hans., St. Com. Res. Dev., Aug. 1994, 1210-1220 hrs.).

Other controls for rehab

Bill 99 legislated the setting of fees with provider groups, and these were completed during 1998 and 1999. Appendix D provides a partial account of these. Notable amongst them are the low fee schedules for physiotherapy clinics and hospital out-patient physiotherapy, as well as for occupational therapy. Those for chiropractic are not much higher. As discussed earlier, these conditions encourage providers either to limit the number of injured workers they see, or to increase volume through such activities as "monitoring" exercise programs (making it possible to see many clients at once), or simply to apply non-hands-on modalities that do not require the therapist's presence beyond their initial physical placement – and even that may be delegated to an assistant. The fee schedules would make much one-on-one treatment not economically viable, consolidating the effect of patient streaming depending on payer.

Summary and Conclusions

Introduction

One of the major, most significant changes during this period, which had begun earlier but became more deeply entrenched now, was the incursion of large corporations, especially managed care organizations (both US and Canadian based), into the rehabilitation marketplace. Their arrival as a major player on the field would mean, inevitably, that they would soon look for new business propsects, especially where weaknesses were seen to exist in Ontario's rehabilitation system – hence, Liberty Canada's and the Insurance Bureau of Canada's reports on private-sector assumption of management and adminstration of workers' compensation.

Hospital restructuring – full health care system restructuring, as had been suggested by the HSRC, did not occur –had resulted in either outsourcing or plans to consider outsourcing outpatient physiotherapy services in as many as 67% of hospitals in the Greater Toronto Area. Contracting out of out-patient physiotherapy services, either to external managers or to privately-owned providers, had led to reductions of about 30% in public funding of physiotherapy services by 1997 alone, and the reduction decisions had been made entirely at the hospital level. Thirty-five per cent of hospital-physiotherapy department administrators, responding to a survey, had said outsourcing had first been proposed in their facilities in 1998-1990, 60 per cent in 1996-1997, and 5 per cent in 1994-1995. In other words, prior to 1995, outsourcing was not a substantial issue. Chief promoters and decisionmakers about outsourcing

were one and the same: hospital administrators. The therapists themselves had limited input to the decisionmaking process (Craning et al., 2000).

Changes Along the Public-Private Boundary Axes

Privatization of Financing

The major public-private shifts in financing had occurred during the previous two administrations. During the first Harris administration, it might be said that some costs had been shifted back onto public welfare and unemployment systems, because tightening administrative and management privatization reduced access to rehabilitation services, and this may have resulted in injured individuals needing to turn to other forms of assistance. But this is hypothetical, especially since both welfare and unemployment insurance access also became increasingly constrained during this period under, respectively, provincial and federal legislative changes in other policy arenas.

Another possible form of privatizing financing was the shifting of potential costs onto individuals who no longer had access under collective financing mechanisms. (Even though "private welfare" is privately financed, it distributes some of the costs through collective bargaining and benefits.) When the Board had provided some services financed by employers, their financing had become collectivized across the labour market, equalizing availability of those services amongst workers in different sectors and enterprises. With enterprises financing services directly, financing still remains somewhat collectivized amongst workers in the enterprise, but something else is more likely to happen: not all enterprises will behave comparably. Under the new arrangements, larger, wealthier or more proactive or more unionized workplaces are more likely to provide rehabilitation and return-to-work help. But workers in smaller, less wealthy or organized settings, may be less likely to receive these financing benefits. So, ultimately, more of the costs of financing disability may be shifted onto individuals. As it was, in 1994, "the true cost of workplace accidents and disease...have been estimated to be anywhere from seven to 20 times the compensation cost" (Hans., St. Com. Res. Dev., Aug. 24, 1994, 1210-1220 hrs.).

Privatization of Management

Employers (or whoever they might hire privately) were given the leverage to be the chief managers of claims under the new *Workplace Safety and Insurance Act.* Bill 99 detracted from the prevention and rehabilitation management incentives that had existed under Bills 162 and

165, and gave employers discretionary power to offer what they consider to be appropriate modified work. These are, at best, to be based on functional abilities evaluations (FAEs) supplied by family physicians. This is notwithstanding the Ontario Medical Association's longstanding policy statement that GPs are not capable of supplying appropriate return-to-work/FAEs themselves (Ontario Medical Association, 1994). Meanwhile, the fee schedules for the people who are best at determining FAEs, namely physiotherapists and occupational therapists, cover them at a rate so low that no therapist in private practice would consider it wise to devote adequate time for a proper FAE (which easily can take over an hour). In short, the legislation created a nice "Catch 22" position that effectively gives employers free rein.

Under automobile casualty insurance, insurers received additional control as well over managing access to medical-rehabilitation benefits.

The changes under both of these acts created long-term implications for privatization of management entirely away from the Board and to private-sector insurers, operating on a competitive model. (The reason both acts were important in combination is that certain insurers would be more galvanized by the prospect of being able to combine management of both categories of claimants, thereby increasing their base for business.)[36]

Additionally, management of patient access to rehabilitation services also had become partially privatized to individual clinics, which were streaming (i.e., managing) patients depending on their available coverage.

Privatization of Administration

Administration of workplace injury claims became privatized along with management. For example, the Board's VR costs dropped from $386 million in 1996 to $326 million in 1997, while still under Bill 165, and then to $133 by 1999, under the new legislation. Thus, if anybody is paying for the difference in vocational rehabilitation costs, that financing is being neither administered nor managed by the Board. It also further decreased administrative charges pooled through the Board, internalizing them instead to enterprises.

Privatization of Regulation

Bill 99 is deregulatory because, as a policy isntrument, it decreases instrumental capacity of the Board to monitor rehabilitation activities or to further them, while increasing reliance on

exhortatory measures. As well, "self-reliance" is a buzzword for deregulation: under it, the Board retracts from mandating and monitoring, and employers become effectively self-regulating with respect to rehabilitation and return-to-work provisions. Such deregulation both opens the market to easier entry and exit, and privatizes decisionmaking.

Privatization of Ownership

While ownership did not become more privatized during this period, there was a major shift from a competitive provider market to a corporatized private market. This is comparable to what happened in American medicine (Starr, 1982), only here it occurred in a non-"core" sector because of the institutional constraints that had been created under the *Canada Health Act*. Also, there was a reduction in not-for-profit ownership of hospital out-patient physiotherapy departments, and a shift towards for-profit ownership, which indicates change along the public-private continuum.

Political Privatization

As both management and administrative information became increasingly privatized under automobile casualty and workplace injury insurance, it became proprietary and without public accountability. The ability to assess whether legislation is or is not working is a public function, and the loss of information with which to do it is an important form of political privatization. Institutional changes at the Board, with respect to the independence of the Tribunal and the composition of the Board of Directors, also privatized conflict by narrowing its scope.

Under both automobile and workplace insurance, control over decisionmaking about rehabilitation or return to work emerged as the major issue, as the earlier shifts in financing responsibilities might have predicted. Under automobile casualty insurance, while responsibility to provide rehabilitation had been the primary issue at the outset of the nearly 15-year period of legislative change chronicled throughout this study, the capacity to curtail it was the issue by the end of it. This trajectory suggests that the next iteration of the Act will be a

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[36] By contrast, a Liberty Mutual study in Alberta in 1990 had concluded that a switch to private insurance carriers for workers' compensation would not be advantageous and may, instead, increase costs (Ontario Network of Injured Workers Groups et al., 1999; Hans., St. Com. Res. Dev., Aug. 11, 1997).

battle over giving insurers the greater powers of veto over benefits access that the Fees and Protocols Committee had insisted upon.

Chapter Six: Highlights and Lessons

It is time to step back from the trees. This concluding chapter uses a historical institutionalist organizing framework to extract the story's highlights and its lessons. This is done with the recognition that the study has its limitations. Designed to address the question of how a privatizing trajectory in a health care sector in one jurisdiction developed across three distinct administrations, it concludes, as will soon be discussed, that the institutional organization of the sector appears to have been the most salient factor. But the study cannot itself test that hypothesis. Its limitations suggest that doing so would require future research using a design that compared Ontario's rehabilitation sector to other, differently-organized health care sectors in this jurisdiciton or to differently-organized rehabilitation sectors in other jurisdictions.

That said, the organizing framework for these conclusions is based on the way historical institutionalism itself works backwards and then forwards again through three steps.[1] It begins by observing and questioning a puzzling outcome of public policy concern. Again: How is it that the steady and largely unobserved privatization of a health-care sector, rehabilitation, occurred over the course of three ideologically distinct administrations and in the context of what appears to be a strong publicly financed health care system? For today, Ontarians truly do find themselves with severely limited access to public out-patient rehabilitation services and dependent on private financing, should they require these services. The situation is the inverse of what existed just fifteen years ago, when the first of these three administrations took office.

The second step historical institutionalists take is to pick out the main threads and trails of policymaking that occurred, as it was relevant to the outcome of interest, and trace them back to where they began to diverge from the direction in which they had been running before. Here, those main threads were those of policymaking under public health insurance, automobile casualty insurance, and workplace injury insurance. And, up until the mid-1980s, those under automobile and workplace injury bore little weight when it came to rehabilitation. They neither did nor had to bear much weight, although they were obviously connected to potential activity in the sector; nonetheless, most of the sector was attached to the public health insurance system,

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[1] This framework is adapted from Pierson and Skocpol (2000, p. 2), who say that historical institutionalists "take macro contexts seriously, analyzing meso- and macro-level configurations of organizations and institutions within which social and political processes proceed.... (and) develop(ing) explanations by tracing these processes over time." Crucially, they "typically address substantive outcomes or puzzles clearly relevant to more than just fellow academics."

where rehabilitation health services were kept distinct from other types of rehabilitation, particularly vocational rehabilitation, occurring elsewhere. But after the mid-1980s, all this changed: both health rehabilitation and vocational rehabilitation became more firmly attached to automobile casualty and workplace injury insurance systems, making them more inter-dependent, and began to detach from the public health system. The threads began to twist together when it came to rehabilitation, to affect each other in ways they had not before.

Finally, historical institutionalism urges the researcher to view these policymaking threads and trails as developing over time within "configurations of organizations and institutions" (Pierson and Skocpol, 2000, p. 2). In this case, these were the organization of the policymaking institutions, the Ministry of Health, the Ministry of Finance, and the Workers' Compensation Board. This institutional framework gives structure and focus to the process of tracing forward through the policies that unfolded over time to the outcome of interest.

This concluding chapter summarizes the findings of having undertaken this process. Firstly, it summarizes the trajectory that occurred in the sector and sketches out the point along it where we now stand. It then summarizes the features of the institutional framework that were most salient. And finally, it draws both theoretical conclusions about public-private change, and practical implications for Ontario's rehabilitation services sector (and by extension, for other jurisdictions within or without Canada that are similarly organized or at similar junctures).

The Story Recapped

Analyzing a Puzzling Outcome

Within a decade, out-patient rehabilitation has been almost entirely privatized in Ontario, virtually without public awareness or discussion.[2] Public policy goal-setting capacity has been eroded steadily as financing, administration, and management became increasingly privatized. This erosion is a privatization of the politics of policy decisionmaking, an aspect of public-private change that frequently is neglected. As more and more information is made proprietary, and as those who own it have greater interests at stake, the difficulty in accessing data and

[2] Home care is an issue that has received far greater attention in the public press than has rehabilitation, which has received almost none whatsoever. Even so, polls in 1999 indicated that many individuals had no idea home care was not an insured service in the Canadian health care system (Picard, 1999); indeed, they had only the vaguest idea that only hospital-based and physician-provided services are insured. The extent to which Ontarians or Canadians know about their vulnerability in the event of injury has not been assessed.

comparing them across insurance policy arenas, will become a self-reproducing mechanism of change in a privatizing direction.

Privatization began to gather momentum in Ontario's rehabilitation sector well before anyone decided it was desirable. Indeed, it was substantially fostered by one administration explicitly against privatization. By the time an explicitly privatizing government was in office, one with the defined retrenchment goals of diminishing the public-sector role and increasing that of the private sector in as many arenas as possible, substantial privatization had been pretty much completed in the sector and was undergoing consolidation. This analysis of policy making under three governing administrations suggests the extent to which both ideology and rational choice are limited explanations when change is viewed over time as a trajectory, a course taken by the threads and trails leading up to the outcome.

The Threads

When this story opened, a framework for private payers' responsibilities for rehabilitation existed under both automobile casualty and workplace injury insurance legislation. For the most part, however, these responsibilities had long remained minimal. And, with minimal responsibility for costs came minimal concern amongst private payers about controlling them. Until the mid-1980s, change in rehabilitation roles and responsibilities for the private sector had been barely incremental under motor vehicle accident (MVA) insurance, and modest under workers' compensation. Even where employers were responsible for physical rehabilitation of injured workers, the services were provided through a hospital owned by the Workers' Compensation Board, a public agency, or in publicly financed hospitals and clinics at the going provincial insurance rates and the activities were publicly transparent. As well, all private payers' costs were kept low through a period of history during which the public health care sector, the single payer, was expansionary.

But then, the latent potential for a much greater private role began to be realized through a series of events that combined decisions, legacies, contingencies, ricochet[3] effects, and outcomes. It is important to note that these did not occur absolutely sequentially, as they are by necessity laid out here, but in a braiding sort of pattern, the various threads both twisting together within periods and progressing over time :

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[3] These will be discussed in the section below on theoretical lessons.

Decision – The North America-wide general insurance liability crisis of the early and mid-1980s led to an unremitting crisis of rising premiums in automobile property and casualty insurance. Ontario's Liberals, with the support of the insurance industry, introduced threshold no-fault insurance in an effort to control premium escalations. In exchange, casualty insurers were given greater responsibilities for rehabilitation, and higher risks of cost exposure should they fail.

Decision – Simultaneously, the Workers' Compensation Board introduced a new rehabilitation strategy that contracted with private clinics, and expanded its experience rating programs, which initially increased employers' incentives to rehabilitate injured workers.

Outcome – A demand-driven private market in rehabilitation services was launched and rapidly expanded, largely in response to casualty insurance changes, but with additional buttressing from new opportunities and incentives under WCB policy. A historical account makes clear that the new market did not represent merely a shift from a diminishing public sector since the public sector had not yet begun to diminish. This market consisted largely of small, competitive private practices and firms.

Contingency – An economic crisis in the early 1990s began a process of hospital downsizing.

Legacy – The history of rehabilitation policy in the public sector made it possible for hospitals to make unilateral decisions about their provision of out-patient rehabilitation services during hospital downsizing in the early 1990s. Neither hospitals nor the Ministry of Health had (or have) publicly accountable, or publicly obvious, responsibilities for maintaining out-patient rehabilitation programs and access to them.

Ricochet effect – The existence of new private resources and responsibilities for rehabilitation under MVA and workplace injury insurance policies created incentives for hospitals to establish separate revenue-generating programs for these different patient streams. The existence of a new private market in rehabilitation services created the feasibility of a "substitute" for public services for individuals with acquired traumatic injury.

Decision – Casualty insurers' responsibilities were further increased under the NDP's new automobile insurance legislation of 1994.

Outcome – The private market swelled still further and prices rose, creating greater incentives for providers to enter the private sector. And, importantly, it awakened powerful new incentives for insurers to gain control over providers' treatment activities.

Decision – The NDP's new WCB legislation of 1995 increased employers' cost exposures for rehabilitation, but also increased the board's responsibilities to monitor rehabilitation and provide in-house services.

Legacy – The Board of Directors, an institution within the Workers' Compensation Board, provides a strong capacity for internal policymaking and interpretation of legislation. It allows employers to gain greater control over cost exposures, and provides an arena within which to contest and expand decisionmaking power.

Decision – The Harris PCs remove the requirement for full bipartism on the WCB's Board of Directors; remove rehabilitation as an explicit goal of workplace injury legislation; devolve injury management to the enterprise level; and give automobile casualty insurers new rights of veto for rehabilitation services.

Decision – Health services restructuring occured under the Harris administration.

Outcome – Restructuring of hospital and physician resources increased the intensity of efforts to re-allocate them. The existence of a maturing private-sector marketplace increased the feasibility of doing so through new arrangements to contract out hospital-based out-patient rehabilitation services.

Outcome – The growth of a thriving private marketplace, the corollary diminution of the public sector tier (for a private sector can only thrive fully where the public one is, or is seen to be, inadequate [Deber et al, 1999a and 1999b]), and new capacities and incentives for rehabilitation care management, attracted new, large players into the market. Mergers, acquisitions and consolidations occurred, transforming the sector fundamentally and, very likely, in a way that cannot be reversed now, because of the introduction of powerful new interests. The rehabilitation sector became the bridgehead for a private managed-care industry in Ontario.

Ricochet – The existence of a full market of services increased the feasibility of complete privatization of rehabilitation services, and devolution of responsibility for return to work planning, under new workplace injury insurance in 1998.

Outcome – The proprietarization of information and the privatization of the scope of decisionmaking have just as radically transformed public capacity to gather coherent, meaningful data, to establish human resource needs, to monitor quality or access, or to set realistically attainable policy goals for the sector, implement them, and track the outcomes.

Not entirely without irony, these entwining strands created some unexpected outcomes even for those players who partially manoeuvred them. By 2000, the automobile casualty insurance industry in Ontario was paying nearly $1-billion for medical and rehabilitation services. Its trade association, the Insurance Bureau of Canada, expressed concerns that the "assumptions of health care policy, insurance regulation, and rehabilitation practices are often unable to effectively address questions of accountability in the current environment" (Insurance Bureau of Canada, 2000b, p. 1). Insurers believed that the public health care sector was shirking its responsibilities for rehabilitation and off-loading them onto private insurers. A longer historical view, however, reminds us that the casualty insurance industry had sought to have its responsibilities for rehabilitation increased in exchange for decreased tort exposure, which occurred with the Liberals' Bill 68. Insurers may have been unhappy to have those responsibilities expanded and made entitlements under the NDP's Bill 164, but they had been instrumental in establishing the framework for such an eventuality. At the same time, the loss of premium tax revenues and of the OHIP levy, and the shift onto workers' compensation, that also accompanied Bill 68, could only have contributed to the fiscal constraints that began to be felt in the hospitals sector. There, decisionmaking traditions and institutions made out-patient rehabilitation – precisely what is needed by most of those with accidental injuries – one of the most expendable services. When expensive rehabilitation costs became a problem for automobile insurers in the mid-1990s, the unintended fallout of earlier decisions had come home to roost.

That all these changes were occurring in the midst of large-scale economic restructuring is not coincidental, it is an important historical contingency: incentives existed for broadening service marketplaces that fostered different solutions than those that had been sought at other times in the 20th century. The economic recovery at the end of the period studied here took a form that highlighted, or shared in the features of, the underlying dynamics of broader economic and labour-market transformation that had been occurring. When recovery came, it did so more disproportionately than ever, with greater disparities not only in income but in the other benefits that accompanied traditional labour-market and employment relationships.

What does this mean for rehabilitation? It means that fewer working-aged people, i.e., those most likely to experience a debilitating injury at a time of life when it will have substantial impact on themselves and their dependents, would have workplace benefits available to them or the resources to purchase private insurance. More people are working in settings in which

neither workplace injury insurance nor health and disability insurance are available. Logic alone suggests that more may be working in unsafe work places but are unable to file claims for injury. Tangentially, there is some evidence that by the end of the decade physiotherapy had become one of the services people were finding increasingly difficult to get because it was not "affordable," i.e., the market had become privatized and they were priced out of it (Berger, 1999).

Like most policy stories, this one is still in progress. But as things now stand, decisionmaking power over access to and definition of appropriate services is the most ardently contested area of conflict between public and private players. While responsibility to provide rehabilitation was the issue at the outset of the story, the capacity to curtail it was when the curtain closed. The trajectory of conflict itself – i.e., increasingly towards being about decisionmaking and control over scope of conflict and management strategies – suggests that this will be the heart of the matter in the next iteration of automobile insurance legislation. In workers' compensation, as in the overall trajectory, it will be about taking the next step towards privatization: that is, allowing private insurers to compete with the board for administration and management of industrial-group injury and disability insurance plans. What these may mean for the rehabilitation sector is the completion of its transition from a traditional health-arena model (in Tuohy's [1999] terms, a sector whose primary institutional mechanism is collegialism) to a full corporate-oligopoly (as opposed to competitive) market model.

The Institutional Framework

These twining threads must be seen in the context of the institutions within which they form. In the language of research design, our dependent variable (public-private change) derived from an independent variable (policy) that itself was the outcome (or dependent variable) of a deeper-lying independent variable: the institutional organization of policymaking. The classical Greeks believed that "ethos anthropoi daemon": man's nature is his destiny; tragedy or comedy derived from his inability to see that nature clearly. In the world of contemporary policy, where flux is the order of the day and nature is not an immutable given, the nature of our institutions – how their organization and rules both shape and are shaped by human decisions – do not create predictability, no matter how clear the sight. Time and place introduce too many uncontrollable

variables for that. But institutions do bound the possible (Weir, 1992a and 1992b) and give shape to the probable in the world of policy change.

Carolyn Tuohy, citing David Wilsford, has written that, "the general observation that policy development tends to be 'path dependent' makes it all the more important to understand the conditions -- the particular conjunctions of events -- under which *deviations* from the path occur" (Tuohy, 1999, p. 113, italics in original). The rehabilitation sector did not so much depart a path, beginning in the mid-late 1980s, as depart the juncture at which it had sat for many years, unleashing latent possibilities for privatization that had been long established by institutional configurations but that had remained largely dormant because of historical events, such as the expansion of public health care and the linkage of rehabilitation professional development with hospitals and physicians. The multi-payer, multi-regulator structure for rehabilitation services was in place already when new circumstances created momentum for escalating public-private change.

Ontario's former Attorney General, Ian Scott, reflecting in 1993 on the Liberals' years in office, said: "I have learned that structural change is very hard. Governments cannot do it and expect to survive. I understand now why Conservatives are conservative. Life is much simpler if you just muddle through" (Ehring and Roberts, 1993, p. 272). But in the rehabilitation sector, the structural frameworks that existed were precisely what made possible the massive changes that did occur. What Tuohy (1999) would call a "window of opportunity" opened in the late 1980s, when both automobile insurance and workers' compensation legislation were changing and when there was the political will, before the economy turned down, to refashion the disability and rehabilitation systems in order to create a more coherent structure for financing, management, administration, regulation, and decisionmaking – forming a potential confluence of public philosophy (ideology) with programmatic ideas. Even if ownership, which defines just one axis for public-private change, had remained private, transparency and accountability along the other axes would have have mitigated, if not entirely obviated, the severe fragmentation that now challenges access, quality, and cost.

But the strength of existing institutional frameworks favoured incremental policy change over the radical changes proposed along the way here and there. Institutional organization – the fragmenting of rehabilitation policy amongst decisionmakers operating separately and with different capacities but with unforeseen consequences for each other – prevailed. In the face of various crises, successive administrations chose to work within the frameworks available to

them. What occurred was the convergence of a deeply entrenched institutional structure with important political-economic changes. The first, the deeply entrenched structure, was paradigmatic and longstanding: rehabilitation rightfully "belonged" to private interests, because they had contracted under workers' compensation and private insurance to assume the burden of certain risks, even if the scope of those risks remained limited . This paradigm encouraged governments to increase casualty insurers' and employers' responsibilities (through the Board and, eventually, not) for funding when crises arose and political-economic conditions limited other options and favoured quick resort to existing frameworks. These in turn, changed private payers' long-term interests and agendas. And the opening of new markets in the midst of major economic and labour-market restructuring similarly fostered and entrenched new interests. Not only does the introduction of new players in Ontario's (and Canada's) rehabilitation system create new interests, but the policy trajectory that created them reinforced the separate domains that exist and, indeed, moved much activity out of the Ministry of Health.

The institutional structures that have existed throughout grew out of a historical process in which their introduction and development happened separately. But the problems of the past had left behind institutions, and particularly an institutional organization, whose separateness and fragmentation belied their growing jurisdictional overlapping and interdependence in the rehabilitation sector. And this institutional fragmentation of policy decisionmaking persists, in spite of equally persistent ideas that "all disability insurance...(should) be subject to a single set of statutory rules" (Ontario Human Rights Commission, October 1999). Today, its persistence is evident in the fact that multiple data collection systems are being developed for rehabilitation services. Automobile insurers are developing one approach to organize data about services they fund, the WSIB is developing another for those they fund, and a separate initiative is being developed by the Canadian Institute for Health Information about hospital rehabilitation services.

While these at least will be a start toward collecting much-needed information, it is possible that each of the three players will collect it in ways that will make comparison or a coherent body of data difficult to achieve, just as today it is impossible to compare automobile insurance rehabilitation costs validly with WSIB rehabilitation costs because the categories include different data. It is only possible to delineate broad outlines and trends. And much of the information will continue to be proprietary because public players have not committed the resources to gather it collectively with private-sector payers.

To point to the powerful channels (both constraints and openings) that institutions create is not the same as to argue that the stronger, or more entrenched, the institutional frameworks, the more incremental the change will be. After all, the changes that occurred in Ontario's rehabilitation health services sector occurred quickly in spite of – indeed, precisely because of – the longstanding and very powerful institutional framework, which channeled new forces along lines that favoured increasing privatization, even without any discrete decision having been made to go in that direction. Incremental policy change does not necessarily lead to incremental change in outcomes. It may result, as it did in this case, in substantial outcomes that vastly redefine the larger game, even if they leave the playing field intact. Pierson is right to say that "There are powerful political forces that stabilize welfare states and channel change in the direction of incremental modifications of existing policies" (Pierson, 1996, p. 174). But it is misleading to infer from this that succeeding incremental changes in overlapping policy areas cannot add up to major change, even if it is not revolutionary in the sense of inverting previous underlying premises and power relations.

Thus, the case of Ontario's rehabilitation health sector suggests that a historical view of institutional arrangements and the organization of policymaking can provide insight into the features of those arrangements that may precondition them to interact variously with the accidents and contingencies occurring around and amongst them. Many countries, Canada amongst them, do not have coherent, comprehensive health care systems, much less health care systems that in any way acknowledge their overlap with labour markets.[4] Rather, they have patchwork arrangements that have developed piecemeal (Canada, the United States). Or, they have coherent systems that are becoming increasingly patchwork (Germany, New Zealand). Or, they are in the process of developing approaches to health and labour issues, as well as to their health care systems (Central Europe, parts of Central and South America). In these cases, consideration of the institutional organization of policy arenas may be an important factor in formulating and striving towards long-term system goals.

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[4] For a compelling account of why this is the case, see Deborah Stone (1984).

Theoretical Lessons

A Nuanced View of Privatization and Retrenchment

The case reinforces Stoddart and Labelle's (1985) argument that, in the context of complicated public-private systems, such as most health policy systems are, our definitions of "privatization" need to be finely nuanced. In particular, they need to include the ways in which accountability, transparency, and scope of conflict in policy decisionmaking also may constitute axes along which public-private change occurs, a form of change that has received relatively little attention in the literature and has here been referred to as "political privatization." An over-emphasis on financing as the chief indicator of privatization, particularly in complex welfare arenas such as health, as Stoddart and Labelle point out, may disguise this. It is quite plausible that some forms of private financing may decrease in the context of increasing privatization along other dimensions. For example, medical-rehabilitation costs may increase initially, but they could easily decrease over time if the privatization of control over decisionmaking about benefits access increases. This is what occurred under workers' compensation, and is precisely what has become the major point of contestation under automobile insurance.

The nuance brought to indicators of privatization in such complex public-private mixes is relevant to how and where we see welfare state retrenchment occurring. Pierson (1994) has written that welfare states have proven surprisingly resilient, with programmatic characteristics being both an important cause and indicator of this. Others, such as Mary Ruggie (1996), believe that what we are seeing is not retrenchment so much as "evolution" towards an "integrative state" characterized by "collaborative decision making," and "the state being more able to guide the private sector toward collective purposes" (p.258). But public systems have to share the most fundamental decisionmaking with actors whom the public considers capable of making them – in the case of health, decisionmaking about treatments must be shared with providers and patients.[5] A greater role for strong private interests requires, paradoxically, stronger (i.e., with greater capacity) state institutions. Yet in this case, the introduction of new players, or the expansion of private players' responsibilities, created powerful new incentives and corresponded with a decreasing public role. Capacity itself is lost where the state reduces

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[5] This perspective helps to clarify how the privileged patient-provider relationship is not as private, i.e., as narrow in scope, as is often presumed. Rather, the privileging of the relationship, under the aegis of regulatory colleges, disperses decisionmaking power amongst a greater number of people.

its own direct role as a corollary of expanding that of private players, as happened extensively along several axes in the rehabilitation sector.

The case, therefore, supports Tuohy's claim that, as the state loses its fiscal presence and private financing grows,

> Cross-subsidization of benefits and the preservation of professional discretion are increasingly squeezed out of privately financed systems, but these elements are key to the maintenance of systems of public finance. Public and private finance, then, involve fundamentally different sets of incentives, and turning to one versus the other shifts not only the means but the ends of the welfare state in the health care arena. (Tuohy, 1999, p. 262)

Even with tough initial regulatory requirements (as existed under Bills 68, and 164 under automobile policy, and Bills 162 and 165 in the workers' compensation arena), the growth in private capacity and responsibility fuelled both the determination to gain control over them and the "optics" of a "right" to do so. It is perhaps the kind of simple observation that can all too easily get lost – that increasing private responsibilities will increase private incentives to reduce costs, and when this occurs in arenas of public policy concern, it will undermine the capacity to pursue those public interests except by continual regulation. And that is frequently anathema to the very governments most likely to support such "integrative" regimes. In short, it will increase gaming opportunities and incentives, within the context of decreasing public means and will to limit them, thereby contracting spheres of public interest. When this occurs without there having been any explicit debate about whether there continues to be a public interest in the arena, although there once clearly was, as in this case, it is problematic.

Institutional Organization and the Development of Policy Trajectories: Ricochet Effects

The multiple, interactive dimensions of privatization – or, more appropriately, change in public-private boundaries, a concept that allows bidirectional change over time – also suggest that we need to consider how the dynamics of public-private change may be related to, indeed inherent within, the way policy and institutions organize the mix itself, and not only to the impact of external forces, be they broader economic change or actors' interests and ideas. One of the things that stands out in this case is the ricochet effect between change along one of the axes and change along others: in particular, the extent to which increased privatization of

financing resulted in incentives to increase management and administrative privatization, which had what are here called "political privatization" effects, as well as having had further feedback effects on management and administrative strategies and ownership. The inter-relationship, and potential for dynamics, amongst dimensions of public-private change is made more apparent in models such as Stoddart and Labelle's, and proved to be a valuable tool for tracking not only the dimensions but the dynamics of change in this case study.

Like the inter-relatedness of axes of public-private change, the inter-relatedness of institutions that have been structured by the state proved to be another important factor in this case. Recalling Pierson's (2000a) typology of dynamic change mechanisms – causal chains, cumulative processes, and threshold effects – we can see a combination of these processes occurring in Ontario's rehabilitation sector because of the braiding that occurred amongst policy arenas that had been created separately over time but had become unexpectedly conjoined. Within each of the three institutional strands, a logic of policy change was unfolding consistent with their separate frameworks: in public health insurance, the relegation of rehabilitation decision making to individual hospitals played out within the context of diminishing resources; in automobile casualty insurance, allocations for rehabilitation became the centre of a political struggle because of the balance between tort and benefits that formed the central levers; in workplace injury insurance, internal institutions such as the Board of Directors and the Appeals Tribunal made possible a gradual shift of power through policy interpretation.

Most important, however, was the way in which threshold and cumulative change within each of the various arenas formed a set of causal events amongst them, yielding rapid, unplanned and (at least initially) unanticipated privatization of the rehabilitation sector lying at their nexus. In this way, the case helps to address Hall's (2000, p. 12) question about how the sequence of events is conditioned "(w)hen the field of action contains multiple institutions" by showing that the organization of those institutions – such as their fragmentation and the lack of ongoing mechanisms for bridging it – is a key factor in how policy trajectories unfold. Thus, it is important to consider Pierson's analysis of mechanisms not only within a policy making arena and its insitutions, but amongst erratically – and historically unintentionally – interwoven arenas and their institutions, such as Ontario's rehabilitation sector, creating ricohet effects.

Unintended Consequences

Theorists have looked at how macroscopic structures and institutions have framed policy directions over time (Tuohy, 1999), and at how institutional requirements and policy legacies, because of the programmatic features they delineate and the interests attached to them, do or do not allow rational decisions to retrench state involvement to be implemented (Pierson, 1994). Often, however, there is an underlying assumption that retrenchment or public-private change is a deliberate or rational pursuit of governments or of societal interests.[6] Institutions matter in shaping those pursuits and interests, and they are historically and unpredictably formed, but public-private change occurs as a rational decision step. Pierson, for example, depicts privatization, or "contraction of the welfare state," as "a painful (economic) necessity" for some governments and "as an end in itself" for others (Pierson, 1994, p. 1).

Without wishing to discount the important roles of both economics and ideology – indeed, wishing to elucidate a framework for understanding how each come to take particular forms in policy – this study suggests that neither adequately explains the early steps towards privatization in Ontario's rehabilitation sector. And specific programmatic features, as legacies of previous policies, only account partially for subsequent public-private change. Rather, the case suggests that the organization of the state's decisionmaking institutions – ministries, departments, and the like – is an undertheorized dimension of how, and especially in what sectors, public-private change occurs. It suggests that the greater the fragmentation for decisionmaking power amongst institutions – and not just the greater the fragmentation amongst interested policy communities – the greater the prospects for unintended consequences.

And, in an environment where much broader economic and political forces are at play, these unintended consequences will be congruent with them and will tend to dominate in policy arenas that have not been clearly delineated. In this way, institutional organization may channel broader operative forces in the policy environment in ways that precede and sometimes even pre-empt deliberative decisions about public and private roles in a sector. The organization of decisionmaking institutions sharing jurisdiction (implicit or explicit) may create the probability, if not the predictability, of them creating contingencies and ricochet effects for each other that increase the prospect of unintended consequences.

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[6] For a broad-ranging cross-section of perspectives that nonetheless mostly all share Pierson's premise that economic necessity or ideological bent are the major determinants of privatization, see the collection of essays in *West European Politics* (1988).

Practical Lessons

Most pure policy studies likely would end here. As this study did not stop at policy outcomes, however, but went on to some cursory discussion of evaluative outcomes, it becomes possible to draw a few conclusions relevant to practical policymaking, in addition to those made about policy studies. These focus on: continuity of care and the public interest; patient-provider relationships; and links to labour-market fluctuations.

Continuity of Care and the Public Interest

For those concerned about issues of continuity of care (or integration within the broader health care system, as it takes in both core and non-core services), the case suggests that a weakness in continuity may not just be a matter of political will, but is linked to the structure of policy decisionmaking. There is no one single institution in Ontario that could make or pursue the policy decison to create a coherent, seamless system for rehabilitation services: no such decisionmaking structures exist; and no programmatic channels currently exist for creating such seamlessness.

It is unlikely that the new corporate players in the field would be either willing or wise to confine their activities, or their aegis, to Ontario or rehabilitation alone. They will be far more likely to seek business in other provinces and other sectors, horizontally linking workers' compensation systems across as many jurisdictions as possible, and vertically linking out-patient rehabilitation, with home care, post-operative care, long-term care, dentistry, and other community-based forms of care (Yellin, 1996). All these are areas of health care to which similar management and administrative strategies might be applied. Whether this would be for the better or for the worse is beyond the scope of this study, although it is worthwhile for policy makers to consider experiences in the United States with these models of private-sector health management, which appear to be the models that form the basis for recent transformations in Ontario's rehabilitation health sector.[7] As well as its faults or virtues with respect to cost,

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[7] In Massachusetts, it was found that private insurance-based rehabilitation funding caps did not mean that even the best programs allocated resources efficiently. Rather, they tended to spend a great deal of resources up front, in the early acute and post-acute stages, leaving little for later-stage care and undermining the prospects of full, successful rehabilitation and community re-entry for the patient. Consequently, it was found that even people with high levels of coverage were "falling through the cracks" into the public welfare system, and the state had to develop a special Rehabilitation Commission to deal with these (Ministry of Health and Acquired Brain Damage Committee, 1987).

With respect to private managed care (which is sometimes linked through ownership to the insurance carrier and sometimes separate from it, and purchased by insurers), it appeared to be the case for a time that its introduction had indeed managed to slow down the country's rapidly escalating health care costs. More recently,

quality and access, it would remove an increasing amount of health care, and information about it, from public accountability and transparency, making it increasingly difficult either to ascertain or to make policy about these goals.

There is an underlying question that emerges from this about the relationship of the public interest to the changing field of public and private players. In order to be viable as a for-profit private industry, insurers must find ways to minimize costs, and one of the easiest ways of doing so is to limit access (either by de-insuring some services altogether, or by controlling decisionmaking about access to them). But, by definition, an area of public interest is precisely one in which access is deemed uniformly important. This is a widespread problem in privatization wherever public interests are at stake, and it was the underlying, implicit issue in both automobile and workplace injury insurance changes that occurred during the period of study in this case.

Continuity of care, in a mixed public-private system, depends on the public ability to declare its interest and to address gaps being created. At this time, if there is a genuine interest in ensuring continuity of care, it is this matter of what constitutes the public interest, and where it is going unmet, that most urgently needs to be addressed, openly and deliberately. If there is none, then the fragmentation in the sector, with respect both to its interests and its decisionmaking organization, will continue to reinforce and reproduce the trajectory we have seen.

Patient-Provider Relationships

As well, the increasing privatization of decisionmaking under for-profit managed-care models would transform provider-patient relationships by introducing the potential for new

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however, it has begun to be suspected that this was an artificial dampening of price to create confidence in the market: premium costs are now rising sharply, while fees are dropping dramatically (Fisher, 1998; Freudenheim, 1998). HMO revenues in late 1990s were in the area of $950 billion/year (Glasser, 1998) and covered a little more than 50% of the US population, i.e., about 5 times as many people as in all of Canada. Meanwhile, Canadians spent, publicly and privately combined, about $77 billion, a twelfth as much, and 100% of the population has at least basic medical and hospital services available (Canadian Institute for Health Information et al., 1999).

There is little reason to believe that managed care, of the sort practiced in the US (which appears to be the prototype now being imported into Ontario's rehabilitation sector), is efficient, given recent rapid premium rises for employers that have led many of them to drop their workers' coverage altogether (Fisher, 1998). Alongside declining payments to providers and rising premiums through employment, many employers are passing the costs directly on to their workers, and there is no evidence whatsoever that the growth of managed care has led either to long-term cost reductions or improvements in health (Kilborn, 1998).

elements of mistrust and by decreasing, rather than increasing, both the patient's choice of provider and the provider's choice of treatment (Tuohy, 1999; Stone, 1997; Freudenheim, 1998). Such changes in patient-provider and provider-payer relationships are forms of narrowed scope of conflict: fewer individuals have a say in the choices made.

Similarly, providers trained within professional healthcare schools, and regulated by professional healthcare bodies, will have their treatment outcomes defined and measured increasingly on the basis of their patients' return to work and closure of the payer's responsibilities, pure and simple. In rehabilitation, as in other areas of health care, there has been considerable discussion about "evidence-based practice." While this is laudable, since the financing and provision of treatment that has no evidence to support it is dubious, rehabilitation is different in some fundamental ways from other areas of health care. For one thing, as a representative of the Medical Reform Group pointed out on June 18, 1997, during the hearings for Bill 99, Ontario's new *Workplace Safety and Insurance Act, 1997*, very little evidence exists to date about rehabilitation services. Payers and legislators may wish to confine duration of services to "the usual recovery times," but nobody really knows what those averages are or what the standard deviations are, or what they should be with respect to outcomes such as ability to perform different functional activities. Should rehabilitation services be withheld or limited while this research is amassed?

Furthermore, rehabilitation is different than many other health care interventions precisely because the legislative frameworks introduce numerous confounding factors that make it difficult to assess cause and effect. The linkage of income-replacement benefits with health benefits introduces factors such as fear of income loss and adversarialism between insurers and claimants that may skew outcomes such as return to work. Individuals may return to work because they are fearful, rather than because they have recovered. Or they may not return for the same reason, or because they are angry.

Therefore, the introduction of certain "evidence-based" practices, e.g., practices shown purely to hasten return to work and file closure, will risk loss of credibility for professionals made to work, or willing to work, in such a context.

Links to Labour-Market Fluctuations

Finally, the shift of disability benefits for rehabilitation into private insurance either will create "job lock" effects for individuals concerned about such benefits, or will have potentially

profound impacts for those individuals who remain unprotected, and whatever public social programs remain to break their fall out of the labour market.

The availability of rehabilitation services in Ontario has become increasingly linked to labour-market fluctuations because of changes in the regulatory frameworks. The widespread labour-market changes that have occurred during the period studied here, mean rising insecurity for anybody who experiences a disruption due to injury. Not just income insecurity, but potential long-term dislocation if both responsibilities for providing rehabilitation, and capacity to play a role in determining it, increasingly diminish the likelihood that full, long-term rehabilitation will be achieved.

This could have particular implications for rehabilitation of those in lower income brackets and more tenuous employment situations. As such services come increasingly to be found outside the basket of the public health care system, their coverage will be a matter of whether and which companies include them in benefit packages. Because of their costs, companies likely will be eager to include them only to the extent that (a) they are important to workers and workers are able to achieve them in collective bargaining, which in turn depends on the strength of worker organization, or (b) the worker's absence from the workplace is more costly than their rehabilitation and return. The latter will be the case for particularly valuable employees (executives and managers, for example), or for employees who have guaranteed long-term access to substantial income benefits (who are likely to be, again, those with higher status or those in workplaces that already have high-paying long-term disability packages in place). Thus, the availability of rehabilitation, structured as it has been by policy fragmentation, will have implications for broader population health outcomes, assuming outcomes of concern include the capacity to work.

Final Observations

Having looked back, what does this historical analysis suggest about future prospects for Ontario's rehabilitation sector specifically? To deal with the problems that have arisen in it – differential access and sometimes no access, poor quality control, questionable costs and resource allocations – will require, first of all, some declaration of a public interest in doing so, as has been said. And it will require careful study and delineation of where gaps in continuity and access to rehabilitation services exist, and simply in the public capacity to identify them. These are the most urgent short-term strategies. In the long-term, it is even less likely now than

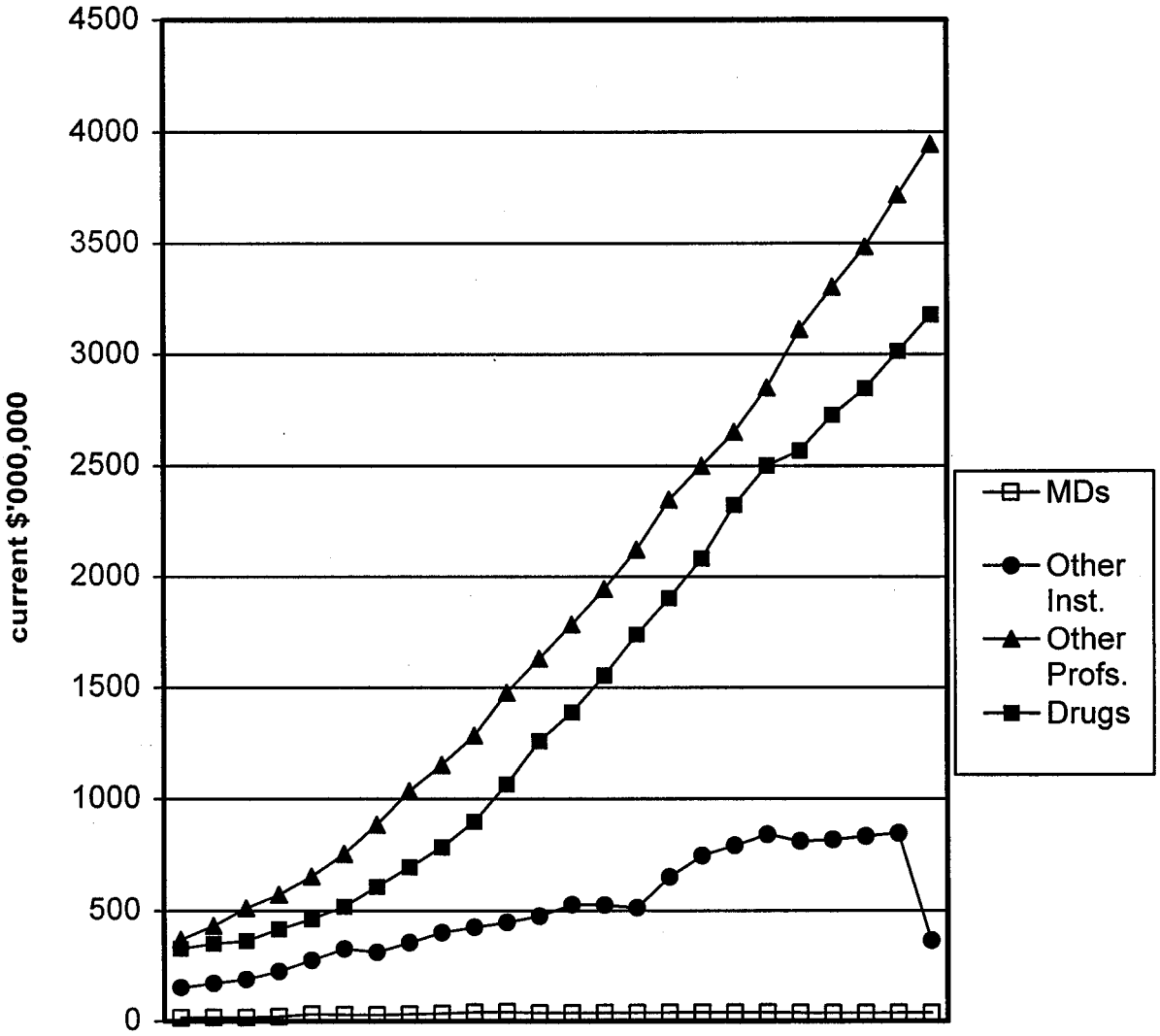
it was in the early years of this period of volatile transition, that existing institutional frameworks can be dismantled and replaced. It would make more sense to set the creation of strong bridging institutions, across the policy decisionmaking structure, that would make coherent action in the decision making process a requirement. Such coherence preferably would range from agenda-setting and problem definition, to choosing solutions, and to implementing them and monitoring their outcomes.

Even this is not possible in the current climate, when the major players have come to define and pursue their own interests so separately. So medium-term strategies – after delineation of gaps and of the public interest in rehabilitation – would need to be two-pronged. Firstly, an investigation of what barriers currently exist to satisfying the defined public interest by unifying action amongst the players. And secondly, a clear mapping of incremental solutions for the gaps that have been created, to address the most egregious consequences that now exist.

These are very broad observations and any one of them would raise multiple questions and challenges that would need to be addressed and resolved. Short of them, however, it is most likely that cost shifting will continue to occur as payers, who have gained greater decisionmaking control over allocation of resources, continue to seek ways to minimize their cost exposures or, in the changing world of rehabilitation services, maximize their profits. Lost in the shuffle amongst them, particularly as the cracks between them widen and the public sector retreats, will be working-aged Ontarians whose ability to earn a living has been compromised.

FIGURES AND APPENDICES

Figure 2: Private Sector Health Expenditures on MDs, Non-Hospital Institutions, Other Professionals, and Drugs, Ontario, 1976-1998



1976 - 1998 incl. ('97 + '98 forecast)
Source: CIHI, National Health Expenditure Trends (1999), Table D.2.6.1

APPENDIX A

COMPARATIVE INTERNATIONAL WORKERS' COMPENSATION SYSTEMS, AND RELATIONSHIP TO BROADER DISABILITY SYSTEMS, AS AT 1991

(Source: C. Arthur Williams. *An International Comparison of Workers' Compensation.* Boston: Kluwer Academic Publishers, 1991.)

GERMANY

Structure: Industrial Injuries Insurance Institutes administered in 3 separate parts: General Accident Insurance (industrial and commercial); Agricultural Accident Insurance; and Accidents at Sea Insurance. General Accident Insurance administered by 36 Industrial Injuries Institutes, which are nonprofit. corporations, self-governing in daily operations. Members in each are in a consolidated industrial group. Each institute has authority to administer statutory provisions under Genreal accident Insurance, and each has a legislative body (Representatives Assembly) and an Executive Committee, containing equal numbers of employer and worker representatives. Joint interests handled by a Central Association, which has same legislative and executive structures as the separate Institutes.

Coverage: Exclusive remedy. Covers all private employees, apprentices, students, children in kindergarten, and family helpers. Some self-employed coverage under separate Institutes; all self-employed may become voluntarily insured. No minimum labour-market service required for coverage.

Medical and Rehabilitation Benefits: Comprehensive medical, rehabilitation, appliances. Provided under public sickness social insurance for first 18 days. After that, relevant Instiutte assumes responsibility. Severe injuries treated in institute-owned hospitals. 950 other hospitals designated as equipped and staffed to handle these, as well.

Financing: Completely financed by employers. Institute sets premiums, which are in form of payroll percentage; average is 1.5%. Rates are set high enough to maintain sizeable reserve fund to cushion fluctuations in loss experience.

Administration: by Institutes for day-to-day operations. Federal Insurance Institute is part of the Federal Ministry of Labor and Social Affairs, which supervises the Institutes, as well as supervising sickness insurance institutes under the federal health insurance program.

Historical Background: Otto von Bismarck, Chancellor of the German Empire, 1887.

NETHERLANDS

Structure: Since 1967 (to time of writing), Netherlands had five major programs providing medical, disability and death benefits regardless of relationship to job. These are: Compulsory Health Insurance Act, Sickness Benefits Act, General Disablement Benefits Act, Disablement Insurance Act, General Widows and Orphans Act.

Coverage: Not exclusive remedy. Different aspects of the five programs cover different residents.

Med/Rehab.: Provided by doctors, hospitals and druggists under contract with sickness funds. Patients cost-share some major expenses (e.g., plastic surgery or artificial limbs) only if they are above a certain income bracket. After 366 days, sickenss fund becomes responsible for continuing care under an extended illness program.

Financing: No separate contribution for work-connected injury/illness. Emplloyees and employers contibute to Sickness Benefits at rates based on industrial codes; govt. subsidizes coverage of those disabled from birth and the low-income. For Exceptional medical Expenses Act (primairly for mental health care), employers contribute 4.55% percent of the employee's salary up to a specified amount.

Administration: Supervised under ripartiate (employer, employee, govt) Social Insurance Council. Medical benefits administred by abt 60 sickness funds, which are supervised by tripartite Sickness Funds Council.

History: Had "a fairly typical workers' compensation system" from 1907 to 1967.

NEW ZEALAND

Structure: No distinction between work- and non-work related injury, though does distinguish when it comes to disease: occupational disease is considered accidental, but non-occupational disease is not. A single no-fault accident compensation system, administred by Accident Compensation Corporation, which replaced workers' comp system, third-party motor vehicle insurance schemes, a criminal compensation tribunal, and a common law fault system applying to all other accidents. A separate social security system rovides medical treatment through public hospital and some means-tested benefits for sickness, invalidity and unemployment. Rape and incest are considered compensable accidents under the scheme, as well as all injuries resulting from medical and dental "misadventure."

Coverage: All NZ residents; no minimum qualifying period.

Med/Rehab.: unlimited medical care from either public hospitals or private hospitals. Use of private hospitals grew primarily because 'early treatment might shorten the duration of disability benefits" (144). Benefits also cover appliances, rehab and doctors' care, which are not covered by the national medical care system (which only applies to hospitals, I gather).
Financing; In 1988, 71% of income to the AC scheme came from employers, 18% from motor vehicle owners, 8% frm generalrevenues, and the remainder from investment income. Employers and self-employed pay an industry-based levy; average in '88 was $2.33/$100 of payroll; of this, $1.25 was for work accidents, $0.99 for non-work acidents, and $0.08 for Department of Labour to fund safety programs.. Rates are the same across everyone in an industrial category, varying from a low of $1.30 to $18.70. This funds all injuries but for MVAs. Vehicle owners pay $100/year as part of licensing fee; this finances all accidents associated with MV use. General tax revenues fund claims from retired persons, unemployed, school children. Of persons claiming cash benefits, more than 75% are wage earners; about 12% are MVA victims.
Administration: Administered by Accident Commission Corporation, not a state agency, but reports to Parliament through Minister of labour. corporation has two responsibilities: to reduce frequency and severity of personal injury by accident; and to rehabilitate the injured. Rehab defined broadly as medical, vocationa, and social, as well as provisionof financial compensation.
History: Royal Commission, chaired by Honourable Arthur Owen Woodhouse, a Supreme Court judge, argued against a privately insured system, saying it would be inconsistent with 'guiding principles" of community responsibility and administrative efficiency.

SWEDEN

Structure: Part of a general social insurance system. First WC law passed in 1901. Current law (at time of writing) dates to 1976. Under collective agreements, most employers accept responsibility for certain benefits over and above statutory benefits provided under social secrity system. One of these is provided through labour market no-fault liability7 insurance, under which employees may make claims; in exchange, employees cannot pursue a claim for damages against any employer covered by labour market no-fault liability insurance. Thus, many employres who otherwise would not have to contribute to the Swedish Employers'

Confederation, who must contribut to the no-fault scheme, voluntariy contribute to it. Therefore, there are almost no common law claims made against employers.

Cvoerage: Not exclusive remedy, but at same time includes non-economic claims on no-fault basis. Al employed persons covered, with no minimum qualifying period.

Med/Rehab.: During first 90 days, injuries compensated (including cash benefits) under general health insurance program. This includes all medical expenses at public or privte facilities ue to physician, dental or other treatments, as well as travel expenses in connection with care; drugs free or reduced cost. Occupational injury insurance is supplementary to this (e.g., full cost of appliances, patient fees for detnal care, all travel expenses for dental treatment and fitting of aids). After 90 days, occupational injury insurance pays entire costs of all medical services. Tempoary benefits continue until recovery or certification of permanent disability occurs.

Financing: Closely integrated with general social insurance, but separately financed. Employers contribute 0.9% of payroll; employees and govt contribute nothing. This is separate from national health insurance program, which is financed by 10.1% of payroll, and $1.5% of total costs from govt.

Administration: Al programs in social insurance system are supervisied by National Social Insurance Board, and daily operations administered by regional and local offices.

UNITED KINGDOM

Structure: See administration below.

Coverage: Not exclusive remedy; tort possible. Includes all wage and salary workers, who also qualify for general social insurance program, of which industrial injuriees scheme is a part (i.e., integrat4ed). No minimum period of service required.

Med/Rehab.: Medical care provided through NHS, covering both occupational and nonoccupational injuuries/diseasese on same terms. Include doctors, hospitals, dental care, and drugs under contract with NSHS. Cost sharing for dental work and drugs; no limitation on duration of care. No clear statement re rehab.

Financing: Financed under broader social insurance scheme, to which employees, employers, and government all contribute. Employees contribute 5-9% depending on wage bracket; self-employed pay a small flat rate plus 6.3% of profits between 4pounds and 15,860pounds. Unemployed can voluntarily contribute at 6.5pounds/wk.

Administration: National Injuries Scheme administered as part of broad social insurance system. Dept. of Health and Soc Security administers contributions and benefits through regional and local offices. NHS administers med services through regional and local health authorities.

History: First WC system in 1897; diff. than Bismarck model. Even further extensively revised by National Insurance (Industrial Injuries) Act of 1946, and Law Reform (Personal Injuries) Act. Unique model; quite different than German one. Unlike German system, first UK system of 1897 did not link it to broader social insurance, and this was the system copied by many other countries, including its colonies (such as Canada and Australia), the US, and Denmark. At the time, however, broader social security did not exist. Health, old-age pension, unemployment were implemented during the following decades. Committee to review was established in 1941, under Sir Wm Beveridge, and repoorted in 1942. Beveridge favoured single system that was not means tested, and financed by employers, workers, and the state. Should not be a separate system. Considered various options, including full unification of WC and NHS, but opted instead for a partial unification.

UNITED STATES

Structure: Like Canada and Australia, has more than one scheme. Not integrated with any other social security or public policy programs.

Coverage: Exclusive remedy; economic losses only. Generally, all employees except those excluded, including railroad workers, farm workers, domestic workers, although a minority of states do cover these employees. In three states, it's elective.

Med/Rehab.: All but two programs cover all medical expenses. No jurisdiction, however, operates special WC hospitals.. Many states limit duration of temporary benefits, with wage replacements generally in the 2/3 level. In addition, all states provide physical rehab services, and all but seven provide voc rehab.

Financing: Solely through employer contributions, mostly either class rated or experience rated, or retrospectively rated.

Administration: Varies widely, In 6 states, there's a state fund. In 31 states, employers must purchase private insurance. In the remaining 14 states, state funds compete with private insurers.

History: Enacted state by state, beginning with Illinois in 1912.

APPENDIX B: CHANGES UNDER AUTOMOBILE CASUALTY INSURANCE TORT AND BENEFITS, ONTARIO, 1969-1996

Pre-OMPP (Bill 68)

	Up to 1969	**1969-1978 (optional partial no-fault until 1972; compulsory thereafter)**	**1978 - 1990**
Tort Access	Full economic and non-economic recovery possible.	Full.	Full economic. Capped/indexed non-economic.
"Threshold"	N/A	N/A	N/A
No-fault medical/ rehabilitation	None	$5,000 Indemnity basis (i.e., contractual; recompensed after cost incurred, with approval).	Combined up to $25,000 for max. 4 years. Indemnity basis.
Care benefits	None	None.	
Other benefits	None	Income: $70/wk. max.	Income: 80% gross to $140/wk. max. ($70/wk. for homemaker, limited to 12 weeks)

APPENDIX B CONT'D

OMPP (Bill 68) vs. Bill 164

	1990 – Jan. 1994 OMPP/Bill 68 (Lib.)	**Jan. 1994 – Nov. 1996 Bill 164 (NDP)**
Tort Access	Economic + non-eco. "Threshold" cases only. Deductibles: $15,000 + income + collat. benefits	Non-economic only. Threshold only. Deductibles: $10,000 + income + collat. benefits
"Threshold"	1. Death 2. Permanent, serious disfigurement. 3. Permanent, serious impairment ... important ... function ... continuing injury ... physical in nature. [s. 231a(1)]	1. Death 2. Serious disfigurement. 3. Serious impairment of an important physical, mental or psychological function. [s.267.1(5)]
No-fault medical/ rehabilitation	$500,000 10 yrs. or 20 yrs. minus age at accident Entitlement basis.	$1 million over lifetime Entitlement basis.
Care benefits	$500,000 Monthly cap: $3,000	Unlimited over lifetime. Monthly cap: $3,000 (contestable) Indexed
Other benefits	Income: 80% gross income to max. of $600/wk. (adequate for anyone making up to approximately $35,000/yr.) Optional top-up. Eligibility: worked 180/365 previous days. Benefits If No Income: $185/wk.	Income: 90% of net to max. of $1000/wk (protected 97% of income earners). Eligibility: worked some time in previous 3 years. BINI: to $185/wk.

APPENDIX B, CONT'D.

Bill 164 vs. Bill 59 (AIRSA)

	Jan. 1994 – Nov. 1996 Bill 164 (NDP)	**OMEGA "WISH LIST"**	**June 1996 – (2000?) AIRSA/Bill 59 (PC)**
Tort Access	Non-economic. threshold. Deductibles: $10,000 + income + collat.	Eco. if fault. Deductibles: $8,500 + all no-fault + collateral	Non-eco. threshold. Economic recovery if fault involved. Deductibles: $15,000 + all no-fault + collateral
"Threshold"	1. Death 2. Serious disfigurement. 3. Serious impairment of physical, mental or psych. function.	1. Death 2. Serious disfigurement 3. Serious impairment of bodily function.	1. Death 2. Permanent, serious disfigurement. 3. Permanent, serious impairment of physical, mental or psychological function.
No-fault med/ rehab	$1 million over lifetime Entitlement basis.	$1 million for catastrophic. Others to $25,000 pending insurer agreement with treatment plan.	$1 million for catastrophic injuries. Others to $100,000, pending insurer agreement to treatment plan.
Care benefits	Unlimited over lifetime. Monthly cap: $3,000	Included in med-rehab	$72,000 in first 2 yrs. $1 million over lifetime for catastrophic
Other benefits	Income: 90% net to max. $1000/wk	Income: 90% net, to $450. First 2 years.	Income: 80% net, to $450/wk. max. Deductible: 80% net of any earned income

Appendix C: Recoveries under Insurance Bureau of Canada's OMEGA Proposal, and final Bill 59, the Automobile Insurance Rate Stability Act

	OMEGA	AIRSA
Tort: Non-Economic Loss	For injuries crossing threshold, less $8,500 deductible.	For injuries crossing threshold, less $15,000 deductible.
Threshold	1. Death 2. Serious disfigurement* 3. Serious impairment of an important bodily function.	1. Death 2. Permanent serious disfigurement. 3. Permanent serious impairment of an important physical, mental or psychological function.
NO-FAULT BENEFITS		
Medical/Rehabilitation Benefits	$1 million for catastrophic* injuries only. All others, up to $25,000 **subject to insurer agreement to treatment plan**	$1 million for catastrophic injuries.*** All others, up to $100,000, **expenditures subject to insurer agreement to treatment plan****
Long-Term Care Benefits	Included in medical/rehabilitation benefits	$72,000 max.; available first 2 years. Exception: $1 million over lifetime if catastrophic injury.
Income Benefits	First 2 years post-onset: $450/wk. max. based on 90% of net income. Thereafter: same, depending on new test of disability.	First 2 years: 80% of net, up to $450/wk. max. Thereafter: same, depending on new test of disability. Deductible: 80% net of any earned income.
Test of Disability	First 2 years: "an impairment of function that causes...an employed person to be substantially unable to perform the essential tasks of his or her employment."** Thereafter: "the insured person is continuously disabled and prevented from performing the essential tasks of any employment for which the person is reasonably suited by education, training or experience."	First 2 years: "suffers a substantial inability to perform the essential tasks of the employment in which the insured person spent the most time during the 52 weeks before the accident." Thereafter: "as a result of the accident, the insured person is suffering a complete inability to engage in any employment for which he or she is reasonably suited by education, training or experience"

Sources:
Insurance Bureau of Canada (1995)
Ontario Regulation 403/96.
Ministry of Finance, Ontario (1996a, 1996b)

* OMEGA does not define "catastrophic" injury. "Serious injury" is defined as: "(a) permanent hemiplegia, paraplegia, quadriplegia, (b) a severe brain injury which resulted ina score of nine or less on the Glasgow Coma Scale when the person was examined at a medical facility after a reasonable period after an accident, or (c) upper bilateral amputation or other injury causing the total and permanent loss of use of both hands or arms."

** As per previous Bills, there are also provisions for homemakers, caregivers, and students, but these are not included here. The reader is referred to the appropriate *Schedule of Accident Benefits* for each Act, e.g., Ontario Regulation 403/96 made under the Insurance Act, *The Ontario Gazette*, Vol. 129-36, Saturday, September 7th, 1996.

*** The SABS for AIRSA defines catastrophic impairment as: (a) paraplegia or quadriplegia; (b) amputation or other impairment causing total and permanent loss of use of both arms; (c) amputation or impairment causing total and permanent loss of use of both an arm and a leg; (d) total loss of vision in both eyes; (e) brain impairment resulting in a score of 9 or less on Glasgow Coma Scale, or a score of 2 (vegetative) or 3 (severe disability) on the Glasgow Coma Outcome Scale; (f) any impairment or combination of impairments that results in 55% or more impairment of the whole person, in according with American Medical Association's *Guides to the Evaluation of Permanent Impairment*, 4th ed., 1993; (g) as per (f) but resulting in a class 4 (marked) or class 5 (extreme) impairment due to mental or behavioural disorder.

**** Past policies, like this one, have stipulated that rehabilitation services must be reasonable and necessary in order to be paid by the insurer. Generally, however, treatments ordered by licensed providers were honoured; and stiff penalties were in place for insurers who were found to unreasonably withhold treatment.

Under AIRSA, however, insurers are obliged to pay only for the first 15 treatments after the accident by a chiropractor or physiotherapist, or for the first six weeks of chiropractic or physiotherapy, whichever is less. Thereafter, all medical and rehabilitation expenses must be submitted to the insurer first as a treatment plan, authorized by a primary caregiver, and await approval before proceeding.

Appendix D: Fee Schedules Negotiated with Providers by WSIB, 1998-1999
Adapted from source: Workplace Safety and Insurance Board, Ontario, <http://www.wsib.on.ca/wsib/wsibsite.nsf/Public/HealthProfessionalFees>

Treatment Limitations:

- Occupational Therapists (OTs) and Physiotherapists (PTs): Authorized through initial twelve weeks, then must seek further authorization from adjuster, case-by-case, based on explicit treatment plan.
- MDs: No authorization required.
- Massage Therapists (MTs): May proceed only with pre-authorization from adjuster.
- Chiropractors (DCs): Authorized through initial twelve weeks. Can then be extended by submitting form request.

Fees ($)

	Assess-ment	**Clinic Visit**	**Home Visit**	**Reports, FAEs**	**Assess-ment Reports**	**Other Reports**	**Acupunc-ture**	**In-office interview**
OTs	14.51	29.01						
PTs	18	18		40	18		37.91	
MDs	OHIP	OHIP		40 (also, 23.01 for FAE clearance alone)	23.01	23.01-109.58	37.91	28.49
MTs	14.51							
DCs	23.01	18.83	23.54	40	23.01	23.01 - 109.58	37.91	28.49

Payments to hospitals are divided into those for in- and out-patient rehabilitation services. Fees are established for various investigative scans, e.g., CAT and MRI, as well as for day care surgery, emergency room services, and follow-up for these. Mention is made of billing for out-patient physiotherapy, but no schedule is provided; the OHIP schedule of $12.20/visit implicitly applies.

Third-party payments for Independent Medical Evaluations are available to medical specialists at a rate of $209.20 per IME. IMEs are assumed to last up to 1 hour. $52.30 is paid for each additional quarter-hour. And "complicated cases" receive a $104.60 premium.

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