Student Public Policy Essays

October 2004, Issue 2

GRADUATE

The Evolution of Public Drug Benefits in Saskatchewan: 1945 - 2002

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UNDERGRADUATE

The Future of Restorative Justice in Canada

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The Student Public Policy Essay is published as a result of a contest targeting students at the University of Regina. The winning essay, judged by an independent group of scholars and policy practitioners, is made available to the public through this publication.

In an effort to engage the student population and better utilize the pool of talent that exists in this province, SIPP developed the Student Public Policy Paper Essay Contest.

Most students have not had the opportunity to publish original pieces of work. The Saskatchewan Institute of Public Policy wanted to reward the top student essay, at both the graduate and undergraduate level, dealing with a significant issue of public policy through publication. Full details regarding the Student Public Policy Essay Contest are available online at **www.uregina.ca/sipp**.

Director's Introduction

GRADUATE PAPER

In his paper, The Evolution of Public Drug Benefits in Saskatchewan: 1945 - 2002, Daniel J. Hickey suggests that public drug coverage remains a policy riddle. While the issues have been studied at length, the enormous demands on the public coffers has contributed to keeping this policy issue in a state of flux.

UNDERGRADUATE PAPER

In her paper, The Future of Restorative Justice in Canada, Sharon M. Desjarlais asserts that there are many positive outcomes from restorative justice programs, in particular, as a means to resolving conflict and healing communities. While many current programs still require adjustments, this approach can lead to positive change.

It is our hope that the student policy essays will showcase the interests and talents of the young women and men in the area of public policy.

Dr. Raymond Blake
Director, Saskatchewan Institute of Public Policy

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The Student Public Policy Essay Series offers a unique perspective on issues of public policy. While SIPP is committed to the success of this series, the papers themselves contain the views of the author, and do not necessarily reflect the opinions of the Institute.

October 2003, Year 1 Winner:
An Econometric Analysis of the Decline in Welfare Cases in Ontario: 1984 - 2002 by Maximilian D. Schmeiser
This paper is available for download at **www.uregina.ca/sipp**.

The Evolution of Public Drug Benefits in Saskatchewan: 1945 to 2002

By Daniel J. Hickey

> The Committee does not recommend inclusion of drug benefits because of the extremely difficult problems of cost control.
> Interdepartmental Committee to Study a Medical Care Program for Saskatchewan (1959, 61).

It is often said there are no new issues in health policy, only old items that occur and re-occur from time to time. Certainly this may be true of public drug benefits; over forty years later, the Saskatchewan Commission on Medicare similarly commented on the wariness of governments to expand drug coverage for the like reasons of costs, and cost control (Fyke 2001, 49). Indeed, it is suggested that much of the provincial experience with prescription drugs and drug benefits reflects a struggle between considerations of equity and costs – a tension between the desirability of a universal drug program as a logical component of a publicly funded health care system – and the affordability of such a venture given the pattern of escalating drug costs and the absence of corrective measures.

This observation is not meant to reduce the Saskatchewan experience with prescription drugs to a mere discussion of program costs and funding. While financing remains a dominant theme, other factors and developments may be considered as influential and critical in shaping provincial drug policy and programs since 1945. These include:

- The change in status of prescription drugs from a largely ameliorative role to that of a "life-saving, life sustaining, pain-killing and disease preventing" (Hall 1964, 39) position, and therefore a suitable candidate for consideration in any discussion of a publicly funded health care scheme.

- The establishment of a comprehensive hospital insurance (including in-hospital medications) and medical care (covering physician services, but not the drugs prescribed by physicians) plan, and the view of pharmacare as being naturally consistent with – and a logical successor to – these initial insured programs.
- A continuing and abiding general social belief in equality of opportunity, and equal access to health care – including prescription drugs – within the capacity of the individual and the state to pay.
- A recognition by the public sector of both the role of private enterprise, and the presence of market failures, in the provision of prescription drugs, and the occasional assertion of public interest primacy in instances of perceived conflict.
- The opportunities initially created, and the limitations later imposed, by changes in federal patent legislation.
- The changes in public financing – the creation of a universal drug scheme during a period of provincial economic growth, high public expectations and growing health services, and the retraction and reconfiguration of these same services in response to a deterioration in public finances.
- The phenomenons of escalating drug costs, the absence of effective tools to curb this exponential growth and the increase in private drug insurance through employment arrangements as a safety valve for public benefits.

In reviewing the evolution of public drug benefits in Saskatchewan, three situations are apparent. First, provincial drug policy and programs emerge not as a result of a deliberate long term plan but (like a number of social programs) as a product of incremental change – a series of distinct and separate acts taken over an extended period of time, with the final outcome being neither certain nor preordained but shaped by a number of internal and external factors.

Second, and as intimated earlier, much of the history of provincial drug benefits reflects the tension between the logical inclusion of drug services within a publicly funded and universal health system and

the significant cost implications associated with such a venture. Proponents of a universal pharmacare program have struggled, and will likely continue to struggle, with this fundamental dilemma.

Finally, and despite considerable interest in prescription drug issues (drug costs now being the second largest area of health expenditures), there is a notable absence in the literature on the development of provincial drug insurance plans. The intent of this paper is to assist in this policy area by providing an initial, and preliminary, analysis of the factors and events that shaped Saskatchewan drug benefits.

The Post War Period (1945 to 1959)

In Saskatchewan, the post war period coincided with the election to government of the Co-operative Commonwealth Federation (CCF) and the introduction of a series of health reforms by the CCF aimed at improving provincial programs and access by residents. These advances included the formation of health regions (1945), the creation of free hospitalisation (1946) and the establishment of a medical school and hospital at the University of Saskatchewan (1950). Other enhancements were introduced in such areas as cancer services, mental health and ambulance services (Mombourquette 1991).

During this period of health services expansion, provincial drug programs and coverage were not part of a single policy initiative, but rather emerged as a product – or perhaps more appropriately as a by product – of three public health service initiatives for certain population groups (social welfare recipients), for select chronic conditions (cancer care, tuberculosis, mental health) and for particular types of care and treatment (hospitalisation).

Drug benefits for certain population groups (specifically, social assistance) is the policy area most frequently cited and referred to in the literature. Although drug reimbursement plans for public assistance recipients were established in other provinces, Saskatchewan is identified as the first jurisdiction to implement a provincially administered health services program for public assistance beneficiaries.

The medical care program for public assistance groups originated in 1945 and was administered as two separate sub-programs, known as "Program I" and "Program II." Program I provided a range of health benefits (hospital care, medical care) to persons receiving or requiring financial support on an

extended basis (pensioners, recipients of Mother's Allowance), while Program II provided similar benefits to residents requiring aid of a short-term nature. Under these public welfare programs, drug products prescribed by a physician were covered by the then Department of Public Health. During the initial years of the program, the full costs of prescribed medications were covered, but in response to increasing utilization and costs, a utilization charge of 20 per cent of the cost of approved drugs was implemented in 1949 for Program I beneficiaries. This amount was increased to 50 per cent in 1959. For Program II recipients, the Department paid the full prescription cost.

In addition to the reimbursement of prescription drug costs for low income groups, Saskatchewan was also engaged in extending drug benefits through - or as part of - the provision of other larger health programs. Following the launch of the social assistance program in 1945, a comprehensive hospital insurance plan was introduced in 1946 with provincial coverage and funding for most in-hospital drugs and medications. Similarly, provincially delivered services for certain chronic conditions (cancer, tuberculosis, mental health) were extended and enhanced, with coverage again provided for most in-patient medications. In the specific case of cancer therapy, the Province also covered certain out-patient medications. Finally, on a separate but related point, the Department of Public Health became involved during this period in the direct purchase of drug products from manufacturers (though a competitive tendering process) for medications used in its public health programs.

The net result of the program experiences gained through the fifteen-year period was an apparent appreciation by the Province of the benefits of drug coverage, but an expressed reluctance to extend coverage for financial reasons. On the specific issue of drug costs, government documents indicated that the cost to the province of drugs supplied to Program I beneficiaries increased substantially from $3.12 to $16.62 per beneficiary during the period 1945 to 1959 (Government of Saskatchewan 1961, 5). As a result of this trend, it was noted "the average family cost for drugs … was beginning to assume considerable importance in the family budget. It is likely that the average amount spent for drugs by a family now approximates the average amount spent for medical care" (Interdepartmental Committee 1959, 60).

Notwithstanding this situation, the 1959 interdepartmental report to the Cabinet on future directions in medicare recommended against offering the program on a universal basis "because of the extremely difficult problem of cost control" (Interdepartmental Committee 1959, 61). Utilization issues and private industry practices were cited as factors contributing to the cost situation. Rather than universal coverage, the Cabinet report proposed the extension of existing targeted benefits to include those residents with certain chronic or long-term illnesses. As acknowledged by the Committee in its report, this recommendation represented essentially an expansion of the targeted benefits program for public assistance recipients.

The comments by the Interdepartmental Committee touch upon a number of themes that recurr in the evolution of provincial drug insurance plans – a recognition of universal drug benefits as a logical component of a comprehensive health care system, a wariness of utilization increases and financial costs, an identified concern with pharmaceutical industry practices and a concluding preference for directing public support to those targeted beneficiaries having the greatest prescription drug needs or costs. All of these themes became more apparent, and pronounced, in the ensuing years.

Medicare But Not Pharmacare: 1960 to 1974

The period from 1960 to 1974 spawned a rather large number of studies and reports, at the national and provincial level, that advanced the consideration of public drug benefits and contributed to the eventual formation of the provincial drug insurance plan in 1975. Because of the marked differences in the nature and scope of investigations by the two jurisdictions, developments at the national and provincial level are treated separately.

a) National Developments

At the national level, three major studies – the report of the Restrictive Trade Practices Commission on the Manufacture, Distribution and Sale of Drugs (1963), the Hall Royal Commission on Health Services (1964) and the final report of the House of Commons Special Committee on drug costs

and prices (1967) – presented a common finding with respect to the high, and excessive, cost of prescription drugs.

The three national examinations may be viewed as somewhat mutually reinforcing, with the recommendations of the Hall Commission regarding prescription drugs being primarily based on the investigations of the Restrictive Trade Practices Commission, and the House of Commons Committee in turn confirmed the findings of the two earlier reviews.

The three investigations are, however, distinct in that the Restrictive Trade Practices Commission and the House of Commons Special Committee focused largely on the issue of drug prices (and the associated implications of federal patent legislation), while the Hall Commission concerned itself primarily with the role of prescription services within the proposed national health care program. With respect to the first matter of drug prices and patent legislation, the Restrictive Trade Practices Commission summarized its findings as follows:

> It is the conclusion of this Commission that the control over drugs exercised through patents in Canada is disadvantageous to the users of drugs in this country by enabling the suppliers of such drugs to charge high prices in relation to the cost of production and distribution of medicines. The Commission did not find any advantages to Canada from the patent control of drugs, which would offset, in any significant degree, the disadvantage to the Canadian public nor does it consider that there would be any change in this situation in the foreseeable future if the patent system continues to apply to drugs (Restrictive Trade Commission 1963, 523).

While similarly noting the high cost of pharmaceuticals, the Hall Commission also articulated a number of views fundamental to the debate concerning public drug benefits. These are: (i) the efficacy of drug therapy (prescription drugs being defined as "life-saving, life-sustaining, pain-killing and disease preventing") (ii) the accompanying need for drug benefits within a national system (the report recommended "the Federal Government contribute grants to the provinces…for the purpose of introducing a Prescription Drug Benefit") (iii) the presence of significant public interest in prescription drug policy (Hall observed "the necessity for solutions that enable essential drugs to be readily available and at reasonable cost") (iv) the inevitability of the involvement of the private sector and (v) the primacy of the public interest (Hall stated "although we accept the manufacture and distribution of drugs …is a

private enterprise venture, we have no hesitation in stating the public interest is dominant") and (vi) the use of co-payments for prescription drugs (the report proposed "that in the provision of the drug benefit, there should be required a $1.00 contributory payment by the purchaser for each prescription") (Hall 1964, 39-41).

These examinations of prescription drug issues contributed to the introduction of federal compulsory licensing legislation in 1969. These legislative amendments had the effect of encouraging generic drug products and lowering prescription drug prices, which, in turn, aided and abetted the introduction and development of provincial drug plans during the 1970's (Lexchin 1993).

b) Provincial Developments

In Saskatchewan, the decade commenced with the presentation of three important documents regarding prescription services: the Government of Saskatchewan's submission to the Restrictive Trade Practices Commission (July, 1961), the interim report of the Advisory Planning Committee on Medical Care (September, 1961), and the final report of the Advisory Planning Committee (September, 1962).

The submission by the Government of Saskatchewan to the national Restrictive Trade Practices Commission reiterated a number of the provincial issues and concerns mentioned earlier in this paper. The report noted the increasing drug costs and the financial costs borne by the provincial treasury as a result of drug benefits for public assistance recipients and increased drugs to in-patients under the hospitalisation plan, and cautioned that "the establishment of a medical care program will make it even more important that drug prices should be at reasonable levels." The provincial document also acknowledged the changing role of drugs and the emergence of pharmaceuticals "to occupy a central curative position" and to be "products of astonishing and miraculous power" (Government of Saskatchewan 1961, 2-3).

However, it is with respect to its assessment of private industry forces, and the accompanying need for public intervention, that the government brief to the Commission was most revealing. The submission expressed strong concerns about the profit-making and promotional activities of the drug industry, and raised ethical objections similar to those noted later by the Hall Commission about

profiteering and public interest primacy. The Government stated "it seems to us as inappropriate for exorbitant profits to be made out of the need of sick people for curative drugs as it would be to demand a ransom from the dying for blood plasma" (Government of Saskatchewan 1961, 3). Related to its observations on private industry practices, the submission also emphasized the beneficial financial results accruing to the Province as a result of the direct government tendering arrangements for pharmaceutical products, and remarked that "if the cost of drugs continues to rise, it may well be necessary for governments to purchase directly a wider array of prescribed drugs" (Government of Saskatchewan 1961, 6). Finally, the government brief presented a series of recommendations aimed at increasing public control and involvement in prescription services, including greater use of generic drug products.

The Interim Report of the Advisory Planning Committee on Medical Care was directed mainly to the development of the medical care plan for Saskatchewan, and the Committee's Final Report to an assessment of other health programs, including pharmaceutical services. Legislation establishing a universal medical care insurance plan received royal assent in November 1961 and the provincial program was implemented shortly thereafter. By proceeding in this particular manner (first investigating, and then establishing, medical services in advance of other programs), Saskatchewan ensured coverage for physician services but not medications prescribed by physicians. This apparent dichotomy added impetus (as will be seen later) to arguments for comprehensive drug benefits by creating (from a utilization and cost perspective) a unique situation, in which the person who makes the choice of the product is not the one who pays for it.

With respect to prescription services, the Advisory Committee focused on the matter of drug costs, noting that the vast majority of drug costs were in fact borne or paid for by individual residents (table below). The major interest of the Committee was therefore directed at "the extent to which there is a need for some type of drug program to assist individuals with meeting the costs of drug therapy" (Thompson 1962, 103).

Total Estimated Drug Expenditures in the Province of Saskatchewan, 1961	
Area	**Expenditures**
Direct personal expenditures by residents	$8,063,000
Provincial Programs	
• General hospitals	$1,007,000
• Public assistance recipients	$350,000
• Mental hospitals, cancer clinics	$192,000
• Other areas (WCB, municipal agencies)	$108,000
Total estimated expenditures	$9,720,000

Source: Advisory Planning Committee on Medical Care (pg, 103)

The Planning Committee cited two principal findings as guiding its recommendations. These were: (i) rising drug prices (the report observed "all evidence …indicates a long-term increase in the rate of utilization of all forms of drugs, in the average prescription price, and in annual expenditures on drugs and consequently in the aggregate consumer bill for the province and the nation"), and (ii) increases in utilization and costs (the Committee concluded "the experience of every country with a comprehensive drug benefit program which we have studied …indicates that rising utilization of drugs, rising drug costs and increasing aggregate expenditures have raised very serious financial problems for these programs") (Thompson 1962, 106-107).

Based on its investigations, and for the reasons described above, the Planning Committee categorically rejected the development of either a universal or comprehensive program of drug benefits, and instead advocated a limited program, introduced in a phased manner, with direct patient cost sharing of each prescribed drug and available public benefits directed towards those residents with high cost drug needs. The recommendations of the Planning Committee echoed in many ways the analysis presented three years earlier by the Interdepartmental Committee to Study a Medical Care Program.

Despite these evaluations, the notion of a comprehensive drug program continued to generate considerable interest. At the national level, and as mentioned earlier, the Royal Commission on Health Services recommended in 1964 that a universal drug program (with patient co-payment) be instituted in Canada. At the provincial level, resolutions were endorsed at the New Democratic Party annual conventions during the period 1963 to 1969 in support of a prescription drug program and benefit plan. In addition, the 1971 election program of the NDP party (New Deal for People) committed the party, upon assuming government, to "establish a prescription drug program based on a drug formulary and central processing to provide drugs at greatly reduced cost" (NDP 1971, 12).

In Saskatchewan, two provincial studies were identified as providing findings in support of a comprehensive public drug program – a 1966 study of prescription costs borne by Weyburn area residents, and a 1973 provincial study of drug prices and dispensing practices. The first investigation was a joint study conducted by the Department of Public Health and the Saskatchewan Pharmaceutical Association which examined the annual drug expenditures of approximately 4,000 families residing in Weyburn. Although the study provided no recommendations, it demonstrated an uneven distribution of drug use and cost among residents. The study reported that, "five per cent of families bear one-third of the bill, ten per cent bear one-half and sixty per cent bear the total burden" (Saskatchewan Pharmaceutical Association 1967, 59).

Distribution of Prescription Drug Prices Among Weyburn Family Households, 1966.

Per Cent of Families (Cumulative)		Per Cent of Total Drug Costs Incurred (Cumulative)
1.1		12.0
2.0		18.5
3.6		26.5
5.3		33.9
10.6		51.3
21.7		74.6
46.3		96.9
61.3		100.0

Source: Canadian Pharmaceutical Journal, 1967

The second study of note was a 1972 survey of drug prices and dispensing practices (entitled Operation Sunrise: a survey of prescription drug prices and dispensing practices in Saskatchewan) sponsored by the Department of Public Health, and undertaken further to the work of a departmental committee investigating prescription drug services. A total of eleven sub-committees (called "Probes") had been established in 1971, following the election of the NDP, with a mandate to review and plan those programmes outlined in the party's platform. The Executive Director of the Saskatchewan Medical Care Insurance Commission, Dr. David Penman, chaired the Probe on Prescription Drugs.

The 1972 survey differed from the Weyburn study in that it focused on variation in prescription drug prices, as opposed to variations in individual use and costs for prescription products. The investigation found differences in drug prices to be unacceptably high and reported "many cases of very wide variations for identical prescriptions between communities, between different stores and even between different outlets of the same chain" (Richards 1971, 1).

In presenting the report, the Honourable Walter E. Smishek, in his letter of transmittal from the Minister of Health, stated:

> The Sunrise Report provides ample evidence of the weaknesses in the drug retail market, and suggests the need for government action to lower drug prices to the Saskatchewan consumer. The report presents evidence of substantial savings through the use of a drug formulary and bulk purchasing. My Department is currently investigating the potential for a major government initiative in this area (Richards 1971, 1).

The report of the Probe Committee was, in turn, released late in 1973. According to Bury (1997), the report did not advocate the immediate adoption of a provincial insurance plan for reasons of cost. Rather, the report focused on reducing the drug costs through three main recommendations: the establishment of a provincial drug formulary (consisting of a core of drugs representing 50 per cent of overall drug expenditures), the use of product substitution (mandatory substitution of cheaper products from the provincial formulary unless otherwise indicated by the prescribing physician) and the initiation of government bulk purchasing of all drugs covered under the formulary. The patient would, however, remain responsible for paying the cost of the prescription drugs.

It is reported that the recommendations of the Probe Committee were rejected for failing to provide a suitably comprehensive and universal insurance scheme and, as a result, the staff of the Research and Planning Branch of the Department of Health began a new plan for a prescription drug services program (Bury 1997, 213). Details of the provincial plan were subsequently announced by the Minister of Health in April 1974 on the occasion of second reading of The Prescription Drugs Act.

Provincial investigations prior to 1974 had rejected the establishment of a universal drug plan for reasons of cost and opted instead for targeted benefit arrangements. The provincial statements in 1974 presented, however, a different analysis. The need for and viability of a public plan was seen to be demonstrated by four main factors – namely, the unequal distribution of drug use and cost among provincial residents, the barriers created to accessibility for disadvantaged groups, the perverse practices of the pharmaceutical industry and the ability of the public sector to lower drug costs. As Minister Smishek noted in his legislative address establishing the provincial drug plan, "we are concerned that the high cost of drugs may prevent some patients from purchasing drugs which have been prescribed by their physicians … we believe that good health is a right and not a privilege – and that individuals should not be denied access to health care because of financial costs" (Hansard 1974, 2451).

The main principles of the new "Saskatchewan Prescription Drug Plan" were identified to be:

- The Prescription Drug Plan should be universal for all Saskatchewan residents;
- Prescription drug benefits under the plan should be comprehensive;
- A drug formulary should be developed and used;
- A drug program should develop ways to assure the quality and comparability of prescription drugs; and,
- Prescription drug costs to consumers should be reduced (Hansard 1974, 2455).

Lower drug costs were to be achieved through a combination of plan features, including: (i) use of a provincial formulary (a listing of covered drugs of "proven quality"), (ii) product substitution (substitution of lowest cost equivalent drug products), (iii) government bulk purchasing of formulary

products, (iv) negotiation of distribution agreements with wholesalers and (v) negotiation of a standard dispensing fee by pharmacists. Smishek said that "the intention of the Provincial Government to use its full weight in the market to negotiate large bulk purchase contracts for prescription drugs with the manufacturer. The Government will also negotiate distribution agreements with wholesalers" (Hansard 1974, 2456). In concluding his address, Smishek described the main advantages of the Drug Program for provincial residents to be:

- The drug formulary should substantially improve the quality of drugs that are prescribed in the province.
- The cost of drugs will be substantially reduced to the consumer.
- The program involves a minimum of disruption to the present drug industry in Saskatchewan.
- The cost of drug supplies will be equalized to all pharmacies. This will enable the small independent retailer to compete with the large chain stores, by extending to the small retailer the bulk purchasing power of Government.
- This program will help to maintain the viability of the small independent retail pharmacy.
- All Saskatchewan residents will pay the same standard charge to their pharmacies no matter where the Saskatchewan citizen lives (Hansard 1974, 2461).

Universal Drug Benefits: 1975 to 1987

The Prescription Drug Act received legislative approval later in 1974 and the Saskatchewan Prescription Drug Plan came into effect on September 1, 1975. The drug plan was one in a series of new or expanded health programs introduced during the 1970's made possible by a growing provincial economy and expanding government revenues (Glor 1997; MacKinnon 2003). The main features of the Prescription Drug Plan were identified as:

- Eligibility: All Saskatchewan residents were eligible for coverage under the Drug Plan.

- Consumer cost: Consumers paid a maximum of $2.00 for each drug covered by the Drug Plan, with the Plan paying the remainder of the prescription cost.
- Formulary: Use of a product formulary. The Formulary was developed by a committee of health professionals (the Saskatchewan Formulary Committee) with advice and assistance by an expert sub-committee (the Drug Quality Assessment Committee).
- Product substitution: Pharmacists dispensed lower priced products of equal quality unless the prescribing physician stipulated "no substitution."
- Bulk purchasing: Drug products were purchased by the Plan through use of a "standing offer contract" (a contract between the manufacturer and the Drug Plan to supply certain drug products to wholesalers at a contract price). The wholesalers purchased the drugs from the manufacturers and, in turn, distributed the products to pharmacies at the Formulary price.
- Dispensing fee: A standard dispensing fee was negotiated by the Plan and was initially established at $2.75 for low volume pharmacies (volumes of 0 to 20,000 prescriptions per year) and $2.50 for larger pharmacy operations (over 20,000 prescriptions per year) (Drug Plan Annual Report 1975, 6-12).

Because of its eligibility and coverage criteria (extending to all provincial residents), Saskatchewan is credited by some sources as introducing the first universal drug program in Canada (Bury 1997). However, other claim that Alberta was the first province to introduce a universal drug program in July 1970, followed by British Columbia in 1974 and Saskatchewan and Manitoba in 1975 (Grootendorst 1999). What is clear is that most provinces introduced some form of prescription drug reimbursement programs during the 1970's, with the implementation dates, amounts of cost sharing and eligibility conditions varying substantially by jurisdiction.

The main program features of the Prescription Drug Plan remained relatively unchanged from the time of its introduction in 1975 until 1987. A review of the Plan was undertaken in 1983 by an external consulting agency (Associated Health Planners). The evaluation concluded "the Plan had, in most

instances, met its original objectives; that it compared favourably with plans in other jurisdictions; that the user groups were generally satisfied with the benefits; that professional groups had concerns which ranged from mild to deep discontent; and that the views of the provider group (manufacturers, administrators, distributors) ranged from unequivocal endorsement to outright hostility." In addition, the consultant's report did not recommend any major alterations to the plan and advised that "given the Plan's popularity among the general public, its qualified approval by professionals and its cost advantages in comparison to other drug programs" (Associated Health Planners 1983, 1).

During this period, Prescription Drug Plan beneficiaries were divided into three general categories: standard beneficiaries, social assistance recipients, and special beneficiaries (residents with certain chronic conditions having particular prescription drug needs, such as those on renal dialysis). By 1986-87, standard beneficiaries received 91 per cent of prescriptions and were responsible for 90 per cent of the total Prescription Drug payment. Social assistance recipients received 8.7 per cent of all prescriptions and accounted for 9.3 per cent of total expenditures. Special beneficiaries received less than 0.5 per cent of all prescriptions and accounted for 0.7 per cent of total expenditures.

Prescription drug usage is, however, not uniform; like a number of health services, it increases with age. The highest percent of Drug Plan prescriptions were in the 65+ age group, with this group representing (in 1986-87) 12.9 per cent of the provincial population and 15.3 per cent of active beneficiaries. This group also received 35.6 per cent of all prescriptions. Expressed another way, the principal beneficiaries of the Drug Plan's creation were the general citizenry, particularly those 65 years of age and older, with those groups whose health care costs were historically paid for by the Province (social assistance recipients and, to a lesser extent, special beneficiaries) constituting a relatively small portion of Plan expenditures.

Distribution of Prescription Drug Plan Payments by Beneficiary Group, 1986-87.

Group	Proportion of Plan Payments (%)	Proportion of Provincial Population (%)
Standard Beneficiaries		
• Under 65 years of age	56.8	80.3
• Age 65 and over	33.2	12.9
Saskatchewan Assistance Plan	9.2	6.8
Special Beneficiaries	0.6	> 0.0
Others	0.2	> 0.0
TOTAL	100.0	100.0

Source: Saskatchewan Prescription Drug Plan Annual Report 1986-87.

Several key trends and developments are evident in an overview of the operational performance, and financial costs, of the Prescription Drug Program during the period of 1975 to 1987. First, despite initial expectations of lower drug prices following the introduction of the Drug Plan, total drug costs actually rose during this period. Total drug costs include payments made by the Prescription Drug Plan as well as private consumer expenditures made through individual co-payments, and total drug costs increased from $6.04 per prescription in 1976-77 to $16.80 per prescription in 1986-87 (an average annual increase of 17.8 per cent).

Second, provincial funding in support of the Drug Plan also grew during this interval, increasing by a total of $62 million over the ten-year period (an average annual increase of 41.2 per cent). The increase in Drug Plan expenditures may be attributed to increases in drug prices (the cost per script) and utilization growth (the total number of prescriptions used), with utilization growth being fuelled by increases in the total number of beneficiaries (residents receiving at least one prescription in a given year) and the utilization rate (the number of scripts per beneficiary).

Finally, while private consumer expenditures through prescription co-payments increased from $7.2 million in 1976-77 to $19.6 million in 1986-87, this increase did not keep pace with the overall growth in drug costs. As a result, the public sector bore an increasing share of overall provincial prescription drug expenditures. As a share of overall drug expenditures, provincial government expenditures increased from 52 per cent in 1976-77 to 73 per cent by 1986-87.

Overview of Saskatchewan Prescription Drug Plan, 1975-76 to 1986-87.

Year	Active Beneficiaries (000's)	Total Rx. (000's)	Total Plan Payments (000's)	Consumer Payments (000's)	Consumer Co-Paymt (Per Rx)	Rx Per Beneficiary	Cost Per Rx
75-76*	452	1,937	$7,173	n.a.	$2.00	4.3	-
76-77	583	3,653	$14,908	$7,167	$2.25	6.3	$6.04
78-79	610	3,931	$19,484	$9,073	$2.60	6.4	$7.39
80-81	627	4,188	$26,216	$11,208	$3.10	6.7	$8.94
82-83	661	4,683	$39,829	$15,450	$3.75	7.1	$11.80
84-85	687	5,083	$54,683	$17,959	$3.95	7.4	$14.29
86-87	723	5,715	$76,447	$19,583	$3.95	7.9	$16.80

*Partial year of operation (September to March)
Source: Saskatchewan Prescription Drug Plan Annual Reports, 1975-76 to 1986-87.

The Drug Plan therefore entered its thirteenth year of operation with a growing caseload, increasing utilization, rising drug costs and an ever-expanding public financial share of overall drug expenditures.

From Universality to Greatest Need: 1987 to 2002

Two events, and one resulting outcome, define and characterize the most recent period. On July 1, 1987, and against a background of rising provincial budgetary deficits, the Prescription Drug Plan was changed from a first dollar cost sharing arrangement with a fixed co-payment to a family based deductible program. Prior to this date, provincial residents paid a maximum of $3.95 per prescription for drugs covered under the Plan. As of July 1st, a deductible scheme was introduced where most consumers paid

the full cost of most drugs covered by the Drug Plan, and then submitted claims for an 80 per cent reimbursement of amounts over the deductible level. The deductible amount was established initially at a level of $125 per family unit and a co-payment of 20 per cent of the cost of a prescription after the deductible amount was reached, and $75 for senior family units. In 1991, family co-payments were increased from 20 per cent to 25 per cent.

Against a background of an even greater deterioration of provincial finances, the Province, on two separate occasions, increased the deductible levels and revised Plan benefits to create a plan based on residents' need and ability to pay. In May 1992, family co-payment increased from 25 per cent to 35 per cent, deductibles changed from annual to semi-annual and regular deductibles increased from $125 annual to $190 semi-annual. A catastrophic drug cost provision was introduced allowing co-payments to be reduced to 10 per cent once a family had reached expenditures of $375 in a semi-annual deductible period. In March 1993, the semi-annual deductibles were revised, with regular deductible levels increasing to $850 and a means based program (entitled "Special Support Program") established for those families having high drug costs relative to annual income.

The change in Drug Plan coverage has, however, done little to dampen the overall growth in prescription drug expenditures. Drug expenditures in Saskatchewan, like the rest of Canada, are, and remain, the fastest growing component of total health care spending. On average, between 1995 and 2000, Canadian per capita drug expenditures increased by 7 per cent. Alberta and Ontario recorded the highest growth in total (public and private) drug expenditures, while British Columbia and Saskatchewan experienced the highest growth rate in the provincial drug plan per capita expenditures, at 11.3 per cent and 10.3 per cent respectively. Consequently, despite the reforms of its publicly funded drug plans, Saskatchewan – like many other provinces – continues to experience substantial increases in program expenditures albeit at rates less than that encountered in the pre-reform era.

Per Capita Drug Expenditures and Growth Rates, 1995 and 2000						
Jurisdiction	**Total Expenditure Per Capita 1995 ($)**	**Total Expenditure Per Capita 2000 ($)**	**Annual Growth Rate (%)**	**Provincial Drug Plan Expenditure Per Capita 1995 ($)**	**Provincial Drug Plan Expenditure Per Capita 2000 ($)**	**Annual Growth Rate (%)**
Canada	340.6	478.3	7.0	n.a.	n.a.	n.a.
B.C.	277.5	385.7	6.8	87.0	148.6	11.3
Alberta	282.7	429.6	8.7	75.4	114.0	8.6
Sask.	322.6	420.0	5.4	62.9	102.6	10.3
Manitoba	303.0	417.2	6.6	70.5	111.7	9.6
Ontario	382.1	545.8	7.4	123.9	158.7	5.1
Nova Scotia	355.4	481.3	6.3	90.3	122.8	6.3

Source: Federal/Provincial/Territorial Working Group on Drug Prices, 2001.

While Saskatchewan Drug Plan payments have increased, the rate has not kept pace with overall prescription drug expenditure growth. As a result, the share of total public spending as a proportion of total spending has fallen. At the national level, the share of prescribed drugs financed from private sources has increased steadily from 1992 to 1998, reaching 58.5 per cent. A comparable trend is evident in Saskatchewan, with private sector expenditures on prescribed drugs amounting to approximately 58 per cent in 1998 (Federal Drug Price Working Group 2000, 8).

The large portion of prescription drug expenditures currently borne by the private sector has led to the observation that drug coverage is increasingly related to the provision of insured benefits through employment, or the purchase of private insurance by upper income groups. Thus, private insurance plans have emerged for certain groups as the safety valve for changes to provincial health care plans.

The recent Saskatchewan Commission on Medicare assessed the situation as follows: “today, Saskatchewan’s publicly funded drug program assists those (families) with low income, those with high drug costs and those with a combination of the two conditions” (Fyke 2001, 49). In focusing upon those

residents with the most pronounced needs, the Plan looks remarkably similar to the arrangement recommended by the Interdepartmental Committee in 1959. As is often said, there are no new issues in health policy, only old ones that occur and re-occur with surprising persistence.

Conclusion

A policy impasse has emerged with respect to public drug benefits. The value and necessity of comprehensive drug coverage, and the inconsistencies evident in current benefit arrangements, have been duly noted by a succession of national and provincial health system reviews over many decades. However, the exponential growth of drug costs makes formation of a universal or expanded public scheme prohibitive, given the enormous financial demands placed on the public purse and the apparent absence of corrective policy and program measures. As a result, public drug coverage remains, or has reverted to, an area of targeted benefits, available to some and not to others. Further, and despite recent reforms of coverage arrangements, drug expenditures are and remain the fastest growing area of health care spending, with the associated implications for affordability and access. The tension between considerations of equity and cost has been a permanent part of the drug policy landscape, and is likely to continue to be so for the foreseeable future.

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The Future of Restorative Justice in Canada

By Sharon M. Desjarlais

Executive Summary

Restorative justice programs face great challenges, but in spite of those challenges there is promise that positive outcomes can be obtained. Many of the basic tenets of restorative justice emanate from the cultural heritage of Aboriginal peoples, and that focus has been shown to have positive results. Restorative justice as a means to resolving conflict and healing communities has demonstrated some success. We need to build on that success and also to learn from any of its shortcomings. Because this approach to justice is so community-focused, responsibility rests primarily on communities to effect positive change by means of these justice measures.

Introduction

Restorative justice programs face conflicting goals and overwhelming challenges from inside and outside the communities they serve. The charges that the programs do a poor job of meeting victim needs while doing a questionable job of meeting offender needs cannot be dismissed; nor can the success of the programs be solidly established when adequate evaluative measures do not exist. Set in a societal context of political oppression, economic disparity and social inequity, the challenges from without seem insurmountable.

The current criminal justice system, however, has failed to be an effective form of justice for most people, and in particular for Aboriginal people. The system perpetuates criminal behaviour,

oppression and discrimination; and, as a result, we see a high degree of over-representation of Aboriginal people in the criminal justice system. Instead of going through the courts in the conventional criminal justice system, we must look to the philosophy of restorative justice as a means to responding to conflict. Restorative justice has the potential to address the needs of people and communities, as well as underlying social problems that may lead to conflict. Success has already been demonstrated by community-based justice initiatives, such as alternative measures programs.

Theory of Restorative Justice

The conventional justice system is ineffective primarily because it does not hold people accountable for their actions. The fear of incarceration keeps people from openly admitting to the harm they have done, so the cycle of violence and silence continues making the community a more dangerous place to live (Hollow Water Assessment team cited in Green 84). The assumption that offenders who have served time in the conventional justice system have paid some sort of debt to the community makes them feel absolved of all responsibility (Berma Bushie cited in Green 84). In reality, it is now widely recognized that the state is taking the moral obligation and responsibility away from the offender. In response to a need for a more accountable system of justice, the criminal justice system has been implementing the principles of restorative justice into programming.

Restorative justice is a philosophical approach adopted by programs such as alternative measures. It provides the basis for an understanding of the criminal justice system that, in the case of the alternative measures program, has been translated into a set of clearly defined procedures. These procedures play a useful role in helping caseworkers, and to some extent the clients, implement the basic tenets of restorative justice. Restorative justice may underlie those measures and procedures, but the theory of restorative justice is more than the program of alternative measures. Restorative justice is a guiding principle with applications that extend far beyond the measures themselves. In the broader sphere, the whole community has to accept the idea that the justice system is there to repair and restore, and not just to hurt people because they have done something wrong.

The basic premise of justice is that the more serious crimes should result in more serious consequences. Restorative justice may appear to make consequences less serious than they should be, in the perception of some members of society. In other words, the bad guy seems to be getting off with impunity. There is a philosophical issue at stake here: is justice meant to punish, or is it meant to restore and repair? It is very important that society seek a consensus on the underlying purpose of justice for restorative justice to be fairly evaluated.

Restorative Justice in Practice

There are several approaches to resolving conflict. The victim-offender mediation and Community Justice Forum (CJF) are two processes within an alternative measures program that divert offenders away from the court system. By using a non-adversarial approach to deal with the offender's behaviour, the offender is less likely to be stigmatized as a criminal. The purposes of the victim-offender mediation and CJF are complex and have many layers. The most profound intent is to help both victim and offender see each other as people with many facets (Ross 20). Another is to help the offender achieve empathy, a visceral feeling for the way his or her actions have had an impact on others (Ross 20). Ultimately, victim-offender mediation and a CJF are meant to repair the harm done as a result of the offender's actions and to restore the relationship between the victim and offender. They should also help the offender to learn from the experience, and take responsibility for his or her actions so they will not re-offend.

In victim-offender mediation, a process usually carried out with adults, the victim and offender face each other and talk about the conflict as they work together to find a resolution. The mediator assists in guiding the process, but does not provide any input into the outcome. The mediator helps the victim and offender to understand each other, and in this process, the emphasis is on the relationship between the two of them.

The Community Justice Forum is a process generally carried out with young offenders and the wider community that is affected. The CJF process distinguishes between the offender as an individual

and the unacceptable behaviour. There is a recognition that everyone makes mistakes at some time, and that we can all be forgiven for those mistakes. If we learn from those mistakes, we can be given an opportunity to be accepted back into the community. Reintegrative shame is used in the process because it has the potential to change the behaviour of the offender, if it is managed correctly and does not stigmatize the individual (Canada 1998:11-2). In part, we obey the law out of moral considerations and in part because we do not want to be disgraced within our community.

The Community Justice Forum is neither offender-focused nor victim-focused; rather it focuses on the community, of which both are a part. The CJF process empowers the community to take ownership for the problem of crime. The CJF is intended to teach offender, family and community that they do have resources within themselves to resolve problems (Ross 20-1). The community is most affected by crime; therefore, it is the community as a whole that should address crime and take part in resolving the conflicts that crime engenders.

A third alternative measure, the sentencing circle, is a sentencing process which takes place outside of the conventional courtroom setting. It involves representatives from various areas within the criminal justice system, the offender, the victim, and members of the community. The ultimate goal is the rehabilitation of the offender and restoration of peace and harmony. The immediate objective is to involve all participants actively in the process (Green 67-9). Another immediate objective is to consider the victim’s needs and the impact of the process on the victim (Green 67-9). In addition, the community has to be brought into the process to share responsibility for implementing justice (Green 67-9). While the final determination of the sentence still rests with a judge, it involves the members of the community in the decision-making process. In some cases, the recommendation has been entirely decided upon by the community (Green 72-4). The sentencing circle is similar to the Community Justice Forum in that it attempts to deter offending behaviour through the shame and reintegration approach (Green 85; 97-8).

Appropriateness of Restorative Justice

Restorative justice has been widely applied to everything from minor offences, such as spray painting a tree to serious offences such as sexual violence. It is not the level of dysfunction that determines whether or not restorative justice is applicable. The determining factor is the level of support from within the community that can and will be provided. Thus, the community has to have the ability to provide the support, and there has to be the will to do so as well. One type of mediation, "John School" for those arrested while seeking the services of a street worker, this does **not** fit within the purview of restorative justice. The process does not involve any healing or reparation of harm. Though clients are required to take responsibility for their actions before they can be admitted into the program, there is no follow-up to ensure that clients have undertaken to get the counseling required to deal with their dysfunction. Restorative justice processes can start the offender on the road to behavioural change, but ongoing local support and counseling for victims and offenders is crucial if the positive change is to be permanent (Green 82). As well, restorative justice should not be used in situations where power imbalances have existed for a long period of time, for example in cases of domestic violence (Green 81). There, the fear and threat of immediate violence needs to be resolved first (Ross cited in Green 81).

Research has shown that circumstances for restorative justice processes are more favourable in small rural communities where everyone knows the offender and cares about the outcome (Green 95: 115). Past experience had shown that it will not work in urban settings but, more recently, there are encouraging signs that there may be some application for restorative justice measures among city dwellers (Green 41:118). The Regina Alternative Measures Program (RAMP) is making significant headway within Regina. Elders from home communities and pastors from local churches are invited to participate in the Community Justice Forums. RAMP works hand in hand with local agencies, which provide valuable services such as educational, spiritual and psychological development; they can also serve as a venue for the offenders to fulfill the terms of their agreement. It seems that it is not the size of the community that matters, but the level of support brought to bear on the problem.

Benefits of Restorative Justice

Restorative justice can bring a variety of benefits to offenders, victims, communities and the overall criminal justice system. A number of these benefits are outlined here, though this list will not be exhaustive.

Offender Benefits

Restorative justice processes give the offender an opportunity to acknowledge the harm his or her actions have inflicted on the victim, to make amends and, it is hoped, to repair the relationship or restore balance and harmony. As well, restorative justice processes can offer an offender more equitable and accessible legal proceedings. Marginalized people, who have typically found satisfactory settlements in law to be beyond their reach, will find restorative justice more adaptable to their needs and within the limits of their resources, financial and otherwise (Barsh and Marlor 134). Unlike the conventional criminal justice system, the offender has the opportunity to actively participate in legal proceedings; restorative justice proceedings thus offer the offender an opportunity to do something about the crime instead of passively accepting the dictates of a court.

Linking restitution to rehabilitation also makes both more likely to occur (LaPrairie 1998:62). By considering the level of harm brought about by the crime and giving the offender the opportunity to express remorse, rehabilitation is more likely to be achieved (LaPrairie 1998:62). Lastly, the outcome from a restorative justice process may provide a less severe and more humane sanction for the offender as it provides alternatives to imprisonment and punishment of the offender. Inasmuch as restorative justice is able to repair damage and reconcile victims with offenders, there is less need for imprisonment and other sanctions. Overall, society becomes more humane (LaPrairie 1998:63).

Victim Benefits

Restorative justice emphasizes the importance of the victim in the process and recognizes the needs of the victim, whereas in top-down legal proceedings, the needs of the victim do not receive the emphasis needed to achieve restitution. Restorative justice processes give the victim the opportunity to

face the offender, to state how his or her life has been affected and to find closure. It also helps the victim gain some insight into any circumstances which may have contributed to an offender's behaviour resulting in the victim being a target of crime. Restorative justice thus puts the emphasis back where it belongs: making things right with the wronged party (LaPrairie 1998:62).

Community Benefits

Restorative justice provides the community with greater control over community-based programming. With greater community involvement and less emphasis on the intervention of the state, the focus of justice shifts to the parties immediately affected: victim and offender. The result is a better opportunity to address the damage of crime and deal with it (LaPrairie 1998:62).

Restorative justice provides a fuller, more lasting response to problems because it delves much more deeply into the situation by addressing causes, not just symptoms. It unites community, family, and government in an effort to resolve conflict in a way that is relevant to the community and the offender. By establishing accountability and responsibility locally, it prepares the way for communities to establish their own justice system and to make their own decisions. Government intervention and paternalism is reduced (Stuart 112).

Restorative justice processes are also more relevant to Aboriginal peoples' cultures because many of the principles that are basic to restorative justice are consistent with values in Aboriginal communities. It is hoped that the result will be greater success of the justice system in the communities (Barsh and Marlor 142). Restorative justice can contribute to greater empowerment of the community as it rebuilds shattered communities by restoring broken relationships and strengthening ties. Fundamental to re-establishing ties within the community is learning to respect others. The community does not give up on one of its own; instead everyone is equally respected, including the offender. Increased respect and responsibility throughout the community means that everyone in the community is strengthened by this process, not just the offender (Stuart 112). The greater the community involvement in seeking justice, the more lasting the solutions will be (LaPrairie 1998:64).

Criminal Justice System Benefits

Incorporating the philosophy and processes of restorative justice creates a more humane criminal justice system. If restitution and rehabilitation can be seen to occur, there is less desire for vengeance enacted through punishment (LaPrairie 1998:62). Strictly speaking, there exists no substantive evidence that restorative justice is more efficacious than "positive law" in transforming individuals and societies; nevertheless, having the ability to negotiate justice heightens public perception that the law is more just (Barsh and Marlor 142).

Challenges for Restorative Justice

Conceptual Difficulties

There are several conceptual challenges that need to be overcome for restorative justice to succeed. First, depending on the situation of the community, there is a possibility for competing and mutually contradictory goals among community members and groups. For some groups, community justice might be a means to achieve self-government and local control. Some community members might see community justice as a way to assist individuals who are facing serious difficulty. Others might hope that community justice will heal the community and make it a stronger, more cohesive unit. LaPrairie states that contemporary Aboriginal communities often lack the ability to reconcile these conflicting goals (1998:69).

Restorative justice advocates may also carry unfounded assumptions about the efficacy of community participation. Involvement of the community in programming is not a guarantee that restorative justice will result. Unfounded assumptions about the efficacy of programs prevent the community from building on strengths and addressing weaknesses in its justice system (LaPrairie 1998:64).

In addition, difficulties in defining and understanding the concept of community may impede the restorative justice processes. Whether the community should be understood to exist within geographic limitations, or whether it should be based on relationships is difficult to determine. There is some

disagreement on this within the legal community (LaPrairie 1998:65). Furthermore, a community can also be considered to go beyond personal relationships or geographic considerations; a community could consist of people who share a culture, background, aspirations, or other common ground.

Another issue is that the needs of programs, and of the people who offer the programs, can be allowed to take precedence over the needs of victims and offenders. Restorative justice is thus subverted. Although the original, moral intent of restorative justice was empowerment of people in their communities, other less high-minded goals have sometimes taken precedence. For example, restorative justice is viewed by some as a means for keeping down the cost of the criminal justice system. Furthermore, it is not possible to dismiss cynical claims that, in some cases, the practitioners of restorative justice programs have sought merely to fund and perpetuate their programs out of self-interest (Barsh and Marlor 137).

Problems of Process

Even if potential conceptual problems are overcome, challenges remain in making the processes work well. Generally, these result from the lack of clear-cut approaches that can guarentee success in all situations. Based on observations in practice, it does appear to some extent that there is no particular style of mediation and no particular type of mediator that will have consistent success in all circumstances of restorative justice (Barsh and Marlor 141). There are still no guarantees and the process is unpredictable.

There is also potential for inaccurate assessments by the facilitator. Especially when participants in the process fail to make full disclosure, the facilitator might employ measures that do not meet their needs. For example, when the conflict is competitive in nature, and a power struggle ensues, restorative justice is generally ineffective (Barsh and Marlor 135).

For restorative justice to be effective within the community, its members need to present a common front when addressing serious matters involving the well-being of individuals and the entire community. This was more straightforward in tight-knit, traditional societies where beliefs about order in the community were common to all. When members of a community do not share common beliefs, there will likely be irresolvable conflict (Barsh and Marlor 144). Many Aboriginal communities are

undergoing social stratification, as traditional roles are disrupted in the face of changes to the economy and changing opportunities for jobs and education. Inequities that are beginning to appear in communities cannot be ignored, as they have an impact on the extent to which community members are able to implement justice measures that depend on a shared value system (LaPrairie 1995:525).

Victim and Offender Concerns

In addition to the problems of defining community values, there is the problem of selecting persons for the justice process who will effectively represent the community on a fair and equitable basis. If there is a tendency on the part of community members to take sides, then the processes of justice are undermined. Political bias or other personal interests would all be part in this problem (LaPrairie 1998:66). Interests of factions within the community have to be kept in check to prevent them engulfing the victim or offender. Strict objectivity and impartiality are basic requirements of community representatives.

Restorative justice programs have been criticized for neglect of victims' needs. There is widespread perception that diversion schemes are focused too much on protecting offenders and too little on the needs of victims (Barsh and Marlor 140), resulting in potential harm to victims. For example, the level of emotional involvement in empathy building with the offender may not be appropriate in sexual abuse cases, where the victim is much more vulnerable (Barsh and Marlor 146). In other cases, where the offence is less serious there is still the possibility for re-victimization of the victim (Cooley 9). This can happen in cases where a victim feels powerless and unable to withdraw from the process. In examples such as these, the harm to the victim can be lasting and can exacerbate the harm already done.

Not only victims, but offenders, can be coerced. In theory, the restorative justice process is voluntary, but given the grave consequences of the alternative, which involves the courts and corrections, the offender is, in effect, forced into alternative measures. This coercion may not be the best basis for true reparation. There is always the possibility that a person charged has not actually committed an offence, but feels pressured to go through the restorative justice process to avoid harsher measures (Cooley 10). In the course of mediation, overwhelming pressure can be placed on offenders (and on

victims) to accept terms that may not be in their best interests, but which further the agendas of other group participants.

There is a potential for this sort of group pressure to exist in any restorative justice process. Group dynamics might not be favorable for achieving justice. There is some danger that, because of group pressure, the offender can be swept into expressions of contrition that are not genuine. There might be a superficial admission of guilt with no acceptance of responsibility. Without real healing, there is a very strong possibility of re-offending. On the other hand, the victim's needs may become subordinate to the needs of the group or the offender (Barsh and Marlor 146).

Lack of motivation by the participants can also undermine the process. In cases where the conflict is based on inequality of power or control over resources, it might be in the interest of one party to continue a dispute rather than seek real resolution. Engaging in mediation gives the appearance of seeking a solution but it may not reflect a genuine commitment. Thus the dispute can become drawn out and waste the limited capabilities of a community's justice system (Barsh and Marlor 136).

Concerns of Communities and Other Participants

Restorative justice programs have only tenuous authority. It is clear to all participants in restorative justice that real authority rests with the state, and it is the state that will take over if mediation fails. The emphasis, therefore, tends to be on taking measures that will keep the offender from going back into the criminal justice system, and not necessarily on negotiating a satisfactory resolution that will meet victim needs (Barsh and Marlor 136).

Restorative justice processes may tax a community beyond its capacity. Demands on the community for time and financial resources may be too great, especially when attempting to deal with chronic offenders. Assessing the level of potential involvement for a community needs careful attention as any perceived failure will cause community justice programs to lose credibility (LaPrairie 1998:66-7). Once greater local control over justice is extended to a community, there is a tendency to assume that the community is capable of handling the responsibility, although the resources to do so may not actually be

in place. When a community takes on more control over justice than it is capable of handling, the situation becomes more harmful than beneficial (LaPrairie 1998:73).

Most young offenders do not re-offend; it is the more serious cases of repeat offenders that can put a strain on the community resources. A much higher level of commitment on the part of the community is required to deal with entrenched criminality and recidivism. Careful evaluation of the community's potential is required before undertaking the more challenging cases (LaPrairie 1998:66-7). In addition to concerns about the level of commitment, there are concerns about the amount of time required to address victim needs and also offenders who appear to have greater needs. Smaller communities just might not have the sheer numbers of people required for the more challenging cases (LaPrairie 1998:67-8). Community burn-out is an issue.

Accountability presents special problems. For judges and other key players, the danger lies in attending only to certain individuals or groups within the community while excluding the views of other segments. Project personnel need to provide regular project reports, including the results of evaluations. Funding sources (especially government) need to provide the necessary level of support and ongoing commitment. Accountability is not automatically in place just because the project is located within the community to which it is responsible (LaPrairie 1998:70).

Evaluation

Effective justice measures are not possible without documented research evaluation to show clearly the successes and failures of the restorative justice initiatives. Without a clear understanding of results, it is impossible to address inadequacies in community involvement, outreach, and benefits to victims (LaPrairie 1998:71). Research, both academic and community-based, could create a knowledge base for directing policy and practice in program implementation (LaPrairie 1999:4).

There is a problem in defining goals when the focus is on behaviours that are irrelevant to the indicators of success. Measuring behaviour change over the short-term may not be a predictor of long-term change. The tendency, also, is to focus on readily observable change in behaviour, such as keeping appointments; but these obvious factors might not be the most critical and relevant to the desired

behaviour change (Barsh and Marlor 138). Defined outcomes are the basis for evaluation. Terminology used in defining outcomes can suggest simplistic notions that the difficulties created by the offender for the victim can be forever erased by the process of restorative justice. Terms such as "dispute resolution, redress, and healing," could be replaced by "peacemaking," which more accurately suggests that conflict and damage can be mitigated but not eradicated (Barsh and Marlor 137).

Lastly, finding control groups for research purposes is at variance with the whole concept of restorative justice processes. It is difficult to establish valid measurements of restorative justice programs since the results are skewed even before the cases are selected. There is a tendency to select cases where the offence is relatively minor and success in changing behaviour of the offender seems likely. The problem is finding a program with which to compare, where the predictable outcomes have a wide range of potential for success (Barsh and Marlor 140).

Context of Poverty, Oppression and Social Inequity

Poverty and isolation present the greatest challenges to restorative justice programs. When individuals do not get the kind of solid support they need from social institutions such as family and school, delinquency is often the result. The justice system, with all the resources it has at its disposal, has had limited success in changing delinquent behavior. Given that fact, according to LaPrairie, it seems much less likely that poor and isolated communities, with their lack of people and financial resources, are going to have any better success (1998:68). If there could be just as much allocation of resources and commitment to justice initiatives in the community as there is for public institutions, then perhaps the communities could do a better job. This seems likely, since communities would be in a better position to look after one of their own. Socially, culturally and empathically, the community is just better equipped to address the needs of the individual.

A further challenge exists for restorative justice in Aboriginal communities. Individuals within the Aboriginal communities have been over-exposed to the criminal justice system, a system designed to control and disempower. It is difficult to determine if restorative justice, with its emphasis on healing, is actually overcoming the mentality produced by the criminal justice system. The oppression,

discrimination, economic disparity, and social inequity that have harmed Aboriginal communities continue unabated to this day. At the same time, other cultural influences are tending to make Aboriginal communities more like the mainstream.

The question is whether Aboriginal communities can succeed in implementing restorative and traditional Aboriginal justice in the face of these overwhelming influences. It does not seem possible, as long as the cause of the damage exists, that the damage can be undone. Nothing short of complete social transformation of the greater society is likely to benefit the communities to the extent that they can be considered whole and healthy once again. Token attempts at changing the communities with healing circles, in the face of continued oppression, "trivializes the oppression" (Barsh and Marlor 144). Furthermore, such views suggest that it is the communities that should change, not the social order. The answer to the question whether Aboriginal communities can succeed implementing meaningful restorative justice with their communities therefore can only be found through long-term evaluative approaches, not short-term surveys and questionnaires (LaPrairie 1998:69-70).

Indicators of Success in Restorative Justice

As discussed above, evaluation measures are key to the long-term success of restorative justice. If we assume that meeting the objectives of restorative justice determines success, then we need to be able to establish criteria for the indicators of success. That is where the difficulty lies. The objectives of restorative justice can be identified as: provision for the needs of victims and others affected by a crime; prevention of re-offending through re-integrative measures; active responsibility on the part of offenders; capacity-building within the community for crime prevention; and cost-effective justice measures (Shaw and Jané 3-4). These are broad-ranging objectives. Establishing criteria for the indicators of success for these objectives could be subject to interpretation from many different viewpoints.

Participant satisfaction with restorative justice processes is used as an indicator of success. In the results of a study on the views of Community Justice Forum participants, satisfaction with the process was highly rated by both victims and offenders (Chatterjee 38-48). These are encouraging results, but the

question still remains whether or not the enthusiasm of participating in a survey has clouded the judgement of the participants. Another problem with focusing on participant satisfaction is that when you adopt a service mentality, you begin to think in terms of participant satisfaction as being the ultimate goal. You try to be all things to all people. The focus has been on measuring compliance and satisfaction rates, but not much of the evaluation measures have focused on capacity-building and cost effectiveness (Cooley 18-9).

Positive experiences of the community in capacity-building have had demonstrated success in communities such as Hollow Water, Sandy Bay (Green 83-101) and Canim Lake Band (Warhaft, Palys and Boyce 168-81). The Hollow Water Community Holisitc Circle Healing evaluation was able to establish dollar cost savings that resulted from their restorative justice program (Cooley 19). The ability of one community to deal with all its problems increased with the ability to conduct its own restorative justice process when it made the community members focus on their shared concerns (Daunt cited in Green 137).

Restorative justice has been criticized for not reducing incarceration rates. It has not yet had a measurable impact because it tends to focus on less serious offences (Canada 2000). Nevertheless, it needs to be said in defense of restorative justice programs that if you can deter people from committing crime, in the long run, it will reduce incarceration rates. Ultimately though, the restorative justice programs may have to accept more serious cases (Canada 2000).

Stories of former offenders may be one way of knowing if restorative justice has been effective in deterring offending behaviour. One participant felt that telling his story had helped him explore his underlying behaviour and had assisted in his counseling program (Green 136). Stories may not be measurable indicators, but they may be a source of evaluation that should be explored more.

Conclusion

Restorative justice programs were established for very good reasons, and those reasons still exist. Programs have shown a high degree of success, and that success has been due to efforts from within the

community and not from outside authority. Restorative justice might not prove to be a perfect process, but it is helping some offenders stay out of jail and there are real indications that it may have brought about some positive changes in attitude for some individuals. There has been demonstrated benefits for many communities as well. As long as there is some indication of success and at least some evidence that there is hope for future success, then we must keep trying, and give restorative justice processes a chance.

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