

The Canadian Identity and the Right to Health Care:
From Waitlists to Social Citizenship?

By

Victoria K. Crites
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Abstract

This thesis examines the recent health care debates and discussions of our “right to health care” amid the claims of a health care “crisis” in Canada, and attempts to determine if, and on what grounds, Canada’s system of health care can be considered an entitlement of citizenship. Methodologically, the thesis explores the nexus between a theoretical basis for claiming a right and the policy environment in which that right may or may not be translated into practical policy goals. Here, T.H. Marshall’s concept of social citizenship is used as the theoretical framework, in conjunction with the historical evolution of health care policy. Ultimately, the thesis argues that the state is morally obligated to provide social rights of citizenship, such as health care, in order to acknowledge the equality of all citizens. However, it also argues that simply claiming that health care is a right of Canadian citizenship is not sufficient to ensure that the state will provide any *particular* version of health care. Our publicly-funded universal health care plan, while it is surely tied to the Canadian identity, and has been institutionalized over the last several decades, only entitles Canadians to a thin version of social citizenship. Moreover, the thesis argues that the commitment to social citizenship in Canada is in more of a crisis than is the health care system *per se*.

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"Canada's health care system is ... a source of cultural identity, a significant economic industry, a way of comprehending the nature of human beings (and of being human), and a political arena for numerous vested interests."¹

I. Introduction

The idea of health care reform has become the norm in Canada. As a CBC news report put it recently, "A lot of dollars and a lot ink have been devoted to finding a cure for what ails Canada's health care system. Health care may not have hit the 21st century, but studying it sure has."² Indeed, most provinces as well as the Canadian Senate³ and a Royal Commission⁴ have produced health care reports in the last few years that attempt to address many of the complex issues that surround the funding and delivery of health care services in Canada. Some of these health policy questions include: what is the best way to provide long-term home or institutional care to an ageing population; how do we deal with rapidly escalating drug costs (and the increase in prescribing them); and how to we apportion public and private costs?

None of these questions are particularly new, but the debate around health care heightened by the year 2000 and continues today, with reports of overcrowded emergency rooms and the lengthening of wait times for some diagnostic and surgical procedures in some provinces. Generally, these health care reports are trying to supply one or more solutions to the supposed health care "crisis." They are trying to answer the media-inspired question: *how do we "save" Canada's ailing health care system?* Of course, framing the issues in this manner tends to focus the health care debate, as if there were only two choices in the

¹ Katherine Fierlbeck, "Canadian Health Care Reform and Decentralization," in Eds. Christa Altenstetter and James Bjorkman. Health Policy Reform, National Variations and Globalization. London: Macmillan, 1997. 17-38. p.17.

² "Studied to Death?" CBC News Online, September 7, 2004.

<<http://www.cbc.ca/news/background/healthcare/studiedtodeath.html>> Retrieved September 15, 2004.

³ The Health of Canadians: the Federal Role-Final Report The Standing Senate Committee on Social Affairs, Science and Technology, Chair: The Honourable Michael J.L. Kirby, October 2002.

⁴ Building on Values: The Future of Health Care in Canada. Commission on the Future of Health Care in Canada, Commissioner: Roy J. Romanow, November 2002.

matter: one side that wants to “save” the Canadian system and the alleged other side that does not. This, in turn, prompts many participants in the debate to invoke one seemingly simple notion as a starting point for any discussion of a wide range of health care concerns: the conviction that Canada’s system of “health care has come to be considered a right of citizenship.”⁵ Indeed, a 2002 survey found that 93% of Canadians agreed with the statement “health care is a right of citizenship.”⁶ Largely this is assumed to be the case, because most citizens and many politicians alike simply *declare that it is*. The claim that our system of publicly-funded universal health care is central to our Canadian identity, and therein that it is a right of citizenship seems to have been repeated often enough in the media that it no longer needs justification.

Yet without justification or at least some further explanation of the meaning behind such claims, much of the debate around health care reform tends to be muddy. Each of these reports offers its own particular vision of the shape of Canada’s future health care system, and these visions seem to be based, not only on the assumed economic and organizational realities of health care provision in Canada, but also more fundamentally on some conception of the connection between “Canadian values” and the meaning that the health care system holds for Canadians today. For example, the Romanow Royal Commission on health care begins its evaluation of the Canadian health care system with the stated premise, “the reality is that Canadian citizens embrace Medicare as a public good, a national symbol and a defining aspect of their citizenship.”⁷ Indeed, how often have we heard critics conjure up the possibility of an eventual slide into *American*-style health care as a potential worst-case

⁵ Antonia Maioni, “The Citizenship-Building Effects of Policies and Services in Canada’s Universal Health Care Regime,” Canadian Policy Research Networks, Policy Papers: Ottawa, 2001. 73-89. p. 73.

⁶ Survey conducted by the Institute for Social Research at York University on behalf of Julia Abelson et. al.. See Julia Abelson et.al., “Canadians Confront Health Care Reform.” in *Health Affairs*, Vol. 23, No. 1, May/June 2004. 186-193. p. 189.

⁷ Roy J. Romanow, *Building on Values: The Future of Health Care in Canada*, p. xviii.

scenario? In a reference to the gap between the rich and poor in terms of health care access in the U.S., a spokesperson for the Canadian Health Coalition remarked, "We're headed for similar polarization to what the Americans are seeing unless we recommit to our values of universal access and fairness."⁸ For many Canadians, our universal publicly funded health care system is the key tangible distinction between *us and them*.

So, it is reasonable to say that our version of health care is regarded, certainly in general parlance, to be something of a right of Canadian citizenship, even though it is not clearly a legally enforceable constitutional right. Of course, some have suggested that such a right *could* be recognized by the courts under section 7 of the Charter of Rights and Freedoms (the protection of the right to "life, liberty and security of the person").⁹ In the meantime however, it is still popularly considered to be a right of all Canadian citizens that, although not necessarily constitutionally grounded, still exists because of some inextricable connection to our history and our values as Canadians. This belief in the existence of a right to health care, naturally leads many to conclude that medicare *must* be saved, or else a vital aspect of what it means to be a Canadian citizen will somehow be lost. And, if we set aside the debate about whether or not the system actually requires "saving," since it could be argued that the system is not about to be "lost," but rather that it just requires some combination of overdue reforms and/or funding increases, the one thing that *is clear* is that Canadian health care is no longer easily thought of as simply a publicly funded insurance scheme that provides universal access for its citizens to doctors and hospitals. It is, in some way, also about values, rights and Canadian identity.

⁸ Andre Picard (Public Health Reporter) "No Winner in Health Showdown," The Globe and Mail, June 3, 2004.

⁹ See Stanley Hartt and Patrick Monahan. "The Charter and Health Care: Guaranteeing Timely Access to Health Care for Canadians." Commentary No. 64, Toronto: C.D.Howe Institute, 2002, and Martha Jackman, "The Application of the Canadian Charter in the Health Care Context," in Health Law and Review. Vol. 9, No. 2, 2000. 22-26.

But what is not clear is exactly how these ideas about values, identity and rights of Canadian citizenship *should* influence health care policy. And this becomes even less clear in the context of government-commissioned health care reports, which all claim to be trying to “save” the health care system, thus preserving the type of health care to which Canadians are said to be entitled. And since these reports are intended to guide health care policy reform, it seems worthwhile to ask the question: what conception(s) of Canadian citizenship do these reports rely upon? And more fundamentally, can we simply call our health care system a “right of Canadian citizenship,” without asking why it is so and *if indeed it is so?*

Therefore, the first aim of this thesis is to determine *if*, and on what grounds, Canada’s system of health care can be considered an entitlement of citizenship, by using a line of inquiry that does not focus on the interpretation of the Charter or other legal-constitutional arguments. Instead the intent here is to try and reveal a theoretical or an historical basis on which to claim that public health care in Canada is indeed a right of citizenship. Of course, that is not to say that there are not strictly legal-constitutional arguments that can be made in defence of a right to health care. Certainly quite the opposite is true.¹⁰

It is that I want to explore a different methodology for thinking about not only whether or not we have a right to health care, but for also considering the complexities of defending such a right. Furthermore, I want to embed the discussion of that right within the public debate that currently surrounds the Canadian health care system and link this context with the historical and theoretical framework that exists around a possible health care right in Canada. The hope is to find the nexus between the theoretical basis for claiming a right and

¹⁰ Candace Redden Johnson explores the linkage between the history of “rights-claiming” in her “third way” approach to health care rights, which lies somewhere between a claim of a “human right” and a “legal-constitutional right” to health care in Canada. See Candace Redden Johnson, “Health Care as Citizenship Development: Examining Social Rights and Entitlements.” Canadian Journal of Political Science. March 2002, 35:1. 103-125.

the policy environment in which that right may or may not be translated into practical policy goals. So, the thesis will look at the concept of social citizenship as a theoretical framework, as well as at the historical evolution of health care, to provide further context for thinking about the recent debate around health care that is invoked by these government-mandated health care reports.

The secondary aim of the thesis is to discuss how the “citizenship” argument is employed in the context of some recent so-called “objective” health care reform reports. The reason for looking at these reports is to fill out an understanding of the current landscape of the health care debate. The thesis will examine and compare four recent Canadian health care reform reports with these questions about health care citizenship in mind. The reports chosen include two that were mandated by provincial governments: A Framework for Reform: Report of the Premier’s Advisory Council on Health for Alberta (“The Mazankowski Report,” Alberta, 2001), and Caring for Medicare: Sustaining a Quality System (“The Fyke Report,” Saskatchewan, 2001). The other health care reports considered are two higher profile ones that were national in nature: The Health of Canadians—The Federal Role (“The Kirby Report,” 2002) and Building on Values: The Future of Health Care in Canada. (“The Romanow Report,” 2002).

Ultimately, the thesis argues that the theoretical framework of social citizenship, as outlined by T.H. Marshall and supported by John Rawls does provide a compelling argument that the state is morally obligated to provide social rights of citizenship, such as health care, in order to acknowledge the equality of all citizens. However, simply claiming that health care is a right of Canadian citizenship is not sufficient to ensure that the state will provide any *particular* version of health care. Our publicly-funded universal health care plan, while it is surely tied to the Canadian identity, and has been institutionalized over the last

several decades, only entitles Canadians to a thin version of social citizenship. Moreover, I argue that the commitment to social citizenship in Canada is in more of a crisis than is the health care system *per se*. The current health care debate reveals a sense of vulnerability to increasing privatization, and a potential that Canadians in some provinces may choose to reject principles of fairness, equity and solidarity, when these are obscured by offers of individual freedom of choice and speedier access to possibly higher levels of care.

The structure of the thesis is as follows: the next (and second) section will review some basic tenets of citizenship theory, with a specific focus on the idea of “social citizenship,” in order to develop a context for thinking about the relationship between state-funded health care and the notion of citizenship. The third section discusses the historical evolution of the health care system and gives a general overview of the health care debate in Canada; the fourth section considers the federal government’s commitment to medicare and the meaning behind the question of “sustainability” in the health care debate; the fifth and sixth sections review the four health care reports; and the seventh section discusses how the preceding arguments demonstrate three tensions that make the realization of social citizenship challenging. Finally, section eight offers some conclusions about health care and the state of social citizenship in Canada.

II. The Resurgence of Citizenship

Unlike slaves, vassals or subjects, whose statuses imply hierarchy or domination, citizens formally enjoy legitimate and equal membership of a society.¹¹

In the last decade or so, the idea of citizenship as a focus for discussions of politics and public policy has enjoyed a resurgence in the academic community. In the 1970s and 1980s, political theorists were preoccupied mainly with explaining constitutional rights, processes of political decision-making and social institutions—what John Rawls called “the basic structure of society.”¹² In the 1990s, the focus began to shift to a concern with the identity and conduct of individual citizens. Will Kymlicka and Wayne Norman claim that much of this shift is likely due to the rise of minority rights and a possible fear held among some groups that “culture wars” have discouraged citizen participation.¹³ They also suggest that increased voter apathy, concerns about long-term welfare dependency in the United States, and the erosion of the welfare state in several Western nations, including Canada and the United States have made concerns with the meaning of citizenship relevant again.¹⁴ Furthermore, some political theorists, prompted by Robert Putnam’s well-known studies on social capital,¹⁵ have re-aligned their work to address the question: what is the best way to understand and promote responsible citizenship?¹⁶

But, of course, that question presupposes an understanding of the concept of citizenship itself. To invoke civic responsibility implies a particular conception of the citizen and her

¹¹ Keith Faulks, Citizenship. New York: Routledge, 2000. p. 4.

¹² Will Kymlicka and Wayne Norman, “Introduction,” in Kymlicka and Norman Eds. Citizenship in Diverse Societies. New York: Oxford University Press, 2000, p. 6.

¹³ Kymlicka and Norman, p.6.

¹⁴ Ibid. p. 5-6.

¹⁵ Robert Putnam, Bowling Alone. New York: Touchstone, 2000. Putnam argues that America’s social capital is declining; he examines what he considers to be the two major features of social capital: “generalized reciprocity” and “trustworthiness,” and then argues that these social conditions, in turn create a social climate that is ripe for cooperation for mutual benefit. Thus societies well-endowed with social capital will be able to overcome collective action dilemmas and increase benefits to individuals and communities.

¹⁶ Kymlicka and Norman...p.6

attendant rights and responsibilities. Here, possibly the most influential study to illuminate the idea of citizenship is T.H. Marshall's seminal essay, "Citizenship and Social Class."¹⁷ Drawn from a set of lectures originally delivered at Cambridge University in 1949, Marshall's essay outlines a post-war theory of citizenship in Anglo-Western industrial states. His theory combines a vision of political history, which sees citizenship as an evolutionary process of ever-expanding rights, with an understanding that human equality is best realized through a focus on membership in a community.

Marshall's view of political history suggests that citizenship has evolved and expanded through the human struggle for rights over the last 3 centuries, and that we are currently engaged in what might be called the "last stage" of that struggle. That is, Marshall presents a typology of citizenship in three stages: *civil rights* (those rights necessary for individual freedom, such as the right of Habeas Corpus, rights of free speech and religion, and the right to own property) gained in the 18th century; *political rights* (the right to vote and participate in the political process) brought about mainly in the 19th century; and *social rights*, which include the "whole range from the right to a modicum of economic welfare and security....[to the right] to live the life of a civilized being according to the standards prevailing in the society."¹⁸

In 1873, economist Alfred Marshall claimed that given current (19th century) world resources and productivity levels, it would soon be possible for all to lead the "lives of gentlemen" (meaning primarily an elimination of heavy labour and the availability of education for all). T.H. Marshall builds on this idea, and further tells us that "the claim of all people to enjoy the conditions appropriate to a gentleman...is a claim to be admitted to a

¹⁷ T.H. Marshall, "Citizenship and Social Class," in T.H. Marshall and Tom Bottomore, Citizenship and Social Class. London: Pluto Press, (1950) 1992.

¹⁸ Marshall...p. 8.

share in the social heritage, which in turn means a claim to be accepted as full members of the society, that is, as citizens.”¹⁹ If we understand the term “gentleman” to mean “those persons leading a good life,” the essential theory that Marshall is developing here tells us that when we talk about equality between society members, or *citizens*, an equality of *status* is required, not just a basic or minimum standard of living (although that is certainly part of the story). T.H. Marshall elevates Alfred Marshall’s vision of a “gentlemanly” life to a fuller vision—a hope that equality will come to mean that all will share in some *common societal good*, regardless of one’s birthright.

Thus, for T.H. Marshall, citizenship holds the promise of substantive social equality; Marshall sees these “rights gains” as historical moves towards the realization of a fuller ideal of citizenship. That is, the expansion of citizenship rights into the realm of social rights moves us towards the abatement of social class.²⁰ Here, Marshall does not mean that we are (or should be) moving towards the end of *income inequality*, since he recognizes that some degree of income inequality is necessary to a free market society (and his argument does not challenge the principles of the free market). Rather, Marshall claims that the continuous progress of citizenship should lead us towards

...a general enrichment of the concrete substance of civilised life, a general reduction of risk and insecurity, an equalization between the more and the less fortunate at all levels—between the healthy and the sick, the employed and the unemployed, the old and the active, the bachelor and the father of a large family.²¹

A move towards such a “general enrichment” did not accompany the first two stages of citizenship rights that were identified by Marshall. On his view, this enrichment is to be delivered in this last stage of citizenship’s evolution; the latter half of the 20th century,

¹⁹ Marshall...p. 6.

²⁰ Marshall...p. 28.

²¹ Marshall...p. 33.

prompted by the post-war surge of interest in *social* rights of citizenship, is presumed to somehow take us there.

2.1 Social Citizenship

In his classification of the three elements (or stages) of citizenship, Marshall is careful to acknowledge that these distinctions, in reality, are not as clear as he presents for the purposes of outlining his theory. There is much overlap across the centuries during the struggle and acquisition of these rights; and there is no clear vision when it comes to understanding just what these rights *mean on the ground*. Marshall did recognize that if rights are to have meaning for citizens, they must be supported and put into effect by institutions. Accordingly, as he points out, civil rights are enforced by courts and the rule of law, while political rights of participation are embodied in universal suffrage and parliaments and other democratically-elected governing institutions. Thus, we can say that civil and political rights have become universally available (at least in the West) and generally undisputed, which makes them more clearly citizenship rights. So, in Marshall's view, as time marches on, and Western societies continue to evolve, social rights will, accordingly be realized through the institutions of education and social services.

Here, rather than just rely on the reasonable claim that universal access to education and social services are essential if a society is to produce responsible, active citizens to safeguard democracy, Marshall asserts that the primary justification for education and social services is the citizen's inherent right to equality of opportunity. And, he states that furthermore, the goal of its implementation is the elimination of hereditary privilege.²² Again, this is not an argument for equality of income. Rather, as Marshall explains, "[i]n essence, it is the equal

²² Marshall...p. 38-39.

right to display and develop differences, or inequalities; the equal right to be recognized as unequal.”²³ It is a right to develop one’s potential as a human being.

So, Marshall’s argument depends on the principle that inequality *fairly* achieved is legitimate, while inequality that results from heredity or unlucky circumstance is *not* legitimate. In other words, it is the equally applied assumption that all members of a society have a potential that is worthy of the opportunity to develop it. In short, it is about fairness. On this view, it is this obligation of respect or “status” to be accorded to all community members based on this principle that we must meet if we are to fulfill the 20th century promise of substantive rights of citizenship. Indeed, one could argue that entrenching civil and political rights for all is not much of a promise if it is not based on a foundation of respect for the equal status of all society members, which thus also implies a provision for universal access to the *means of participation* in that society. A right to vote does not mean much to a homeless person.

The conviction that we are all entitled to a reciprocal respect from others is a principle that has been much discussed and expanded, through a variety of lenses, in the works of Charles Taylor, John Rawls and others.²⁴ Taylor discusses the emergence of this idea of the obligation of respect that is due to others, when he explains how the “notion of honour” that existed before the collapse of social hierarchies in Western societies eventually shifted to the “notion of dignity, now used in a universalist and egalitarian sense, where we talk of the ‘inherent dignity of human beings,’ or of citizen dignity.”²⁵ Taylor further defends the imperative to recognize the equal dignity of all humans, by tracing its origin to the Kantian

²³ Marshall... p. 38.

²⁴ Charles Taylor, “The Politics of Recognition,” in Amy Gutmann Ed. *Multiculturalism*. Princeton, New Jersey: Princeton University Press, 1994. John Rawls, *A Theory of Justice*. Cambridge: Harvard University Press, 1971. Will Kymlicka, *Liberalism, Community and Culture*. New York: Oxford University Press, 1989.

²⁵ Taylor...p. 27.

notion of a “universal human potential, a capacity that all humans share. This potential, rather than anything a person may have made of it, is what ensures that each person deserves respect.”²⁶ This idea, of course, is in keeping with Kant’s view that people should be treated as ends in themselves, rather than as *means* to any end.

Paul Kershaw further demonstrates this point in his dual analysis of T.H. Marshall’s argument for social rights of citizenship and John Rawls’s classic work A Theory of Justice where he observes a “mutual support between Rawls and Marshall for regarding collective commitments to social security, substantive equality and dignified inclusion as prerequisites for the effective exercise of political and civil liberties.”²⁷ For Kershaw, Rawls’s acclaimed two principles of justice affirm Marshall’s conclusions about social equality.

Specifically, Rawls’s first principle is a commitment to those equal individual liberties of citizenship, which one might say is simply another expression of Marshall’s recognition of the achievement in the West of political and civil liberties as rights of democratic citizenship.²⁸ And correspondingly, Rawls’s second two-pronged principle (the “difference” principle) reflects a Marshall-like concern with “illegitimate inequalities.”²⁹ In particular, Rawls’s second principle tells us that where unequal income distributions undercut equal opportunity, it must be remedied, so as to ensure a real commitment to the first principle of individual liberties. Like Marshall, Rawls does not dispute that people should be free to earn unequal benefits from their efforts and natural talents, but he argues that fairness (or justice) is only achieved when these inequalities are harnessed to the betterment of those least advantaged in the society, from which the unequal benefits have been garnered. And this is

²⁶ Taylor...p. 41. Taylor also points out that this is a principle that says we are due equal respect because of something that is the same about us, whereas the “politics of difference,” concentrates on, and often also tries to preserve the particularities of some peoples and cultures.

²⁷ Paul Kershaw, Work-Family Balance: Rethinking the Rights and Responsibilities of Canadian Social Citizenship, PhD Dissertation, UBC, 2002. p. 44.

²⁸ Kershaw...p. 59-60, and Rawls...p. 61, as cited in Kershaw...p. 59.

²⁹ Kershaw...p. 59.

not an argument for charity, but an argument for ensuring that people are given the right to lead lives of dignity—of social inclusion. This, in turn means that we must ensure that all citizens have the means to obtain some minimum socio-economic standard of living (or as Marshall put it, “living a civilised life, according to the standards prevailing in the society.”) Indeed, it is this life of dignity and a feeling that a person is a part of society—that they *matter*, which gives them the freedom to *exercise* their civil and political liberties. This is the distinction that is classically referred to as the difference between “positive” freedoms (a freedom that *enables* a citizen to exercise their civil and political liberties) and “negative” freedoms (a freedom *from* interference by the state into a citizen’s life).³⁰

In a sense, Rawls’s difference principle and Marshall’s social citizenship theory allow liberals to preserve the principle of respect for individual liberty, while accommodating their intuition that tells them that the lottery of life should not unfairly disadvantage others, *because it could just as easily have been them*. This seems to be precisely what Marshall means by the obligation a society (or indeed a nation) carries to help provide the groundwork for equality of opportunity to its members, in order to acknowledge the equality of status of all citizens. So, it would appear that both Rawls and Marshall supply a foundation for the state to provide at least a modest redistribution of wealth in society, through universal access to some social services, such as education and health care.

To sum up, Marshall insists that the goal of citizenship is “equality of status,” which he claims is necessary and *right*, if people are to be treated as “full members of a society;” Taylor emphasizes the importance of recognizing the dignity of human beings, based on their common human potentiality; and Rawls’s principles of justice explain why the liberal idea of

³⁰ One of the classic discussions of the distinction between positive and negative freedom is Isaiah Berlin’s “Two Concepts of Liberty,” in Four Essays On Liberty. New York: Oxford University Press, 1969. 118-172.

individual liberty also requires a rule of fairness, where individuals can (and should) support a redistribution of wealth to accommodate the least advantaged members of society.

So we are not just talking about equal political or civil rights, but of something more fundamental and substantial: human dignity and the fair access to those political and civil rights by way of the provision of some necessary material goods and services. In short, these theorists demonstrate that a reciprocity of respect is owed to all citizens, in virtue of their simply being human and therein a member of a society of humans. Ensuring the dignity of others and respecting others in our community, is an essential aspect that defines equality. And this conception of equality, in turn, leads us to a politics of social citizenship. Indeed, the growth of social services that defined the rise of the welfare state during “the almost uninterrupted expansion of capitalist economies after the Second World War” in most Western states is what some have called the “expansion of the frontiers of social citizenship.”³¹

2.2 The Challenge of Actualizing Social Citizenship

The basic notion of citizenship is undoubtedly a powerful concept. One practical example of its power is always evident during times of war: surely, the ideal of citizenship and its legally enforceable duties were heavily relied upon by most of the world’s nations during both World Wars. Citizenship provided the means to recruit and command thousands of troops and to ensure the loyalty of citizens at home throughout the economic hardship and uncertainty that accompanied war. Providing social services to citizens could thus be seen as repayment for sacrifices made on behalf of the nation. As one citizen put it

³¹ Michael Moran, “The Frontiers of Social Citizenship: The Case of Health Care Entitlement,” in The Frontiers of Citizenship. Eds. Ursula Vogel and Michael Moran. London: MacMillan Publishing, 1991. p. 32.

after World War I, “Every nation has been expecting every man to do his duty, and now that the war is over, every man will expect every nation to do its duty.”³²

Furthermore, after the second World War, the experience of the Depression and the devastation brought on by both wars had demonstrated that social services were often necessary to enhance citizens’ abilities to participate in society (and more specifically, in the economy). That is, social and economic conditions at that time were ripe for, at a minimum, welfare and unemployment insurance schemes, which promised Keynesian-style growth. This strategy of combining economic liberalization with a social safety net has been referred to as “embedded liberalism,”³³ and also as the promise of the liberal democratic welfare state.³⁴

However they are labelled, imparting social rights of citizenship is a task that ultimately relies on the fiscal resources of the state. Whether the services in question are education, unemployment insurance, welfare payments, old age pensions or health services, all require practical budget planning, tax revenues and expenditures. Thus social rights rely on the state’s fiscal abilities. And when it comes to assessing those abilities, this

raises questions about income redistribution between members of a community, including the share of personal or family income that should appropriately be paid to purchase public services... This line of questioning inevitably confronts concerns about individual property rights. The result is that the social dimension of citizenship exists in continual tension with citizenship’s civil element.³⁵

Arguably, this inevitable tension between social rights and civil rights of citizenship is one reason that social rights have not been formally (or constitutionally) recognized in the same way as political or civil rights. Putting into effect a formal (written) expression of a guarantee

³² Dr. Charles Hastings (Toronto’s Medical Health Officer, 1919), as quoted in Aleck Ostry, “Public Health and the Canadian State: The Formative Years, 1880-1920,” in Canadian Journal of Public Health, Sept-Oct 1994, 293-294.

³³ Kershaw...p. 50.

³⁴ Will Kymlicka, Contemporary Political Philosophy. Second Ed. New York: Oxford University Press, 2002.

³⁵ Kershaw...p. 51-52.

to almost any sort of social right would without doubt require the raising of funds and/or the shifting of funds from other programs, without regard to a state's fiscal situation. This type of guarantee would seem tricky to sustain. Moreover, entrenching any particular conception of social rights (no matter how vague) would also open up the state to a host of legal challenges, if in the minds of its citizens (and their lawyers), the state somehow failed to deliver on their conception of the obligations of the state with respect to that social right.³⁶

Also, the inherent practical difficulty of embarking on any kind of constitutional change, as we discovered during the Meech Lake and Charlottetown Accord years, makes the idea of constitutionally recognizing social rights problematic. It is rational to say that reaching a consensus across provinces (and interest groups) on the particulars of social rights or even on the identification of the *general areas where social rights should be guaranteed* for the purposes of the constitution, would be nearly impossible. For example, consider how the provinces and the federal government would come to agree on social rights questions such as: should every Canadian be guaranteed a home? Or alternatively, should every Canadian be guaranteed a minimum income?

³⁶ Although, on the other hand, one could argue (and many have) that the Canadian Charter of Rights and Freedoms has already opened up the state to a number of legal challenges where particular citizens (or groups of citizens) claim that the state is not fulfilling its promise of rights and freedoms as outlined by the Charter. Indeed, two recent cases before the Supreme Court of Canada could result in a more formal definition of social rights, when it comes to Canada's Medicare system. The cases generally revolve around what should constitute "medically necessary" services under the federal legislation of the Canada Health Act, which creates the guidelines for Canada's health care system. The "Chaoulli case" argues that a Quebec law which prevents payment for medically necessary services is a violation of both a doctor and a patient's constitutional rights under section 7 of The Charter of Rights and Freedoms (the right to life, liberty and security of the person). And the "Auton case" argued that the BC government's refusal to pay for treatment for children with autism is a violation of sections 7 and 15 (equality) under the Charter. See < http://www.scc-csc.gc.ca/information/hearings/spring/spring_e.asp#c29272 >. The Court found in favour of the BC government in the Auton case; a decision in the Chaoulli case is expected in the Spring 2005.

Indeed, when Marshall considers the specifics of social rights, he observes that

[b]enefits in the form of a service have this further characteristic that the rights of a citizen cannot be precisely defined. The qualitative element is too great. A modicum of legally enforceable rights may be granted, but what matters to the citizen is the superstructure of legitimate expectations.³⁷

Here, the notion of “legitimate expectations” is clearly important when it comes to thinking about social rights, because legitimate expectations with regard to a norm of living can only be created in a community of citizens, where people have become accustomed to (or of *aspiring to*) a certain standard of living through the experience of a common life—whatever that may mean at any period in time. It would also seem that the creation and existence of a universal medicare system in Canada (whatever its faults) has led Canadian citizens to share some basic set of legitimate expectations when it comes to health care services. Indeed, the persistent interest of the Canadian public and the media in the topic of wait times for diagnostic tests or surgical procedures has led some to observe that “citizens share expectations about how much time we should reasonably wait for medical procedures.”³⁸

Yet, despite such examples of consensus for some medical procedures, there is still much debate about just how sustainable the publicly funded health care system is, and whether or not it might be necessary to increase the role of the private, for-profit sector at either the funding or the delivery end of health care. Furthermore, we also need to ask: can *expectations* be equated with the status of *rights* necessarily? So far, the answer seems to be: *maybe*. Even though the *term* “social rights” is currently applied to the idea of extending social benefits to

³⁷ Marshall, p. 34.

³⁸ Kershaw...p. 54. The recent news story of a young boy in Newfoundland who had to wait an expected 2 ½ years in the public health care system for an MRI exam that was recommended by his physician (because of the doctor’s suspicion of possible cancer) prompted many Canadians to forward offers of money to pay for an MRI at a private clinic either in Canada or the U.S.. This demonstrates that most of us would agree that a 2 ½ year wait for a test, when a doctor recommends it, is too long. Interestingly, a spot at a public hospital opened up shortly after the story became public, and the boy had the test done within a couple of weeks. See Lisa Priest, “Four-year old who faces 2 ½ year wait for MRI may turn to U.S.” *The Globe and Mail* January 27, 2005. p. A8.

citizens in a liberal democracy, and we can certainly point to social benefits that Canadian citizens receive all the time (such as welfare benefits, education and health care) those expectations are always subject to change and competing interests. We may also agree that all citizens should be entitled to *some* minimum standard of social services, and these are sometimes instituted by the state, but agreeing on just what that minimum standard *is* over time (and changing societal circumstances) may be problematic. Thus constructing qualitative expectations in the form of *rights* becomes a thorny business.

To be sure, Marshall recognized this dilemma; he noted that as citizens are provided services, they will progressively come to expect more of the services provided by the state. And as a society progresses in terms of its economic and social prosperity, the state's "...obligations automatically get heavier. The target is perpetually moving forward."³⁹ Yet, at the same time, Marshall also seemed to believe that the shared expectations of citizens for a certain standard of living are tangible enough to *somehow* form the foundation of a third social element of citizenship rights, regardless of their uneasy relationship with *the concept of rights* (as they are applied to civil and political rights). Indeed, Kershaw offers health care as one example of a policy area where "the state may be motivated to create initiatives" in response to citizens' legitimate expectations, depending on their community's socio-economic context.⁴⁰

Rights of social citizenship are generally considered to be "universal entitlements, claimable under impersonal eligibility rules by all people called citizens...."⁴¹ In other words, we draw boundaries around those social benefits that are *uncontested*, and that are therefore regarded as rights. So, if we use the notion of *universally agreed-upon boundaries* around social

³⁹ Marshall...p. 35.

⁴⁰ Kershaw...p. 53.

⁴¹ Moran...p. 35.

rights as a means to consider some expectations to be *legitimate*, then perhaps we can use Marshall's idea of "legitimate expectations" to help define a model of health care citizenship.

For example, we might consider the public provision of education in the context of social citizenship. The children of Canadian citizens are guaranteed access to a publicly provided kindergarten-to-grade 12 education, but we do not guarantee post-secondary access for citizens (although we subsidize its provision). Thus we can say that a publicly provided education through to grade 12 is a *universally agreed-upon expectation*—it is therefore *legitimate*—and considered to be a social right of citizenship, because we *know* the limits on that right. And just because we might hope or even expect our children to obtain a post-secondary education, we know that the state is not obligated to provide it, and thus post-secondary education is not currently a "legitimate expectation" for our purposes of defining a citizenship right to education. And this seems to hold true, despite cuts to some provincial education budgets and consequently to various extra-curricular activities and educational resources at the school board level in some provinces. Local political struggles may occur over these sorts of implementation details around the provision of the service, but the basic right to a public education (financed through general tax revenue) remains uncontested.

Canadian health care may appear to be a case where we can similarly outline some basic legitimate expectations (and therefore also clear limits—and clearly understood state obligations—to health care), but the current debate at the core of the health care system *also* contests the ability (and the legitimacy) of the *publicly financed system* to sustain itself over the coming decades. So, is it clear that we can identify some national consensus around a set of *legitimate expectations* of the Canadian health care system and thus consider it a *social citizenship* right? And if there is such a right, so defined, is it extensive enough to be meaningful?

III. Canadian Health Care: Some Current and Past Expectations

To answer the question about an identifiable “superstructure of legitimate expectations,” we might first turn to the current context of health care expectations in Canada. Here, at first glance, it seems fair to say, that citizens generally share some basic health care expectations, because of the enduring institution of medicare. That is, the ability to access doctors and hospitals without regard to the ability to pay (or what is called “first-dollar coverage”) has become institutionalized across Canada through past public policy.⁴² So, we *could* stop here and claim that since we all by and large *expect that Canadians will have access to both doctors and hospitals* when necessary, we can confidently draw a circle around this idea and call it a social right to health care. Then we would be left to question our politicians about waiting times where they seem excessive and standards of service where they seem to be lacking; and this could properly be seen as an important part of defending and maintaining our rights as citizens. Indeed, to a certain extent, this *is* a large part of the current debate.

However, it is not the whole story. Moreover, it may not even be the most important part of the story. That is, we also need to acknowledge that much of the debate is also about two additional and separate issues. First, health care policy is currently surrounded by many *increasing* expectations. Second, the public funding of doctors and hospitals, while it has formed the cornerstone of health care policy for decades, is now subject to increasing scrutiny by those that insist that this system is unsustainable without injections of market incentives and private, for-profit management.

On the first issue of increasing expectations, there have been recent calls for the state (at both the provincial or federal level) to step in with “Pharmacare” and/or “catastrophic drug

⁴² Julia Abelson et. al. “Canadians Confront Health Care Reform,” in Health Affairs, Vol. 23, No. 1, May/June 2004. 186-193. p. 189.

coverage” programs to ease reliance on either out-of-pocket payments or private health insurance premiums (many Canadians have this type of extended coverage through their employer). The movement for state-provided drug plans is partly fuelled by the increasing costs (and growing availability of more varieties) of prescription drugs. Prescription drugs are currently only covered by medicare if the drugs are administered to patients while in hospital or as “out-patients” from hospital, although some provinces do offer extra coverage (with or without health care premiums) for some classes of drugs for eligible (low-income) citizens. At the same time though, some provinces have “de-listed” certain types of drugs from their provincial coverage in recent years, leaving some provincial citizens paying more out-of-pocket than they were accustomed to paying.

The resulting call for increases in *national* medicare coverage for prescription drugs is also a part of a general increase (or at least a *change*) in citizens’ expectations of the state’s responsibilities where public health care is concerned. One observer argues that “citizens’ expectations have changed regarding health care as the contours of disease have changed, [and] advanced medical technology has become available....”⁴³ Indeed, the cost of CAT and MRI scans,⁴⁴ which are now standard diagnostic tools for physicians, were never factored into the original policy architecture of publicly-funded doctors and hospitals. Furthermore, when provincial budget cuts to social services prompted the closure of long term care beds in many provinces, the care for many mental health care clients and seniors was moved into communities, before adequate infrastructure was in place to accommodate this increase in community-centred care.⁴⁵ This, in turn, has prompted increasing calls for state assistance in

⁴³ Candace Johnson Redden, “Health Care as Citizenship Development: Examining Social Rights and Entitlement,” in *Canadian Journal of Political Science*, March 2002, 35:1 103-125. p. 112.

⁴⁴ Computed Axial Tomography and Magnetic Resonance Imaging.

⁴⁵ The province of BC has been following a policy of moving care from institutions to the community since 2001. Current plans are to increase the proportion of home and community care clients with high care needs living in their own home, rather than in a facility by 5% in 2005 and 5% in each of the next two years. See *Report*

the communities for “home care” and “assisted-living” programs, as well as funding for community organizations that help seniors, the mentally ill and the homeless population.

Additionally, as technology advances, in for example, the area of diagnostic testing (such as the movement from CAT scans to MRIs and PET⁴⁶ scans), citizens have come to expect that all will have equal and quick access to these technologies, whenever necessary. And where waitlists exist for access in the public system for such diagnostic tests, patients sometimes understandably choose to undertake these tests at privately-run facilities, which will likely charge a user fee for the service. And although the private operation of an MRI or other diagnostic centre is not “illegal” in Canada, as it is sometimes believed, the charging of a fee to a Canadian citizen for a “medically necessary” service (one where they could receive it via a doctor or hospital in the public system without any individual charge) is contrary to the federally legislated Canada Health Act (CHA). An additional problem is created when patients who have paid privately for a scan take the diagnostic information back to their publicly-funded doctor and effectively “queue-jump” for treatment ahead of those still awaiting diagnostic scans within the public system. So, we are left to question whether or not we want to pay (all things being equal, more taxes) to include access to *additional* technologies and pharmaceuticals as a part of our current publicly funded insurance program.

At the same time, the second issue that complicates the defining of legitimate expectations of health care is that there exists another camp in the debate: those that believe that the public system is fiscally unsustainable, because of the lack of market incentives in either (or both) the funding and the delivery end of public health care. For example, lawyers involved in court challenges to the CHA, and some provincial premiers, among others, argue

on *Health Authority Performance Agreements (2004/05)*, BC Ministry of Health Services. But there is no equivalent plan for community support to help care for these people once they are moved out of institutions and into communities.

⁴⁶ Positron Emission Tomography.

that it is simply *wrong* to disallow Canadians from privately purchasing health care services. An argument frequently floated in the media claims that it is absurd that we can privately purchase an MRI for our pets, but that it is illegal for us to do the same for ourselves in our health care system. One health reporter responds to this argument by saying: “yes, but we are also allowed to tie up our dogs in the backyard, but we cannot do this to our children; and all that [these statements show] is that we have different laws for humans and pets in our society.”⁴⁷ More specifically though, we do not have a “public” insurance plan that we all contribute to in order to cover our pets; therefore all of our pet health care must be paid for privately, and those that cannot afford to do so are sometimes left only with the option of “putting down” their pets. We have chosen a different path for our own health care.

Clearly, the argument about scanning our pets seems to miss the point that our health care system deliberately pools public funds and administers a single-payer system, because it is a more efficient way to administer health care when compared with multi-user systems, such as the U.S..⁴⁸ And more importantly, it allows equity of access, so that those that could not afford to pay approximately \$660 for an MRI scan would still have access to the necessary diagnostic scan.⁴⁹ Whether or not the system is providing timely enough access to all public services, because of either budget cuts or inadequate management is a *separate question* from the question of whether or not we should be “allowed” to purchase health care services. Still, many Canadians continue to believe that many health care services, such as MRIs, should be turned over to the private sector, because of a general (and often vague) claim about the “unsustainability” of the public system.

⁴⁷ Globe and Mail Health Reporter Andre Picard, Presentation at Health Canada Conference, Aylmer, Quebec, March 2, 2005.

⁴⁸ See for example, Ted Marmor, “The rage for reform: sense and nonsense in health policy,” in Daniel Drache and Terry Sullivan Eds. *Health Reform: Public Success, Private Failure*. New York: Routledge, 1999. 260-272.

⁴⁹ This is the average fee calculated from the published fees at the nine private diagnostic facilities in BC. A PET scan in BC costs on average \$2850.

The most vocal promoter of the need for private sector involvement in the funding of health care is Alberta's Premier Ralph Klein. He has repeatedly claimed that Canada's health care system is unsustainable without the introduction of more (incentive-driven, for-profit) private clinics and the possibility of user-pay services, supposedly to encourage more "responsible" use of the health care system. Indeed, during the premiers' meeting (July 28-30, 2004) Klein remarked that Canadians are free to buy new clothes, cars and houses, but "the only thing you can't do in this country is spend money on your own health care. I think it's wrong."⁵⁰ This of course is another variation of the misleading "dog scanning" argument. More recently, Klein has proposed "a third way" approach to health care, but he has only hinted at what that might mean in practical terms.⁵¹ The private sector and the federal government await further developments from the Premier as he enters his last mandate as leader of the province.

On the other hand, federal Health Minister Ujjal Dosanjh, since taking office in July 2004 has clearly (and repeatedly) exclaimed that health care is "Canadians' most cherished social program," and therefore we must "stem the tide of creeping privatization."⁵² So, the increase in *possibly legitimate* expectations coincides with a debate about the "sustainability" of Canadian health care, and mixed into the discussion is a defence of Canadians' freedom (sometimes referred to as the "right to choose" when it comes to health care), which is cast by those advocating more private sector involvement in the health care system as the only way to "save" our most cherished social program. But we also need to ask: does opening up

⁵⁰ "Klein takes centre stage—again." The Globe and Mail p. A4. July 30, 2004.

⁵¹ Katherine Harding, "Klein prepared to go 'third way' without provinces." The Globe and Mail. p. A4, January 13, 2005.

⁵² Dennis Bueckert, "Health Minister Dosanjh vows to stem the tide of privatization in health care." Canadian Press. July 20, 2004.

the public health care system to more private, for-profit funding and delivery really “save” the system, or does it erode it?

Interestingly, the survey mentioned earlier, which found that 93% of Canadians felt that health care was a right of citizenship, also found that “younger Canadians were consistently more supportive” of three given options for reforming the health care system: a user-fee option where patients paid for a portion of the health care services they receive, a two-tier delivery option where people would be “allowed to pay for faster and/or higher quality care” and for-profit care where private firms would be allowed to set up and compete with the not-for-profit and public system.⁵³ Furthermore, the survey found that those respondents who were more supportive of the three market-oriented options were characterized by attitudes that were “more supportive of science, technology and individualism; more socially conservative; and more opposed to equity and solidarity as overarching principles.”⁵⁴ Thus many younger citizens appear to be questioning the traditional foundation of the health care system itself, while at the same time others seek to *expand* the current boundaries of public health care provision.

Therefore, in the current debate landscape, rather than identify a consensus for a “superstructure of legitimate expectations” of our health care system, we have found a fundamental tension at the heart of the debate. Whether or not the rising expectations (or even the past expectations of simply the “doctors-and-hospitals” system) are *legitimate* is a question about the proper proportional contribution of citizens’ incomes to the provision of a public service—health care. At root, this is a question about the willingness to share (through redistributive social services) as a community.

⁵³ Abelson et. al. ...p. 190.

⁵⁴ Ibid., p. 190-191.

If the boundaries of publicly funded health care are to expand, the funds will have to come from somewhere, either from other areas of government spending or an increase in taxes. Then again, those that advocate health care reform that focuses on a "population health" perspective (which means an increased emphasis on health promotion and disease prevention) argue that this is the sort of boundary shifting that should, in fact, realize savings, rather than increase costs. But this is not as quantifiable (nor as obvious in the short-run) as arguments that show an *immediate decrease* in costs to the public health care system, when they are simply offloaded to the private sector (which will charge fees to individuals and therefore likely impede equity of access and health outcomes for some, but will provide speedier access and possibly better service for others). Put another way, the debate is about different conceptions of the good, and the proper place of the state in the lives of individual citizens. In this sense, Klein versus Dosanjh represents a dichotomy, with respect to how we see the place of the health care system as a part of social citizenship (and therefore of how we understand what it means to treat citizens as equals).

Reconciling the two positions is not likely, since each is based on a different conception of the role of the state and the role of the market in providing an essential service like health care. This is where the idea of social rights begins to conflict with civil rights. It provokes the question: to what extent should the state restrict our individual freedom (by collecting taxes) to fund the maintenance *or expansion* of public services, which share the burden of risk and enhance the positive freedoms of fellow Canadians? And is there a point at which we say that public health care is simply too expensive for the state to provide? Of course, these are the sorts of questions that are answered, at least temporarily, by the democratic process. Still, these questions *appeared* to have been largely answered by the earlier establishment of a national medicare program in Canada. Indeed, medicare arose primarily *because medical*

treatment was too expensive for many individual Canadians to access on their own. Nevertheless, it would seem that the original consensus may not be as watertight now as it was then, which in turn leads us to the question: what principles influenced the creation of the “original medicare idea,” and can we preserve (or return to) those foundational principles or have they become outdated?

3.1 The Evolution of Canada’s “Most Cherished Social Program”

The earliest known medical insurance contract in North America was written in what is now Montreal and dates back to March 3, 1665.⁵⁵ The contract was between “master surgeons” in Ville-Marie and 17 men and their families: the surgeons promised:

to well and truly serve the hospital of Ville-Marie, to treat, dress and physic all the sick persons who may be there, and this for periods of three months each in turn and to visit such sick persons assiduously at about seven o’clock each morning and at such hours as may be necessary.⁵⁶

Evidently although much progress has been made in terms of medical science in the more than 3 centuries since the Ville-Marie contract, we cannot necessarily say that the dedication of physicians has improved! History does not tell us when the Ville-Marie contract expired, nor does it tell us much about the various medical insurance arrangements that may have existed prior to Canada’s Confederation. But what we do know is that health care policy in Canada has been mired in the federal context, ever since the Constitution Act (1867) gave jurisdictional authority over health to the provinces.

Therefore prior to the creation of any public health insurance programs, the burden of providing for the “sick poor” rested with the provinces, and specifically with the municipalities in all of the Canadian provinces.⁵⁷ Church-related organizations were generally relied upon for the creation of hospitals (in accordance with the Elizabethan Poor Law

⁵⁵ Chief Justice Emmett Hall, Royal Commission on Health Services. (1964-65) Volume 2, p. 381.

⁵⁶ Ibid.

⁵⁷ Ibid., p. 384.

tradition), but wherever these organizations failed to provide a hospital when one was needed, the municipal governments were left to fill the gap. In this regard, Western Canada was disadvantaged when compared with Eastern Canada. A sparsely-settled population and a comparative lack of large fortunes in the West meant that local, large-scale philanthropic projects for hospitals and health services were unreliable.⁵⁸ Thus, in the early 1900s, some provinces began to get more involved in health funding. Alberta and Saskatchewan amalgamated their towns and rural villages, in order to combine funds for the building of hospitals. And, in 1931, when faced with the increasing loss of doctors due to peoples' inability to pay for services, Saskatchewan implemented a "municipal doctor system," which centralized payment schemes for doctors' services across several municipalities in the province.⁵⁹

But the Depression of the 1930s worsened still the fate of those requiring health care as many municipalities, and especially rural municipalities, quickly approached bankruptcy.⁶⁰ Few individuals could afford the extravagance of health care. In the direst of circumstances, individuals who required health services were usually forced to appeal to municipal relief officers to gain admittance to a hospital. At the time, a grass-roots principle began to emerge in the West that can best be summarized by the statement: "Never again will I crawl on my hands and knees before I can be admitted to hospital."⁶¹ Citizens were beginning to think that there must be a better way to get access to much-needed health services.

The account of a "grass-roots" principle or idea contributing to the eventual emergence of universal health insurance is supported by Carolyn Tuohy, a political scientist, who

⁵⁸ Hall...p. 383.

⁵⁹ Hall...p. 384.

⁶⁰ Malcolm G. Taylor, Health Insurance and Canadian Public Policy: The Seven Decisions that Created the Canadian Health Insurance System, Montreal: McGill-Queen's University Press, 1978. p. 4.

⁶¹ Taylor, (1978)... p. 4.

compared the evolution of the Canadian health care system with that of the American health care system.⁶² She observes that, in Canada, by the 1930s, “a climate of ideas broadly sympathetic to governmental health insurance had developed.”⁶³ Tuohy credits ideas with a significant background role in health care policy development in Canada. Perhaps reflective of this public opinion, it was during this period that a number of provincial commissions recommended health insurance programs, including two in Alberta (in 1929 and 1933), and one in British Columbia (1932). The British Columbia recommendation even passed in a plebiscite that confirmed the BC citizens’ desire for such a program.⁶⁴ Still, none of these commissions actually triggered the implementation of public health insurance in either province.

Even the Royal Commission on Dominion-Provincial Relations of 1937 (the Rowell-Sirois Commission), which did not recommend many significant policy actions, did acknowledge the merit of a plan that would include “state medicine and state hospitalization or health insurance.”⁶⁵ Certainly there was good reason to make such a *national* recommendation; while the provincial governments have constitutional jurisdiction over health, the federal government has broader taxation powers under section 91 (3) to facilitate the “raising of Money by any Mode or System of Taxation.”⁶⁶ Consequently, given the potential costs of a health care insurance program, there would be a fundamental inequity

⁶² Carolyn Tuohy, Accidental Logics: The Dynamics of Change in the Health Care Arena. New York: Oxford University Press, 1999.

⁶³ Tuohy...p. 41.

⁶⁴ Malcolm G. Taylor, Health Insurance and Canadian Public Policy: ... p. 7.

⁶⁵ Royal Commission on Dominion-Provincial Relations, Report, Book II, p. 42, as cited in Taylor... p.7.

⁶⁶ Antonia Maioni, “Federalism and Health Care in Canada,” in Keith Banting and Stan Corbett Eds. Health Policy and Federalism: A Comparative Perspective on Multi-Level Governance. Montreal: McGill-Queen’s University Press, 2002, 173-199. p. 174.

between the responsibility of the provinces in health care (should they adopt a public health insurance program) and their ability to pay for it.⁶⁷

Still, despite all of these recommendations, it was not until 1947 that a provincial government put the idea into action; and it was nearly another 20 years before the federal *Medical Care Insurance Act* (1966) was passed. Evidently, the prairie “grass-roots” idea to cooperate and provide a public health care insurance program took awhile to take hold at the provincial level of government, and longer still to reach the federal level. However, the point here is not to attempt to strictly explain *how or why* a universal public health insurance plan took root in Canada, but instead to consider the context and some of the contributing factors to the birth of medicare. To do that, a closer look at the birthplace of the Canadian model of health care seems appropriate.

3.2 Saskatchewan's Contribution

On the provincial front, it is well-known that Saskatchewan was the first province to launch a public hospital plan (1946) and a public medical care services plan (1962) that would later become the model for medicare as we now know it in Canada. The Saskatchewan CCF government, under the direction of Premier Tommy Douglas, passed legislation in 1946 that would establish universal, comprehensive hospital care insurance for the province's citizens. And although the 1946 legislation is considered to be the watershed moment in health care development, the groundwork that contributed to that particular policy took place much earlier in the province. As mentioned above, by 1931, the Saskatchewan “municipal doctors system,” enabled municipalities and even portions of municipalities to cooperate in the contracting of doctors' services.

⁶⁷ Of course this situation is still the source of many federal-provincial conflicts; undoubtedly, it was the central theme of the recently televised First Ministers' Meeting on health care in Ottawa, Ontario, September 13-15, 2004.

The municipal doctors system had originated with an amendment to the Rural Municipalities Act in 1919.⁶⁸ This amendment gave municipalities the authority to use general land tax revenue for the purpose of contracting with doctors. The impetus for this action can be traced back further still to a Saskatchewan legend of sorts, which claims that when the rural municipality of Sarnia was about to lose its doctor in 1914, the municipality, in desperation, and without the legislative authority to do so, offered the doctor an annual retainer of \$1500 to stay.⁶⁹ Evidently this worked, and legislation followed action: a number of amendments were subsequently made to the *Rural Municipalities Act*. These amendments allowed municipal councils to not only pass bylaws in order to grant “aid or relief to any needy person who is a resident of the municipality” (one of the original duties of the municipal council under the Act, passed in 1909), but to go further and levy land taxes for this purpose, and thus enable the towns to enter into contracts with doctors as needed, and as new tax revenues allowed.⁷⁰

Then in 1939, the Saskatchewan provincial legislature passed the *Municipal and Hospital Services Act*, which allowed municipalities (individually or collectively) to go beyond general land taxes and levy a personal annual tax on families who did not own land, in order to raise funds to pay doctors.⁷¹ In addition to the patchwork of municipal doctors’ contracts that were popping up across the province, a number of Union Hospital Districts (UHDs) were being created at the same time through the ongoing cooperation of villages, towns and rural municipalities, through the 1920s, 1930s and the early 1940s. This move enabled the continued pooling of resources for the building of public hospitals.

⁶⁸ Taylor (1978)...p. 70.

⁶⁹ Taylor (1978)...p. 70.

⁷⁰ Ibid., p. 70-71.

⁷¹ Ibid., p. 71.

Without a doubt, underlying all of these developments is a spirit of cooperation and community. The fundamental belief that cooperating and pooling resources with others in the community would lead to a greater good for all was well-established in Saskatchewan in the early part of the 20th century. As Professor S.M. Lipset noted, by 1945, the average farmer in Saskatchewan belonged to four of five cooperatives.⁷² It would seem that the landscape of Saskatchewan was ideal for such a venture as public health insurance, since "...cooperative endeavours were characteristic of pioneers committed to sharing each other's burdens."⁷³ Indeed, this spirit of collective responsibility seems even more significant, when we consider that many of the key developments on the road to medicare occurred during the Depression of the 1930s. Clearly, it is not only important to note that citizens, because of their lack of resources turned to one another (and their governments) to find joint answers to public problems, but also that they were able to solve an economic problem, *in spite of* their lack of resources, due to their ability and willingness to work together (and offer up tax payments) as a community, in order to share the risk and burden of health care. Unmistakably, there was an element of trust or social cohesion at the heart of these communities.

Similarly, the move to close "the major gap in the health services spectrum,"⁷⁴ with the province's further introduction of a medical care services plan in 1962 was rooted in this collective sense of responsibility. Yet, it was not easy legislation for the longstanding CCF government (in office for 15 years by this point and still led by Premier Douglas), to realize.⁷⁵

⁷² S.M. Lipset, Agrarian Socialism. Berkeley: University of California Press, 1950, as cited in Taylor, p. 70.

⁷³ Janet Storch, "Foundational Values in Canadian Health Care," in Efficiency vs. Equality: Health Reform in Canada. Eds. Michael Stingl and Donna Wilson, Lethbridge: Fernwood Publishing, 1996. p. 22.

⁷⁴ Malcolm G. Taylor, Health Insurance and Canadian Public Policy... p. 239.

⁷⁵ However, Premier Douglas left provincial politics to become the leader of the new NDP, and to run in the federal election (June 18, 1962) shortly before the Saskatchewan legislature officially passed the province's Medical Care Insurance Act on July 1, 1962. Premier Woodrow Lloyd and his CCF government oversaw the final drama of passing the Act.

In December 1959, on a local radio broadcast then-Premier Douglas outlined his plan for five basic principles of “a comprehensive medical care program that will cover all our people.”⁷⁶ They included: the pre-payment principle; universal coverage; high quality service; “a government-sponsored program administered by a public body responsible to the legislature and, through it, to the entire population;” and the format should be acceptable to both providers and patients.⁷⁷

Making the format acceptable to the providers proved to be the biggest hurdle. The negotiations between the government and the Saskatchewan College of Physicians and Surgeons, which strongly opposed the introduction of a province-wide, government-controlled medical care plan, were bitter and hard-fought. Moreover, the Canadian Medical Association (CMA) and the Canadian insurance industry were both against the plan as well; in agreement with the Saskatchewan doctors, they preferred a government assistance plan for low-income earners that would subsidize payments to the private insurance industry, thus allowing doctors to set their fees as they wished (including the use of a “sliding-scale” method where doctors charged people higher fees if they had higher incomes).⁷⁸

The 1960 provincial election was fought on this issue, with the Saskatchewan College charging its members \$100 each to wage a publicity campaign against the current CCF government’s medical care plan; and the national CMA contributed \$35,000 to this cause.⁷⁹ Nevertheless, the CCF increased its legislature seats in the election (slightly increasing its majority), and the government then continued trying to reach an agreement with the medical profession. They offered a number of compromises that were all refused by the College (including the right of doctors to opt out of the public plan entirely and charge fees on their

⁷⁶ Taylor, (1978)...p. 278.

⁷⁷ Taylor, (1978)...p. 278.

⁷⁸ Ibid., p. 293-294.

⁷⁹ Ibid., p. 281.

own). Eventually, the government went ahead without an agreement and passed the medical services plan legislation on July 1, 1962. The insurance plan was to be universal and compulsory, and thus it required the payment of premiums by all residents. Insured services were defined as the services of physicians and surgeons provided in the doctor's office, hospital or a person's home.⁸⁰

But that was not the end of the story; after the law was passed, the government then had to withstand a tense 23-day doctors' strike, before securing doctors' grudging cooperation in the administration of the plan (although many doctors left the province altogether). The strike and the events leading up to the strike were nothing short of a crisis situation in the province. One local newspaper, The Moose Jaw Times-Herald (July 3, 1962) was typical of many local newspapers, when it declared:

How far does the good of the community require the limitation of the rights of the individual and the community? This is the vital question that points like a dagger at the heart of every citizen of this province, and to reveal to them what it means when a democracy is transformed into a dictatorship...July 1st, 1962... will be marked with a black blotch on the calendar as the day when freedom died.⁸¹

Other local newspapers agreed and called for the government to repeal its "totalitarian" legislation, but the press in many of the other provinces, and also much of the press in the U.S. and Britain were instead critical of the medical profession and supportive of the government. The Toronto Globe and Mail (July 4, 1962) exclaimed, "The doctors of Saskatchewan have taken an action which is not open to any individual or any group in a democracy. They have deliberately decided to disobey a law of that Province...Such action cannot be condoned in a law-abiding community."⁸² The British paper, The Observer (July

⁸⁰ Taylor (1978)...p. 285.

⁸¹ Ibid., p. 312.

⁸² Ibid., p. 308

6, 1962) wrote, "...the medical situation in Saskatchewan is more than a [doctors'] strike, it is a mutiny."⁸³

Based on the drama that characterized the negotiations and the eventual passing of the *Medical Care Services Act* in Saskatchewan, it seems plain that the pioneering spirit and the ability to cooperate were not enough of a motivating factor for the policy process to eventually culminate in the passing of the *Act*; the vigorous opposition of the organized interests of the medical community meant that the process also required a very strong political will and a longstanding commitment on the part of the government. Of course, the 1960 re-election of the CCF government by the voters of Saskatchewan, when the controversial plan was the key election issue, gave the government a clear mandate from the voters to move ahead with its legislation, despite the opposition of the medical community.

So, at the end of the day, the launch of the Saskatchewan medicare plan in 1962 was the result of a vigorous struggle between opposing interests: the interests and goals of the provincial CCF party government versus the well-organized interests of the doctors. It may even be possible to view this struggle from Marshall's perspective and say that, in a sense, it was a struggle against social hierarchy, which in the end still preserved the free market (doctors could still negotiate their fees, but now with the state instead of individual patients). Furthermore, we can also say that the new provincial medicare plan institutionalized the values and hopes of most of the citizens of Saskatchewan, by legislating the medicare principles of *universality* of access to health services, *common responsibility* through compulsory premiums paid to government to provide health services access for all and public *accountability* (to the legislature) for the program through the government's administration of the program.

⁸³ Taylor (1978)...p. 311.

3.3 The Emmett Hall Report: A Foundational Act?

The transition that occurred from the 1947 provincial health insurance “experiment” launched by Saskatchewan to the national program of medicare in 1966 can hardly be seen as a direct result of Saskatchewan’s legislative efforts, although there is an undeniable connection. In addition to the success and popularity of the 1962 Saskatchewan medicare plan, Malcolm Taylor identifies two other “major events giving impetus to the [national] medicare thrust.”⁸⁴ These include: the federal Liberals’ commitment in both the 1962⁸⁵ and 1963 elections to a national medicare plan, and the June 1964 release of the *Report of the Royal Commission on Health Services*.

Indeed, the Report, chaired by the Hon. Emmett Hall (who was appointed by Prime Minister Diefenbaker) is often cited as the “inspiration for Canadian health insurance policy.”⁸⁶ The Hall Report finds that a federally funded medical insurance program is necessary, because of “the growing awareness of the cost to society as a whole of the failure to be concerned and to act on behalf of its members.”⁸⁷ The report also refers to the national “Sickness Survey of 1951,” which showed the “appalling cost to Canada of ill-health, proving that the family and the nation pay heavily in terms of lost production for failure to make available to all Canadian citizens the standard of health service we know how to provide.”⁸⁸ Here, the Hall report highlights the “costs” to society of illness, and thus implies that in order to increase our nation’s prosperity as a whole, public health insurance (that goes beyond only hospital services) is necessary.

⁸⁴ Malcolm G. Taylor, “Health Insurance: The Roller-Coaster in Federal-Provincial Relations,” *Federalism and Political Community*. Eds. David P. Shugarman and Reg Whitaker. Peterborough: Broadview Press, 1989. 73-92. p. 79.

⁸⁵ Former Saskatchewan premier Tommy Douglas was the new federal NDP leader in this election, and it was he, who made medicare a central issue in the federal election of 1962. Douglas ran in Regina, but was defeated.

⁸⁶ Alan Davidson, “Dynamics without change: Continuity of Canadian health policy,” in *Canadian Public Administration*, Vol. 47 no. 3, Fall 2004. 251-279. p. 257.

⁸⁷ Chief Justice Emmett Hall, *Royal Commission on Health Services*. (1964-65) Volume 1, p.5.

⁸⁸ Hall...Vol. 1, p.5-6.

In other words, Hall believed that Canadians should share the burden of health care with their fellow citizens, but not because of a fundamental sense which dictates that we should accord dignity to all by way of equal access to required social services, such as health care. Instead, the reasons offered by Hall are more practical and tied to an economic justification; the claim was that a public health scheme would increase the overall productivity of the nation. Moreover, the report tells us that “the well-being and happiness of society is simply the sum total of the well-being and happiness of its individual members.”⁸⁹ So, Hall’s economic rationale relies on a utilitarian argument, where we are presumed to be able to add up individual “happineses” to demonstrate the overall happiness of a given society; the implication is that *more overall* is always better for the individual in society—this might be viewed as a sort of “trickle-down” equality, rather than a “from-the-ground-up” version.

But this line of reasoning has been shown elsewhere to be insufficient to ensure the equality of individuals in a society.⁹⁰ It is insufficient, so the argument goes, because utilitarianism can allow for the exploitation of some individuals in a society, if it means that others can gain “units of utility” by doing so, thus giving the society an *overall higher* number of “units of utility,” than it would have if everyone were given their “fair share.”⁹¹ For example, slavery in the pre-Civil War southern U.S. contributed to significant economic gains (or *units of utility*) for the overall society, but that society can hardly be seen as egalitarian. Therefore, those that advocate a liberal egalitarian society would reject the utilitarian paramount goal of working towards simply a higher *overall* sense of the “well-being and happiness of society.” Instead, they would argue for a “fair shares” sense of well-being.

⁸⁹ Hall...Vol. 1, p.4.

⁹⁰ Certainly John Rawls’s *A Theory of Justice* (Cambridge: Harvard University Press, 1971) can be seen as an argument that rejects utilitarian principles, in favour of his “two principle” approach to justice as fairness. Also, for a summary of these arguments and another refutation of utilitarianism see Will Kymlicka, *Contemporary Political Philosophy: An Introduction*. New York: Oxford University Press, 1990.

⁹¹ Will Kymlicka, *Contemporary Political Philosophy: An Introduction*. New York: Oxford University Press, 1990.

They would argue that citizens should be treated first with respect as *individuals*, and therefore be accorded an equal sense of dignity by others in the same community. And this translates into some minimum standard of living in that society. Again, this is where Marshall would claim that citizens are entitled to a “kind of basic human equality associated the concept of full membership of a community.”⁹²

On this argument, we can see that happiness or the “good life” is not just a sum total sort of game; it must be balanced with some appropriate minimum share for individuals, so that all have reasonable access to a share in the good life that that society can offer. This is once again the point that both Marshall and Rawls laboured to explain as a theory of social citizenship (Marshall) or justice (Rawls). For both theorists, equality was a more important goal than the overall economic success of society, but they also did not see the two goals as conflictual, since their theories rely on the idea that a move to a redistribution of wealth could provide the necessary foundation for social inclusion of all citizens, while allowing unequal incomes to be earned. Providing citizens with the minimum means to participate in the economy makes good economic policy, as well as social policy.

Having said all of that, it may not be fair to accuse the Hall Commission of what it did *not* do—that is, for not rooting its analysis in a full enough moral account of society, and for not explaining more carefully why society should choose to protect the social conditions of its members—especially given the time frame in which it was written, and the fact that it was not *intended* to be a philosophical investigation. Nonetheless, if we are to consider the Hall Report as a foundation for national health care citizenship, it is meaningful that the Hall Commission based its findings primarily on economic arguments, rather than on a full

⁹² Marshall...p. 6.

account of the meaning of Canadian citizenship, or even some universally agreed-upon values on which to base a national medicare program.

It is also relevant that the Hall Commission, which was set up by the federal government at the insistence of the Canadian Medical Association found that the major health care issues at the time were “underfunding and underservicing.”⁹³ This conclusion and many of the other (200) recommendations of the Hall Commission were “closely aligned with the beliefs and interests of the medical profession, regarding the significance, place and nature of the practice of medicine.”⁹⁴ And at the time, the most immediate way of improving health was to improve access for all Canadians to a broad range of basic medical services. So, the Report followed the advice of the medical profession and advised government support to increase the funding of the medical profession, thereby increasing the services accessible by Canadians. At the same time however, this idea “institutionalized policy beliefs regarding the link of medical services to health....”⁹⁵

Therefore it would seem that the Hall Report as a foundational document in the creation of health care only provides support for a limited set of *legitimate expectations*. From an historical perspective, it only provides an *instrumental* economic argument for extending the provision of basic health care services (access to doctors and hospitals) to all Canadians. Moreover, this argument is more closely associated with the interests of the medical profession, than with Canadians as a community. So while the Hall Report helped create the enduring “doctors-and-hospitals-fee-for-service” model that we know as medicare, it did not draw upon a national struggle for this right nor upon a clear set of community based values in the way that the Saskatchewan model did. Ultimately, the Hall Commission reached the

⁹³ Davidson...p. 258.

⁹⁴ Ibid.

⁹⁵ Ibid., p. 260.

conclusion that the federal government should implement a cost-sharing arrangement with the provinces to facilitate the implementation of a national medical care system that would include payments for (private practice) physicians, in addition to in-hospital treatments.

3.4 The Transition to a National Medicare Program

The conclusions of the Hall Commission in 1964 were hardly a surprise to either the federal government or any others waiting for the report. Indeed, Saskatchewan's 1947 public hospital insurance plan and its 1962 extension to physicians' services were so successful with the general public (despite the short-term "crisis" and controversy of the doctors' strike) that the federal government became convinced that a national health insurance plan would be viable.⁹⁶ Furthermore, a 558-page report issued in December 1942, by the federally-appointed Heagerty Committee had also completed an ambitious study that had consulted with the CMA, five other health professions and nine consumer groups. In due course, it also recommended a public health insurance plan, which would call for great federal involvement in the provinces' administration of the program.⁹⁷ In fact, the report even outlined two draft bills that "proposed the most extensive intervention into provincial law-making and autonomy in Canadian Confederation history."⁹⁸ How the provinces would have reacted to that legislation will never be known, since criticism by the federal finance department and a change of the ministers involved stalled the implementation of the draft bills. Soon enough the whole strategy of imposing extensive health care legislation on the provinces was shelved.⁹⁹

⁹⁶ Katherine Fierlbeck, "Canadian Health Reform and Decentralization," in Eds. Christa Altenstetter and James Bjorkman. Health Policy Reform, National Variations and Globalization. London: Macmillan, 1997. 17-38. p. 20.

⁹⁷ Malcolm G. Taylor, "Health Insurance: The Roller-Coaster in Federal-Provincial Relations," Federalism and Political Community. Eds. David P. Shugarman and Reg Whitaker. Peterborough: Broadview Press, 1989. 73-92. p. 75.

⁹⁸ Malcolm G. Taylor, "Health Insurance: The Roller-Coaster in Federal-Provincial Relations," ... p. 74.

⁹⁹ Taylor (1989)...p. 74.

The subject stayed on the shelf until the end of the war prompted a "Dominion-Provincial Conference on Post-War Reconstruction" in 1945, when a number of health schemes were proposed within the range of social programs offered in the so-called "Green Book Proposals." One of the reasons for implementing such social services as health care as cited by in these federal government proposals was "less tangible perhaps, but in some ways most important of all, [that these services] would make a vital contribution to the development of our concept of Canadian citizenship and to the forging of lasting bonds of Canadian unity."¹⁰⁰ But the conference collapsed in 1946 without any fundamental agreement between the federal and provincial governments. So, national health care was to arrive in a more piecemeal fashion. In 1948 the federal government offered grants to the provinces to build hospitals; and then, in 1957 the *Hospital Insurance and Diagnostic Services Act* (*HIDSA*) was passed unanimously by Parliament, marking the real beginning of the federal government's involvement in the health care insurance field.¹⁰¹

The program also marked an increase in the complexity of intergovernmental relations, now that provinces would have to meet federal conditions to obtain funds required for a program, in which it was difficult to forecast associated costs. *HIDSA* stipulated that any province that offered a hospital services insurance plan, which met the federal conditions of universality and comprehensiveness, would receive 50% coverage of the programs' costs.¹⁰² So, in a sense, by this point the environment was ripe (some might say *over-ripe*) for a national health care plan to finally emerge.

¹⁰⁰ Dominion-Provincial Conference on Reconstruction, Proposals of the Government of Canada. (Book II) Ottawa: King's Printer, 1945. p. 28.

¹⁰¹ Duane Adams, "Canadian Federalism and the Development of National Health Goals and Objectives," in Ed. Duane Adams. Federalism, Democracy and Health Policy in Canada. Montreal and Kingston: McGill-Queen's University Press, 2001. p. 71.

¹⁰² Davidson...p. 255.

At the 1965 Federal-Provincial Conference, which was set up to discuss a medicare strategy for the country, Prime Minister Pearson tried to set a new tone of cooperation, when he stated, "This proposal does not require detailed agreements [as the *HIDSA* program had] governing the Medicare plan. It calls only for a general Federal-Provincial *understanding* as to the nature of the health programs...."¹⁰³ And yet when the plan finally emerged in the form of the 1966 *Medical Care Insurance Act*, the federal government had taken the same approach it had with *HIDSA*: it offered the provinces 50% of the costs of carrying out this type of plan, which now covered doctors' fees, in addition to medically necessary hospital services, providing they met a few conditions. That is, the legislation tacked on two more "principles" to the two conditions that already existed under *HIDSA*. Now, in order to get the 50% cost-shared coverage, the provinces would have to comply with four principles of medicare that were established with the implementation of the new Act: *universality* (which meant that everyone had to be covered by the plan); *comprehensiveness* (all medically necessary services had to be covered by the plan); *portability* (citizens should not to be denied coverage when leaving their province or moving between provinces); and the plan was to be *publicly administered*.¹⁰⁴

There is some uncertainty about whether or not the *Medical Care Insurance Act* includes a "fifth principle"—accessibility—since it also stated that "reasonable access to insured services by insured persons" had to be maintained, but no formal principle of "accessibility" was articulated at the 1965 conference.¹⁰⁵ Nonetheless, at minimum, the four principles created an outline of conditions for the provinces to meet, in order to secure federal funding for health care services. So, although the Prime Minister had said he planned to "proceed by

¹⁰³ Malcolm G. Taylor, "Health Insurance: The Roller-Coaster in Federal-Provincial Relations," ... p. 80.

¹⁰⁴ Davidson...p. 255.

¹⁰⁵ Keith Banting and Robin Boadway, "Defining the Sharing Community: The Federal Role in Health Care," in Eds. Harvey Lazar and France St-Hilaire. *Money, Politics and Health Care*. Montreal: IRPP, 2004. p. 9.

another route” based on a more general, mutual “understanding” between the federal government and the provinces, medicare was indeed “a conditional program like the others.”¹⁰⁶

To be sure, conditions and federal-provincial relations continued to play a significant role after the federal *Medical Care Insurance Act* was passed. From the beginning, not all provinces were eager to sign on to this compassionate national idea once it was finally legislated. The conservative governments of Alberta, British Columbia and Ontario were very committed to the idea of *private* health insurance at the time.¹⁰⁷ Ontario’s Premier Robarts called medicare “a Machiavellian scheme...that was one of the greatest frauds that has ever been perpetrated on the people of this country.”¹⁰⁸ Alberta initially opposed the program, because it felt that the conditional principles would restrict freedom of choice for its citizens, as well as remove the financial responsibility for health care from individuals.¹⁰⁹ Alberta’s long-serving health minister even resigned his position in protest. Quebec also protested the move, because it felt that the federal program would impose on the province’s autonomy, but the need for the federal funding eventually convinced Quebec to sign on in 1970. And although BC, Alberta and Ontario initially opted out of the program, continuing to rely on the private health insurance industry for awhile, they all did eventually sign on to the federal cost-sharing program by 1971, joining the rest of the provinces, in what has come to be considered the “national” program of medicare.¹¹⁰

¹⁰⁶ Taylor (1989)...p. 82.

¹⁰⁷ Banting and Boadway...p. 9.

¹⁰⁸ Banting and Boadway...p. 9, as quoted in Malcolm G. Taylor, *Health Insurance and Canadian Public Policy: The Seven Decisions that Created the Canadian Health Insurance System and Their Outcomes*. Toronto: Institute of Public Administration of Canada, 1987, p. 375.

¹⁰⁹ Adams...p. 73.

¹¹⁰ Banting and Boadway...p. 9.

IV Ottawa's Wavering Commitment to National Medicare

Cost-sharing on a 50/50 basis was thus the arrangement that ushered in a national approach to medicare. But it did not last long. By the mid-1970s, the federal government was becoming nervous about its open-ended 50/50 cost commitment, in light of rising provincial health costs, the state of the economy, and its lack of ability to control the provinces' spending.¹¹¹ The provinces were also uncomfortable with a number of the particular conditions that outlined which aspects of the health care system qualified for cost-sharing and which did not.¹¹² Subsequently, as a result of extensive federal-provincial negotiations, the *Established Programs Financing Act* (EPF) was passed in 1977 under Prime Minister Trudeau. The EPF created a single block fund for all federal transfers for medicare, hospital insurance and postsecondary education. "Tax room" of 13.5 points (combined income tax and corporate tax) was vacated to the provinces by the federal government to approximate half the cost of the transfers; and the other half was transferred as cash to the provinces. The annual cash block transfer was then tied to a growth rate of increases in per capita GNP.¹¹³

This change effectively removed the federal government from direct cost-sharing responsibility for health care services across the country, which also meant that the provinces were fully at risk for any cost increases. Yet it also gave them an incentive to attempt to control health spending, since transfers now would *not* be reduced if their spending went down. Most of the provinces thought that they were getting a good deal, until the harsh recession of the early 1980s prompted the federal government to begin a trend of cutting back its cash transfers (by reducing the growth rate in the EPF formula) to the

¹¹¹ Adams... p. 75.

¹¹² Banting and Boadway...p. 12 and Adams...p. 75.

¹¹³ Malcolm G. Taylor, "Health Insurance: The Roller-Coaster in Federal-Provincial Relations," ...p. 83.

provinces as budget deficits rose.¹¹⁴ By 1986, the EPF formula had been reduced to GNP *minus* two percent.¹¹⁵ This was no longer the deal that the provinces had envisioned.

Also by the mid-1980s, small pockets of extra-billing by physicians had cropped up in BC and Ontario. At the time, government fees to physicians were not being increased by the provinces, despite demands by doctors, since the provinces had to deal with their own health budgets at a time of decreasing contributions on the part of the federal government. Moreover, the provinces were also facing budget deficits as a result of the economic recession. Then, in response to these pockets of extra-billing, on the basis that such practices were considered to be a potential barrier to “reasonable access” to insured services and given that the issue was becoming increasingly controversial in the media, the federal government stepped in and unilaterally passed the *Canada Health Act* (CHA) (1984).

The CHA was a consolidation of existing legislation that also made explicit the previously ambiguous understanding of the principle of “accessibility.” That is, the Act strictly made user fees, “facility fees” or any extra charges (for any insured health care service) to a patient by a physician or clinic illegal. (Physicians may opt out entirely from the public system and then charge patients privately for their services, but they cannot do so if they want to bill provincial health plans for insured services to patients.) And while the CHA did not really change or expand the health insurance program in any significant way, as a *political* move, it secured the position of the federal government as the caretaker of the health care system in the minds of the public.

Given the difficult fiscal position of the provincial governments at the time, this move by the federal government to expand their moral authority, while they were “continually shaving

¹¹⁴ Adams...p. 75-76.

¹¹⁵ Banting and Boadway...p. 12.

their sharing with the provinces” was nothing less than a major insult to the provinces.¹¹⁶ Former Deputy Minister of Health for Saskatchewan (and long-time federal public servant) Duane Adams has commented: “this arrogant act did provoke much intergovernmental conflict that has lasted for a generation.”¹¹⁷ Indeed, *all* of the provinces opposed the CHA, and it became “a symbol of federal unilateralism.”¹¹⁸

Other scholars have characterized the tense relationship between the federal and provincial governments in the 1980s as a “faltering of cooperative federalism,”¹¹⁹ exemplified by the provinces’ bitter complaints about the reduction in federal transfers. Newfoundland Finance Minister Hubert Kitchen complained in 1992 that “asking for more money [from Ottawa] is like getting blood from a turnip.”¹²⁰ The reductions that began with the EPF continued with the introduction of the 1995 Canada Health and Social Transfer (CHST) arrangements.¹²¹ The CHST (the new combined block of funding for health, welfare and post-secondary education) replaced the EPF, and further reduced the federal cash transfers to the provinces. Starting in 1996-97, cash transfers to the provinces were cut by more than \$4 billion from the fiscal year prior and by over \$6 billion in 1997-98.¹²²

Although there is disagreement between the provinces and Ottawa about how much federal transfers have declined since the late 1970s (the value of the initial tax point transfer is disputed between the two levels of government), there is no denying that the reductions

¹¹⁶ Tom Kent, “Paul Martin’s Sugar-Daddy Federalism, Donating to a Favoured Cause—Health Care.” *Policy Options*, November 2004. 29-34. p. 32.

¹¹⁷ Adams...p. 77.

¹¹⁸ Banting and Boadway...p. 15.

¹¹⁹ Kent...p. 31.

¹²⁰ As cited by Katherine Fierlbeck, “Canadian Health Care Reform and Decentralization,” in Eds. Christa Altenstetter and James Bjorkman. *Health Policy Reform, National Variations and Globalization*. London: Macmillan, 1997. 17-38. p.17.

¹²¹ Antonia Maioni, “Federalism and Health Care in Canada,” in Keith Banting and Stan Corbett Eds. *Health Policy and Federalism: A Comparative Perspective on Multi-Level Governance*. Montreal: McGill-Queen’s University Press, 2002, p. 195.

¹²² Adams...p. 78.

were significant as a share of overall provincial health expenditures, especially after the creation of the CHST. Keith Banting explains that for the period 1977-2000, the federal government estimates that the overall decline in transfers to the provinces was approximately *one-third* of provincial health expenditures, whereas the provinces see the federal government as having withdrawn about *one-half* of its original commitment (that is, a steady move from contributing to 25% of provincial health costs in 1977 to contributing about 13% in 2000).¹²³

At any rate, the original commitment to an equal cost (at 50%) and risk-sharing arrangement has clearly been altered by the federal government. Ironically, Ottawa has seen fit to expand its moral authority in the provincial jurisdiction of health care (via the CHA), while simultaneously reducing its contribution to the health care realm. Antonia Maioni logically argues that, in the health care policy realm, because the federal government has failed to shoulder the “lion’s share of [the] financial and administrative burden... [its] fiscal and symbolic role... [and its] binding function may be unravelling.”¹²⁴

Certainly, at minimum, it is logical to question the federal government’s role in maintaining a *national* universal public health care system, in light of its wavering commitment to the transfer of necessary funds to the provinces for the delivery of health care services over the past 30 years. If we only look back as far as the early 1990s, we can see that citizens’ expectations collided with the agenda of the *then-new* federal Liberal government, under the direction of Prime Minister Chrétien and his Finance Minister Paul Martin, who made the elimination of the annual deficit a federal priority from 1993 onwards. This agenda meant significant cutbacks to the provinces in their annual transfers for social

¹²³ Banting and Boadway...p.16.

¹²⁴ Maioni...p. 197.

services, including health care, with the creation of the CHST. Consequently, the debate has grown more intense, as public expectations of the health care system seem to go unmet, in the wake of a decade of cuts in social transfers, which has created a backlog of waitlists for surgical and diagnostic procedures.¹²⁵

So, if we return to the issue of Canadians' rising expectations of the health care system, one could argue that expectations have not actually increased as much as it appears. Rather it may be the case that previous federal budget cuts in social transfers to the provinces, led to health care and other social services cuts (or at least a *lack of increases* where both demographics and increasing technology and pharmaceutical costs may have warranted them). These cuts have meant that *static* expectations are going unfulfilled in many instances, which in turn has led to *louder and more frequent* public demands and media attention to the issue of an "ailing" health care system. Thus it would seem that the health care system *per se* is not "ailing" or "in crisis," but rather that the promise by the federal government to support the national program was broken relatively shortly after it was made.

Even the recent cash injections to health care (and the "10-year federal commitment to fix the health care system") by the currently surplus-rich Paul Martin minority government has been aptly called "sugar-daddy federalism."¹²⁶ The implication here is that the causes to which Ottawa contributes are subject to the personal (and politically fickle) discretion of the Prime Minister; and health care only happens to be a current "favoured cause" of Prime Minister Paul Martin. But as we know, in 1995, when he was finance minister, the

¹²⁵ Robert Evans, "Political Wolves and Economic Sheep: The Sustainability of Public Health Insurance in Canada." CHSPR, Working Paper, December 2003.

¹²⁶ Tom Kent, "Paul Martin's Sugar-Daddy Federalism, Donating to a Favoured Cause—Health Care." *Policy Options*, November 2004. 29-34.

paramount goal of the elimination of the federal budget deficit, took priority over social transfers to the provinces.

Of course, the argument that economic considerations at that time warranted just such a strategy is plausible; but on the other hand, it is also the case that it is precisely at times of economic downturn that citizens (and the provinces with their lower tax-raising capabilities) rely on the national government to fulfill those entitlements that we view as rights of citizenship. Ergo, the federal government's unsteady fiscal commitment to a "national" vision of medicare plainly demonstrates that any particular level of health care provision is only an ideal or a "promise" of social citizenship that cannot be guaranteed. These commitments are, as they have always been, subject to the direction of the government of the day and its short-term economic (and of course political) strategies.

Our "legitimate expectations" of the state cannot be taken for granted. Like other rights, they are only assured, so long as our ability and interest in defending them is maintained. Our expectations of public health care services will only be met, if they can be translated into clear political priorities, with attendant consequences should they not be met. Indeed, a key part of the "original medicare idea" embedded in the federal *Medical Care Insurance Act* was a conditional promise that was broken; and for the moment, it appears to be on the mend, given that it is in the political interests and within the economic means for the Prime Minister to make a new fiscal commitment to health care. However the premiers would be justified in remaining sceptical.

So far this thesis has discussed T.H. Marshall's theory of social citizenship, and offered specifically his notion of "legitimate expectations" in the context of achieving equality as a means to tie Canada's universal, publicly-funded health care system to a right of social

citizenship. It has also briefly introduced the context of the current health care debate, which further refined the focus of the study to two questions: what are our legitimate expectations, when it comes to health care? And what is the original medicare idea that we are trying to save? From there, the thesis attempted to make three claims: *first*, that the “birth” of the medicare model in Saskatchewan was embedded in the province’s spirit of community and collective responsibility, which overcame the vigorous opposition of the medical community; *second*, that the transition to a “national” program of medicare was less rooted in any clear values of a national citizenry, and instead was more of a timely policy solution to the instrumental, economic problem of too few citizens having access to basic health care services; and *third*, that the federal government’s commitment to medicare, such as it was—a 50/50 cost-sharing conditional arrangement—has proven to be unreliable, and moreover shows that a social right of health care, which is always subject to fiscal arrangements, cannot be practically guaranteed.

Now, before we turn to look at the health care reform reports in light of the above context, it is necessary to touch briefly on the “sustainability” issue that lies at the heart of the health care reform debate and thus within the reports as well. Most provincial governments (and especially those of BC, Alberta and Ontario) have claimed in recent years that Canada’s health care system is “unsustainable.” The reasons given are multiple and intertwined, and go beyond just a complaint that the system is unsustainable in light of shrinking federal transfers. The “unsustainability” argument rests primarily on the allegation that health care spending is rising uncontrollably, for any number of stated reasons, including rising technology and pharmaceutical costs, as well as a variety of claims about the ageing population.

4.1 The Question of Sustainability

It is the “unsustainability” argument, in conjunction with the effects of the fiscal austerity of both levels of government triggered by the combination of two economic recessions (early 1980s and again in the early 1990s) and the supposed political unpopularity of tax increases, that spurred provinces to take on the struggle to contain costs in the health sector. A variety of reforms were undertaken across the provinces, such as “de-listing” some previously insured services (like optometry and physiotherapy) and the straight-up closure of long-term hospital and mental health beds. And all the provinces, in the early 1990s, except Ontario, regionalized their health delivery systems, in the hopes of achieving the twin goals of cost efficiency and effectiveness.¹²⁷

On the regionalization strategy, there is little evidence yet to show that regionalization has delivered improved efficiency or effectiveness in the health services.¹²⁸ And from the still continuing public debate about waitlists (and longer *wait times*), it appears obvious that health care budgets (and services) may have been cut or frozen, but we know little about whether or not the health care system has become more efficient as a result of budget cuts. In the meantime, provincial governments continue to claim that health care costs are spiralling out of control and that the current health care system is “unsustainable” without increases in federal transfers and/or significant reforms. Provincial health ministers frequently claim that without making the system more “efficient,” “crowding out” of other programs will have to occur, since health care is continuing to take an increasingly large bite out of provincial budgets.

¹²⁷ Jonathan Lomas, “The Evolution of Devolution: What does the Community Want?” Eds. Daniel Drache and Terry Sullivan. Health Reform: Public Success, Private Failure. New York: Routledge, 1999.

¹²⁸ Steven Lewis and Denise Kouri, “Regionalization: Making Sense of the Canadian Experience.” In Healthcare Papers: New Models for the New Healthcare. Vol. 5 No. 1. Toronto: Longwoods Publishing, 2004. 12-31.

Furthermore, provincial affiliates of the Canadian Medical Association in BC, Alberta and Ontario (as well as the national organization of the CMA) claim that we need to open up the private market for health services, since the cuts to public funding are making the principles of the *Canada Health Act* “unsustainable.”¹²⁹ Here, it seems that we are being asked as Canadian citizens to lower our “legitimate expectations” of state-provided health care because they are simply not sustainable.

But are health care costs, and thus provincial health spending rising uncontrollably? On both fronts, health economist Robert Evans does not think so.¹³⁰ Evans points out that the supposed health care spending increase in the early 1980s was largely a “denominator effect.”¹³¹ In other words, public health spending remained static, but national income fell. And in the early 1990s, “public expenditures [across Canada] were frozen or cut across the board after 1992, including for the first time actual cuts in hospital spending. By 1997 hospitals and physicians’ services were absorbing the same share of GDP as they had in 1971.”¹³²

So, health spending is *not* rising unsustainably. Still, Evans admits that looking only at GDP is something of an abstraction for provincial treasurers trying to balance the books. So, he also investigates provincial health spending as a total of all program spending, and here he finds that indeed health spending (by all provinces) rose from 34.8% in 1995/96 to 41.1% in 2001/02.¹³³ And although this appears to back up the claim by health ministers (and premiers) that health spending is rising rapidly and therefore crowding out other areas of

¹²⁹ Maioni...p. 187.

¹³⁰ Robert Evans, “Political Wolves and Economic Sheep: The Sustainability of Public Health Insurance in Canada.” CHSPR, Working Paper, December 2003.

¹³¹ Evans...p. 6.

¹³² Ibid., p. 6-7.

¹³³ Evans...p. 9.

public spending, Evans offers another perspective after examining the spending trends in provinces over the time period from 1980 to 2002.

In doing so, he finds that aggregate provincial health spending *does not* show an upward trend over this period, and he also finds that provincial spending in other program areas was, in fact, cut back steadily from 11-12% in 1995/96 to 9% in 2001/02.¹³⁴ Therefore, it is only by comparison that health spending *seems* to be crowding out other program spending; health spending has, in fact, remained more or less constant. This is not to say that the cost of, and spending on, pharmaceuticals has not risen significantly; in fact, drug costs now take up a higher share of national health care spending than does the reimbursement of doctors.¹³⁵ At the same time, national spending on hospitals has been declining steadily since the late 1970s. So waitlists for surgical and diagnostic procedures are not necessarily indicators of an increasing “unsustainability” of the Canadian health care system, they may just be indicators of a long-term plan to move funds from one area of the health care system to another, without proper consideration of a way to accommodate the short-term procedural requirements. Indeed this may be a case where an investment of funds in reform was needed, instead of a spending freeze. But again the need for investment is not necessarily a sign of “unsustainability.”

The fact that overall spending on health has remained somewhat constant however does not mean that “crowding out” of other important areas cannot still occur. For example, if government revenues decline (via tax cuts) and political pressure to maintain health care spending at, at least, current levels remains, then naturally other program areas would have

¹³⁴ Evans... p. 10.

¹³⁵ Maioni...p. 181.

to incur cuts. Again, this move would make it seem as if health spending were increasing as a percentage of public spending, when, in fact that would not be the case.¹³⁶

Moreover, when it comes to the issue of sustainability, Evans points out that when compared to other systems which allow more private sector funding and delivery of health care services (using the U.S. as an example), costs are more easily contained in Canada's publicly funded system, because

single-payer public financing creates an institutional environment encouraging the supply of ingenuity to contain costs; costs are higher in multi-source funding systems where ingenuity is diverted into shifting costs onto someone else.¹³⁷

Yale Professor of Public Policy Ted Marmor concurs. Marmor argues that the Canadian mode of cost control, via the public system—"monopsonistic power"—is an example of a "more general pattern" of successful cost control against medical inflation across the OECD states, whereas "American claims about cost control through competition is speculative."¹³⁸

The point here is not necessarily to argue that the universal public system of health care is better or more efficient than a more fragmented system of private and public funding (although it certainly seems to be). Rather this discussion is meant only to demonstrate that it is not sufficient for a government to argue that our current health care system is "unsustainable," given the current economy, nor can it argue that any particular spending cut or a move to shift publicly provided services to the private sector is necessary simply because of the inherent "unsustainability" of health care. Therefore the argument that the public health care system is in "crisis" or "unsustainable" is not only misleading, it is false. To be sure, if we consider the government cutbacks to program spending throughout the 1990s, we could say that the provinces actually "sustained" a higher commitment to medicare in the

¹³⁶ Evans...p. 10.

¹³⁷ Ibid., p. 6.

¹³⁸ Ted Marmor, "The Rage for Reform," in Eds. Daniel Drache and Terry Sullivan, Health Reform: Public Success, Private Failure. New York: Routledge, 1999. 260-272. p. 268.

1970s, than it actually does today: thus it is not the health care system *per se* that is becoming unsustainable, but the moral commitment to a publicly-funded system that appears to be hard to sustain. This seems especially difficult, given the “alarmist media coverage [of the health care system that] has fuelled a crisis in public confidence.”¹³⁹ This persistent “crisis” lens through which we see health care covered in the media lends support to those who claim that public health care is unsustainable. Whereas, sustainability questions in public policy require a fuller context to explain *what good is being restricted, given a choice of goods, who is paying for them and who benefits*, in order to be more clearly considered. Put another way, sustainability in the public realm is not a question of objectively “running out” of any good or resource; it is a question about the choices the government makes *between goods*. In short, we have to ask: just what is it we are trying to sustain?

And the health care debate, which fundamentally is about competing conceptions of the good, is only muddled by the misleading, but enduring “unsustainability” argument. It is not likely that those who argue for more private sector involvement in health care do so because they necessarily believe that the public health care system is unsustainable, rather it is that those who support private sector involvement are more likely to be convinced by the sustainability argument, because it “fits” with their beliefs about the role of the state in providing services, such as health care. Accordingly, health care spending in the context of public accounts is much more complex than the usual “unsustainability” argument suggests. Of course, it is precisely the complexity of the health care system (and possibly the temporary respite from having to *implement* any policy changes) that encourages governments to turn over questions about our legitimate expectations to “panels of experts” and appointed commissions to decide.

¹³⁹ Keike G.H. Okma, “What is the Best Public-Private Model for Canadian Health Care?” in Policy Matters. May 2002, Vol. 3, no.6, 33-48. p. 46.

V. National Visions of the Right to Health Care

5.1 The Romanow Report: Canadians are Committed to Medicare, *Really*.

Canadians view medicare as a moral enterprise, not a business venture.¹⁴⁰

In April 2001, amidst ongoing public perceptions of a looming “health care crisis,” Prime Minister Jean Chrétien initiated the Commission on the Future of Health Care in Canada and appointed former Saskatchewan premier Roy Romanow as Commissioner. The final report of the Commission, issued in November 2002, explains that Romanow’s mandate was to “review medicare, engage Canadians in a national dialogue on its future, and to make recommendations to enhance the system’s quality and sustainability.”¹⁴¹ Underlying the analysis of the final report, Building on Values: The Future of Health Care in Canada is one general and unsurprising conclusion: that “medicare is sustainable if the health care system is prepared to change.”¹⁴² And clearly, Romanow’s focus is on preserving the value-rooted, traditional vision of the publicly-funded, universal and publicly administered “medicare,” which requires, according to the report, some necessary alterations to the *health care system*.

The key idea underlying the report is the fact that the Commission believes that maintaining medicare is to be considered an end in itself. The idea of possibly dismantling medicare, in favour of another method of paying for or delivering health care services is not seriously considered. This is so, because, as the report explains, medicare is rooted in the values of Canadian citizens—it is a part of what makes us Canadian. Thus, the Romanow Report offers its strongest message: a firm commitment to what might be called an “original

¹⁴⁰ Roy J. Romanow, Building on Values: The Future of Health Care in Canada, p.xx.

¹⁴¹ Ibid. p. xv.

¹⁴² Romanow...p. 45.

vision of medicare,” which is rooted in an even deeper commitment to the Canadian “core values of equity, fairness and solidarity.”¹⁴³

It is this foundation of values from which Romanow claims medicare is a right of Canadian citizenship. And Romanow may be justified in claiming that he knows the values of ordinary Canadians, since the Commission took its mandate on citizen consultation seriously. It reviewed formal submissions from health care provider and other stakeholder organizations and over 14,000 pieces of informal correspondence from individual Canadians, as well as participated in 12 regional “deliberative dialogues” between Commission members and randomly selected Canadians.¹⁴⁴ This extensive consultation with “ordinary Canadians” led Romanow to conclude that Canadians “remain deeply attached to the core values at the heart of medicare.”¹⁴⁵ The Report also tells us that these values are “tied to [Canadians] understanding of citizenship.”¹⁴⁶ To be sure, Romanow views both medicare and Canada’s health care system as the natural outgrowth of these values. But he offers 47 recommendations to alter the health care *system*, in order to preserve that original understanding of medicare that proclaims it to be “a public good, a national symbol and a defining aspect of ...citizenship.”¹⁴⁷

The first two major recommendations form the foundation for the remaining, more detailed recommendations, which I will not delve into here as they are more relevant to specific questions about the efficiency of services delivery than to the questions of interest

¹⁴³ Romanow...p.xvi.

¹⁴⁴ From June to December 2001, the Commission held its “Fact Finding” phase, during which it received formal and informal submission from a range of organizations and individual stakeholder. See Romanow, p. 259-270. In addition, the Commission also held “citizens’ dialogue sessions and Canadian Public Affairs Channel (CPAC) aired six public education forums “to encourage informed discussion” from January to March, 2002. Also, 21 public hearings were organized from March to May, 2002 to allow more input from individual Canadians, health care providers, advocacy groups and other stakeholders. See Romanow, p.271-290.

¹⁴⁵ Ibid. p. xv.

¹⁴⁶ Ibid. p. xvi.

¹⁴⁷ Ibid. p. xviii.

here.¹⁴⁸ First, Romanow strongly suggests the establishment of a *Canadian Health Covenant* to “confirm our collective vision.”¹⁴⁹ The idea underpinning the *Covenant* is the Commission’s belief that we need to carefully elucidate our health care entitlements and responsibilities, before we can move on to discuss potential changes to the system. In other words, if we are going to focus on the “sustainability” of the system, we need to first define just *what it is* that we are trying to sustain (or depending on how you see the state of the current health care system, *achieve* in the first place).

Here, Romanow connects his conclusion that Canadians embrace the core values of “equity, fairness and solidarity,” to the medicare principle, which says that all citizens will get the health care they need, without regard to their income or social status. Furthermore, the principles of the *Canada Health Act* (CHA) (1984) have become “more than simple conditions attached to federal funding for medicare. Today, they represent both the values underlying the health care system and the conditions that governments attach to funding a national system of public health care.”¹⁵⁰ And these principles/conditions are “widely valued by Canadians.”¹⁵¹ The report also offers an outline of these “entitlements and responsibilities” in the proposed *Covenant*, which is subject to revision by Canadians and their governments.

Secondly, the Report recommends the creation of a *Health Council of Canada*, which will set up “indicators and benchmarks” for health care system performance-tracking and reporting to citizens.¹⁵² The *Council* is to be made up of 14 members, which will include four representatives of health care providers and other health care experts, three public

¹⁴⁸ Two of the often-cited recommendations of the report are the proposals to expand “homecare” and provide a “catastrophic drug program for all Canadians,” as well as, of course, increased federal funding to health care overall.

¹⁴⁹ Romanow...p. xxiv.

¹⁵⁰ Ibid. p. 60.

¹⁵¹ Ibid. p. 61.

¹⁵² Ibid. p. 61.

representatives and seven government appointees (from the provincial governments).¹⁵³

Beyond trying to lay out a framework for understanding just what health care means to Canadians, both of these recommendations also remind us that health care is a policy area with a *national* image, despite the fact that constitutionally it falls under the jurisdiction of the provinces. Indeed, the *Health Care Covenant* does not specifically discuss the federal and provincial governments at all, rather for the purposes of outlining “responsibilities and entitlements” in the health care arena, it divides the world into individual Canadians, health care providers and just plain *governments*. And while Romanow does not deny provinces’ rights in this area, the proposed *Health Covenant for Canadians* optimistically relies on the overarching national importance of the health care system in order to invoke a sense of cooperation and collaboration between governments.

From here, the proposed *Covenant* focuses on a statement of principles that Canadians, health care providers and governments will presumably agree to adhere to in the shaping of their health care system. These principles include: a promise of “mutual responsibility” of Canadians for their own individual health and their health care system via their “actions and tax dollars...within their means;” and a declaration that “our health care system is a public resource and a precious national asset.”¹⁵⁴ It also makes statements that pledge to maintain equity of access, public input, transparency, accountability, quality, efficiency, effectiveness, a “respectful, ethical system,” and a focus on “patient-centred care.”¹⁵⁵ Accordingly, the list of “responsibilities and entitlements” for individual Canadians, health care providers and governments is extensive in order to accomplish the aforementioned affirmations.

¹⁵³ Romanow... p. 59.

¹⁵⁴ Ibid. p. 50.

¹⁵⁵ Ibid. p. 50-51.

Nevertheless, even though the list is extensive, none of the items is specific with regards to how these responsibilities may be carried out. Moreover, most of them simply appear to be a re-statement of the existing expectations of Canadians vis-à-vis their health care system. Indeed, as the report tells us, the *Health Covenant for Canadians* is about “restoring Canadians’ confidence, reaffirming our collective commitment to medicare, and reflecting Canadians’ values in a clear and compelling statement of our vision and expectations for Canada’s health care system.”¹⁵⁶ Thus, Romanow does not claim to be attempting to introduce any new principles or responsibilities, rather he is trying to re-assert those principles that he believes already exist within the original vision of medicare, which was the natural outgrowth of our Canadian values. This vision of medicare is, on this view, the birthright of all Canadians.

But why does the Commission feel it is necessary to do so? If these are the founding principles of medicare and the Commission believes (after extensive consultation) that Canadians *remain* steadfastly committed to them, what is the point of re-hashing them here, and formulating a detailed oath of commitment to them yet again? The only reason to do so would be if the Commission feels that the commitment of Canadians to these values of (equity, fairness, solidarity and the conditions/principles of the *CHLA*) which are expressed in a common desire to continue funding a universal health care program, are, in fact, *at risk*. If Canadians were as committed to the “national principles” of medicare as Romanow and his Commission seem to believe they are, they would not need to draw up a long list of responsibilities to fulfill and entitlements to claim. This is not a list that outlines and “re-asserts” our commitment as Canadians to universal health care; it is instead a *wish list* of those responsibilities and entitlements that would *ideally* describe such a commitment—and this statement reveals a basic unsteadiness in that supposed connection between Canadians

¹⁵⁶ Romanow... p.52.

and medicare. It also suggests a lack of consensus around a set of legitimate expectations for the health care system.

Nonetheless, this renewed commitment is supposed to be a “new social contract—that reflects our commitment to health care as a vital part of our society.”¹⁵⁷ But under the *Covenant*, the only responsibilities that signal change are those assigned to *governments*, not to citizens. Here, governments have a responsibility to:

- dedicate adequate, stable and predictable funding...
- to work collaboratively with each other and with the public and health care providers
- to regularly review the performance and operation of the health care system and report to the public so that Canadians can make informed decisions and contribute to the system in an informed way
- to ensure that decisions regarding the future direction of our health care system are made with transparency and accountability to all...
- to establish appropriate mechanisms that allow the public and health care providers meaningful input into decisions on the future of our health care system....¹⁵⁸

It would appear that invoking this sense of cooperation and collaboration is also the role of the proposed *Health Council of Canada*. The *Council* is supposed to operate as a solution to the often “dysfunctional” intergovernmental relations by providing “strategic advice to federal, provincial and territorial health ministers....”¹⁵⁹ The hope of the report is that the *Council* will thus serve to “depoliticize” the debate over health care issues.¹⁶⁰ In addition, the emphasis on “transparency and accountability to all,” and the offer to include regular reports on the “performance and operation of the health care system,” seems to demonstrate citizens’ lack of trust in their government when it comes to the delivery of health care.

Thus the proposed *Health Covenant for Canadians* and the formation of a *Health Council of Canada* are an attempt to elevate medicare to the level of an element of citizenship—to put it beyond the reach and debate of politics. So, while the report reveals a sincere effort to assert

¹⁵⁷ Romanow...p.47.

¹⁵⁸ Ibid. p. 51-52.

¹⁵⁹ Ibid. p. 54.

¹⁶⁰ Ibid. p. 47.

an unambiguous Canadian right to health care, it shows instead that even the commitment of Canadians to the “values and CHA principles” of medicare are, in fact, uncertain. In other words, there is no national consensus around our legitimate expectations of our public health care system. Certainly, the Commission would not have spent the money (\$15 Million), time and nearly 400 pages of reporting to tell us repeatedly how committed to the values and their right to health care Canadians are, if in fact that commitment were not somehow in danger. And without that firm commitment to medicare, the Report has concluded that Canadians alone cannot be trusted to hold their governments to account through the usual democratic means—we need a *Health Council* and a *Health Covenant* to fulfill that function.

Romanow further proposes the addition of a sixth principle: “accountability” to the other five principles of the CHA,¹⁶¹ to reinforce the need to have the government step up and report on the health care system, which is supposed to properly reflect the values and the health care vision of Canadians. This theme of a lack of a firm commitment to medicare and the lack of trust that Canadians have in their governments (*and perhaps in each other*) is palpable throughout the report, despite the optimism that Romanow tries to evince with tidy “lists” of values, entitlements and proposed reports designed to show whether or not we are meeting these obligations.

¹⁶¹ Romanow... p. 63.

5.2 The Kirby Report: Fairness with Incentives

Senator Michael Kirby, Chair of the Standing Senate Committee on Social Affairs, Science and Technology delivered the last volume (of six) in the Committee's Report¹⁶² on Canada's health care system in October 2002, just a month before the Romanow Report was released. It did not receive anywhere near the same media coverage, but it was nevertheless read carefully by health policy activists and various stakeholder groups. It was certainly more controversial than the Romanow Report, once health care policy activists pointed out that Senator Kirby also serves on the board of directors of a private health services company, *Extendicare* (Canada) Incorporated, and that he holds stock options in the company which are worth approximately \$1 Million.¹⁶³ However, the Report itself still warrants review, albeit with heightened skepticism, since Senator Kirby's impartiality (especially with respect to the debated issue about the relative "efficiency" of public versus private sector delivery of health care services) may be in question.

To begin, the Report states in a similar spirit to that of the Romanow Report, by reminding us that Canadians "cherish their public health care insurance plan for what it is, and for the values it represents: shared risk, compassion, fairness and common responsibility."¹⁶⁴ However, Kirby does not claim that medicare is a right of citizenship; in fact, the Report states clearly that on the question of a right to health care, there is "no explicit or implicit right to health care" in the CHA or in the *Charter*, but the Report does say that an argument *could* be made and recognized by the courts under section 7 (right to life) of

¹⁶² Standing Senate Committee on Social Affairs, Science and Technology. The Health of Canadians—The Federal Role. (Volumes 1-6). Ottawa: Senate of Canada, 2002. I will refer to this as "The Kirby Report" or just "Kirby" for ease of citation.

¹⁶³ Glen McGregor, "Senate needs ethics referee to investigate Kirby: Critics" The Ottawa Citizen, September 11, 2004. p. A4.

¹⁶⁴ Kirby... Vol. 1, p. 45.

the *Charter* that there is an implicit right to health care.¹⁶⁵ Interestingly, however, the Report also goes on to ask, “Is it fair to deny someone, who could afford to purchase a health service, the right to make such a purchase?”¹⁶⁶

So, here we see the focus of “rights” language in the report shift from that of considering an “entitlement” (or a positive right of “social citizenship”) to that of a (negative) *freedom from* the state’s interference with a “consumer purchase” in the marketplace. And since the Committee accepts the notion that Canadians do not possess a clear right to health care (or at least not yet), its framework of analysis is free to consider how to make health care work better using market principles, rather than by trying to construct health care reform options from a foundation rooted in “Canadian values” or citizenship, which was the approach used by the Romanow Commission.

That is not to say that the Kirby Committee does not recognize the values that are at play in any attempt to reform medicare; it does recognize those values, but it just does not see them as holding much in the way of *foundational significance* in the development and meaning of Canadian medicare. Rather Kirby only acknowledges those Canadian values of “shared risk, compassion, fairness and common responsibility” as the by-products of an insurance plan that has been around for a long while, and thus Canadians have naturally become attached to it. As the Report points out, health care is seen in Canada as “very much a public good, in spite of the fact that more than 30% of total health care costs are paid out of private funds.”¹⁶⁷ The Committee seems to be trying to use this fact to support the idea that if 30% of health care services are paid for privately now, why not open up the system to a bit more private funding?

¹⁶⁵ Kirby... Vol. 4, p. 38.

¹⁶⁶ Kirby... Vol. 4, p. 40.

¹⁶⁷ Kirby... Vol. 4, p. 137.

The Kirby Committee also considers the “original vision of medicare” to be the result of a much more instrumental beginning, rather than the natural outgrowth of Canadian core values, as Romanow found. Of course, the Committee may be right on that point, when we consider the statements of the Hall Report, which relied primarily on an economic justification for recommending a national, public health care plan. Having said that, even if we agree that medicare emerged out of economic, instrumental reasoning, rather than a moral account about equality of citizens, it does not necessarily mean that the institution of medicare has to remain forever restricted by its narrow beginnings.

Still, the Committee seeks to define *today's* medicare policy by tying it to what the Committee considers the “original vision of medicare”—the Liberal Party health care policy of 1961. The 1961 party policy tied citizens' actual usage of the health care system to the amount of taxes that they paid; it was clear in this policy that Canadians would still pay for their health care services under the proposed medicare program. The program was only conceived in order to ensure that all Canadians would have access to “medically necessary services,” regardless of their personal financial circumstances.¹⁶⁸ Specifically, the plan was for citizens to receive an annual statement, which detailed the health costs they had incurred and they would then pay for them according to their personal income through the tax system. In this way they would be “responsible” for their health costs, but not be prevented from getting those services at the time they were needed.

Kirby links this “original medicare vision” to the CHA, and rather than find that the five principles of the CHA are tied to Canadians' values (as Romanow claims), Kirby argues that the Liberal policy objective of 1961 “explains *four* of the principles of the *Canada Health*

¹⁶⁸ Kirby...Vol.1, p. 43.

*Act.*¹⁶⁹ The four principles of universality, portability, comprehensiveness and accessibility are, by the Committee's reckoning, the only CHA principles that are "patient-centred."¹⁷⁰

The fifth principle, which states that medicare must be publicly administered, is, according to the Committee, about the *means used* to achieve the medicare policy, not the policy *per se*. And therefore, so the argument goes, it is not really a legitimate part of the original vision of medicare.

While the Committee may be correct in that the CHA principle of public administration is aimed at controlling the "means" of delivering medicare policy, rather than at a policy which directly affects patients, if we recall the outline of the Saskatchewan medicare plan in 1962, *the means* to achieve the plan was not at all insignificant to the overall purpose of the plan. That is, the commitment to a publicly administered plan was made in order to ensure the accountability of medicare to the provincial legislature and therefore to the people of the province. Indeed, it was particularly the *public administration* of the insurance plan that so incensed the local and national offices of the Canadian Medical Association and the College of Physicians and Surgeons. The doctors' associations were instead in favour of a government subsidy plan that would help low-income citizens pay private insurance premiums, which would in turn help assure that doctors would always get paid (but that they could still set their rates independently). They strongly opposed a single-payer, publicly-administered insurance plan, which would give the government power vis-à-vis the doctors' associations, when it came to setting their fees through negotiations. Furthermore, as health economist Robert Evans noted, it is in large part, the public administration principle that helps to contain costs, when compared with fragmented health care systems, such as the U.S. system.

¹⁶⁹ Kirby... Vol. 1, p. 40. (emphasis mine.)

¹⁷⁰ Ibid. Vol. 1, p. 41.

Yet, once the Kirby Committee establishes that the principle of public administration is of a “completely different character,”¹⁷¹ from the other CHA principles, and thus from the “original medicare idea” as well, the Committee considers itself free to explore options for achieving “sustainability” of the health care system without being restricted by this principle. Economist Tom Courchene agrees with the Kirby Committee on the meaning of the “public administration” principle and further supports Kirby’s suggestion that the “door should be opened to competitive provision of health care services, or what economists would refer to as ‘internal markets’ in the health care sector.”¹⁷² Kirby reinforces this point by referring to a poll, which demonstrates that Canadians throughout the 1990s continued to support the principles of the CHA, but that the principle of public administration, received the lowest level of support of all five principles. In 1999, the principle of universality was thought to be “very important” by 89% of respondents, while the public administration principle was considered “very important” by only 59%.¹⁷³

It is also interesting to note that within the context of its discussion of the meaning and merits of the principle of “public administration” the Committee points to the Goldfarb survey, which reveals that, in 1999, when Canadians were asked about the “most desirable use of the federal budgetary surplus,” the choices that received the two highest levels of support from the respondents were: “spend more on health care,” and “cut personal income tax” at 49% each.¹⁷⁴ The 1999 Goldfarb poll thus does not offer the Kirby Committee any clear option about what Canadians want to see done with the federal surplus; and some members may use the information to conclude naturally enough that Canadians want

¹⁷¹ Kirby... Vol. 1, p. 41.

¹⁷² Thomas J. Courchene, “Medicare as a Moral Enterprise: The Romanow and Kirby Perspectives.” *Policy Matters*, Montreal: IRPP, October 2003, Vol. 4, No. 1, p. 16.

¹⁷³ Conference Board of Canada, *Canadians’ Values and Attitudes on Canada’s Health Care System: A Synthesis of Survey Results*, October 6, 2000, p. 12. as cited in Kirby... Vol. 1, p. 52.

¹⁷⁴ Goldfarb Consultants, Presentation to the Committee, March 22, 2000 (Slide 22), as cited in Kirby... Vol. 1, p. 49.

“more” health care, but they likely do not want to pay for it, since they equally support tax reductions.

On the other hand, it is also possible that the 49% of Canadians who want more health care *are not the same* 49% of Canadians who want tax reductions. In other words, Canadians are *divided* with respect to how they want the surplus spent. Still, the Kirby Committee appears to follow the first interpretation, when it remarks, “we wish to say, upfront, that there is no such thing as a ‘good’ tax.”¹⁷⁵ Furthermore, the Committee rejects raising income taxes to fund health care, because it believes that Canada needs to remain “competitive with other OECD countries, particularly the United States.”¹⁷⁶ And moreover it regards *consumption* taxes to be less of a distortion to the economy and more likely to be “efficiently imposed” than would the raising of personal income taxes.¹⁷⁷

In keeping with its marketplace philosophy, the Kirby Committee also claims to proceed from its conviction that the

major problem with health care insurance is that conventional economic principles do not fully apply. Because most bills are picked up by insurance, people pay little attention to the cost of health care. In addition, they have no way to assess the quality of health services they receive.¹⁷⁸

So the Committee assumes that cost-savings can be realized if economic principles can be brought into the health care system. That is, the Committee claims that if Canadians were aware of the costs of health care, and if they were able to “assess the quality” of health care services, they would somehow *behave* differently. The assumption is that the interaction of supply and demand in a free marketplace would result in a more efficient system, because

¹⁷⁵ Kirby... Vol. 6, p. 286.

¹⁷⁶ Ibid. Vol. 6, p. 288.

¹⁷⁷ Ibid. Vol. 6, p. 274.

¹⁷⁸ Ibid. Vol. 1, p. 43.

health care consumers would be affected by price and thus behave more responsibly as health care consumers.

However, this assumption is misleading, because health care as a commodity is consumed based on *need*, not on the interaction of supply and demand, where price is the connection that mediates commodities in a free market. Professor Raisa Deber offers a simple 'thought experiment' that helps clarify the difference:

Suppose you were offered a free dinner at your favourite restaurant at a mutually convenient time. Would you accept? Most people would. Now...suppose you are offered free open heart surgery at your favourite hospital. Would you accept? The response 'only if I needed it' violates the assumptions inherent in normal markets; charitable impulses may wish to ensure that no one starves, but it is not an issue whether someone 'needs' the free dinner....[Now,] consider whether an individual who presents to a hospital emergency room with a ruptured appendix and an empty wallet should be turned away.¹⁷⁹

Most of us, including the Kirby Committee, would say that no one should be denied necessary health care services, because of a lack of funds and very few of us would want to undertake medical treatment, simply because the price was attractive. Indeed, it would be unethical for a physician to perform unnecessary medical treatment. Therefore free market mechanisms seem to be inappropriate as analytical tools, when it comes to understanding the behaviour of people within a needs-based system like health care. Nevertheless, the Committee outlines its "set of principles," by drawing on free market assumptions, as well as by making an implicit (but unexplained) linkage between a need for incentives and a necessary move to open up the health care system to more private administrators and providers.

¹⁷⁹ Raisa Deber and Natasha Sharpe, "One Million Decisions at the Micro-level: Patient Choice," in Drache, Daniel and Terry Sullivan Eds. Health Reform: Public Success, Private Failure. New York: Routledge, 1999. 275-291. p. 277.

Here, the Kirby Committee bases its recommendations on “three fundamental realities:” first, that the health care system is “not fiscally sustainable given current funding;” second, that Canadians want a strong role for the federal government in health care; and third, that there is a “need to introduce incentives” into the system.¹⁸⁰ The Committee questions the efficiency of the health care system, which is not surprising, but it is not clear why it makes the leap directly to privatization as a solution. Certainly ‘incentives’ could be incorporated into the public system, while retaining the cost-efficiency and accountability of a publicly administered system. On the “sustainability” issue, the Report claims that “once it is recognized that the publicly funded health care system does not currently have sufficient resources,” then Canadians must choose between three basic options: a continued rationing of health services (and the growth of waiting lists), increasing government revenue (either by direct tax increases or other means), or lastly by making some services available more quickly to those who can afford to pay for them in a parallel, privately funded system, but still maintaining a public system for all other Canadians.¹⁸¹ Yet, as we have seen, the question of sustainability in health care is not as simple as this characterization. Without outlining the extent of the “publicly funded health care system” that we are trying to sustain, it is difficult to decide whether or not the willingness to contribute the tax dollars is there.

Kirby also makes a number of suggestions quite similar to those of the Romanow Report.¹⁸² The Committee believes that a “permanent, independent evaluative body” that reports annually to the public on the health care system is necessary.¹⁸³ So the Kirby Committee, like Romanow, is concerned about the accountability issue. Accountability and

¹⁸⁰ Kirby... Vol. 5, p. 5.

¹⁸¹ Ibid. Vol. 5, p. 12.

¹⁸² For example, Kirby and Romanow both support the expansion of the definition of “medically necessary” services under medicare to include first-dollar coverage of home care and drug costs; and both reports call for a firmer federal funding commitment to medicare.

¹⁸³ Kirby... Vol. 6, p. 9-10 and 13.

transparency are important, because as Kirby puts it, “Canadians will be willing to contribute more to public health care spending only if they are convinced that the money will actually be spent on health care...and spent wisely.”¹⁸⁴ And at the end of the day, the report does, in fact, recommend an increase in income taxes, but Kirby calls it by a more specific label, intended to sound as if it were somehow *different* from a tax. The “Variable National Health Care Insurance Premium,” is thus designed to raise \$5 Billion annually for medicare, plus it will “encourage patients to make cost-effective use of publicly funded health services.”¹⁸⁵ The Committee’s other chief recommendation is for a “Health Care Guarantee,” which would set a maximum waiting time for major procedures and treatments, after which Canadians would be allowed to seek treatment outside of Canada and have the government still pay for it.

Therefore the Committee’s proposals fit its outline of the “three realities and three options” framework. Of the three options mentioned above, the Committee has chosen to recommend the increase in government revenues through a national health insurance premium. And it has adhered to their framework of “reality,” which states that “incentives are needed in the system,” by recommending a supposed incentive for patients to be cost-effective in their health service choices (through the transparency of the health premium). In addition, the Committee has recommended that the “public administration” be interpreted as a public *payer* principle only, so that the health services system can be opened up to more private administrators and providers, thus supposedly creating cost efficiency through competition and a profit incentive in the marketplace for public health dollars.

¹⁸⁴ Kirby... Vol. 6, p. 262.

¹⁸⁵ Kirby... Vol. 5, p. 14.

VI Provincial Visions of Health Care

The Kenneth Fyke “Commission on Medicare”¹⁸⁶ issued its report on “reforming and improving Medicare” to Premier Lorne Calvert of Saskatchewan in April 2001, and the Don Mazankowski “Council on Health”¹⁸⁷ delivered its report to Alberta’s Premier Ralph Klein in December 2001. So, both commissions worked on their reports during a similar time period, likely because both provincial governments had drawn the same fundamental conclusion that their province’s health care systems were in need of reform, citing lower federal social transfers and increasing costs in the health care sector.

For our purposes then, we can assume that much of the context of issues and the relevant public opinion regarding the need for policy reform were largely similar for both provinces. Furthermore, both councils were given similar mandates: to do research and consult with health care experts (which would include health care professionals, policy analysts and economists), and ultimately propose policy solutions that would better serve patients’ needs and ensure the long-term “sustainability” of the system itself. However, in the end, the reports offered substantially different analyses of the policy problem, and in turn, they formulated several dissimilar recommendations.

¹⁸⁶ Caring for Medicare: Sustaining a Quality System. Saskatchewan Commission on Medicare, Commissioner Kenneth J. Fyke, April 2001.

¹⁸⁷ A Framework for Reform: Report of the Premier’s Advisory Council on Health for Alberta. Chair Right Hon. Don Mazankowski, P.C., O.C.. December 2001.

6.1 The Fyke Commission: Caring for Citizens

Under the “Terms of Reference” section in the Fyke Report, the Commission explains the health care “values” of the Government of Saskatchewan and its citizens. These include the commitment to: the five principles of the *Canada Health Act* (universality, portability, accessibility, comprehensiveness and public administration); a “high standard of quality” in health services; a promotion of the “collective good and overall health and well-being of the population;” and a “fair and equitable” distribution of costs.¹⁸⁸

The Commission goes on to outline a number of detailed recommendations that pertain broadly to two main “categories” of change to the health system, under the headings of “structural” and “cultural” changes. The structural changes include a shift away from fee-for-service physicians as the gateway to all primary health care services and towards an interdisciplinary “health team” approach to care. In this model, “Primary Health Service Networks” would integrate a variety of likely salaried health care providers (family doctors, nurse practitioners, mental health workers, social workers, etc.) not only within the same physical location over time, but the report proposes an improved coordination of efforts through a better communications system, to be facilitated by the use of electronic health records.¹⁸⁹ The objective of this model is to reduce service overlap and specifically reduce the incidences of overqualified personnel, such as doctors, handling all health concerns, when many could be handled more quickly and efficiently through a team/network approach, thus

¹⁸⁸ Caring for Medicare: Sustaining a Quality System. Saskatchewan Commission on Medicare, Commissioner Kenneth J. Fyke, April 2001. Appendix A, p 86-87.

¹⁸⁹ Fyke...p. 9. Part of this model would also include a 24hour/7day telephone access health advice line. This integrated team approach model to health care is one that has since been recommended in nearly all of the provinces, however the approach is meeting with resistance from the physician community. Thus change is very slow in coming.

reducing costs and providing quicker patient access to the appropriate health care provider.¹⁹⁰

The “cultural” changes promoted by the Fyke Report are explained as the need for a reorientation in the overall “attitude” of the health care system. In other words, much of the system’s processes should be changed, in order to encourage all health care professionals and administrators to properly monitor the quality of care that is being delivered, as well as to consider *care* in a different way. For example, the Commission states that there should be a stronger emphasis on “wellness” (health promotion and disease prevention), and that the system should look at broadening their focus, by for example considering options, such as assessing the quality of life of individuals and improving social housing (again with a social-health team approach), rather than “simply warehousing the disabled and elderly.”¹⁹¹

Perhaps the most interesting statement that the Fyke Commission makes is that, in its view, the essential problem with health care is not the usual claim that there is a lack of money in the system, instead the Commission relies on its research and findings that show that structural and cultural changes can lead to good quality health care that will “cost considerably less than poor quality.”¹⁹² The focus on the “whole” patient as a person via a team approach, as well as a review (and recommendations therein) of the effects of social spending in other areas, such as education and housing, on the health of Saskatchewan’s citizens is emphasized as the means to both improve overall health outcomes and therefore reduce health care costs further upstream, before people enter the health care system.

Most of Fyke’s recommendations only address the issue of costs indirectly, but underlying the report is a review of the provincial budget’s projected costs and revenues and

¹⁹⁰ Fyke... p.12. The report contains a much more detailed explanation of the structure of changes and what they would mean to specific rural areas and Aboriginal communities.

¹⁹¹ Fyke... p.16.

¹⁹² Ibid. p.6.

not surprisingly, the report concludes that funding for the existing health care system is expected to increase (over the next 4-5 years at approximately 6.5% per year), while available government revenues are expected to only increase by about 3% over the same time period. And after reviewing some public/private funding mix options, similar to the options explored by the Mazankowski team, the Fyke Commission ultimately concludes that increasing *private* funding and delivery of care would indeed lower *government's* costs, but these options would not keep *overall health care costs for Saskatchewan's population* lower. More importantly, the report emphasizes, these options would also lead to a "decrease [in] equity."¹⁹³

The Commission also considers ideas such as income-related mandatory premiums and user fees, but concludes that neither of these options would improve funding or health care delivery. The premiums are dismissed on the grounds that the administration of them would be costly and would really amount to a tax anyway (and thus they should not be disguised, instead of being addressed as a tax issue elsewhere if deemed necessary). The user fees are dismissed based on the understanding that they would not provide much revenue unless the fees were substantial; and if they *were* substantial, then that would create an access and equity problem.¹⁹⁴

In the end, the Commission is instead confident that if its recommended "structural" and "cultural" changes are implemented quickly, the health care system will improve in terms of both its quality of care and its long-term sustainability, given the focus on improving the quality of life of individuals in their communities and the belief that this will lessen the costs of health care services, if the health of citizens improve as a result. This is undoubtedly something of a leap of faith, since future economic gains (or costs savings) as a result of

¹⁹³ Fyke...p.77.

¹⁹⁴ Fyke...p.78. See also Appendix C: Supplementary Materials, for a more detailed review of the funding options that the Commission considered, p. 95-103.

improvements in quality of care, social housing and education are not easy to quantify for future projections, and moreover it will take some courage for a government to implement such reforms, since the gains will not be obvious in the short-run. The notion of a leap of faith is not a trivial point, since the report itself relies on a sense of trust within and between health care providers, as well as between citizens and their governments, when it comes to the fulfilment of their health care responsibilities and expectations.

6.2 The Mazankowski Report: Serving Consumers

“It’s time to open up the system, take the shackles off, allow health authorities to try new ideas, encourage competition and choice, and see what works and what doesn’t.”¹⁹⁵

The mandate given to the Premier’s Advisory Council on Health by Premier Klein was similar to the Saskatchewan mandate; the Council was to: “...review Alberta’s health system and develop recommendations to ensure that the system meets Albertans’ needs and is sustainable for the future.”¹⁹⁶ Within this mandate, the Council also explains the type of health system that Alberta should be striving for: one that is “research and evidence based...has the right incentives and is a model for Canada and the world.”¹⁹⁷ What is more, the Council plans to tackle the overriding problem with the health care system—that it “operates as an unregulated monopoly.”¹⁹⁸ The Council’s report proceeds in a comparable manner to the Fyke Report, but it delivers its recommendations as a sort of “top ten” list of general recommendations; they can be summarized as follows:

- 1) Encourage Albertans to “stay healthy”
- 2) “Put customers first”
- 3) Redefine “comprehensiveness” in health care
- 4) Invest in technology
- 5) Reconfigure the system for more competition, choice and accountability
- 6) “Diversify the revenue stream”
- 7) Make quality the “top priority”
- 8) Create “better incentives” for retaining and attracting health care providers
- 9) “Promote Alberta’s health sector as a dynamic, powerful asset to the provincial economy.”
- 10) Establish a “clear transition plan” for the above nine recommendations and monitor progress.

There are a number of more specific recommendations under each of these guiding principles; however there are two fundamental changes that seem to be driving the overall thrust of the Council. First, the Council seeks to “enable” citizens to take more

¹⁹⁵ Mazankowski...p.12

¹⁹⁶ Ibid., p.12.

¹⁹⁷ Ibid., p.12.

¹⁹⁸ Ibid., p. 21.

“responsibility” for their health. And this, according to the Council, can be facilitated in two main ways: create less confusing health information that is more readily available to Albertans and implement proper financial incentives (and disincentives), such as medical savings plans or electronic health debit-cards to track health system usage and/or penalties for bad lifestyle choices, to encourage Albertans to use the health care system more responsibly and improve their health, as a result of financial motivations.¹⁹⁹

Second, in a similar fashion to the Kirby Committee, the Council recommends a reform that is presented in the Report as one of only *two options available* to Alberta. The two options are either a “rationing” of health care services, or allowing more private health care providers into the system in order to “diversify the revenue stream.”²⁰⁰ Now given these two options, the Council naturally opts for the latter (and it would likely assume most readers of the report would do so as well). Thus we are to infer from the Council’s recommendations that re-casting citizens (and patients) as responsible *consumers* with more choice and allowing more private health care providers into the health care system is going to intrinsically lessen the burden on the system, therefore lowering costs to government. In turn, this will solve the “sustainability” problem.

However, this seems to be a solution aimed more specifically at the chief problem that the report explicitly *states* it is addressing—the notion that the health care system “operates as an unregulated monopoly.”²⁰¹ Again, in a similar method to the Kirby Committee, the Mazankowski Council leaps from the “unregulated monopoly,” identified as the primary problem, to the solution of choice, competition and “diversification of the revenue stream” as the only viable solution to the system’s ills. Like Kirby, Mazankowski does not explore the

¹⁹⁹ Mazankowski...p. 16-17.

²⁰⁰ Ibid. p. 40.

²⁰¹ Ibid. p. 21.

possibility of imposing regulations or change *within* the public system as a means to improve services, rather the Council seeks to open up the health care system to the free market, competition and the profit incentive.

In keeping with the goals of lowering government costs and creating proper financial incentives, the Council also offers a wide range of options for raising government revenues at the same time. These include: increasing existing health care premiums, implementing user fees, introducing a health care tax that is linked to the health services that people “purchase,” medical savings accounts (so that “customers” are “allowed” to know what they are costing the system), and allowing privately *funded*, as well as privately delivered health care services.²⁰² Within their review of the funding options, the Council draws on numerous reports, “task forces” and evidence to show how these options compare in terms of potential costs and benefits to the health care system.²⁰³

Here, the citizen is portrayed as an “unaware” and potentially reckless consumer of health services, and thus citizens are irresponsible and need to be controlled by economic disincentives. Moreover, it shifts the underlying rationale for providing public health care services to citizens from that of ensuring social equality through a redistributive mechanism to an economic framework, where citizens’ acquisition of health care services is assumed to be a function of demand and supply. Again, this is the same mistaken assumption that the Kirby Committee makes about price being a key driver of health services consumption. In the end, the Council is equivocal about which options are best, but it strongly suggests, at

²⁰² Mazankowski...p. 60-62.

²⁰³ Ibid. p. 11.

minimum, a gradual increase in health care premiums to eventually directly fund approximately 20% of health care costs in the province.²⁰⁴

The Council is also careful to state that no low-income individuals should be denied access to health care as a result of any of the various funding incentives; additional provisions or programs should be implemented to safeguard these individuals. And while this might be of some reassurance to citizens concerned about utilization-tied health care fees, these programs may possibly stigmatize low-income persons as they would have to be identified as such when they sought medical treatment under the “debit-card” or similarly administered plans as proposed. The result may be that many are deterred from seeking medical treatment where costs or programs seem difficult or embarrassing to access. Surely, this kind of program would not respect the dignity and equality of individuals that Marshall describes as the goal of social citizenship. Indeed, preventing this situation is exactly what many believe was the intention of the “universality” clause of the *Canada Health Act*. Universality is not just about citizens having the technical ability to gain access to “medically necessary” services, but rather it is a statement that says that all persons should, in practice, have the *same* access without regard to income. That also means that requiring individuals to go through a means-testing procedure would be inappropriate if equal access is truly the goal.

Of course, digressing into this kind of *normative* analysis of the Council’s recommendations may seem unfair since the Council claims that its report is based on “research and evidence” and a series of “over 100 reports.”²⁰⁵ The Council, which is made

²⁰⁴ According to the report, current health care premiums contribute approximately 11% to the actual costs of insured services. Mazankowski...p. 61.

²⁰⁵ Mazankowski ...p. 11-12.

up of experts from the fields of medicine, economics and business,²⁰⁶ assures us that their alternatives are the only choices that *exist for the sustainability of health care* in Alberta.

Furthermore, according to the Council, the health care system is properly viewed as “a driving force in Alberta’s economy,”²⁰⁷ and as such, we are left to infer that economic models of market incentives are quite naturally applicable to health care policy, and thus any normative questions should be set aside in the analysis.

Yet, the Council also attempts to provide a “values-based” commitment within health care policy by declaring that their recommendations are “consistent with the spirit and intent of the *Canada Health Act*,” but it also warns that if many of their recommended changes are not implemented, it is possible that the province will be forced to look beyond the limitations of the *Canada Health Act* and its five principles.²⁰⁸ So, values, for the Council are only important insofar as they can be “sustained” by the principles of the market and therein by the implementation of their recommendations to “unshackle” the system. Plainly, the goal of a realization of social citizenship for Albertans through a clearly articulated right to health care is not at the heart of the Mazankowski Report.

²⁰⁶ See “Council Members and Advisors,” Mazankowski ...p. 73.

²⁰⁷ Mazankowski...p. 69.

²⁰⁸ Mazankowski...p. 72.

VII. Obstacles on the Road to Social Citizenship?

7.1 Legitimate Expectations and the Definition of Health Care

The general idea of universal health care and its attendant benefits have been around for more than 40 years in Canada, and close observers of the federation claim that medicare and other social programs have “created a set of benefits and rights founded not on a region or language but on a common Canadian citizenship.”²⁰⁹ Yet, there are at least *three fundamental tensions* that problematize the act of defining our shared and legitimate expectations, in order to claim and defend a meaningful right to health care. *First*, there is a federal-provincial tension in the structure of health care policy, which makes claiming a “national” right of health care citizenship challenging. *Second*, there is a conflict of both goals and approaches between the medical model (doctors and hospitals) of health care, in which the “original medicare idea” was founded and the population health model, which has generally been acknowledged as a more effective means to improve the overall health of individuals. *Third*, there is also a tension between the conceptualization of the Canadian as a “consumer” versus that of a “citizen,” which implies a range of conflicting ideas about the freedoms, responsibilities and entitlements of Canadians.

²⁰⁹ Keith Banting, “The Past Speaks to the Future,” in Ed. Harvey Lazar. The State of the Federation: Non-Constitutional Renewal. Kingston: IIGR, 1997. 39-69. p. 59.

7.2 Federal-Provincial Tension

Richard Vernon asks: "Can the concept of citizenship lend itself to dual political allegiance?"²¹⁰ As he makes clear,

a federal citizen has two official loyalties....Federal constitutions explicitly provide that neither provincial nor national authorities are supreme over the other, that obligations are owed to each within their defined spheres. Because authority is divided in this way, the citizen too is divided.²¹¹

This divided loyalty is reflected in the dual history of the development of public health care policy in Canada. The Saskatchewan legislature entrenched four principles with the passing of the *Medical Care Services Act* of 1962: the pre-payment (or premiums) principle; the principle of universal coverage; a "high quality service" principle; and a principle of accountability through the public administration of the program. Furthermore, these principles were rooted in the social history of the citizens of Saskatchewan. That is, the habit of collective responsibility and cooperation and the commitment to "share each other's burdens" were well-established prior to 1962 through the evolution of the *Rural Municipalities Act* and the creation of Union Hospital Districts. And these convictions were further reinforced by the struggle that the government and its citizens had to wage before the medicare model was firmly established in the province. Thus there is a collective memory of the struggle to achieve the "birth" of medicare, as well as a belief that government has a role to play in social services, and this, in turn, contributes to a consensual set of legitimate expectations for the *citizens of Saskatchewan*.

Furthermore, we can see this level of trust and social cohesion reflected in the Fyke Commission's report on health care, where the report reinforces the collective commitment to the health and well-being of all its citizens in its recommendation to shift its health care

²¹⁰ Richard Vernon, "The Federal Citizen," in Eds. R.D. Olling and M.W. Westmacott. Perspectives on Canadian Federalism. Scarborough: Prentice-Hall Canada, 1988. 3-15. p. 3.

²¹¹ Ibid., p. 4.

service orientation to an increased emphasis on health promotion and other non-medical determinants of health, including housing and education.

By contrast, no such struggle at the level of citizens across Canada and their federal government took place. Nor, was the establishment of the national model of medicare rooted in a collective understanding among the citizens of Canada. The passage of the *Medical Care Insurance Act* (1966) was more of a “multi-causal accident,” since medicare’s “window of opportunity” was opened by the “convergence of propitious partisan and federal-provincial climates. The policy that was chosen, made possible by a period of economic boom, fit well with the existing structures of interests in the health care arena...”²¹² Thus, the collective expectation that Canadians will and *should have* access to doctors and hospitals is more the result of the policy legacy of medicare than of a national struggle for access to doctors and hospitals.

Indeed, the only clear *national* aspect of our universal health care system is the Canada Health Act (1984), which is a federal piece of legislation that functions specifically as a means to enforce conditional funding to the provinces. Canadians may well be attached to the principles of the CHA, but that is not because it represents a solid national vision of the Canadian health care system, rather it is the national piece of legislation that *comes closest* to representing that vision in a country with 10 provincial and 3 territorial health care systems. It is thus not a guarantee of a citizenship right to our current system of health care delivery. In fact, at the time of its passage it was (and today it still is) a controversial piece of legislation that contributes to the tension in federal-provincial relations. Furthermore, the question of whether or not a policy issue which is run provincially, with the sometimes wavering, non-guaranteed, but ultimately necessary federal contribution can ever be properly

²¹² Tuohy... p. 56.

constructed as a “national” right of citizenship remains unanswered. There is also, of course, a built-in structural tension in the division of jurisdiction that gives the provinces the power to administer health care programs and the federal government the “spending power” to influence the conditions and standards that provinces may have to adhere to in order to receive the federal transfers that they require to carry out the programs.

This tension is implicit in the health care reports: Romanow wants to claim a “national” medicare program as a right of citizenship, and he recommends doing this by implementing a Health Covenant to create (or re-affirm) a national commitment to the five CHA principles, plus a sixth: accountability. Romanow recognizes the difficulty of the federal-provincial aspect of maintaining a firm moral and fiscal commitment to medicare, so he attempts to bypass the often intractable federal-provincial wrangling by suggesting the creation of a Health Council. The idea is to make “governments” accountable to *the Council*, since the complexity of holding two levels of government accountable for a system as complex as health care is difficult for the Canadian electorate.²¹³ It remains to be seen, however, if both levels of government will feel much obligation to report to this body.

The Mazankowski Report, on the other hand, explicitly states that if it becomes necessary, Alberta may have to violate the principles of the CHA, in order to make health care in the province “sustainable.” It is evident that some of the earlier conceptions of the role of the state in health care programs still exist: as mentioned above, Alberta took a few years and then only grudgingly signed on to the *Medical Care Insurances Act*, since it was opposed to the violation of individual freedom that it represented. The conception of the individual and her responsibility with respect to the health care system that is represented in the Mazankowski Report is not significantly different from Alberta’s viewpoint in 1966.

²¹³ The 27-member Health Council was established in 2003 as per the 2003 First Ministers’ Accord on Health Care Renewal. See < http://www.hc-sc.gc.ca/english/media/releases/2003/2003_97bk1.htm. >.

7.3 Population Health vs. The Medical Model

The current model of medicare is not oriented toward attainment of the highest level of health for the Canadian population, but rather towards the treatment of illness. When both the initial model of medicare was set up in Saskatchewan in 1962 and the federal *Medical Care Insurance Act* was passed in 1966, the public policy problem that they were designed to address was the lack of basic access to doctors and hospitals for the population. At the time, that was the most obvious way to improve the health of the population.

Since then however, it has been widely acknowledged that despite Canada's well-established health care system with universal access, "significant inequalities in life expectancy and health status across different socioeconomic groups" persist.²¹⁴ As early as 1974, the federal government published a health care report called *A New Perspective on the Health of Canadians* (the Lalonde Report), which recommended that health care in Canada be re-oriented around a population health/health promotion perspective, which would emphasize lifestyle, environment and a reorganization of health care delivery.²¹⁵ The report argued that this approach would be more effective and less costly than the traditional focus on only treating illnesses. Since then, a shift to a population health perspective has been advocated by a number of reports on health and the health care system.²¹⁶ This shift in approach calls for integration across the health care system and for an increased emphasis on other "non-medical" determinants of health, such as lifestyle, income and education. Yet, the health care system remains firmly rooted in the medical "fee-for-service" model, where

²¹⁴ Robert G. Evans, "Canada: The Real Issues," in J.A. Morone and G.S. Belkin eds. *The Politics of Health Care Reform*. Durham, N.C.: Duke University Press, 1994. 461-486. p. 482. as cited in Fierlbeck...p. 28.

²¹⁵ Fierlbeck...p. 29-30.

²¹⁶ See for example: R.G. Evans, M.L. Barer and T.R. Marmor eds. *Why are Some People Healthy and Others Not? The Determinants of Health of Populations*. New York: Aldine de Gruyter, 1994.

medical doctors are the gatekeepers to all other public health care services, and funds are focused heavily on acute care services.

Moreover, our “increasing expectations” seem to arise from this model, where we want quicker access to better and more expensive technologies, as a priority over a more equal distribution of the socioeconomic benefits that would, in turn, significantly contribute to better population health outcomes, and the kind of dignified inclusion that social citizenship entails. Then again, that is not how the policy choices are framed in the public domain. Alan Davidson summarizes the difficulty in making this policy shift in Canada:

Population health is an alternative policy framework, not an incremental change in the existing one, because the search for measurable impacts on the health of populations leads toward a focus on the determinants of human health and the inevitable conclusion that health care services is only one and not the major contributor to health. Socioeconomic conditions and community context...become terms in the policy dialogue, with potentially profound effects on who has voice in health policy-making and how public resources will be allocated.²¹⁷

Universal health care has indeed become a defining element of Canadians’ elusive cultural identity, but at the same time, the original medical model has “institutionalized policy beliefs regarding the link of medical services to health and the connections between both to citizen rights.”²¹⁸

Ironically, it seems that the importance of universal health care to Canadians and the intensive “crisis” media coverage of the system, coupled with the recent increases in the flow of federal money into health care research and reform, have opened a window in health policy through which a number of policy analysts are trying to squeeze. That is, the rising awareness and continuing discussion of the “non-medical” determinants of health in the health services research community is trying to push the long known importance of food security, income and education as key factors in determining the health of citizens into the

²¹⁷ Davidson...p. 253.

²¹⁸ Ibid. p. 260.

medical community through various entry points, because the money is now there. As one general practitioner wryly observed at the Centre for Health Services and Policy Research (CHSPR) 17th Annual Health Policy Conference, “it has come to our attention that patients, in fact, spend 95% of their time outside of the doctor’s office.”²¹⁹ More clinicians are now looking at social services and community organizations for support in delivering better health outcomes, while those in the social services industry have long known the detrimental effects of poverty and social dislocation on health.

This appears to be taking place, even though it is not necessarily medical clinics and physicians (who are trained to treat illness) that are best positioned to take on this role of improving or facilitating community supports. In this regard, the health care system seems to be pushing up against the eroding welfare state. Past cuts to welfare, employment insurance and other social services have likely placed additional pressure on the health care system in many provinces. Indeed, it may be that if we are really trying to achieve the level of social citizenship that Marshall described, where individuals have “a right to a share in the social heritage” of that community and to “a general enrichment of the concrete substance of civilised life, a general reduction of risk and insecurity, an equalization between the more and the less fortunate at all levels—between the healthy and the sick,” then we need to look at much more than the medical model. In reality, we need to even go beyond the “health care system,” to look at more broadly-based means of ensuring a secure position in society for all citizens. What we may be observing is not so much a crisis in the health care system, but a crisis in our conception of social citizenship, and in our willingness to pursue it.

²¹⁹ Dr. Robert Reid, Associate Director, Department of Preventive Care, Group Health Cooperative, Seattle, WA., presenter, CHSPR Conference on Health Policy, February 25, 2005, Vancouver, BC.

7.4 Portrayal of the Citizen vs. the Consumer in Health Care

One of the easily overlooked, but key distinctions across the health care reform reports is the different perceptions of how Canadians interact with the health care system. In both the Kirby Report and the Mazankowski Report, Canadians are portrayed as “consumers,” whereas Fyke and Romanow see Canadians as “citizens.” This conceptual difference holds a number of potentially important policy implications.

If you envision Canadians as consumers in a health care marketplace, the assumptions about their behaviour, responsibilities and entitlements will be markedly different than if you imagine them as citizens. Consumers are assumed to interact with firms in a marketplace, where prices (and marketing) determine health care usage, and where the choice of individual consumers trumps collective decisions. Consumers (and firms) are assumed to be only self-interested actors, without responsibilities to other consumers or firms in the marketplace. The marketplace is an environment where it is assumed that we need “incentives” to do the right thing. Here, as Kirby and Mazankowski inform us, health care consumers need to be aware of their health care costs, in order to be more responsible and control their consumption of health care services.

On the other hand, citizens exist in a community, where interactions are mediated not only by the marketplace, but by broader considerations for other individuals and groups within that community. Citizens expect the state to intervene where free markets may not be the best environment to provide a service without regulation. Furthermore, decisions about the extent of such interventions are the kinds of democratic choices, in which a citizen is expected to participate, since a citizen carries responsibilities, as well as entitlements. Citizenship can thus be a vehicle for realizing a more substantive view of equality within a community, whereas consumers are on their own and equality depends on your pocketbook.

How these health Committees and Councils envision Canadians vis-à-vis their health care system is indicative of their understanding of the role of the state in people's lives. It also influences how they understand the health care debate and the question of what needs to be "sustained" in the health care system. Those who see Canadians primarily as consumers seek to improve consumers' freedom of choice in the health care marketplace through a combination of either taxes or user fees and the increase of privatized funding and delivery of health care services. Here, what they are trying to "sustain" (and arguably improve) is the level of services that individuals can access. By contrast, those who view Canadians as citizens want to establish and "sustain" a moral commitment to universal health care that is rooted in those values of "equity, fairness and solidarity," that Romanow highlights. On this perspective, the level of services that *all* Canadians will have access to takes priority over the level of services that *some* individual Canadians will be able to access.

VIII. Conclusion: Health Care at the Crossroads of Social Citizenship

The debate about health-care as a right of citizenship remains a debate about the appropriate principles of distributive justice and the scope of individual rights, and these conceptions vary not only across political parties, but across provinces. The Canadian health care system is the complex result of values, federal-provincial conflicts and political timing; and while we can trace its roots to a collective sense of responsibility and shared values of equity in the birth of the medicare model in Saskatchewan, it is not clear that this commitment has taken root across Canada. There may be a strong argument to be made that Canadians (and indeed humans) have a right to *health*, but there is not such a clear argument to be made that Canadians have a right to their particular health care system. Certainly, the “values-laden” *language* of health care policy resonates strongly with most Canadians, which makes it a politically powerful policy issue, as well as volatile ground for federal-provincial relations, but this does not bring our health care system or any particular version of it to the level of uncontested, universal entitlement.

Moreover the medicare plan itself is not just about a fair distribution of the risk and burden of ill health in society, it also includes institutional arrangements for funding and services that favour a medical model of health care, which is arguably more reflective of the medical profession’s interests than of the interests of Canadians as a whole. Still, there is an attachment to the ideal of health care and the notion of “sharing each other’s burdens” in the Canadian mythology, but it has to grapple with the competing interests and visions of health care as primarily a business enterprise.

Thus, health care reform reports that claim that their analysis is focused on preserving Canadians’ right to health care do not enhance the debate or tell us much about their reform proposals, since there is no objective standard or “right” to which any of these reports can

be held. Indeed, answering the basic questions of whether Canadians are even conceptualized as “citizens” or “consumers” in each of these reports tells us more about the proposed reforms than does any “citizenship” or “rights claiming” language. Moreover, each report offers its own interpretation when it comes to Canadian “values,” since these “values” and what they mean in terms of particular policies *vary with each report*. Even the “original medicare idea” cannot clearly be used as an objective standard, since it was not based on a principle of *national* citizenship, but rather on an economic rationale. Moreover, there is no reason to believe that the past conception of medicare should hold our future ideal of social citizenship hostage. Old ideals can be altered and the future ideal of social citizenship seems yet to be clearly articulated.

Health care may be on the verge of becoming a right to social citizenship in Canada, and the intensity of the debate may be an indication of the struggle for the soul of the welfare state that lies at the heart of medicare currently. But it does not seem to be just a debate about where to draw the line with respect to publicly funding new types of health care services outside of doctors and hospitals, but also more fundamentally about just how *universal* public health care should be. We have not yet achieved a consensus around our legitimate expectations of the health care system. Maybe Marshall was right about the evolutionary aspect of citizenship rights, and we are on the way to guaranteeing, as a matter of social inclusion for all citizens, a number of social service policies that will thus be elevated beyond the debates of politics. But for now, however, we are not able to rest assured that things such as health care are simply guaranteed as rights of citizenship, they are still fundamentally “up for grabs.” Progress in the direction of social citizenship is not inevitable.

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