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**Health Care Entitlement and Citizenship Development:
Re-Evaluating the Social Rights Thesis**

by

Candace Johnson Redden

Submitted in partial fulfillment of the requirements
For the degree of Doctor of Philosophy

At

Dalhousie University
Halifax, Nova Scotia
April, 2000

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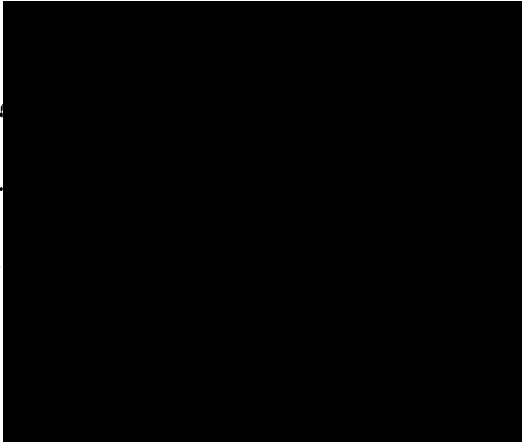
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DATE: April 1, 2000

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TITLE: Health Care Entitlement and Citizenship Development:
Re-Evaluating the Social Rights Thesis

DEPARTMENT OR SCHOOL: Political Science

DEGREE: Ph.D. **CONVOCATION:** May **YEAR:** 2000

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**In memory of my friend and colleague,
Richard J. Matthews**

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Abstract

Candace Johnson Redden

As provincial governments devise health care reform strategies to respond to the changing dynamics of budgeting, federalism, and health, citizens resist changes to what they perceive to be social rights of citizenship. Such resistance is beneficial in that it serves to protect entitlement to a range of services and secure health care as a symbol of national identity. However, the right to health care has been defended categorically as an infungible, sustainable element of the state-society relationship in spite of the evolutionary nature of citizenship. As the universal health care system developed throughout the 1940s, 50s and 60s, and the range of available services expanded, citizens' expectations were elevated. And by 1980, when retrenchment was imminent, health care had become a symbol of Canadian identity, and as such, a politically charged policy field. The political potency of health care has proven to be a serious constraint to change at a time when decision-making for health care requires dynamism and flexibility, rather than stability and stasis. Further, the analysis presented indicates that Canada has entered a new stage of citizenship development. Continued defences of the right to health care cannot by themselves secure access and entitlement for all Canadians. What is needed, instead, is recognition of the multiplicity of differentiated citizenship claims across the country, an understanding of how those claims can be expressed and accommodated in public policy, and a strategy for identity-based communities informing and interacting with geographically-based entities.

The challenge for health care reformers, then, is to attenuate stasis, and, at the same time, protect entitlement. The analysis of this dissertation provides some foundational support for understanding the right to health care and the need for policy change. Paradoxically, it seems that the former precludes the latter. Patterns of entitlement often protect the very models or components of the system that are in serious need of reevaluation. This is not to say that the problem is one of dichotomous choosing between universal public provision and privatization. Epidemiological, technological and political patterns indicate a far more sophisticated and irresolvable conundrum of balancing individual responsibility-taking with collective entitlement.

Acknowledgements

To begin, I would like to thank the external examiner of the thesis, Pat Armstrong (York University), whose work in the area of health care politics has had a great impact on me, and my committee members, Peter Aucoin (Dalhousie), Lawrence Nestman (Dalhousie), and Katherine Fierlbeck (Dalhousie). Peter Aucoin and Lawrence Nestman read several drafts of the thesis and offered thoughtful suggestions despite their exceedingly busy schedules. I feel particularly fortunate that my thesis was supervised by Katherine Fierlbeck. Throughout the process she provided me with constant feedback and support. Her commitment to intellectual rigor was challenging, and helped me to create something of which I am very proud. I learned an incredible amount from her about research, writing, and teaching. I could not have found anyone better to work with, anywhere. She is the best scholar I know.

I am also very grateful to Paulette Chiasson in the Political Science department at Dalhousie for her friendship and kind help in finding wayward thesis drafts while I finished my thesis in the United States. Thanks also to everyone at Graduate Studies, especially Linda Sanford and Barb Maynard, for their assistance.

David Wolfe at the University of Toronto provided the initial inspiration for the thesis. In my final year as an undergrad at U of T, Dr. Wolfe, the most enlightening professor I have ever had, introduced me to the idea of social rights, and motivated me to continue to think about how conceptual discussions of citizenship relate to public policy. I am still thinking.

Special thanks are owed to my colleagues at American University in Washington, DC, notably, Robert Boucher, Nathan Dietz, and Joe Soss, who endured a considerable amount of my complaining and self-commiserating as I completed the thesis (and then re-completed it). Extra special thanks are in order for Gregg Ivers, who offered no help whatsoever.

I am forever indebted to A.R. Gillis (University of Toronto) and Karen O'Connor (American University) for mentoring me throughout the process. A.R. has been a great

friend and confidant for several years. Karen encouraged me in the final stages of my writing, and continues to push me to succeed.

I would also like to thank my fellow Ph.D. candidates at Dalhousie University, Anna Lanoszka, Allison Young, and Richard Matthews (to whom this thesis is dedicated). Without their support I would not have persevered.

Last but certainly not least, I would like to thank my partner in all of my endeavours, scholarly and otherwise, Greg Redden.

CHAPTER ONE

Health Care Entitlement and Citizenship Development

Health is moving rapidly from the field of thinking of a service or a charity for some to be given by the better privileged to others. . . into the field of thinking of it as an integral part of the life of every Canadian. In other words, the people are thinking of health as a right of citizenship, of even greater importance than education or police protection, which are taken for granted.
Canadian Federation of Agriculture, 1942¹

I made a pledge with myself long before I ever sat in this House, in the years when I knew something about what it meant to get health services when you didn't have the money to pay for it. I made a pledge with myself that someday if I ever had anything to do with it, people would be able to get health services just as they are able to get educational services, as an inalienable right of being a citizen of a Christian country.
Tommy Douglas, 1962²

The support shown by Canadians for a universal, one-tier, single-payer health care system depends on their belief that it will provide to everyone, regardless of income, access to health care of the highest possible quality when that care is needed. . . The perception and the reality of decline -- and the worry about further decline to come presents us with one of the greatest public policy challenges facing this country today. After all, for Canadians, health care is not simply another government program. It has become tantamount to a right of citizenship. It reflects and it embodies some of the most fundamental values and principles of being a Canadian.
Federal Minister of Health, Alan Rock, 1997³

¹ Canadian Federation of Agriculture quoted in Malcolm Taylor, *Health Insurance and Canadian Public Policy: The Seven Decisions that Created the Canadian Health Insurance System*. Montreal: McGill-Queen's University Press, 1987, p. 33.

² Ibid, p. 80.

³ Health Canada: Speaking notes for The Honourable Alan Rock, Minister of Health at the 130th Annual Meeting of the Canadian Medical Association, Victoria BC, August 20, 1997.

Introduction

The above statements clearly indicate that health care in Canada is considered to be a right of citizenship. Patterns of entitlement were gradually institutionalized in the 1940s, 50s and 60s, and now seem to be threatened by fiscal restraint measures, neo-liberal trade agenda and various reform efforts that have resulted in marginal erosion of the health system. In the face of such challenges, the right to health care is consistently defended. The bulwark that is created against retrenchment has a clear political message: citizens are entitled to universal health care, and expect that their social rights will be protected regardless of changing economic circumstances. This might indeed be a reasonable and legitimate expectation. However, the political implications of repeated defences of the social rights thesis have been consistently neglected, and need to be evaluated.⁴

⁴ For defences of the social rights thesis see:
 Desmond King and Jeremy Waldron. "Citizenship, social citizenship and the defence of welfare provision." *British Journal of Political Science*, 1988, vol. 18, 415-443.
 Gosta Esping-Andersen. "Power and distributional regimes." *Politics and Society*, 1985, vol. 14, 223-56.
 Desmond King. *The New Right: Politics, Markets and Citizenship*.
 Kathi Friedman. *Legitimation of Social Rights and the Western Welfare State*. Chapel Hill: UNC Press, 1981.
 Julie Parker. *Social Policy and Citizenship*. London: Macmillan, 1975.
 Ralf Dahrendorf. *The Modern Social Conflict: An Essay on the Politics of Liberty*. New York: Weidenfeld and Nicholson, 1988, chapters 7 and 8.

Retrenching Health Care

In the 1980s and 1990s, governments in most advanced industrialized democracies were firmly committed to exercising fiscal restraint, which often meant retrenchment in the field of health care. Expenditures for health care in Canada have grown rapidly since the creation of national hospital and medical insurance programmes in 1957 and 1966, respectively, and now seriously outpace governments' ability to provide adequate funding. As programmes expanded throughout the postwar decades, citizens' expectations rose continuously. People came to demand, as a matter of citizenship, virtually unlimited access to a comprehensive range of health services: this was partially the result of governments eagerly offering and delivering additional services within the popular universal health care system in order to secure voter support. By the mid-1970s this cycle of rising expectations and entitlement began to breakdown as governments came under pressure to contain costs in all areas; by 1977 the federal government replaced its generous intergovernmental cost sharing arrangement with a block transfer, which allowed the federal government more control over total spending in the field of health. In 1984 the Canada Health Act secured for the federal government its role as defender of Canada's "sacred trust"; health care came

Ralf Dahrendorf . "The changing quality of citizenship." In Bart van Steenberg (ed.) ,*The Condition of Citizenship* . London: Sage, 1994.

to be an important symbol of national identity, which could now authoritatively be enforced (the Act established the conditions upon which transfer payments would continue to be disbursed to the provinces). From 1977 to the present, the federal government has reduced transfers to the provinces at the same time that it has continued to insist on compliance with (at least some of) the conditions specified in the Canada Health Act.⁵ Not surprisingly, this has led to provincial resentment and subsequent demands for decentralization. Whether the federal government can, or ought to, maintain its role as defender of universal health care in Canada and thereby strengthen the cohesive effects of health care as social right, or resign from its role as senior partner in the social union in order that full decision-making authority can be devolved to the provincial level and beyond is perhaps the most pressing question of the day.⁶ It is certainly of great importance to citizens who fear that the public system is in peril and that further retrenchment and federal abatement will make privatization (American style) inevitable.

⁵ Odette Madore. *The Canada Health Act: Overview and Options*. Ottawa: Economics Division, Research Branch, Library of Parliament, 1995.

⁶ Alan Maslove. "Time to Fold or Up the Ante: The Federal Role in Health Care." John F. Graham Memorial Lecture, Dalhousie University, March 9, 1995 ; Thomas Courchene. *ACCESS: A Convention on the Canadian Economic and Social Systems*. Working Paper prepared for the Ministry of Intergovernmental Affairs, Government of Ontario. Reprinted in *Assessing Access: Towards a New Social Union, Proceedings on the Symposium on the Courchene Proposal*. Institute of Intergovernmental Relations, Queen's University, 1996.

However, it is difficult to find solutions to Canada's health care "crisis" of funding, authority and entitlement in the context of this ongoing debate. There is increasing ambiguity regarding levels of public support for universal health care, federal and provincial governments engage in relentless and highly ideological "wrangling" to preserve Canada's "sacred trust" at the same time that they reduce spending commitments for health care. For political reasons, politicians continuously misrepresent the principles, intentions and limitations of the health system that they inherited from previous governments and tend to cast debate in terms of impossible dichotomous choices. Such misrepresentation is legitimated by citizens' resistance to changes to what they perceive to be social rights of citizenship. Citizens consider a universally accessible, comprehensive set of portable benefits to be their right, and any attempts by politicians or bureaucrats to make changes in the system are considered to constitute rights violations. But how did this right develop? How is it changing? And is it still relevant at the beginning of the twenty-first century?

In this dissertation it will be argued that the symbolic appeal of health care, viz. its importance as a feature of Canadian identity, seems to have become institutionalized to such a degree that it constrains governmental decision-making. In the context of budgetary restraint, demographic

changes and technological advancement, such constraint is problematic. The defense of health care as a social right of citizenship is no longer a sufficient response to pressures for change.

In fact, it is entirely possible that the social rights thesis, propounded by T.H. Marshall in 1949, is no longer relevant, and that Canada might be on the much feared and maligned "slippery slope" to health care business. Health Canada reports that private expenditures now represent 30.1% of all health expenditures⁷, and Canadian doctors are leaving the country to practice in the United States. In recent years, the Canadian Medical Association has come close to formally supporting a two tiered system (which exists already), and there is a large faction within the medical profession that argues the position with conviction and authority on a regular basis. Marshall's inspiration, that citizenship is an evolving concept, has long been forgotten by defenders of the welfare state, and now serves only as a warning what should have been heeded, as approaches to health care provision in North America seem to be converging.

Health Politics in North American Perspective

The United States' health system is considered to be one of the most inequitable and expensive in the industrialized world. Administrative costs, in addition to technological

⁷ Health Canada: *National Health Expenditures in Canada 1975-1996*. Policy and Consultation Branch, June 1997.

and demographic changes, have contributed to the rapid escalation of health care expenditures which now represent approximately 13.7 percent of GDP.⁸ Yet despite the rising costs and apparent expansion of the system, it is estimated that the percentage of uninsured workers ages nineteen to sixty-four who are not covered as a dependent or by a public program is approximately 23.3, and will increase to approximately 27 in 2005.⁹ Governments, medical societies, employers, and citizens are well aware of the serious problems presented by an (arguably) well funded health system that leaves a significant and growing proportion of the population uninsured, although there is no consensus on how the system should be reformed.

For Canadians, the universal health care system is a source of national pride, and it is an important symbol that distinguishes Canada from the United States.¹⁰ In this regard, Canadian health care politics is appropriately considered on a North-South rather than a left-right axis. Canadian health care reformers must exercise rhetorical

⁸ U.S. Department of Health and Human Services, Health Care Financing Administration. *Health Care Financing Review* , 17, Spring 1996, p. 229.

Public expenditures for health care represent approximately 6.6 and 6.8% GDP for the United States and Canada, respectively. World Bank , *World Development Report: Knowledge for Development 1998/99* , 1999, Table 7, p. 202-203.

⁹ Kronick, Richard and Todd Gilmer. "Explaining the decline in health insurance coverage, 1979-1995." *Health Affairs* , 1999, vol. 18, no. 2.

¹⁰ Miriam Smith. "Retrenching the Sacred Trust." Francois Rocher and Miriam Smith (eds.), *New Trends in Canadian Federalism* . Peterborough: Broadview Press, 1995.

caution in order that their efforts are not labeled "Americanizations", and Canadians seem to be relatively satisfied with their withering health system because it is at least better than what is offered in the United States.¹¹ Hence, the suggestion that a competitive market approach to health care would be feasible in Canada is counterintuitive, if not somewhat disturbing.

In fact, the pressure to adopt more market type mechanisms in Canada has been seriously and successfully resisted by Canadian reformers, and the social rights thesis has been consistently defended. But the structure of the debate needs to be changed so that it is no longer an ideological debate between those on the social democratic left who defend social rights as a remedy to inequality, and those on the right who argue that social rights are an affront to responsibility, efficiency and freedom of choice. The social rights thesis needs to be more thoroughly critiqued and revised from the left, rather than merely defended with various caveats, for two reasons. First, the social rights thesis is outmoded, and has been critiqued and revised rigorously only from the right.¹² But those on the

¹¹ In fact, it might be the case that Canada's most revered social program is Canada's ONLY well developed social program. For a revealing discussion of the dynamics of social policy in Canada, see Carolyn Tuohy, "Social policy: two worlds." In Michael M. Atkinson (ed.), *Governing Canada: Institutions and Public Policy*. Toronto: Harcourt Brace Jovanovich, 1993.

¹² See for example, Lawrence Mead on US poverty. I know of no such commentators who focus exclusively on Canadian health care.

left need to recognize that new challenges, such as those posed by differentiated citizenship, are not satisfied by the promise of equality that is inherent in social rights. In addition, the changing nature of rights claims and public budgeting change the context for, and hence substance of, social rights; health care as a community right (its original formulation) is running headlong into legal rights claims, and the vagaries of budgeting in periods of chronic and acute scarcity redefine social rights that were institutionalized in conditions of relaxed scarcity and political commitments to Keynesianism.

Second, the right to health care has become institutionalized as a potent political symbol in Canada. The political importance of health care makes governments reluctant to significantly alter patterns of service provision, even when evidence exists to indicate that change is necessary (i.e. need for changes to medical/institutional model of care, but hospital closures result in public outcry). To be sure, that the social rights thesis is outmoded does not mean that the market approach to health care is either inevitable or fair; Marshall's essay needs to be updated in order to clarify and strengthen commitments to equality, not overturn them. The institutionalization and continued uncritical defence of social rights in Canada has caused stasis, and presents a stumbling block to discursive and policy progress.

Revisiting the Social Rights Thesis

In the following chapter, I will explain in greater detail that social rights developed as the result of the confluence of many social, political and economic factors. It is not surprising that citizens came to consider universal health care to be their right; health care was established as an entitlement program (as opposed to means tested, for example). Enrollment in the public plan was guaranteed as a matter of citizenship and citizens considered these social benefits to be "their due"¹³: recognition and compensation by the state for the difficult times endured throughout the 1930s and 1940s. Furthermore, and again in the language of rights, citizens "justly expected"¹⁴ that the recent advances in medical technology should be made available to all, on an equal basis. The "bargain" that was struck between citizens and the state, which entailed relatively high rates of taxation and heavy regulation of the economy in return for social programmes, was maintained for approximately three decades (1945-1977). As the politico-economic climate changed from one of relaxed, to chronic and then acute scarcity, it became apparent that citizens' expectations do not easily adjust downward, especially when the burdens of

¹³ H.L.A. Hart. "Are there any natural rights?" In David Lyons (ed.), *Rights*. Belmont: Wadsworth, 1979.

¹⁴ Arthur Dyck . *Rethinking Rights and Responsibilities: The Moral Bonds of Community* . Cleveland: The Pilgrim Press, 1994.

citizenship (taxes, restraint, unemployment) are high. There is no doubt that health care has become an important social programme (because it mitigates inequality of status) as well as a powerful political symbol.

However, the promise of social rights, namely the guarantee of a minimum standard of citizenship in order to secure substantive equality, is somewhat empty. Citizenship in the 1990s is marked by increasing differentiation and requires variable definitions of political equality. According to identity theorists, welfare state political commitments to equality and universality have been only marginally successful in delivering substantive citizenship benefits. In other words, while equal procedural rights have been accorded to all citizens, gains in equal substance of citizenship have been quite thin. And the rhetorical force of the former tends to diminish the claims concerning the latter. Therefore, that an empty promise continues to constrain much needed reform efforts, should raise concern. It should also present a paradox in that health care, as Canada's most important social programme, might be undermined by its strength as a political symbol.

Social Rights and the Promise of Equality for Citizens

The need to revise the social rights thesis is not so much a critique of its original formulator, T.H. Marshall, as it is a critique of those who have interpreted and advanced the idea of social rights as citizenship. In his 1949 essay,

"Citizenship and Social Class", T.H. Marshall examines the compatibility of formal rights of citizenship with social class, and argues that "the inequality of the social class system may be acceptable provided the equality of citizenship is recognized."¹⁵ In the twentieth century, equality of citizenship is guaranteed through social service provision.

To fully understand how Marshall explains the historical evolution of citizenship, it is necessary to revisit his analysis and retrace the lines that link social class distinctions to rights possession. It is important to recognize that the relationship of social class to rights has not always been grounded in assumptions of political equality. To be sure, the notion that all human beings are entitled to certain inalienable rights (and ought to be entitled to a range of social rights) is only a few hundred years old, and has not been formally endorsed in all democratic nations.

The general theme of Marshall's argument, hereafter referred to as the social rights thesis, is quite well known. Marshall explains that there are three "elements" of citizenship, that have been "dictated by history even more clearly than by logic."¹⁶ These are the civil, political and social:

¹⁵ T.H. Marshall, *Class, Citizenship and Social Development* . New York: Doubleday, 1964, p. 76.

¹⁶ Ibid, p. 78.

The civil element is composed of the rights necessary for individual freedom -- liberty of the person, freedom of speech, thought and faith, the right to own property and to conclude valid contracts, and the right to justice. . . By the political element I mean the right to participate in the exercise of political power, as a member of a body invested with political authority or as an elector of the members of such a body. . . By the social element I mean the whole range from the right to a modicum of economic welfare and security to the right to share to the full in the social heritage and to live the life of a civilized being according to the standards prevailing in the society.¹⁷

According to Marshall, these elements of citizenship did not develop in mutual exclusion, although it is possible to identify their moments of congealment in the eighteenth, nineteenth and twentieth centuries, respectively. Each element of citizenship, or type of right, is aimed at minimizing inequality in social status in order that every citizen will be able to fulfill his or her duties, and thereby be accorded full membership in the political community.

That social rights could guarantee equal status of citizenship regardless of social class (wealth or income level), was a grand promise. Indeed, Marshall's historical and sociological analysis of citizenship development provides theoretical foundations for countless arguments both in defence and repudiation of the welfare state. However, the complexities of his argument are either outmoded, or seriously underdeveloped by those who have popularized the social rights thesis.

¹⁷ Ibid.

On the first charge, that the social rights thesis is outmoded, there are two main points to be made. Marshall was concerned about limiting the effects of class distinctions. He believed that all citizens should have equal status, regardless of social class: "...social rights imply an absolute right to a certain standard of civilization which is conditional only on the discharge of the general duties of citizenship. Their content does not depend on the economic value of the individual claimant."¹⁸ So, the first point is that it is important to notice that Marshall considers social class to constitute the primary source of inequality among citizens. Certainly, class abatement was an important achievement, on which many other social gains (in the direction of equality) were contingent. However, fifty years after Marshall's lecture, it is not at all clear whether social rights, as both a theoretical construct and a pragmatic political promise, can accommodate or mitigate more profound and immeasurable forms of inequality (gender, sexual orientation, race, ability).

Second, in Canada, the promise that equality could be delivered through social programmes, namely universal health care, became institutionalized as a highly charged political symbol. That all Canadian citizens should have access to a comprehensive range of health services seems to be a non-negotiable, self-evident tenet of the state-society

¹⁸ Ibid, p. 103.

relationship. Hence, governments' efforts to restructure the health care system are often construed as an affront to social rights of citizenship. Careful political posturing is necessary in order that changes can be made without causing alarm among the populace. On the one hand, the institutionalization of social rights has a positive effect, in that the benefits conferred by social rights (to achieve equal status of citizenship), universal health insurance being the most prized, cannot easily be rescinded by governments bent on balancing their budgets. On the other hand, however, the political importance of universal health care constrains governments in constructing viable reform agenda. And it is this negative effect that indicates the need to revise, rather than continue to blindly defend, the social rights thesis. To be sure, such a suggestion does not render Marshall's analysis useless. Rather, it makes necessary a clarification of Marshall's original argument from those of his defenders.

The second charge, that defenders of the social rights thesis have either misinterpreted Marshall's argument, and/or failed to revise it, is confined here to analysis of the health system in Canada, although it has global implications. Those scholars and practitioners concerned about the erosion of the welfare state by the forces of globalization, catalyzed by a neo-liberal trade agenda (environmentalists, nationalists, those who defend borders as a means of protecting hard-won social policies), for example, have

little choice but to come to terms with what they perceive to be threatening forces, and find new ways to defend or promote their interests within that context.¹⁹ Similarly, those scholars who categorically defend the social rights thesis misunderstand the dynamics of change that have to be considered within the definition of citizenship, and need to recast their arguments in accordance with fiscal, administrative, demographic and ethical pressures for reform. Prolonged, uncritical defense can do real damage, because it serves to reinforce the strength of health care as a political symbol regardless of imperatives for change.

The main problem is that defenders fail to recognize that social rights might protect existing patterns of authority and provision (dominance of medical profession, institutional care, and so on). In short, social rights hold constant the mechanics of the health care system. Of course, this might be further simplified to say that in-between periods of comprehensive policy change, there is a degree of "path dependency" that accounts for stability in policy development.²⁰ Such stability in the Canadian context is both beneficial and burdensome, the ambivalence conveniently bound

¹⁹ See for example Allison Young (1999). "Labour Mobility and the GATS: Where Next?" Paper presented at Services 2000: New Directions in Services Trade Liberalization (A Preparatory Conference Sponsored by American Enterprise Institute; The Brookings Institute; Center for Business and Government, Harvard University; CSI Research and Education Foundation). Washington, DC, June 1-2.

²⁰ Carolyn Hughes Tuohy, *Accidental Logics: The Dynamics of Change in the Health Care Arena in the United States, Britain and Canada*. New York: Oxford Univ. Press, 1999, Chapter 1.

up in health care rights claiming. Canadian scholars and casual observers seem to have too much faith in the ability of social rights to equalize status of citizenship, and such faith is becoming less and less feasible as the contours of citizenship, economics and health change. Continued rights claiming in regard to health care is problematic for both the theoretical and political inconsistencies that it presents. Conceptually, current patterns of health care rights claiming are disjunctive with what Marshall envisioned, in that they are increasingly individualistic, and Marshall's thesis, the enduring standard in social rights discourse, has not been revised to sufficiently recognize identity rights. Politically, social rights, as the embodiment of citizens' expectations for continued development of welfare state programmes, hold less promise in contemporary intergovernmental, budgetary, medical, and epidemiological contexts.

Defending the Social Rights Thesis: Problems and Puzzles

As explained, there are two main problems with the social rights thesis: it is outmoded, and has become institutionalized in Canada to such an extent that it causes stasis. However, there are a number of more specific reasons why the social rights thesis is outmoded, and hence problematic as an entrenched component of Canadian citizenship.

A. Marshall's historical narrative and conceptual argument pertain directly to Britain. Over the past fifty years, the social rights thesis has become, seemingly, universally applicable, yet it has not been well developed to fit with, or describe, circumstances in other countries or temporal periods.

B. Similarly, Marshall might have originally intended his analysis to have equal relevance for all components of the "modicum of social benefits", but most contemporary discussions of social rights address issues of poverty or education. Thus, in order to evaluate the right to health care as a sub-entitlement of social rights, further modifications and specifications must be made.

C. Marshall's unidimensional understanding of inequality, i.e. as the result of social class differences, does not fully account for inequality in multi-ethnic, multi-cultural states. There are a number of critiques and discussions that probe further this problem, but, even taken together, they are not sufficiently specific (to country or policy field), and do not address the political implications of new sources of inequality (or perpetuating the old).

For example, J.M. Barbalet considers the intersection of class inequality and rights struggle.²¹ According to Barbalet, Marshall's contribution to citizenship discourse is unparalleled, yet imperfect for a number of reasons, the most

²¹ J. M. Barbalet. *Citizenship: Rights, Struggle and Class Inequality*, Minneapolis: University of Minnesota Press, 1988.

important of which is that Marshall underestimates the divisive effects of social class. Specifically, the social rights thesis fails to recognize the substantial degree to which inequalities in wealth and income create barriers to the exercise of rights. So, while Marshall is unconcerned with the logic of capitalism, and addresses only the effects of markets as a means of achieving substantive political equality, Barbalet argues that this "glossing-over" class inequality might exacerbate rather than mitigate that inequality.

However, the problem thus identified is still class inequality, which might currently have greater relevance in Britain than in Canada. As noted, class is one of many cleavages in Canada, but is not, arguably, the most politically divisive or salient. Language, region, gender, and sexual orientation intersect with class, and the elimination or reduction of inequalities generated by these differences is contingent in many cases on class abatement. However, consideration of social class as the sole determinant of inequality is problematic in multicultural, multiethnic states.

This problem is addressed by Bryan Turner²² and Barry Hindness,²³ who demonstrate a conventional understanding of

²² See Bryan Turner. "Contemporary Problems in the Theory of Citizenship." In Bryan Turner (ed.) , *Citizenship and Social Theory* . London: Sage, 1993.

²³ Barry Hindness. "Citizenship in the Modern West." In Bryan Turner (ed.) , *Citizenship and Social Theory* . London: Sage, 1993.

the social rights thesis, yet recognize the importance of incorporating a differentiated perspective in discussions of social citizenship. Hindness' critique from the left is particularly compelling. The argument he advances is that equality has not been achieved by the institutionalization of social rights, and gains that have been made through political commitments to social rights and under the rubric of equal status of citizenship do not sufficiently close the gap between citizenship and social class, and reinforce certain traditional familial patterns. However, neither Hindness nor Turner considers the political implications of either model of citizenship.

D. The development of social rights in the postwar period was, in part, due to the macroeconomic trends of that time. Commitments to Keynesianism, as part of the Breton Woods Agreement, allowed governments to spend on social (and other) programmes regardless of budgetary circumstances. The feasibility of such an approach declined in the 1970s, and by the 1990s, budget balancing had become the priority of virtually all Canadian governments. The macroeconomic trends of the period of social rights development, then, are markedly different from those of the period of social rights defending, or health care rights claiming, and deserves examination. Such an important undertaking has been categorically neglected.

E. In addition, the need for social rights, and in particular, universal health care, was pressing in the period of social rights development because of the prevailing dynamics of health and disease. State action was necessary in the 1940s and 50s in order to respond to citizens' suffering caused by public health epidemics and communicable disease. In the 1990s, the main cause of death and illness is non-communicable disease, which has profound social effects. This shift in main causes of death from communicable to non-communicable diseases, in addition to trends of deinstitutionalization, which leave home care and pharmaceuticals (sometimes prohibitively expensive) outside "universal" programmes, require a new blend of individual responsibility-taking and collective entitlement, as well as more differentiated approaches to service delivery.

F. As noted, Marshall conceived of social citizenship as a reciprocal arrangement between citizens and the state. The implications of such reciprocity have not been thoroughly examined or sufficiently understood in contemporary defenses of the social rights thesis.²⁴ However, Marshall's

²⁴ King and Waldron recognize that there is tight reciprocity between social rights and duties, but do not evaluate the correlation. At the heart of their analysis is the assumption that social rights constitute legitimate expectations. This assumption, concerning the normative claim that citizens are entitled to a modicum of social benefits is valid, but the implications of the claim need further examination. King and Waldron's uncritical assessment serves to maintain the polarization of statist and market approaches to addressing social inequality. Their argument, structured as a debate between proponents of social rights theory and the New Right, gives the impression that social rights can either be defended, or rejected outright: no middle ground, just a tug of war between ideologues.

description of social rights development, and suggestion that states ought to institutionalize social rights as a matter of citizenship, is contingent on his historical analysis, which finds that rights were accorded by governments in a piecemeal way, and in response to the *requirements* of capitalism.

This is an important detail, and one that has been almost completely ignored by Marshall's followers. In the eighteenth century, the basic civil right in the economic field was the right to work,

that is to say the right to follow the occupation of one's choice, subject only to legitimate demands for preliminary technical training. This right had been denied by both statute and custom; on the one hand by the Elizabethan Statute of Artificers, which confined certain occupations to certain social classes, and on the other by local regulations reserving employment in a town to its own members and by the use of apprenticeship as an instrument of exclusion rather than recruitment. The recognition of the right involved the formal acceptance of a fundamental change of attitude. The old assumption that local and group monopolies were in the public interest, because 'trade and traffic cannot be maintained or increased without order and government', was replaced by the new assumption that such restrictions were an offence against the liberty of the subject and a menace to the prosperity of the nation. (82)

In other words, the right to work (as an expression of liberty), and the duty to exercise that right, were secured (through the courts) because they were essential to the economic well-being of the nation. In the next century, political rights were also won (by certain segments of the population) through economic struggle; the right to vote, or stand for political office, were necessary in order for

citizens to protect their private property, and participate in decision-making that would affect their right to work. And it was because economic liberalism required an educated and healthy populace that the rights to education and health care were granted to all British citizens, regardless of social class, in the twentieth century.

With the institutionalization of the first part of Marshall's citizenship equation (rights), a certain (passive) conception of equality was engendered. The duty side of the equation generates a more active conception of equality, which has become appealing to both left and right wing proponents of change. Provincial health reform agenda harbour these competing notions of equality, which makes difficult the implementation of coherent reform measures.

Pluralism and the Politics of Difference

Before I delve into the details of my argument, I think it is necessary to briefly explain how the debate concerning the politics of difference is relevant to discussions of health care, entitlement and the role of the state. To begin, citizenship, as the relationship between citizens and the state, is contingent on the very ways in which the state is conceived of, or the ways in which it functions. Most political scientists describe North American states as pluralist in nature, meaning that groups form and interact in society in order to articulate the interests of their members. The controversial conclusion that pluralists

draw from their analyses of decision making is that policy outcomes (arrived at through incremental steps) accurately reflect the full range of competing interests in society.

Pluralist and neo-pluralist²⁵ conceptions of the state, however, are not adequate to explain the current context in which there is a multiplicity of differentiated citizenship claims (as well as a context in which incrementalism needs to be supplemented with some strategy). Radical pluralists, such as Iris Marion Young and Chantal Mouffe, do not question the principles of democracy or pluralism, but are critical of the ways in which they are operationalized. In other words, the promise of equality of citizens in influencing political decisions is theoretically sound, yet practically problematic. Procedural guarantees need to be combined with recognition (through public policy) of substantive differences among citizens and groups of citizens. The mechanisms through which recognition could be institutionalized might, for instance, include "public funds for advocacy groups, guaranteed representation in political bodies, and veto rights over specific policies that affect a

²⁵ Neo-pluralist approaches recognize the privileged position of business above all other groups competing for political resources in polyarchies. However, it is also the case that in certain sectors single interest groups dominate the policy agenda, such as organized medicine in the health policy field. Such organizations are properly considered to occupy the same privileged positions as business in that they have very clear, vested economic interests and an unrivaled level of expertise that allow them to exert an inordinate amount of influence in decision making.

group directly."²⁶ Such an approach could help to address historical patterns of marginalization, as well as allow for a more effective distribution of resources.

To be sure, "radical pluralism" is not usually offered as a theory of the state. Rather, it is, in the main, a challenge from feminist theory to incorporate identity and difference into dominant cultural and political systems. The degree to which theories of radical pluralism serve to inform pluralism as a theory of the state, however, is considerable. Radical pluralism, or differentiated citizenship claims, or identity rights, enriches the conceptual debate over social rights and citizenship, and offers a thoroughgoing critique of welfare state patterns of entitlement. It also provides a model for rethinking health policy in a context of insufficient resources (i.e. government funding) and rising citizen expectations. Different communities (the elderly, women, persons with HIV/AIDS) need to use the health system in variable ways, and public policy should reflect these differences, not dissolve them into the existing programmes. This does not suggest repudiating universality, but building on it in new ways. In fact, there are already different services and programmes available for Native Canadians, people with diseases that require prohibitively expensive medications, and the elderly (who have drug entitlements that are not made available to the general Canadian population).

²⁶ Iris Young's position as explained by Kymlicka and Norman, "Return of the Citizen." See also Iris Marion Young.

So, in some respects I am merely suggesting that this approach needs to be expanded, which might pull the health system out of its current "static" position. But what I am suggesting also makes necessary a complete rethinking of the Canadian social citizenship bargain. While I argue that it is possible to continue to distribute health care as a public good in Canada, it is also the case that a fair distribution no longer denotes strictly equal distribution. "Political communities," as the basis for understanding the population's health care needs and delivering on them, need to be reconceived as identity-based so that they can inform and interact with geographically-based decision making entities. This strategy will be discussed more thoroughly in Chapter Four.

Chapter Outline

As provincial governments devise health care reform strategies to respond to the changing dynamics of budgeting, federalism and health, citizens resist changes to what they perceive to be social rights of citizenship. Such resistance is beneficial in that it serves to protect entitlement and secure health care as a symbol of national identity. However, the right to health care has been defended categorically as an infungible, sustainable element of the state-society relationship in spite of the evolutionary nature of social citizenship. Furthermore, the meaning of

"the right to health care" has never really been determined. What do citizens mean when they say that they have the right to health care? Does the claim indicate a normative asseveration of collective entitlement, or protection of individual moral property? In chapter two I argue that the right to health care has changed significantly over the past fifty years in response to a variety of forces (many pulling in the same (individualistic) direction). This argument will serve to examine problems A and B; Marshall's analysis pertains directly to Britain, and addresses issues of education and poverty, which necessitates modifications in order to fully understand the importance and/ or effect of the social rights thesis in different geographical contexts and in regard to health care (these problems are also addressed obliquely throughout the thesis). More specifically, the argument of this chapter addresses problem C, one of the most troubling aspects of contemporary defences of Marshall's analysis: unidimensional account of inequality. By the end of this important conceptual chapter, it will be clear that the right to health care in Canada is most accurately conceived as a second order human right, reliant on ought statements rather than the precepts of natural law. As such, the right to health care is fluid, and changes as citizenship develops beyond the social rights stage. Citizenship development is pushed by changes in constitutional arrangements, public management practices, and

corresponding citizen expectations. Paradoxically, as expectations advance, they also stay the same. This is to say that citizens' expectations rise incrementally; new expectations build on, rather than replace, previously held and institutionalized expectations. The result of the paradox in expectations, is stasis.

In chapter three I argue that social rights stasis is reinforced by the dynamics of budgeting, the politics of federalism, citizens' fear of privatization, and organized medicine. Social rights made more sense in context of Keynesianism (domestic commitments to balancing the economy through countercyclical economic management), relaxed scarcity, and postwar nationalism, and is somewhat outmoded in budgeting environments marked by increasing numbers of competitive claims. The goal of governance in the 1990s has become respecting the diversity of these claims, not reducing them to a common denominator (problem D). Further, in this chapter I argue that stasis is problematic because of its consequences for health. The shift in main causes of death from communicable to non-communicable diseases (the epidemiological transition), requires a new blend of individual responsibility-taking and collective entitlement, as well as more flexible approaches to service delivery. Defences of social rights, as originally formulated, reinforce the medical model at the same time that they recognize the need for change (problem E). The argument of this chapter serves to explain the main causes of confusion

and lack of change in the health policy field. Building on the conceptual argument of chapter two, this chapter introduces institutional and system level analysis as a means of substantiating the ongoing conceptual project and establishing a context for the following policy-specific chapter.

Chapter four addresses the sixth and final problem with Marshall's social rights thesis: defenders have neglected the reciprocal nature of state-society relationships (problem F). In this chapter I argue that provincial exercises in community engagement for health care decision-making might provide important opportunities for citizens to fulfill their duties of citizenship. That is, citizens can become more active in determining the ways in which health care is delivered in the context of technological advancement, alternative service provision, changing demographics and epidemiological patterns, and finite resources. The problem is that such opportunities might be undermined by social rights stasis, which perpetuates the existing welfare state model. The development of community governance structures for health care, as a major component of provincial health care reform packages, is considered in detail and is suggestive, if not representative, of other trends in health policy. This chapter crystallizes several lines of argument pursued in the thesis, and concludes that differentiated citizenship claims can be accommodated and promoted by a more fragmented, localized set of decision making structures

because citizen and "community" empowerment and consultation can inform policy reform and provide some balance to the power of the medical profession.

In chapter five, the argument is concluded with evaluation of social citizenship development in Canada. The empirical evidence and theoretical arguments presented indicate that Canada is entering a fourth stage of citizenship development. Of course, not all problems of third stage were solved, and, health care, as Canada's sacred trust and irresolvable social policy dilemma, is not likely to be perfected in the next stage, either. But it is essential to understand that the social rights thesis, as popularly defended, is outmoded, in order that change can be effected.

Conclusion

The argument of the thesis, as explained in this introductory chapter, while distinctly political, employs an interdisciplinary approach to understanding and evaluating social rights. Contributions by sociologists, philosophers and health policy analysts provide the framework in which answers are sought to the question: how have social rights become institutionalized in Canada, and what are the political implications of the institutionalization of social rights of citizenship? The temporal period for this analysis is approximately 1977 (the year in which many economic and political forces culminated in a major change in funding

arrangements for health care: Established Programs Financing) to the tabling of the Federal Budget in February 1999, although much of the analysis has a broader historical context. As the universal health care system developed throughout the 1940s, 50s and 60s, and the range of available services expanded, citizens' expectations were elevated. And by 1980, when retrenchment was imminent, health care had become a symbol of Canadian identity, and as such, a politically charged policy field. The political potency of health care has proven to be a serious constraint to change at a time when decision-making for health care requires dynamism and flexibility, rather than stability and stasis.

CHAPTER TWO

Revising the Social Rights Thesis: Understanding the Right to Health Care in Canada

Introduction

The resonance of T.H. Marshall's work on citizenship is remarkable. In a series of lectures he was able to cogently explain the evolution of citizenship over three centuries, and at the same time, capture the essence of contemporary and emerging sentiment concerning social inequality and entitlement.¹ However, the social rights thesis has been consistently defended as an infungible, sustainable element of the state-society relationship, in spite of Marshall's caveat that citizenship is an evolving concept. In this chapter I examine closely the third stage of citizenship development (social rights) in Canada in order to evaluate the extent of change in social and political contexts and the consequent transformation of the right to health care. Such an exercise will serve to address three main problems with contemporary defences of the social rights thesis. First, Marshall's analysis, intended specifically as an historical analysis and set of normative claims pertaining directly to Britain in the immediate postwar period, has been imported to other geographical and temporal contexts without careful consideration of how the meaning and substance of citizenship as rights development differs among countries and decades.

¹ T.H. Marshall. *Class, Citizenship and Social Development* .
New York: Doubleday, 1964.

Second, although Marshall mentions health care as one component of the required modicum of social rights, his historical narrative most clearly deals with issues of poverty and the need for inclusive measures of poor relief. Therefore, to make a case about the right to health care, further modifications to the social rights thesis must be made. These modifications would include, among others, evaluation of different policy areas (namely, health care), countries (in historical context), political systems (federal, executive-driven), cultural dynamics, and temporal periods. And third, in the Canadian context it is likely that citizenship is developing beyond the social rights period. That is to say, the simple unity that was generated by the implementation of universal social programmes has become dissonant with emerging, differentiated citizenship claims.

In order to examine these problems, through historical narrative and theoretical argument I will offer an answer to the following question: How did the right to health care become institutionalized in Canada, and how has it evolved over the last half century? I will argue that the meaning of the right to health care (as a subset of social right) has changed significantly in Canada throughout the last fifty years, and citizenship in Canada might have entered a fourth period, marked by the emergence of identity rights.

There are at least two meanings or "right", according to which social rights can be evaluated. The first is a broad

category of "human rights" which would include what Ronald Dworkin calls rights in the "strong sense"², and a more general grouping of normative assertions. Rights in the "strong sense" are argued to be prior to governments or political communities, and therefore not alterable (without strong moral justifications) by either. It is not clear whether the right to health care constitutes a human right, and if so, what the referent is. In other words, the human right to health care might indicate entitlement to publicly provided services, or privately available medical choices. The argument of this chapter does not necessarily assume that health care constitutes a human right, in the strong sense, although it seems that a convincing case can be made for its conception as such.

Within the general category of human rights, is right as "just expectation," which can be discerned in citizens' resistance to change in the health system. Citizens seem to expect that, as a matter of social right, entitlement to health care will continue to be distributed universally as a public good regardless of changing political or budgetary conditions. This conception is specific to Canada, and might or might not generate any universally applicable normative claims.

The second conception is that of right to health care as legal right. It seems to be the case that rights claims for

² Ronald Dworkin. *Taking Rights Seriously* . London: Duckworth, 1978.

health care are increasingly legalistic in nature. When citizens claim that they have the right to health care, they have two intentions. The first is to assert their expectations. And the second is to back-up their claim with legal force (even if this force is only rhetorical, and does not precipitate any litigious action). In short, there are two points to observe about contemporary health care rights claiming. One, citizens' expectations seem to be consistent over time. The incremental nature of their expectations reflects past experiences and patterns of entitlement, as well as future entitlements to advanced medical technology, pharmaceuticals and services. And the legalistic, individualistic force of the claims, as the result of changing political, economic and social circumstances, impairs the possibility for much needed improvements in the health system because it is employed to reinforce or protect a rather rigid set of expectations.

Social Rights as Citizenship

There are generally considered to be two periods of social rights development in Canada. The first is a "relatively stable citizenship regime that lasted from the 1940s to the 1980s."³ In this period the "federal government funded a wide range of citizen groups that were seen as the vehicles for helping disadvantaged segments of the population achieve

³ Katherine Graham and Susan Phillips. "Citizen engagement: beyond the customer revolution." *Canadian Public Administration*, vol. 40, no. 2, Summer, p. 257.

equality through collective action and, in so doing, reaffirm their Canadian identity."⁴ Also, in this period many important social programs were created and "were generally pan-Canadian in nature, supported by the use of the federal spending power."⁵ These programmes drastically altered the citizenship regime; what it meant to be Canadian evolved in this period to include access to a range of social benefits. The universal health care system would become the most revered of the social programmes.

The commencement of the second period is marked by the Charter of Rights and Freedoms. Graham and Phillips explain that

on the one hand, the Charter made a commitment to "categorical equity." Women, the disabled, aboriginal peoples were designated as categories of citizens who should receive equitable treatment. On the other hand, the Charter entrenched individual rights and provided a reference point for the emerging philosophy of individual responsibility taking.⁶

The latter points to an individualistic turn in Canadian rights culture, which has contributed greatly to the shift in citizens' expectations that is discernible in this period. As governments exercise fiscal restraint, levels of service are declining. This harsh reality, in addition to the more individualistic rights culture that is emerging, is that disjunction is created in the distribution of benefits and

⁴ Ibid.

⁵ Ibid.

⁶ Ibid.

burdens of citizenship. Moreover, as social rights are diminished in the context of retrenchment, citizens are making legalistic, possessive individualistic rights claims in hope of preserving the social rights regime. This is itself a paradox because social rights are rooted in a normative/ objective conception of right, which is a major departure from more modern, possessive conceptions. Seems like the need to defend social rights is more pressing than ever.

However, the Charter commitment to "categorical equity" also demands consideration in this debate. While rights have become more individualistic, the legal recognition of social inequality based on gender, race and sexual orientation, has created new definitions of "community", and identified more sources of inequality (other than social class).

Thus, the requirements of citizenship in Canada (and other Western democracies) are becoming greater in number and diversity, which makes it less likely that the promise of simple unity (from universal access to social goods as a matter of citizenship) obtains in current (and future) social, political and economic contexts. This is not to say that universal health care provision is no longer important. It is. The point to be made is that the social rights thesis needs to be revised so that it can provide an appropriate theoretical context for reform, rather than an obstacle to debate and action.

Health Care: Canada's Collective Conscience

Perhaps the most important information about the first period of social rights development is economic. This was a period of "relaxed scarcity"⁷; there was nearly full employment, governments ran budget surpluses, and the post-war economy was strong. Government had acquired the means necessary to address the deleterious effects of the Great Depression, which proved that everyone was vulnerable to economic adversity, regardless of social class. The 44% rejection rate of young male recruits for the war effort further demonstrated the need for national action in health care in that those in poor health could not fulfill their obligation to country.⁸

The development of the universal health care system began with the report of the Rowell-Sirois Commission on Dominion-Provincial Relations, which recommended state medical insurance.⁹ This recommendation was a reflection of the growing need for health services among the populace, as well as the recognition, in the aftermath of the Great Depression, that provincial governments might not have

⁷ Allen Schick. "Budgetary adaptations to resource scarcity." In Charles Levine and Irene Rubin (eds.), *Fiscal Stress and Public Policy*. London: Sage, 1980.

⁸ Malcolm Taylor. *Health Insurance and Canadian Public Policy: The Seven Decisions that Created the Canadian Health Insurance System*. Montreal and Kingston: McGill-Queens University Press, 1978, p. 33.

⁹ This point is debatable. Public health insurance was considered initially at the federal level by Mackenzie-King in 1919. In my estimation, it is with the Report of the Rowell-Sirois Commission that momentum toward publicly insured hospital and medical insurance began to build.

revenue capacity sufficient to fund social initiatives. Further, it was the view of the Commission that "the necessary solvent, the circumstance under which enough consensus results to make federalism workable, is thus widely distributed economic well-being."¹⁰ In other words, redistribution was important not only as a matter of fairness, but because it was required by federalism.

The Commission was also prudent to recognize that federal involvement in areas of provincial jurisdiction was a volatile undertaking. In 1937, the same year that the Royal Commission on Dominion-Provincial Relations (Rowell-Sirois) was appointed, the JCPC declared most of former Prime Minister R.B. Bennett's New Deal legislation to be *ultra vires*. The purpose of the New Deal was to provide relief to Canadians who had suffered through the Depression, as well as to create a social vision for the country. Despite the fact that the legislation was could not be passed, it marked the beginning of a new era of social policy in Canada.

Then, in 1948, the CCF government in Saskatchewan became the first provincial government to bring about a public hospital insurance program. This was a particularly bold move since the federal government had not yet committed to the establishment of a national hospital insurance programme or to support provincial initiatives.¹¹ The CCF government,

¹⁰ Donald Smiley (ed.). *The Rowell-Sirois Report Abridged* . Toronto: McClelland and Stewart Ltd., 1964, p. 5.

¹¹ *Ibid*, p. 81.

led by Premier Tommy Douglas, had campaigned on the promise to implement a hospital insurance plan (and fulfilled the promise two and one half years into its mandate in spite of deadlocked federal-provincial relations on the issue). The pioneer legislation was the product of the culmination of many economic factors as well as new political forces. Municipal doctor and hospital plans were failing due to the inadequacy of provincial resources; the citizens of Saskatchewan were desperate for a competent public health system. And, clearly, Saskatchewan farmers' duty to work was contingent on their own health, and that of their families. Harley Dickinson explains:

Agricultural production in Canada in general, and Saskatchewan in particular, is based on production for the market. It is not primarily organized on a subsistence basis. Consequently farmers' incomes depend upon farmer productivity on the one hand, and relative market strength on the other. Anything that threatens productive capacity, including injury or illness, also threatens the economic well-being and survival of farmers. Because Saskatchewan farmers are both owners of capital in the form of land and equipment, and dependent on the use of their own and family members unpaid labour to produce crops, they have a direct interest in ensuring the quality and productive capacity of that labour power. Medical and hospital services, in addition to other illness and injury prevention programs and health care services, are important in this regard.¹²

The CCF party's commitment to public health insurance recognized these issues and in so doing generated subsequent demand among other sectors of the population. In 1962

¹² Harley Dickinson. 'The struggle for state health insurance: reconsidering the role of Saskatchewan farmers.' *Studies in Political Economy*, 1993, vol. 41, Summer, 137-38.

political conviction and broad public support led to the development of public medical services insurance in Saskatchewan; again, this was the first programme of its kind in Canada.

In 1957 the federal government implemented a national hospital insurance program. The federal contribution for hospital insurance was allocated to the provinces on a cost-matching basis; 25% of the cost of national average per capita hospital services and 25% average per capita costs in the particular province, multiplied by the number of insured persons.¹³ The programme conditions¹⁴ were perceived by the provincial governments to constitute a massive intrusion into a field of exclusive provincial jurisdiction, although the programme itself was heralded as a victory for the provinces.¹⁵

In any case, the federal government, following Saskatchewan's lead, had begun the process by which universal hospital and medical insurance would be institutionalized as

¹³ Paul Barker. "The development of major shared-cost programs in Canada." In R.D. Olling and M.W. Westmacott (eds.), *Perspectives on Canadian Federalism* (Scarborough: Prentice-Hall, 1988), p. 201.

¹⁴ Malcolm Taylor. "Health insurance: the roller-coaster in federal-provincial relations." In David Shugarman and Reg Whitaker (eds.), *Federalism and Political Community* (Peterborough: Broadview Press, 1989) p. 78.

¹⁵ Following the war, the federal government made several proposals for public health insurance (Green Book Proposals, 1945). However, at this time the federal government was in a very strong position vis-à-vis the provinces, and was not compelled to act on the proposals. By 1957 the balance of power shifted and the federal government recognized its role in hospital insurance. Taylor, 1989, p. 78.

components of Canadian citizenship. The health care system was being transformed from a parochial arrangement of citizens, communities, churches, doctors, and other caregivers, with informal obligations to one another, to a state managed programme of universally accessible health services, to which all citizens were formally entitled. The right to health care in the context of the former translated as the expectation that communicable diseases and other public health issues would be brought under control, and that a range of advanced medical services would be available in Canada for private consumption. In the latter, the right to health care indicated the expectation that hospital and medical services would be distributed as public goods. Health care as social right was essential for the prosperity of the country, the abatement of social class (perhaps the most significant cleavage of the time), and, eventually, national identity.

The Medical Profession

In 1943 the Canadian Medical Association endorsed, in principle, a national health insurance program, and seemed to be quite willing to comply with governments' formalization and institutionalization of the right to health care.¹⁶ The historical record shows that in 1943, "during the public hearings of the [House of Commons Select] Committee on Social

¹⁶ See Health Charter for Canadians in Hall Commission Report.

Security, the CMA gave a ringing endorsement of the proposed national program, assuring the Committee that the profession would "render any assistance in its power towards the solution of one of the country's most important problems. . .".¹⁷ However, due to political inaction on the issue, physicians organized themselves to develop prepayment schemes, thereby preempting the public health insurance programmes that would come into effect in the next two decades. The 1945 Green Book Proposals of the federal government, which had outlined an intergovernmental approach to health care in which the federal government would take a lead role, effectively "foundered in the failure of the Dominion-Provincial Conference on Post War Reconstruction 1945-46, at which federal-provincial agreement could not be reached on the transfer of tax fields to the federal government to finance the measures."¹⁸ The willingness of the medical profession to take action to address the problem associated with heightened citizens' expectations and inadequate access to health services (as well as problems securing adequate remuneration for physicians), in addition to the intergovernmental inertia in the immediate postwar period, "enabled the profession to make giant leaps in

¹⁷ Malcolm Taylor, Michael Stevenson and Paul Williams. *Medical Perspectives on Canadian Medicare: Attitudes of Canadian Physicians to Policies and Problems of the Medical Care Insurance Program*. Toronto: Institute for Behavioural Research, 1984, p. 3.

¹⁸ Ibid.

establishing profession-controlled prepayment plans to fill the vacuum."¹⁹

The prepayment plans, established and administered by professional associations in conjunction with the commercial insurance industry, insured patients against sickness and injury, which effectively improved access; citizens now had choice in planning financially for their health care (an issue of grave importance in the aftermath of the Depression). They also guaranteed some remuneration for physicians who were adversely affected by economic uncertainty.

As a result of continued government inaction and the rapid expansion of the prepayment plans, by 1949 the Canadian Medical Association had reversed its decision to endorse national (public) health insurance. Taylor explains: "[w]hile continuing to support the objective of health insurance it now declared that the role of government should be limited simply to paying to the voluntary plans the premiums, in whole or in part, on behalf of those unable to pay the full amount."²⁰ Clearly, the commercial benefit of these voluntary plans had shaped the interests of organized medicine in health care. The medical associations became quite comfortable with their newly acquired "private government"²¹ status, and were prepared to defend it against

¹⁹ Ibid, p. 4.

²⁰ Ibid, p. 5.

²¹ Ibid.

what they perceived to be encroachment by the state. By 1947 a public hospital insurance program had been successfully implemented in Saskatchewan, followed by similar action on a national level exactly one decade later. Taylor, Stevenson and Williams explain that:

[T]he success of national hospital insurance by the end of the 1950s focussed public attention on the issue of medical care and the prepayment plans were, in a sense, the victims of their own success. They had proved that medical care insurance was as desirable and workable as hospital insurance but they, together with the commercial insurance industry, had been able to insure less than half the population (10.6 million in 1965).²²

The medical associations' demonstrated competence in the health insurance field indicated to governments that public programs would be similarly viable. Moreover, the equity issue loomed large, as the voluntary prepayment plans did not cover the entire Canadian population. This issue was presented as a glaring injustice in the 1964 Report of Hall Commission, which directed the federal government to extend the benefits of available technology to the entire population as a matter of social right.

Great Expectations: The Royal Commission on Health Services

The Royal Commission on Health Services²³ 1961-1964 is, perhaps, the most important milestone in the history of the

²² Ibid, p. 6.

²³ Emmett Hall. *The Royal Commission on Health Services* (Report). Ottawa: R. Duhamel, Queen's Printer, 1964.

Canadian health care system.²⁴ The primary concern of the Commission²⁵ was that the benefits of new medical technology be extended to the entire Canadian population. Prior to 1957 there were a variety of health insurance schemes in operation in the provinces, which included both hospital and medical plans. In 1957 *The Hospital Insurance and Diagnostic Act* implemented a broad, universal program which subsumed many of the existing grants-in-aid (which were established under the National Health Grants Program, 1948), such as the Hospital Construction Grant, and grants for tuberculosis control, mental health, venereal disease, children with disabilities, and cancer, etc.²⁶ By the late 1950s -- early 1960s,

²⁴ The Hall Commission is of particular importance for two main reasons: 1) it is remarkably comprehensive and was ahead of its time. The report presented a very advanced view of the future of the Canadian health system ; and 2) many of its recommendations were implemented.

²⁵ The Commission also had to grapple with one of the most important (and still unresolved) issues of Canadian politics and government: the limits and political implications of federalism. The Commission recommended that public action was necessary to ensure equal access to health care among provincial populations; provinces had substantially unequal resources, and the national government was responsible for providing balance.

²⁶ The Royal Commission on Dominion-Provincial Relations (Rowell-Sirois) in 1939 recommended support by the federal government to provincial governments in the form of grants-in-aid. These grants would recognize provincial responsibility for constitutionally-defined jurisdictions, but would enable federal financial support. "To resolve the constitutional issue of provincial responsibility for health, the National Health Insurance Program recommended by the [advisory] Committee was to be achieved by the enactment of a Dominion Statute which would provide grants-in-aid to provinces enacting health insurance measures along the lines suggested in a model provincial bill. In addition to the insurance program, the province would be required to agree to undertake a general public health program approved by the dominion government and toward which a further grant-in-aid

communicable diseases such as venereal disease, tuberculosis, small pox, were largely under control, and a more comprehensive health care programme was needed to replace many of the specific grants that existed for such maladies. In fact, with new medical developments, all of these diseases (and many others) could be controlled, and therefore it was believed that they should be controlled as a matter of social or community right. The success and popularity of the national hospital services program generated demand for a comprehensive public medical insurance plan. The Commission posited that: "with almost the total population becoming entitled to prepaid hospital services, the next essential service to be organized is care provided by physicians and surgeons and some ancillary services all of which we refer to as "medical services"".²⁷ It was recommended that these services be provided by physicians on a fee-for-service basis, which was closer to the American (private) model than the British model, in which physicians are salaried employees of the state.

The Commission's terms of reference focused on individual responsibility for health and well-being at the same time that they recognized the importance of the community's needs. The areas that were designated to be matters of "public interest" were: environmental controls

would also be given." *Hall Commission* , Report vol. 1, p. 401.

²⁷ *Hall Commission* , vol. 1, p. 28.

(including clean drinking water, sewerage systems, communicable disease control, etc.), education of health care professionals, health care facilities, personnel, and universal availability and access to services.²⁸ Regarding the public interest in individual health, the Commission stated that:

The public interest in individual health has been typically manifested by community action to deal with health problems that the individual was incapable of managing himself. In the past this meant community measures to prevent and control communicable diseases. Organized health activities in Canada originated in community efforts to stem the epidemics of the last century.²⁹

The contours of communicable disease required that collective action be taken. C.E.S. Franks explains that early government action in public health included commitments to "Sewerage systems, pest control, assurance of pure water supply, pasteurization of milk, meat and food inspection, sanitary inspection of public eating establishments, public conveyances and the like...".³⁰ These areas were considered to be within the realm of public responsibility because they could not be dealt with by individual citizens. It would have been unreasonable to expect water purification systems or sewers to be installed on an individual basis. Such measures are only advantageous if they are undertaken by every member of the community. Public health cannot be

²⁸ Ibid, p. 10.

²⁹ Ibid, p. 4.

³⁰ CES Franks. *The Parliament of Canada* . Toronto: Univ. of Toronto Press, 1987, p. 7.

improved if some homes are supplied with water purification systems and sewers, and others not; some milk subject to the pasteurization process and some not; some meat inspected and some not; some persons immunized against communicable diseases and some not. In this way, these public health services are properly regarded to be community rights, exercised by communities on behalf of their constituents.

In contrast to the differentiated group rights that will be explained in a subsequent section (such rights define the fourth stage of citizenship development in Canada: identity rights), these examples are definitive of universal community rights. In the case of the latter, all citizens are equally entitled, and equally benefited, and individual responsibility-taking is an issue of relatively minor importance.

Universality Congealed: National Medical Insurance

The Health Charter for Canadians, proposed by the Hall Commission, brought into being the terms of the National Medical Insurance Plan. It is stated in the document that the objectives of health policy "can best be achieved through a comprehensive, universal Health Services Programme for the Canadian people," which will be implemented in accordance with "Canada's evolving constitutional arrangements," and recognizes the right to "freedom of choice" to be exercised by individual patients and practitioners. The problematic

broadness and symbolic importance of these terms would become major (controversial) issues soon after the implementation of the plan.

The arrangements for public medical insurance (1966) established that the federal government would pay 50% "of the national per capita cost of insured services, multiplied by the insured population of the province"³¹, and the provinces were required to operate programmes in accordance with federally determined standards. However, there were many problems with the shared cost funding arrangement. Paul Barker explains that:

The reasons for uncontrolled growth in costs were easy to detect. One was the openness of the arrangements. The only limit was the ability of the provinces to spend. Another was the matching element, which provided an incentive for provinces to spend on shared-cost programs. A further reason was that the federal government often shared with the provinces only the most expensive services. Under this kind of arrangement, the provinces had little incentive to develop more efficient ways of delivering services. . . . The federal government shared only in the cost of expensive hospital and medical care, which in turn inhibited the development of less expensive but equally effective of health care.³²

The development of "less expensive but equally effective health care" would become the goal of health care reformers in the 1990s. During the formative years of Medicare, however, other objectives, such as improving the health of

³¹ Paul Barker. "The development of major shared-cost programs in Canada." In R.D. Olling and M.W. Westmacott (eds.), *Perspectives on Canadian Federalism* . (Scarborough: Prentice-Hall, 1988), p. 205.

³² Ibid, p. 207.

Canadians, guaranteeing access to all citizens regardless of socio-economic status, and ensuring a fair distribution of the benefits and burdens of citizenship in a technologically advanced democracy, were paramount.

In the first nine years of the programme, the provinces held the balance of power because they had the ability, by virtue of the financing arrangements, to determine total (federal and provincial) spending on health services. However, the 1970s were marked by increased need for the federal government to improve planning in all policy areas as well as the strengthening of provincial autonomy claims. In this context, the implementation of Established Programs Financing to replace the cost-matching arrangements began to shift the focus of the debate from accessibility criteria to efficiency and effectiveness criteria. This meant that the right to health care, initially guaranteed in rather open-ended terms, was being increasingly subject to limits. Most obviously, entitlement was constrained by budgetary planning and belt-tightening. At the same time, fiscal planning and belt-tightening were constrained by the popularity (in both practical and symbolic terms) of the universal health system.

Toward Scarcity and Stasis

Not surprisingly, with the increasingly volatile political situation of the 1970s came a change in federal-provincial fiscal arrangements. In 1977 the federal government implemented Established Programs Financing (EPF) which

unilaterally altered the intergovernmental funding arrangements for health care and post-secondary education. The purpose of EPF was to discontinue the practice of provincial governments determining federal spending levels through shared-cost arrangements, thereby enabling the federal government's budgetary planning initiatives. In addition, it was a response to provincial demands for relaxed conditionality of federal funds. The federal government, in this period of "relaxed scarcity,"³³ was able to make concessions to provincial governments (amidst the volatility of province-building and Quebec nationalism), at the same time that it attempted to increase the degree of certainty in its budgetary environment. Then, in 1982 the federal government began reducing the EPF escalator, which meant that the provinces suffered from budgeting uncertainty caused by federal fiscal restraint. In the meantime, the federal budget deficit was growing rapidly.³⁴

By 1990 most provincial governments had devised reform strategies to respond to the growing uncertainty that impacted all policy areas, but affected health care in particular because of the large proportion of the expenditure budget devoted to this sector and the rapid advancement of medical technology and the aging of the population which meant that health care costs continued to rise in spite of

³³ Schick.

³⁴ See Marion G. Wrobel. *The Federal Deficit and Universality of Social Programs*. Library of Parliament, Economics Division, 1989.

cutbacks. In 1995 the federal government announced that EPF and the Canada Assistance Plan (CAP) would be amalgamated into a single transfer: the Canada Health and Social Transfer (CHST). This reduced the total transfer for health, post-secondary education and social assistance by approximately 6 billion dollars³⁵, generating further uncertainty in this area.

In the early stages of this period of retrenchment, governments were careful not to alarm the citizenry, which meant that somehow it had to appear that social rights were being protected within the environment of increasing scarcity. Hence, expectations had to be reshaped or replaced with more appealing prospects in order to address and reverse the trend of widening disjunction between the benefits and burdens of citizenship. Citizens felt entitled to a comprehensive range of health services, provided in decent facilities by competent caregivers within a reasonable amount of time, not just because they believed that the state ought to provide such benefits, but because they had paid for them already through their taxes. However, citizens' corresponding belief that the universal health system was a matter of national identity, transformed the social programme into a potent political symbol, which was effective as a constraint to change. This proved to be particularly frustrating for politicians, public servants and

³⁵ See Canada : *Budget 1999. Federal Financial Support for the Provinces and Territories* . February, p. 15, chart 3.

practitioners, virtually all of whom agreed that the system needed to be reformed (although there was no consensus on *how* it should be reformed).

Changed Expectations: The New Language of Rights

As briefly noted, the right to health care in the 1940s translated as the expectation that communicable diseases and other public health issues would be brought under control, and that a range of advanced medical services would be available in Canada for private consumption. Then in the 1950s and 60s, with federal action in the policy field, the right to health care began to indicate an expectation that hospital and medical services would be distributed as public goods. Health care as social right was essential for the prosperity of the country, and the abatement of social class. By the end of the next decade, health care had become part of Canada's collective conscience, and protecting the right against retrenchment was a matter of practical concern, as well as national identity. In the 1980s, three major (and mutually reinforcing) forces commenced and gained momentum in Canada which, in combination, explain the pursuant change in rights culture. The first is the rhetoric of the "marketization of the state." The second is the dual emphasis on individual/ legal rights and collective identities that is the legacy of the 1982 Charter of Rights and Freedoms. And the third is the Canada Health Act (1984) that asserted the

role of the state in the health care arena.³⁶ As noted in the introduction, there are (at least) two dynamics to observe in regard to the "shift". First, expectations were already high, and increasing in response to retrenchment and perceived threats to social entitlement. With each of the three "forces" noted above, there was a discernible change in expectations. Second, the form of the rights claims changed. That is, distinct from the change in expectations, there was a change in acuity of intentions. For example, it seems that instead of rights claims indicating that the state ought to provide publicly the benefits of medical advancements to the entire Canadian population (as was the case in the 1960s), they have come to indicate that, by virtue of consumer power or as a matter of individual legal compensation, citizens are entitled to services because they have purchased them in advance, or simply have legitimate and legally enforceable claims against the state.

Explaining the Shift in Rights Culture: Expectations and Intentions

The New Public Management

The first factor in the trend is the decline of the citizen as *citizen* and the rise of the citizen as client or consumer of public services. This shift is part of a larger

³⁶ Tuohy, 1999, p. 90.

international trend that has been identified as the "marketization of the state."³⁷ According to Jon Pierre,

Politics and markets appear so far to be just as intertwined as they were in the 1960s and 1970s, only with the important difference that this time it is the market philosophy dominating politics, not the other way around as was previously the case. Along with the "rolling back of the state" there evolved a "vacuum" with regard to the rights of individuals; as the material elements of citizenship were abolished or transformed into services provided under private auspices, citizenship had to be redefined and reaffirmed. Moreover, since such a reaffirmation of the individual in relationship to the state was at the heart of the individualistic culture which characterized the 1980s, there were a number of different political forces pulling in the same direction.³⁸

One result of this convergence of forces is the redefinition of Canadian social citizenship. Retrenchment in health care seemed to be inevitable given the fiscal situation (marked by uncertainty and scarcity), and citizens began to assert their rights to health services with new meaning and unprecedented conviction.

In order to achieve quiescence in the face of reform efforts, which amounted to perceived rights violations, governments offered "client" or "consumer" status to a less deferential populace. The "political empowerment" that was conferred through social rights was being replaced with

³⁷ Jon Pierre. "The Marketization of the State: Citizens, Consumers and the Emergence of the Public Market." In B. Guy Peters and Donald Savoie (eds.), *Governance in a Changing Environment*. Montreal and Kingston: McGill-Queen's University Press, 1995.

³⁸ Ibid, p. 60.

"economic empowerment."³⁹ This changed the nature of the citizen-state exchange process from a traditional model of exchange based on "needs, obligations and entitlements, with a market-like exchange process."⁴⁰ In this [latter] exchange process, service providers under different auspices are assumed to be in competition with each other. Customers choose in a rational fashion between different service providers, thus sending signals regarding the quality of different services."⁴¹ This conception has not been fully institutionalized in Canada, although its limited appearances likely influenced citizens' expectations.

The rhetoric of the new public management contributed to the redefinition of citizenship. In theory, the much sought after efficiency that is assumed to be generated by private market-type processes becomes the end goal of governance. In order to achieve this goal, changes are made to the management structures of public organizations, and an ethic of customer service replaces the ethic of entitlement. In the process, "rights" become service standards.

In Britain, for example, a Patient's Charter was drafted to inform National Health Service (NHS) clients that they were entitled to health services provided according to

³⁹ Ibid.

⁴⁰ It should be noted that this type of public market has been created for health services in New Zealand and Great Britain; in Canada only the rhetoric of marketization has penetrated reform efforts.

⁴¹ Pierre.

specified criteria (such as maximum waiting times), and that there were options for recourse in the event that the criteria were not met. Changes to the structure of the NHS in Britain were extensive: a system of "managed competition" was devised to maximize efficiency in health services provision. This included the designation of certain fundholding GPs to manage budgets for all NHS general practitioners in a given area.

In Canada, changes to the management of public health services were not as extensive. However, the rhetoric of change in public management, as well as initiatives for structural change, give the appearance that government is working hard to get the budget under control at the same time that it is making necessary improvements to the health care system.

Coincident with this trend is the frequent complaint that citizens have paid for health services in advance through their taxes, and therefore ought to be able to use those prepaid benefits when need arises. The expectation, then, is that of a simple market-type exchange of money (taxes) for services (health care). The intention, or course of action open to patients who feel that this exchange has not been completed, is unclear. It is not always possible for citizens to "exit" from the relationship, and seek to exchange money for benefits elsewhere (of course it is impossible for citizens to "exit" from the burden of paying taxes).

Charter of Rights and Freedoms

The second factor is the new conception(s) of rights that emerged with Charter of Rights and Freedoms. On the question of whether the Charter privileges the rights of individuals or groups, there is no consensus. According to Raymond Bazowski, "by endorsing affirmative action programs. . . the Charter has paved the way for yet another concept of equality to emerge in the contemporary Canadian political vocabulary - equality of groups."⁴² However, the degree to which the Charter promotes "affirmative action programs" and hence group rights, is highly debatable. The Charter does not contain any substantive public policy prescriptions. On the contrary, the Charter promotes a "procedural view of justice in which the commitment to treat all individuals equally and fairly takes precedence over any substantive shared end a society might favour."⁴³ In other words, the Charter is primarily about legal procedure in which the possessive (property) rights of individuals take precedence over other, non-liberal conceptions of right. Reginald Whitaker is unequivocal in his assessment: "certainly it is self-evident that a dominant rights-based discourse is tied logically to the leading role of the courts in defining the boundaries of rights and defining many of the public policy implications of

⁴² Raymond Bazowski. "Canadian political thought." In James Bickerton and Alain Gagnon (eds.), *Canadian Politics*. (Peterborough: Broadview, 1995), p. 103.

⁴³ Charles Taylor cited in *Ibid*, p. 105.

these rights."⁴⁴ Again, the Charter is correctly identified as a procedural document, in which the rights possessed by individuals are codified. Hence, the Charter represents a departure from, and therefore an indirect attack on, the normative conception of right that defines social rights. What ought to be done (by society, for society)? is replaced with: what constitutes an illegal infringement on the moral space of an individual?

Quite clearly, it is the intention of rights-claiming that has changed. Although there are only a few cases of health care litigation (for instance, the case brought against hospitals in BC in regard to access to sign language interpreters for hearing impaired patients), it is likely that the courts will be increasingly involved in important decisions concerning distributional equity in health care. So, even if expectations remain the same (expectations of hearing impaired patients to have full access to care), the form or intention of the claim has changed; it is now backed-up with legal action. This is a change that was also pushed by the conditions of the Canada Health Act.

As explained, the changes effected by the Charter's dual commitments impacted both individuals and groups. And the post-Charter era in Canada is marked by attempts to recognize the rights of the latter without diminishing those of the

⁴⁴ Reg Whitaker. "Rights in a free and democratic society: abortion." In David Shugarman and Reg Whitaker (eds.), *Federalism and Political Community*. Peterborough: Broadview, 1989, p. 327.

former. Similarly, Will Kymlicka and W.J. Norman thoroughly explain the most recent challenge to social rights:

Marshall saw citizenship as a shared identity that would integrate previously excluded groups within British society, and provide a source of national unity. He was particularly concerned to integrate the working classes, whose lack of education and economic resources excluded them from the "common culture" which should have been a "common possession and heritage."

It has become clear, however, that many groups -- Blacks, women, aboriginal peoples, ethnic and religious minorities, gays and lesbians -- still feel excluded from the "common culture", despite possessing the common rights of citizenship. Members of these groups feel excluded, not only because of their socio-economic status, but also because of their socio-cultural identity -- their difference.⁴⁵

The promise of equality (sameness of status) from universally available social programmes, is somewhat outmoded in the context of differentiated citizenship. If the social rights thesis is outmoded, what are the implications for the right to health care in Canada?

Paradoxically, the institutionalization of the symbolic value of health care is beneficial in that it protects the right to health care (i.e. the existing, universal distribution of health services), but problematic in that it perpetuates old models of care (medical, institutional), at a time when new approaches need to be considered (such as preventive medicine, recognition of social determinants of health, deinstitutionalization and home or community-based

⁴⁵ Will Kymlicka and Wayne Norman (1995). "Return of the Citizen: A Survey of Recent Work on Citizenship Theory." In Ronald Beiner (ed.), *Theorizing Citizenship*. New York: SUNY Press, 1995, p. 301-302.

care). Further, continued, uncritical defences of the right to health care are coincident with the marginal erosion of the health system. It seems to be the case that, in their reluctance to explicitly ration health services, governments ration on the margins by delisting some medical procedures, move patients from hospital to un- or under-funded home care settings, and so on.

The Canada Health Act

In response to pressing issues of cost, access and accountability, the federal government introduced in 1984 the Canada Health Act (CHA). The primary purpose of the legislation was to assert the role of the state in health care, especially that of the federal government as defender of Canada's sacred trust. The Act specified conditions of payment upon which transfers would continue to be disbursed to the provinces (initially iterated in the Established Programs Financing arrangements), and, more importantly, the penalties that would be exacted for contravention of the Act. Such penalties were intended to discontinue the practice of extra-billing by physicians, which constituted a symbolic disparagement of the state's commitment to universal health care (rather than a serious threat to public access).⁴⁶

⁴⁶ See Tuohy. "Medicine and the State in Canada: The Extra-Billing Issue in Perspective." *Canadian Journal of Political Science*, 1988, vol. 21, June.

The degree to which the CHA heightened expectations is debatable. The five stated conditions of payment, comprehensiveness, accessibility, portability, universality, and public administration, are commonly, and incorrectly, referred to as "principles" of medicare. Such misrepresentation might indicate that the CHA ought to represent higher goals, or fundamental precepts. This is partially accurate. The CHA does embody the stated goals of the federal government. But the authority of the Act is connected to the financial penalties, not to the "rightness" of moral assertions. Further, the CHA, as an assertion of the state's responsibility, correlates with the just expectation that this responsibility will be fulfilled.

Rights Turbulence

The purpose of explaining this change in rights discourse as it pertains to rights claiming for access to health services, is not merely to engage in hand wringing over the individualistic and legalistic attack on the "good old days" of community based norms of social citizenship. Rather, the point is to evaluate the evolving meaning and substance of the right to health care in Canada (again, as a subset of social right). Marshall himself would encourage revision in the context of new social, political and economic dynamics. What is the direction of citizenship development for the twenty-first century?

In the next section, the discussion of expectations and intentions will be broadened to include the philosophical arguments of Richard Tuck and Thomas Paine. The apparent irreconcilability of citizens' just expectations and consumerist and individualistic/legalistic intentions needs further consideration. More forceful demands are being made to protect old patterns of entitlement which is problematic because such demands reinforce "old models" in a dynamic policy field.

The Right to Health Care: Evolutionary Collective Entitlement

The preceding analysis of the collective nature of health care as social right is reinforced by the historical account of Richard Tuck, as well as the philosophical arguments of Thomas Paine and Arthur Dyck. Dyck's general assessment of "right" is useful as a point of departure. He claims that: "A right, then, is first and foremost a just expectation, that is, a state of being characterized by ties of mutually expected responsibilities to one another, as individuals and as members of groups and institutions".⁴⁷ This definition seems to capture quite accurately what is being expressed when citizens claim that they have rights to universal health care, heavily subsidized post-secondary education, adequate levels of welfare assistance and the like. "I have the right

⁴⁷ Arthur Dyck. *Rethinking Rights and Responsibilities: The Moral Bonds of Community*. Cleveland: The Pilgrim Press, 1994, p. 311.

to health care" can be translated as "I justly expect that the state will provide the social goods that are necessary to guarantee an adequate standard of living to members of my political community".

However, citizens' expectations have changed as the contours of disease have changed, advanced medical technology has become available, and other components of the state-society relationship have been altered. Thus, the general statement that rights constitute just expectations, is, in itself, insufficient as a means of understanding contemporary rights claims. In order to more fully comprehend the evolution of social rights as citizenship in Canada, there needs to be thorough examination of citizens' expectations, and a more precise definition of the right to health care, and the form that rights claiming takes.

Non-Possessive Rights

Richard Tuck⁴⁸ explains that "right" (*ius*) is rooted in Roman Law and originally distinct from "property" (*dominium*). In other words, "right" had a normative meaning that did not refer to the moral space (i.e. property) of individuals. Rather, the early Romans used the term within the context of divine judgment to define the way in which disputants in a trial ought to behave toward one another:

⁴⁸ Richard Tuck. *Natural Rights Theories: Their Origin and Development*. Cambridge: Cambridge University Press, 1979, p. 1.

Disputants took oaths as to the righteousness of their claims, one of which was upheld in a subsequent ordeal or other supernatural judgment. The favourable verdict was a *ius*. This is a significant origin in two ways. First, it shows that a *ius* was taken to be something objectively right and discoverable, and in this sense it remained as a kind of synonym for 'law' throughout the history of Latin as an effective language. . . . But the early use of the term *ius* also shows that it was generally taken to be the right way in which two disputants should behave towards each other, and did not (for example) cover criminal matters.⁴⁹

This conception of "right" is relevant to the discussion of the social right to health care because it reveals that the tangible benefits of universal health service provision are coupled with a strong, historically grounded, normative argument. The definition of "right" in non-market, non-individualistic terms helps to explain how the right to health care is distinct from other (legal) rights. Like the *ius* that normatively determined how disputants in Rome ought to behave toward one another, social rights define how citizens ought to treat one another and what ought to be provided for them by the state.

Social Rights as Compensation

There are, however, competing philosophical justifications for social rights. Thomas Paine, in a "little essay" entitled "Agrarian Justice" explains that because poverty does not exist in a natural state, the first principle of civilization ought to be: "That the condition of every person

⁴⁹ Ibid, p. 8.

born into the world, after a state of civilization commences, ought not to be worse off than if he had been born before that period".⁵⁰ According to Paine, every person born into the world has certain property rights. These are rights of usage -- the right to chop down a tree for wood to burn, to hunt animals for food, to pick apples from trees, etc., which exist because God gave the earth to humans in common. The institution of private property has thereby "dispossessed" some people of these natural property rights. Paine's proposed solution to this problem is

to create a National Fund, out of which there shall be paid to every person, when arrived at the age of twenty-one years, the sum of fifteen pounds sterling, as a compensation in part, for the loss of his or her natural inheritance, by the introduction of the system of landed property: And also, the sum of ten pounds per annum, during life, to every person now living of the age of fifty years, and to all others as they shall arrive at that age.⁵¹

This redistribution scheme reflects the view that in order for a person to acquire personal property, the cooperation of others is required:

All accumulation, therefore, of personal property beyond what a man's own hands can produce, is derived to him by living in society; and he owes on every principle of justice, of gratitude, and of civilization, a part of that accumulation back again to society from whence the whole came.⁵²

⁵⁰ Thomas Paine, "Agrarian Justice" in Philip S. Foner, ed., *The Complete Writings of Thomas Paine* (New York: The Citadel Press, 1945), p. 610. Originally published in 1796.

⁵¹ *Ibid*, p. 612-613.

⁵² *Ibid*, p. 620.

The idea of social rights, then, can also be developed based on this notion of compensation. Because the institution of private property has caused some people to be relatively disadvantaged in that they cannot adequately provide for themselves, a supplementary set of rights to ensure substantive equality in society is required. The state has an obligation, as do all members of society (via taxes rather than charity), to guarantee a minimum standard of living to all its citizens, which includes health care, education and income assistance benefits. States that do not provide such welfare rights to their citizens fail to recognize the nature of the dispossession that Paine describes, and thereby deny their citizens important benefits.

Paine's argument can be considered an early formulation of the social rights thesis, which was not popularized until the mid-twentieth century. As noted, for Paine, welfare entitlements are required as compensation for the violation of natural (individual) property rights. This conceptualization is rooted in the ideas of "possessive individualism" (property-based rights), which came to replace earlier notions of right.⁵³ However, normative, non-property-based, collective dimensions still seem to account for some of the vagaries of social rights discourse.

⁵³ C.B. Macpherson. *The Political Theory of Possessive Individualism*. Oxford: Oxford University Press, 1962.

Between Tuck and Paine: *Ius versus Dominium*

The trend, for approximately the past 600 years, has been toward property-based, individual rights (*dominium*). Twentieth century social rights seem to be an anomaly in that the original normative meaning of right (*ius*) is manifest in their conception. As can be discerned from the argument of a previous section, until 1980 there seemed to be conceptual equilibrium between *ius* and *dominium*. That is to say that the right to health care was (perhaps inadvertently) conceived as a collective entitlement, definitive of Canadian citizenship, at the same time that it indicated an area of individual entitlement. However, the changes effected by the New Public Management and, more significantly, the Charter of Rights and Freedoms, redefined the meaning of rights claims for access to health care. The nature of rights claims in the 1980s became more individualistic and legalistic. As perceived entitlements were challenged (and in some cases rescinded) in this period of increased legal-constitutional and consumer rights, citizens responded in-kind. Citizens have come to feel entitled to health services because they have paid for them in advance through their taxes, and the (inevitable) rationing of services is perceived as a rights violation. The right to health care is no longer merely a "just expectation" or normative claim, but a serious legal matter.⁵⁴

⁵⁴ See for example, *Eldridge v. British Columbia (Attorney General)*, [1997] 3 S.C.R. 624.

Evaluating Entitlement in the Context of Epidemiological Trends

The argument of this chapter has been that citizenship in Canada is moving beyond the social rights stage, away from simple notions of universality, and in the direction of differentiation and more individual rights claiming and responsibility-taking for health. The conceptual argument intersects with epidemiological (community health) trends. As the main causes of illness and death have changed from communicable to non-communicable diseases, the role of the individual in preserving her or his own health has increased. Richard Wilkinson identifies the "epidemiological transition" as the "shift in the main causes of death - from infectious diseases to degenerative cardiovascular diseases and cancers."⁵⁵ In the first half of the twentieth century, populations were plagued by such diseases as tuberculosis, small pox and malaria. The development of public health insurance in Canada was predicated on the need for action at the national level to address and coordinate responses to public health issues. By approximately 1960⁵⁶, communicable diseases were effectively under control in Canada, and the challenge for governments became the funding of health

⁵⁵ Richard G. Wilkinson. "The epidemiological transition: from material scarcity to social disadvantage." *Daedalus*, 1994, fall, p. 65.

⁵⁶ *Ibid*, p. 66.

systems to the extent necessary to deal with non-communicable disease.

Cancer, stroke and heart disease are social diseases, linked, among other environmental factors, to social disparities within populations. The "transition from the primacy of material constraints to social constraints as the limiting condition on the quality of human life,"⁵⁷ generalizes current epidemiological patterns. In other words, health is a factor of relative inequality within a society, rather than relative inequality among societies. Wilkinson elaborates:

Health is affected by differences in relative income (differences between groups of people within the same society), not by the absolute level of average incomes for each society as a whole. This is confirmed by the surprisingly strong relationship between income distribution and mortality rates in developed countries. . . . As relative income is inherently a social concept it cannot be dealt with at an individual level: societies, not individuals, have income distributions.⁵⁸

Thus, although individuals are increasingly required to assume greater roles in their own health care (changing diet and lifestyle), the adoption of private market type changes will exacerbate the social constraints by further polarizing income distributions. Commitments to universality ought to be strengthened with more flexible models of care that will allow for greater differentiation in the system (for example, public support for home care programmes and community

⁵⁷ Ibid.

⁵⁸ Ibid, p. 68-69.

governance structures for health). In other words, what is needed is not a market approach to health care but an approach that recognizes both the individual and collective dimensions of health.

To be specific, what is needed are policy responses to observable trends, such as deinstitutionalization, that will preserve entitlement (citizens ought to continue to have access to a range of medical services provided under public auspices), and at the same time serve to eliminate gaps in access, not by reiterating defences of social rights, or merely restoring funding to the system, but by creating complementary programmes. For example, as the number of hospital beds are reduced, the need for a pharmacare programme, and well developed home care options, becomes more pressing. In addition, home care options vary among provinces, are seriously underdeveloped and dependent on familial and community resources.⁵⁹ In the context of an increasing private share of health service delivery (30%), the need to decide what policy directions to pursue becomes all the more compelling. While there will never be enough money to satisfy all demands on the health system, any funding that is being restored to health care (such as the \$11.5b announced in the 1999 Federal Budget) might be

⁵⁹ For a detailed examination of differences among provinces in home care and pharmaceutical benefits, see Saskatchewan Health: Policy and Planning Branch. *Interprovincial Comparisons: Provincial/Territorial Health Services and Selected Data*. February, 1998.

channeled to these areas first. Continued marginal erosion of the system and insidious privatization is not a viable course of action. Such policy directions will also serve to address differentially entitled "communities" that intersect with the epidemiological transition as well as with enduring trends of communicable disease (eg. AIDS).

Universality Contested?

Recently, a scholar of American health care politics noted that one of the absurdities of the U.S. social security program was that beneficiaries were obligated to shop around for private insurance plans for pharmaceuticals (reimbursed by medicare), yet all recipients of social security needed the benefit.⁶⁰ That is to say, the logic of the entitlement pattern (pharmaceuticals needed by everyone) would seem to be consistent with a single insurer. Why require beneficiaries to individually shop around for something that is needed universally?

Of course, this argument is applicable to other areas of health insurance. The simple logic of a single-payer system, i.e. the Canadian system, is that all people will require, at some time in their lives, health care, and ought to have access to that care regardless of ability to pay. However, as the range of available benefits expands (due to technological or medical advancements, or alternative

⁶⁰ Ted Marmor. Roundtable with Tuohy at APSA. Atlanta, GA, Sept. 1999.

approaches), both assertions become questionable and complex. It is more and more likely that individuals will require very different health services. Some will require very expensive drugs for treatment of AIDS or Multiple Sclerosis. Some will require long-term nursing care in institutions, while others will require home care. Some patients will need chiropractic medicine, the service of midwives, or massage therapy. In short, as the category of "medically necessary" services expands, questions of entitlement become more burdensome.

To further complicate issues, patterns of deinstitutionalization leave segments of the population effectively deinsured for certain medically necessary services. While in hospital or other institutional settings, pharmaceuticals are covered under the public insurance plan. When patients are treated for the same ailments or diseases outside of institutions, however, the same pharmaceuticals are no longer provided under the public plan.⁶¹ With the increase in treatment outside of hospitals, this type of deinsurance has become a serious problem.

Trends in deinstitutionalization, coupled with greater differentiation in "medically necessary" services, reinforce the argument presented, that the social rights thesis, and its promise of an equal measure of citizenship amidst inequality, is outmoded. Issues of entitlement to health services are complex, and the possibilities for reaching

⁶¹ Pat Armstrong and Hugh Armstrong. *Wasting Away: The Undermining of Canadian Health Care*. Toronto: Oxford, 1996, p. 179.

solutions seem to be limited, given the constraining effects of rights claiming. In addition, and by no means a minor point, the coordination that seems to be required for addressing deinstitutionalization, for example, is precluded by the politics of federalism. The creation of a national pharmacare programme seems to be an inarguably good idea, although the provinces have insisted (and the federal government has agreed to comply) that the federal government establish no new national programmes. Intergovernmental arrangements and entanglements as they affect health care will be considered in greater detail in the next chapter.

Conclusion: Toward a Fourth Period of Citizenship Development

It might be concluded that Canada has entered a fourth stage of citizenship development in which both collective and individual dimensions ought to be (and in some cases, already are) recognized. This development can be discerned in the parallel arguments concerning differentiated citizenship in general, and the right to health care in particular, which reveal the same patterns. To be clear, citizens' expectations or "rights discourse" often do not reflect trends in health care provision, so much as they provide resistance to them. While the argument in this chapter has been that rights claiming for health care have become more individualistic, health care is universally distributed as a public good. And when the collective assertions of right

were made by the Canadian Federation of Agriculture, or Tommy Douglas (see first page of Chapter 1), health services were delivered and funded privately.

The Charter's dual commitments to legal, procedural rights of the individual and categorical equity of historically marginalized groups, demonstrate that citizenship in Canada requires Constitutional respect for individual rights as well as group difference. Differences based on gender, sexual orientation, ethnicity, and language, as they intersect with one another and social-economic status, demand recognition and accommodation, not strict equality. In the field of health care, flexibility is constrained by the institutionalization of health care as social right. And while the importance of universality has not abated, the way in which universality is achieved (through preservation of the medical model, and patterns of institutional care) is no longer entirely appropriate.

CHAPTER THREE

Sources of Stasis: Budgeting, Perceptions of Privatization, the Politics of Federalism, and Organized Medicine

Introduction¹

In chapters one and two I explained that the social rights thesis was outmoded. In this chapter I argue that the changing dynamics of citizenship, in addition to the effects of a post-Keynesian, global economy, altered the substance of social rights. Also, I will consider the implications of the institutionalization of the right to health care in Canada, and argue that social rights stasis is reinforced by citizens' resistance to the commodification of health services and the politics of federalism. Stasis is problematic because it precludes adoption of more appropriate models of care. Paradoxically, defenses of social rights, as originally formulated, reinforce the medical model at the same time that they recognize the need for change in the system. As noted in the introductory chapter, social rights hold constant the mechanics of the health care system. The principles and logic of the system, not caused by social rights but defined by them, are dependent on stable patterns of public finance and service provision. Thus, reluctance to question social rights seems to translate as reluctance to question the institutional logic of the system.

¹ Parts of this chapter appear in Candace Redden, "Through the Looking Glass: Federal Provincial Decision Making for Health Policy." Institute of Intergovernmental Relations, Queen's University, Working Paper no. 6, 1998.

The problems presented by stasis reach well beyond intergovernmental discord and symbolic disparagement. If stasis continues, health will deteriorate. As the World Health Organization reports, "a clear historical lesson emerges from health systems development in the 20th century: spontaneous, unmanaged growth in any country's health system cannot be relied upon to ensure that the greatest health needs are met."² The epidemiological transition, as explained in chapter two, defines the shift in main causes of disease and death from communicable to non-communicable disease. The noting of such a shift is important not only because it effectively indicates the changing contours of disease, but because those contours reveal new dynamics of citizenship.

Sources of Stasis

Issues of entitlement in health care are becoming, at the same time, both more complex and important. In the United States, for example, access to health insurance, and hence services, is likely to become a major campaign issue in the 2000 presidential election. Those who are not "entitled" to health care, either through their jobs or government programs, are concerned about cost and quality of care.³ To be blunt, for approximately 41 million Americans with no

² World Health Organization. *The World Health Report: Making a Difference*. Geneva, 1999, p. 37.

³ Certainly, this statement is infinitely complex due to the various arrangements, both private and public, for funding and delivery.

insurance, and a for an even greater number whose insurance is meager, with substantial co-pays, and contingent on employment, the question: what do I do if I (or my kids, or parents, or spouse) get sick? is engulfing.

And, to borrow again from American experience, changing notions about the omnipotence of medicine adds to the complexity of health care issues.⁴ In the 1970s in the US the development of Health Maintenance Organizations, in addition to the engagement of communities in decision-making exercises, challenged the autonomy of physicians. The situation today is such that corporate control of medicine gives the appearance, at the very least, that doctors' hands are tied in decision making, and care is dependent on cost feasibility.

In addition, the emergence of AIDS in the 1980s (as the major exception to current epidemiological trends) broke the confidence of physicians practicing in the area of infectious diseases (among other areas).⁵ Modern medicine is imperfect, although it seems that it is expected to solve to all social and medical problems. Questions of entitlement and cost, accordingly, move to the forefront of the debate.

⁴ It is useful to borrow from American experience, for several reasons. One is that, despite the vast differences, Americans have few pretenses about the superiority of their system. Hence, there is more information about the misgivings and failings of the US system, which are indicative of trends elsewhere.

⁵ See Dr., Abraham Verghese. *My Own Country: A Doctor's Story* . New York: Vintage, 1995.

The lost confidence due to the emergence of AIDS, for instance, in addition to the cost of treatment for those with the disease, present serious obstacles for any health system. The cost of pharmaceuticals alone for AIDS, or MS, or cancer or a host of other diseases, in a context of increasing deinstitutionalization, can upset any nation's delicate balance of entitlement and expenditure management. In the US, it is often the case that those in marginal entitlement zones⁶ must declare bankruptcy, and thereby qualify for public coverage (through MEDICAID) in order to gain access to health services and pharmaceuticals.

And in Canada there are discernible cracks in the pavement of universality. In most cases, pharmaceuticals are outside the purview of public plans, and, as such, there are "communities"⁷ of affected persons with spurious and indefinite entitlements. In Canada, although there is complicated interprovincial variation in patterns of entitlement for expensive drugs, it is likely the case that few will have to declare bankruptcy in effort to preserve their health. However, the entitlement issue becomes the availability of drugs, regardless of costs.

The cracks in the pavement are usually examined on two axes. The more common, that of federalism, and the

⁶ Marginal entitlement zones refer to ambiguities in patterns of entitlement to health services for segments of the population.

⁷ See Simon Watney (1990). "Practices of Freedom: 'Citizenship' and the Politics of Identity in the Age of AIDS." In John Rutherford (ed.), *Identity, Politics and Community*.

counterpoint, medical profession-state accommodation, are carefully examined in relation to one another by Carolyn Hughes Tuohy, who argues that the latter is the better explanatory axis.⁸

Tuohy's work is convincing and more sophisticated than the litany of scholars that favor the former. Miriam Smith (as a proponent of the former explanatory axis), for example, argues that "the combination of parliamentary governance and the particular features of federal arrangements in medicare increases the federal government's scope for unilateral retrenchment in the medicare field."⁹ But this seems to be only scratching the surface. What pushes the intergovernmental agenda? What are the details in the big picture?

⁸ See Tuohy, Carolyn Hughes. *Accidental Logics: The Dynamics of Change in the Health Care Arena in the United States, Britain and Canada*. New York: Oxford University Press, 1999.
 Tuohy, Carolyn Hughes. "Conflict and Accommodation in the Canadian Health Care System." In Robert Evans and G.L. Stoddart (eds.), *Medicare at Maturity*. Calgary: Univ. of Calgary Press, 1986.
 Tuohy, Carolyn Hughes. "Health Care in Canada." In William M. Chandler and Christian W. Zollner (eds.), *Challenges to Federalism: Policy-Making in Canada and the Federal Republic of Germany*. Kingston: Institute of Intergovernmental Relations, 1989.
 Tuohy, Carolyn Hughes. *Policy and Politics in Canada: Institutionalized Ambivalence*. Philadelphia: Temple University Press, 1992.
 Tuohy, Carolyn. "Social policy: Two Worlds" in Michael Atkinson (ed.), *Governing Canada: Institutions and Public Policy*. Toronto: Harcourt Brace Jovanovich, 1993.
 Tuohy, Carolyn. "Medicine and the state in Canada: the extra-billing issue in perspective." *Canadian Journal of Political Science*, 1988, vol. 21, no. 2.

⁹ Miriam Smith. "Retrenching the Sacred Trust: Medicare and Canadian Federalism." In Francois Rocher and Miriam Smith (eds.), *New Trends in Canadian Federalism*. Peterborough: Broadview, 1995, p. 320.

Tuohy believes that the truth in the details can be discerned in the dynamics of the politics of the medical profession. In brief, the monopolist position (organized medicine) has been stronger than that of the monopsonist (government), because "the state developed a "second-level" agency relationship with the profession, which acknowledged the primacy of professional judgment."¹⁰ However, with the extra-billing issue in the 1980s, for the first time, organized medicine failed to win major concessions from the state, in part because citizens' expectations did not permit concession.

And, as Tuohy points out in *Accidental Logics*,

In the 1990s, the state sought both to reduce sharply the rates of increase in public spending and to substantially extend the terms of its accommodation with the profession. In so doing, it placed great strain on the profession-state relationship and on the ability of the profession to manage the complex internal balances upon which that relationship depended.¹¹

However, there seems to be another important factor in the determination of health policy. In the case of governments reversing decisions to de-list certain "medically necessary services",¹² it seems to have been public sentiment that was the main source of pressure, not physicians. Perhaps, then, the Canada Health Act (1984) was less benign than is sometimes thought in that it confirmed the entrenchment of

¹⁰ Tuohy, 1999, p. 23.

¹¹ Tuohy, 1999, p. 204.

¹² See Tuohy 1999 p. 217-220.

social rights.¹³ Citizens expectations and entitlement have, therefore, challenged, at the very least, professional judgment and interests as the primary explanation for stability.

Tuohy's argument seems to make good sense, and covers both major axes, but does not directly address the linchpin issue. How can Tuohy explain patterns of medical profession - state accommodation without examining the "just expectations" of citizens? Why would the state regularly make major concessions (Tuohy) to the medical profession if citizens' expectations or social rights did not factor-in?¹⁴ Is it not the case that the citizenship bargain is at the foundation of interest group-government and intergovernmental disputes?

The Canadian Medical Association (CMA) is clearly influenced by "wavering" (some might say "flagging") public support for health care, as evidenced by the reluctance of the CMA in 1997 to "go against the grain" of public opinion and formally endorse a two-tiered system, as it was inclined to do. Of course, this is because it has its own agenda, not simply because it is benevolently interested in promoting

¹³ See Paul Barker. "Is the Canada Health Act Important?" Paper presented at the Annual Meeting of the Canadian Political Science Association, University of Ottawa, June 1998.

¹⁴ See Taylor, Malcolm, H. Michael Stevenson and A. Paul Williams. *Medical Perspectives on Canadian Medicare: Attitudes of Canadian Physicians to Policies and Problems of the Medical Care Insurance Program*. Toronto: York University, Institute for Behavioural Research, 1984.

social justice. The interests of organized medicine are served by the existing system, but the question remains, why do governments concede? Why is in the interest of the state to protect the interests of the medical profession? Physicians are skilled at making it appear that threats to their autonomy are tantamount to infringements on entitlement (i.e. social rights violations).¹⁵

Further, why bother with the fanfare of Paul Martin's 1999 budget, a "health care budget" signifying that Canada has "turned a corner", so to speak? The "deep" cuts of 1995 (CHST) were reversed in typical bloated fashion, with a big save by the federal government, as the provinces continue to struggle with reform. Sure, federalism is a constraint in its own right but it is not driven by intergovernmental politics. Intergovernmental disputes must have subtexts, wrangling must be directed at securing a political position. So, those who say that federalism constrains change are not quite right in placing the causal arrows. In effect, they argue that federalism causes intergovernmental tension. But that is disingenuous, at very least. It is certainly not a very ambitious explanation: it does not explain why governments relentlessly quarrel over the issue of health care, it merely observes that they do.

¹⁵ In the congressional system, the answer to this question is straightforward and relates directly to political institutional logic. But in Canada, there are relatively few institutional constraints, or "veto points" (Maioni 1998). In contradistinction, the parliamentary system enables major political transformation with limited legislative resistance.

The view of citizenship as it pertains to health care in Canada seems to be a much better (if elusive and mercurial) explanatory factor for government behaviour. Rights claiming does not seem to be wavering, regardless of public opinion concerning support for the existing system. The challenge is for governments to notice and address the cracks in the pavement and guide reform efforts accordingly.

Differentiated citizenship, as argued, is replacing the paradigm of universality and can be observed in health care politics. Communities of citizen-patients that fall outside of traditional entitlement zones need representation and recognition that mere defences of the social rights thesis cannot accommodate. In short, social rights claiming influences patterns of behaviour of governments and organized interests.

How the issue has not directly been addressed is somewhat of a mystery. Prominent scholars have hinted at it, but seem reluctant, perhaps for good reasons, to critique universal entitlement to health care.¹⁶ Clearly, much is at stake.

My argument in this chapter proceeds as follows. Social rights claiming constrains change because (1) it does not reflect differentiation, but individual entitlement to a

¹⁶ Armstrong, Pat and Hugh Armstrong. *Wasting Away: The Undermining of Canadian Health Care*. Toronto: Oxford University Press, 1996.

Armstrong, Hugh and Pat Armstrong. *Universal Health Care: What the United States Can Learn from the Canadian Experience*. New York: The New Press, 1998.

public good (as explained in chapter 2); (2) governmental decision-making seems to be subordinate to citizens' expectations. This is called democracy, and not a completely negative arrangement. However, at this point, the citizenship "bargain" seems to prevent the system from reforming itself.

In this chapter sources of stasis are examined in order to develop the foregoing argument. There are four main sources of stasis, which constitute layers on the foundation of the citizenship bargain: budgeting, perceptions of privatization, the politics of federalism, and organized medicine.

Privatization and the Politics of Federalism

Contributors to the health care debate who defend health care as a social right¹⁷ or assert that health care is an important symbol of Canadian identity, often fail to realize that the symbolic value of health care and the politics of federalism are mutually reinforcing. That is, intergovernmental discord perpetuates the symbolic appeal of universal health care (federal and provincial governments both try to appear to be defenders of the "sacred trust"), at the same time, the symbolic appeal of health care constrains political decision making in the policy field. And it is the latter dimension that requires further examination.

¹⁷ See *ibid.*

As noted, four factors serve to reinforce stasis by lending strength to defences of the social rights thesis. First, the justification for social rights made sense in the context of Keynesianism, relaxed scarcity in budgeting environments, and postwar nationalism, and has not been revised to take into account new trends. Second, there is heavy resistance of citizens to increased private sector involvement in health care.¹⁸ This resistance limits the range of options available to governments to respond to the current financial situation. Third, decision-making is constrained by the politics of federalism; federal and provincial governments compete for the role of defender of citizens' rights to health care. More precisely, the federal government strives to maintain its moral authority in the health policy field by way of its constitutional spending power, and provincial governments blame the federal government for interfering in an area of provincial jurisdiction. And while this predicament might not be new or remarkable in nature, the context in which it is cast draws attention. And fourth, the politics of organized medicine in intergovernmental context and the need for continued accommodation of professional interests further complicates an already complex policy field.

¹⁸ See Angus Reid Group, "Public policy focus: Canadians' perspectives on their health care system." *The Angus Reid Report*, Jan.- Feb ., 1997.

Redistributing Health Services

Health care reform in Canada, as a response to the widening gap between citizens' expectations and levels of service, focuses on institutional rather than system change. The universal, single-payer system is not directly threatened by rational, comprehensive policy redirection (there are few explicit policy initiatives aimed at increasing the role of the private sector in the health system), although it might be threatened indirectly by incremental, institutional changes. On the one hand, it seems that governments are maintaining a holding pattern in order to avoid making specific commitments for the future of the universal health system. On the other hand, the nature of the issues involved (distributional, bioethical) precludes prompt and decisive action. Issues concerning the reallocation of health resources and the replacement of medical and institutional models of care, are not easily managed by governments, for several reasons, including the complexity of the issues involved, the degree of coordination required, and that citizens have come to regard health care as a right and an integral component of Canadian identity; attempts to reduce or limit access to the health system are considered to constitute rights violations.

At first glance, this seems to be a virtue. Governments must respect social rights and maintain political commitments to equity, regardless of their budgeting environments. But when given more careful consideration, it becomes clear that

these political commitments also constrain much needed changes. For example, there is evidence to indicate (and public opinion that supports it) that a more holistic and preventive approach to health is needed, yet physicians' services and hospitals consume the vast majority of resources.¹⁹ However, when resources are redirected, and access to physicians is limited, or hospitals are closed, there is public outcry. The result is that rhetorical commitments are progressive and pay lipservice to empowerment²⁰ and preventive medicine, and population health models, but political action is rendered static by the voracious symbolism of the right to health care.

What is Stasis?

Carolyn Tuohy explains that the relative stability of the Canadian health system, discernible in the context of pressurized budgeting and policy-making environments, presents a puzzle: "Canada had, after all, one of the most expensive publicly funded health care systems in the world (see table 1). Yet it experienced one of the lowest levels of institutional and structural change in the 1980s and 1990s."²¹ According to Tuohy, such stability can be

¹⁹ Carolyn Hughes Tuohy , *Accidental Logics* .

²⁰ For an excellent discussion of the language of reform, see Pat Armstrong. "Unravelling the Safety Net: Transformations in Health Care and their Impact on Women. " . In Janine Brodie (ed.), *Women and Canadian Public Policy* . Toronto: Harcourt Brace and Co. Canada, 1996.

²¹ Tuohy, 1999, p. 34.

Table 1

Health Expenditures in Selected OECD Countries, 1980-1992

	Total Health Spending as Percent of GDP 1992	Average Annual Increase in Ratio of Total Health Spending to GDP, 1980-92	Public Health Spending as % of Total Health Spending 1991
Australia	8.8	1.6	67.8
Canada	10.3	2.8	72.2
France	9.4	1.8	73.9
Germany	8.7	0.3	71.8
Italy	8.5	1.8	77.5
Japan	6.9	0.4	72
Netherlands	8.6	0.6	73.1
New Zealand	7.7	0.6	78.9
Sweden	7.9	-1.4	78
United Kingdom	7.1	1.7	83.3
United States	13.6	3.2	43.9
OECD Average	8.1	1.2	75.4

Source: Carolyn Hughes Tuohy (1999). Accidental Logics: The Dynamics of Change in the Health Care Arena in the United States, Britain and Canada. Toronto: Oxford University Press, p. 235.

attributed, in large part, to the accommodation between the medical profession and the state. Even as the hospital share of total health care expenditure declined, there has been a relatively constant share of total health care expenditures distributed to physicians between 1975 and 1996 (see table 2).²²

Stability in the distribution of expenditures for health care is supported by continued federal commitment to universal health care. The National Forum on Health (NFOH), appointed by the Chretien government in 1994, tabled its report in 1997, which served to publicly reinforce the principles of the existing system.²³ The report of the NFOH, an almost exclusively federal document,²⁴ reasserted the "key features" of the system -- "public funding for medically necessary services, the 'single payer' model, the five principles of the Canada Health Act, and a strong federal/provincial/territorial partnership."²⁵ However, the existing system was reaffirmed but not reassessed, so that the important recommendations made, regarding implementation of pharmacare and home care programmes, and the creation of

²² Tuohy, 1999.

²³ Tuohy, 1999, p. 95.

²⁴ The provinces refused to formally participate in the national dialogue of the forum ., although the composition of the commission was regionally balanced. See Tuohy 1999, p. 95.

²⁵ National Forum on Health. *Canada Health Action: Building on the Legacy. The Final Report of the National Forum on Health*, 1997, vol. 1, p. 20.
Tuohy 1999, p. 96.

Table 2

Percentage Distribution of Total Real* Health Care Spending by Category
Canada 1975-1996

Year	Hospitals	Other Institutions	Physicians	Other Profes- sionals	Drugs**	Capital	Public Health	Other Expend- itures	Total
1975	44	9.2	15	7.3	10.2	4.4	3.8	6.1	100
1980	40.6	11.3	14.4	8.8	9.9	4.7	4	6.3	100
1985	39.7	10.2	15	8.4	10.8	4.6	4.2	7.1	100
1990	38.2	9.3	15.3	8.3	12.4	3.7	4.4	8.5	100
1996*	34.9	10	14.9	8.3	13.9	2.5	5.2	10.5	100

* Deflated by CPI.

** Includes drugs provided inside and outside hospital.

*** Estimate.

Source: Carolyn Hughes Tuohy (1999). Accidental Logics: The Dynamics of Change in the Health Care Arena in the United States, Britain and Canada.

Toronto: Oxford University Press, p. 235.

Health Canada 1997, Table 5.

an ethics advisory committee, seemed to be options for additional services, and not constitute a new approach. As a result, the NFOH recommendations seemed to constitute a broad and hopeful agenda for the future, rather than a viable blueprint for change.

Although "stasis" seems to be a pejorative term (relative to "stability"), it is not simply an ideological locution that reflects disapproval of the status quo, or planned restructuring in the social policy field. In fact, the traditional position of the left would be the defence of health care as a social right, not the repudiation of that assertion. To be clear, there are three indications of "stasis", as one step beyond "stability". The first indication of stasis is gridlock in federal provincial decision-making. For example, the reluctance to critically reassess existing services and patterns of delivery, especially without support of the provinces, indicates the inadequacy of the NFOH exercise. In fact, it seems that with the NFOH the federal government was effectively putting up resistance to provincial strategies for reform.

The second indication is policy reversals in response to public pressure. For example, in Ontario, the government's attempt to delist services that were not deemed to be medically necessary (beginning in 1993) was met with heavy public resistance. One of the most controversial items on the block was the annual health exam. The annual "physical" exam provided little benefit, but in the end, was not removed

from the list because it was "premature pending the development of practice guidelines for preventive health care. It was also consistent with the government's own fears of the political ramifications of deinsuring such a commonly offered service."²⁶ And in Alberta, beginning in 1985, several procedures were delisted, such as family planning counselling, tubal ligations, vasectomies, and mamoplasty²⁷, but many were eventually put back on the list due to public pressure. There are many other examples of policy reversals, or ambiguous policy commitments. The most significant of the latter will be discussed in some detail in the next chapter.

And the third indication is stability in face of evidence of need for change. Changing demographics, new pharmaceuticals, deinstitutionalization, preventive medicine, advanced medical technology, and the epidemiological transition, all suggest that change is required. Yet the system is remarkably stable. Of course, some stability in a turbulent policy field is advantageous. But in the case of health care, the complexity of issues and the importance of services, as well as the expense of the programme, make it impossible that stability will prevail indefinitely.

What follows is a more detailed explanation of the sources of stasis that account for the lack of change in the health policy field (all of which are coincident with the

²⁶ Tuohy 1999, p. 220.

²⁷ Tuohy, 1999, p. 219.

entrenchment of the social right to health care), and, at the same time, indicate the need for change.

**Budgeting for Health Care:
The Changing Dynamics of Distribution**

As the days of expanding public revenues begin to reemerge in what has been termed the "post-deficit" era, governments in North America continue to grapple with the complexities of budgeting in an uncertain and unstable environment. In the decades following the Second World War, governments ran budget surpluses (although they continued to amass debt, **see figure 1**), which were spent on the development of social programmes. When economic growth declined and fiscal restraint became necessary in the 1980s, governments ran deficit budgets in the hope that the economic times were merely temporary. However, by the 1990s, the situation was recognized to be unsustainable, and eliminating deficits and reducing debt became top priorities.

The effects of fiscal restraint in federal and provincial budgeting can be clearly discerned in health care, although Canada's "sacred trust" was shielded from cuts that befell other, less politically divisive, policy areas. In the period 1991-1996, expenditures for health care declined (in real per capita terms) by approximately 5% (total) (**see figure 2**), and the proportion of private expenditures increased (**see table 3**). Health care reform (and retrenchment) exercises were implemented at the margins of established programmes, so that it would appear (to citizens)

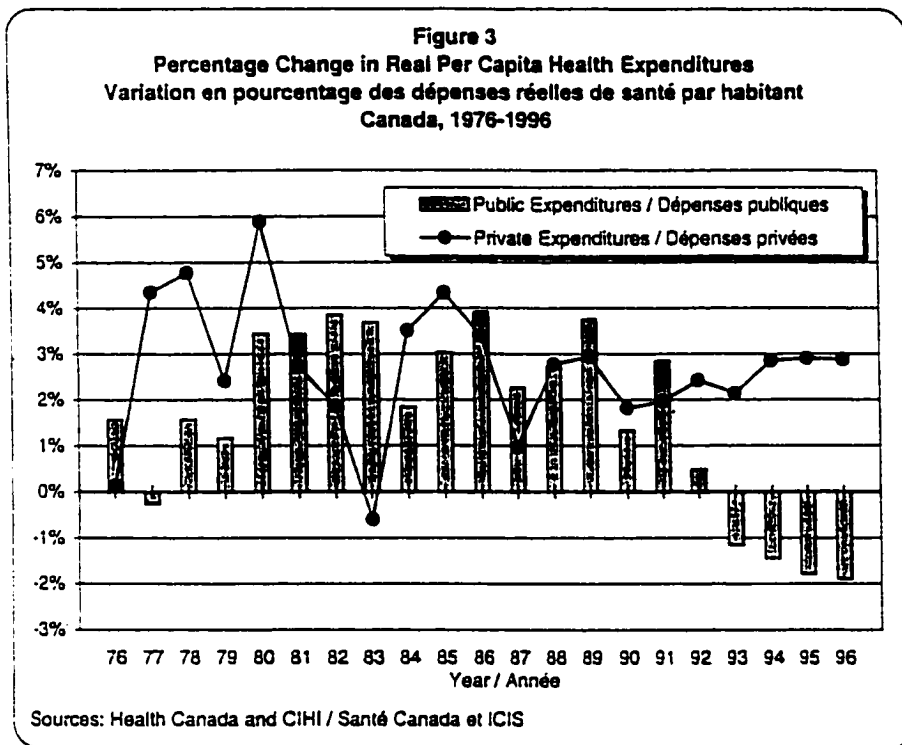
Figure 1

Growth of Federal Debt, 1940-1984

	1940	1956	1960	1970	1980	1984
Debt Data, (billions of dollars)						
1. Gross debt	4	19	21	38.2	103.6	196.9
2. Net debt	3.3	13.4	12.1	16.9	68.6	157
3. Net interest	0.1	0.3	0.5	0.8	5	13.2
4. Debt held by general public	3.7	11.2	11.1	13.8	54.9	131
Reference Data (billions \$)						
5. GNP	6.7	11.9	37.8	85.7	297.6	420.9
6. Federal expenditures	1.3	2.9	6.7	15.3	61	107.3
7. Money supply	3	6.7	13.2	30.8	134.2	183.3
Ratios (in percent)						
8. Line 1/line 5	60	159.5	55.6	44.5	34.8	46.8
9. Line 2/line 5	48.7	112.9	32	19.8	23.1	37.3
10. Line 3/line 1	2.8	1.8	2.4	2.1	4.8	6.7
11. Line 3/line 2	3.5	2.5	4.1	4.8	7.3	8.4
12. Line 3/line 5	1.7	2.9	1.3	1	1.7	3.1
13. Line 3/line 6	9.2	11.8	7.4	5.3	8.2	12.3
14. Line 1/line 7	134.7	281.3	158.8	123.7	77.2	107.4
15. Line 4/line 5	54.7	94	29.3	16.2	18.5	31.1
16. Line 4 (line 4 +line 7)	55.1	62.4	45.6	31	29	41.7

Source: Richard Musgrave, Peggy Musgrave, and Richard Bird. Public Finance in Theory and Practice. Toronto: McGraw-Hill Ryerson Ltd., 1987, p. 634

Figure 2



Source: Canada: Health Canada, Policy and Consultation Branch. National Health Expenditures in Canada, 1975-1996. Fact Sheets, June 1997, p. 4, figure 3.

Table 3

Total Health Expenditures – Summary Table
Canada, 1975 - 1996

Year	Total Health Expenditures (in current dollars)		Real Total Health Expenditures (in constant 1986 dollars)		Health Expenditures as % GDP in Canada			
	Total	Per Capita	Total	Per Capita	Total	Public	Private	U.S.
	(\$'000 000)	(\$)	(\$'000 000)	(\$)	%	%	%	%
1975	12 260.9	528.28	29 144.6	1255.73	7.1	5.5	1.7	8.2
1976	14 103.7	599.71	29 895.6	1271.21	7.1	5.5	1.6	8.5
1977	15 501.8	651.44	30 500.1	1281.71	7.1	5.5	1.7	6.8
1978	17 172.4	714.44	31 531.9	1311.84	7.1	5.4	1.7	8.5
1979	19 292.6	794.69	32 317.1	1331.19	7	5.3	1.7	8.7
1980	22 408.3	911.15	34 065.6	1385.15	7.2	5.5	1.8	9.1
1981	26 449.1	1062.21	35 607.9	1430.03	7.4	5.7	1.8	9.4
1982	30 912.9	1226.61	37 244.7	1477.85	8.3	6.3	2	10.2
1983	34 168.1	1342.23	38 603.7	1516.47	8.4	6.5	2	10.5
1984	36 819.9	1432.58	39 852.3	1550.57	8.3	6.3	2	10.4
1985	40 058.1	1544.16	41 573.3	1602.57	8.4	6.3	2	10.7
1986	43 583	1663.23	43 583	1663.23	8.6	6.5	2.1	10.9
1987	47 057.2	1772.42	45 015.7	1695.52	8.5	6.4	2.1	11.1
1988	51 142.3	1901.57	46 846.2	1741.83	8.4	6.3	2.1	11.5
1989	56 337.6	2057.67	49 384.8	1803.72	8.7	6.5	2.2	12
1990	61 168.9	2201.06	50 853.5	1829.88	9.1	6.8	2.3	12.7
1991	66 426.3	2362.24	52 807.6	1877.93	9.8	7.3	2.5	13.5
1992	70 107.8	2456.29	54 112	1895.86	10.2	7.5	2.6	14.1
1993	71 785	2479.9	54 694.6	1889.49	10.1	7.4	2.7	14.3
1994	73 027.5	2496.19	55 082.2	1882.79	9.8	7.1	2.7	14.1
1995*	74 306.4	2509.05	55 444.8	1872.17	9.6	6.8	2.8	14.2
1996*	75 224.7	2510.53	55 753.9	1860.72	9.5	6.6	2.9	14.2

Annual percentage change

1975				
1976	15	13.5	2.6	1.2
1977	9.9	8.6	2	0.8
1978	10.8	9.7	3.4	2.4
1979	12.3	11.2	2.5	1.5
1980	16.1	14.7	5.4	4.1
1981	18	16.6	4.5	3.2
1982	16.9	15.5	4.6	3.3
1983	10.5	9.4	3.6	2.6
1984	7.8	6.7	3.2	2.2
1985	8.8	7.8	4.3	3.4

1986	8.8	7.7	4.8	3.8
1987	8	6.6	3.3	1.9
1988	7.7	7.3	4.1	2.7
1989	10.2	8.2	5.4	3.6
1990	8.6	7	3	1.5
1991	8.6	7.3	3.8	2.6
1992	5.5	4	2.5	1
1993	2.4	1	1.1	-0.3
1994	1.7	0.7	0.7	-0.4
1995*	1.8	0.5	0.7	-0.6
1996*	1.2	0.1	0.6	-0.6

*1995 and 1996 are preliminary estimates. Provincial estimates are based on government budgets.

**OECD 1997 Health Data.

Source: Health Canada and CIHI. National Health Expenditures in Canada, 1975-1996. Fact Sheets

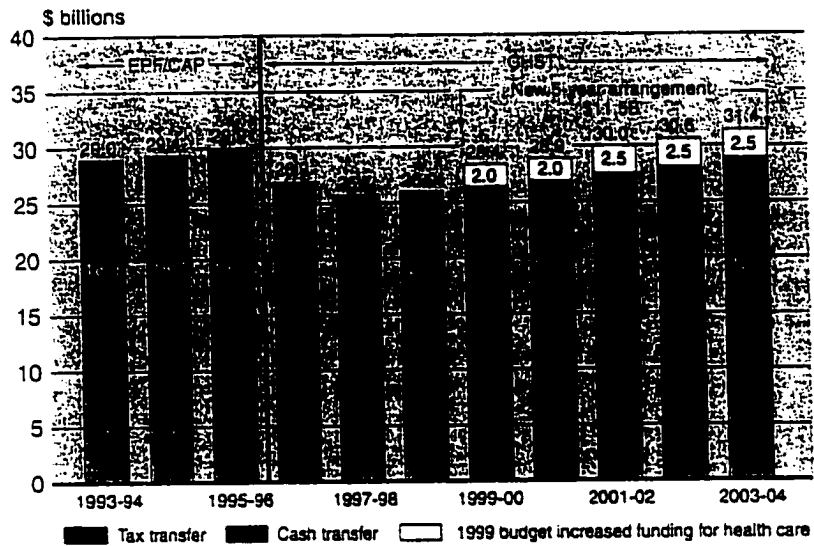
that their right to health care was being protected as governments worked to eliminate budget deficits. In 1995, the federal government amalgamated funding for health and post-secondary education (Established Programs Financing) with the largest remaining shared-cost programme (the Canada Assistance Plan) into a single transfer (the Canada Health and Social Transfer), which reduced federal financial commitments by approximately 6 billion dollars over three years (see figure 3). The position that governments would be able to protect health care despite fiscal "crisis" had become untenable.

For the next three years (1995-98), provincial governments dealt unhappily with federal reductions in transfer payments. In many provinces, labour force contraction, de-insurance of "medically unnecessary" procedures, and regionalization schemes were undertaken by governments as means of dealing with increased uncertainty in their own budgeting environments. Citizens were promised that such measures were temporary, and that funding would be restored when the "crisis" was over.

The 1999 Federal Budget looked like good news for all those concerned about erosion of the health system. The promise of renewed funding had been fulfilled. With the elimination of its budget deficit, the federal government had committed 11.5 billion dollars for reinvestment in health care (see figure 4), to be disbursed to the provinces over the next five years. In the context of changing demographics

Figure 3

CHST: 1993-94 to 2003-04



Note: The \$11.5-billion increase includes the \$3.5-billion CHST supplement, which will be accounted for in 1998-99 by the federal government. The pattern of payments over the three years (1999-2000 to 2001-2002) may be varied to best meet health care needs as requested by individual provinces and territories. Payments will be made in a manner that treats all jurisdictions equitably, regardless of when they draw down funds.

Source: Canada: Department of Finance. Budget 1999. Building Today for a Better Tomorrow: Federal Financial Support for the Provinces and Territories, February 1999, p. 15.

Figure 4

Canada Health and Social Transfer

	1999-2000	2000-01	2001-02	2002-03	2003-04	5 years
	(billions of dollars)					
Increased funding for health care	2.0	2.0	2.5	2.5	2.5	11.5
<i>Of which:</i>						
CHST		1.0	2.0	2.5	2.5	8.0
CHST supplement ¹	2.0	1.0	0.5			3.5
Existing CHST cash	12.5	12.5	12.5	12.5	12.5	62.5
Total CHST cash	14.5	14.5	15.0	15.0	15.0	74.0
CHST tax transfers	13.9	14.4	15.0	15.6	16.4	75.3
Total CHST	28.4	28.9	30.0	30.6	31.4	149.3

¹ The \$3.5-billion CHST supplement will be accounted for in 1998-99 by the federal government. Payments will be made in a manner that treats all jurisdictions equitably, regardless of when they draw down funds.

Source: Canada: Department of Finance. Budget 1999. Building Today for a Better Tomorrow: Federal Financial Support for the Provinces and Territories, February 1999, p. 14.

and the advancement of medical technology and new pharmaceuticals, this money was much needed. But it might not be sufficient to satisfy rising expectations. That is not to say that even stronger federal financial commitments are required to keep pace with demand, but that problems in the health system run deeper than mere funding shortages. The medical model of care is paternalistic and outmoded, new medical equipment and drugs make institutional care increasingly unnecessary, and new patterns of inequality have been linked to health, all of which indicate the need for fundamental change.²⁸ However, change is constrained by the institutionalization of health care as a social right of citizenship. Governments are reluctant to take any action that might be perceived as a threat to that right.

In short, the justification for social rights made more sense in the context of political commitments to Keynesianism, relaxed scarcity, and postwar nationalism, and is somewhat misplaced in budgeting environments marked by increasing numbers of competitive claims. The goal of governance in the 1990s has become respecting the diversity of these claims, not reducing them to a common denominator.

Economic Equilibrium Versus the Budget

According to John Maynard Keynes, whose economic doctrine guided North American economies during the postwar period of growth (1945-1977), "the goal of policy should be to balance

²⁸ See Armstrong and Armstrong, *Wasting Away* .

not the budget, but the economy. The government should adopt the levels of spending, taxing, and borrowing that will produce acceptable levels of GNP, inflation and unemployment."²⁹ At the same time, sociologist T.H. Marshall argued that the economy should be balanced by offsetting the inequalities generated by private markets with universal social programmes.³⁰ Social rights, manifest in the creation of a universal health care system, are the products of economic equilibrium. The need to balance the economy, as indicated by Marshall, means that the distortions created by the economy (i.e. inequalities generated by capitalism) ought to be offset by recognizing social rights, and thereby guaranteeing social services as a matter of citizenship, rather than leaving social benefits to be determined by the market or other economic forces.³¹ The favourable economic conditions of the postwar period allowed governments to offer an expanded range of public services to their citizens. In many cases these increased resources were distributed as social programmes, and responded directly to the demands placed on the state by rising expectations in a context of relative prosperity and technological advancement. A consequence was that citizens came to regard these new programmes as entitlements, and so began a process of

²⁹ Aaron Wildavsky and Naomi Caiden. *The New Politics of the Budgetary Process*. New York: Longman, 1997, p. 71.

³⁰ Ibid.

³¹ T.H. Marshall, 1964.

incremental "ratcheting-up" of the resources to be distributed.³² Entitlement programs, such as universal health care in Canada, and Medicare, Medicaid and Social Security in the United States, came to be regarded as social rights of citizenship. They were more fully developed in Canada in part because, in the US, the civil rights movement demanded the attention of governments and the courts diverted the focus from social rights to civil rights during this formative period.

It seems to be the case that as governments in the 1990s struggle to eliminate budget deficits, they have lost sight of the need to "balance the economy". The need to address the importance of social rights in capitalist societies, the requirement for social safety nets to guard against economic adversity, or the proper distributions of the benefits and burdens of citizenship, are no longer considered; the economy is micro-managed in order to achieve the ultimate goal: a balanced budget. As Aaron Wildavsky and Naomi Caiden state: "controlling the deficit has become a "metaphor for governing."³³ But it does not make sense to suggest turning back the clocks. It has become clear that new complexities are not well accommodated within the context of the social rights paradigm. The social rights thesis, and substantiated

³² See Daniel Bell. *The Coming of Post-Industrial Society* . New York: Basic Books, 1973.

³³ Aaron Wildavsky and Naomi Caiden, p. 96.

by political commitments to health care as a right of citizenship, needs to be revised, not defended blindly.

The social vision of Keynesianism¹⁴ had been replaced with more limited and immediate fiscal concerns, the impact of which was first felt in areas other than health. Health care has been relatively well shielded from an explicit rationing of budgetary resources, which indicates that health care as social right is resilient to change. Such resilience has positive as well as negative consequences. While it has guaranteed universal coverage for all citizens, it has not allowed for flexibility in reconsidering entrenched models of care.

Resistance to Privatization

Health care policy disjunction, the difference between rhetorical commitments and political action, is not likely to be addressed by the direct and transparent commodification of health services in Canada. However, the possibility merits

¹⁴ Keynes' counter-cyclical economic doctrine challenged much of the prevailing wisdom on economic management. According to Keynes, budget deficits are sometimes necessary and desirable in order to stimulate the economy. This means that during the "bad times" of economic downturns governments do not have to increase taxes and cut spending. Rather, as Aaron Wildavsky explains, "politicians could finally justify doing what they had long desired to do, namely, do something (spend) to help people (and, in turn, help the economy) in a time of crisis." (Wildavsky and Caiden, p. 70) Conversely, during times of growth and relative abundance, that is, "good times", "spending should be limited and taxation increased to keep the economy from overheating. Put in terms of political appearance, "times are good so we should do less because citizens can afford to pay (their real income is rising) and they won't notice." (Ibid) Not surprisingly, it was difficult for governments to curtail spending for entitlement programmes during "good times".

some attention because there exists potential for increased indirect commodification, and many Canadians fear what they consider to be signs of "slippage" into an American-style system. The levying of user fees and the practice of extra-billing in the provinces over the last two decades have been met with heavy resistance by the federal government, even though the actual instances and effects of extra-billing were negligible.³⁵ This has helped to reassure Canadians that the federal government is on moral high ground in the federation and is willing to impose its vision of citizenship on the provinces and enforce it with financial penalties. The degree to which the federal government will be able to defend citizens' social rights against pressures for relaxed national standards in health care in the current fiscal context is a matter of steady debate.³⁶

Health Care On the Slippery Slope

The most recent figures from Health Canada indicate that "public sector health expenditures represented 69.9% of total health expenditures in 1996; with the public share continuing its downward trend from 74.6% in 1991," while "private sector

³⁵ See John Ralston Saul. "Health Care at the End of the Twentieth Century: Confusing Symptoms for Systems." In Saul (ed.), *Do We Care? Renewing Canada's Commitment to Health*, 1999; Tuohy 1999.

³⁶ To be sure, Canada's health system is properly considered to contain private elements in that physicians and surgeons are not employed by the state, but are in private practice, and bill the government on a fee-for service basis.³⁶ This is called a single payer system, because the government is the only agency billed for insured medical services.

health expenditures represented an estimated 30.1% of total health expenditures in 1996."³⁷ That Canada has now fallen below 70% public contribution to health care is significant because it seems to present a dangerous "slippery slope" to increased commodification of health services; increased private sector involvement in an area of such import is unacceptable to many Canadians. Very shortly after the Health Canada document was released, the Canadian Institute for Health Information (CIHI), a government-funded not-for-profit organization that works very closely with Health Canada, produced data that suggest that the "slight" decline in public expenditures noticed in 1996 will be arrested in the following year.³⁸ The CIHI explained that the more optimistic projections that it has prepared are "more up to date than Health Canada's"³⁹. Seemingly, the CIHI attempted to perform a damage control function for Health Canada (by

³⁷. "Private sector health expenditures are sub-divided into three major types of expenditure which reflect the source of funds as well as the source of data: a) expenditures from health insurance firms; b) out-of-pocket expenditures of individuals; c) patient service revenue paid by private insurers or out-of-pocket, such as differential charges for preferred accommodation (private rooms), chronic care co-payments, charges for services to non-residents of Canada and to uninsured residents and charges for services that are not medically necessary; non-patient service revenue received by health care institutions that does not apply to services provided to patients, such as dietetics, investment income, philanthropic donations and ancillary operations (parking and concessions); and expenditures on capital and health research." Health Canada: *National Health Expenditures in Canada 1975-1996*. Policy and Consultation Branch, June 1997.

³⁸. Jane Coutts, "Cutbacks are over, health data suggest." *Globe and Mail*, August 21, 1997.

³⁹. *Ibid.*

confirming the more positive forecast), which had revealed figures that were, evidently, alarming for many. However, despite the efforts of CIHI, the potential for creeping privatization in the much revered universal health system seems to have been confirmed.

In fact, one needs only look as far as the United States to confirm fears of private control of medicine. Regularly, citizens in that country find themselves without adequate (or any) health insurance coverage, have their premiums increased because of "risks" (i.e. illness or disease), or are dropped from private insurance plans altogether. Aside from these equity issues, the US continues to spend upwards from 13.5% GDP on health care (the highest of all OECD countries). The predominance of Health Maintenance Organizations (HMOs), since 1970s, has contributed to the diminishment of medical authority to such an extent that physicians in some states are organizing labor unions, in order to counterbalance corporate power. In addition, there have been several attempts (at both federal and state levels) to adopt some aspects of the Canadian system in movement toward universality. And there are plenty of "how-to" books and articles available to guide the process.⁴⁰ Such evidence seems to prove the inviolability of health care as Canadian identity. However, there is no clear consensus on the importance of health care as symbol of national identity. It

⁴⁰ The most comprehensive and compelling of these is Armstrong and Armstrong, *Universal Health Care* .

might even be the case that Canadians are ready to accept a two tiered system. In 1998 a study conducted by the Harvard School of Public Health found that 23% of Canadians believed that the health system needed to be completely rebuilt, 37% thought that fundamental changes were needed, and 46% stated that recent reforms has diminished quality of care.⁴¹

However, as David Naylor states regarding public opinion polling, "much depends on the wording."⁴² In a 1996 Gallup poll, almost 60 percent of Canadians rejected the concept of "two levels of health care service: a basic one that government funded for everyone, and another under which those who could afford it paid the full amount and received whatever kind of services they wanted."⁴³ In that same year, another Gallup poll found that:

44 percent of respondents favored a two-tier system (described as government insuring basic services, with private insurance or direct payment options available for further coverage). With this formulation, even supporters of the nominally socialist New Democratic party registered a 42 percent level of support for a two-tier plan.

Thus, it seems that what is of real importance is the rhetorical force of political arguments. From this study it can be concluded that citizens want governments to remain committed to equity, but do not necessarily demand that every

⁴¹ See R.J. Blendon, K. Donelan, and K. Binns. *Commonwealth Fund International Health Policy Survey: Summary of Key Findings*. Mimeo: September, 1998.

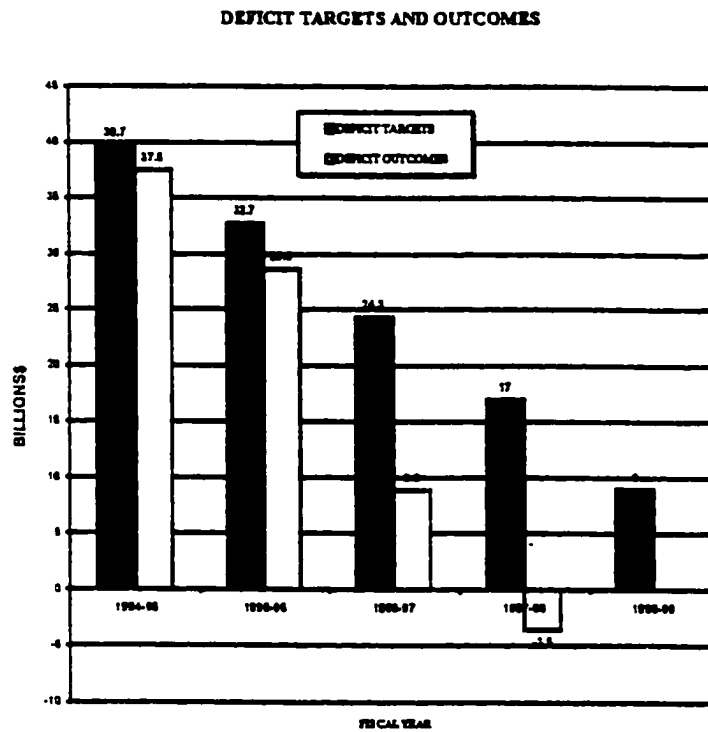
⁴² David Naylor. "Health Care in Canada: Incrementalism under Fiscal Duress." *Health Affairs*, May/June 1999, p. 23.

⁴³ Cited in Naylor, 1999, p. 23.

aspect of service provision be strictly equal. In fact, the numbers might reflect not levels of support for future directions for health care so much as they reflect support for the existing system, wherein everyone has the same basic coverage, with private insurance available for eyeglasses and eye examinations, dental services, chiropractic medicine, and the like.

Yet in spite of the "murky" evidence that indicates that citizens are willing to move in the direction of increased privatization, quite the opposite is true. Universal health care is not just about services, but about national identity. And while the former seems to be negotiable, the latter is not. Of course, excessive renegotiation of services might threaten to undermine commitments to universality. But, in any case, increased rights claiming for health care, regardless of particular collective or individual intentions, and fear of movement toward an American-style system, amount to defences of existing configurations of health service entitlement and provision. In the context of retrenchment, decision-making is difficult for governments in that costs must be contained, benefits rescinded, while citizens demand that levels of service are maintained, if not increased. But in the post-deficit era (see figures 5 and 6), decision-making is likely to be even more difficult; there is still pressing need to reform the health system, but there is no longer any convenient excuse for governments trying to effect

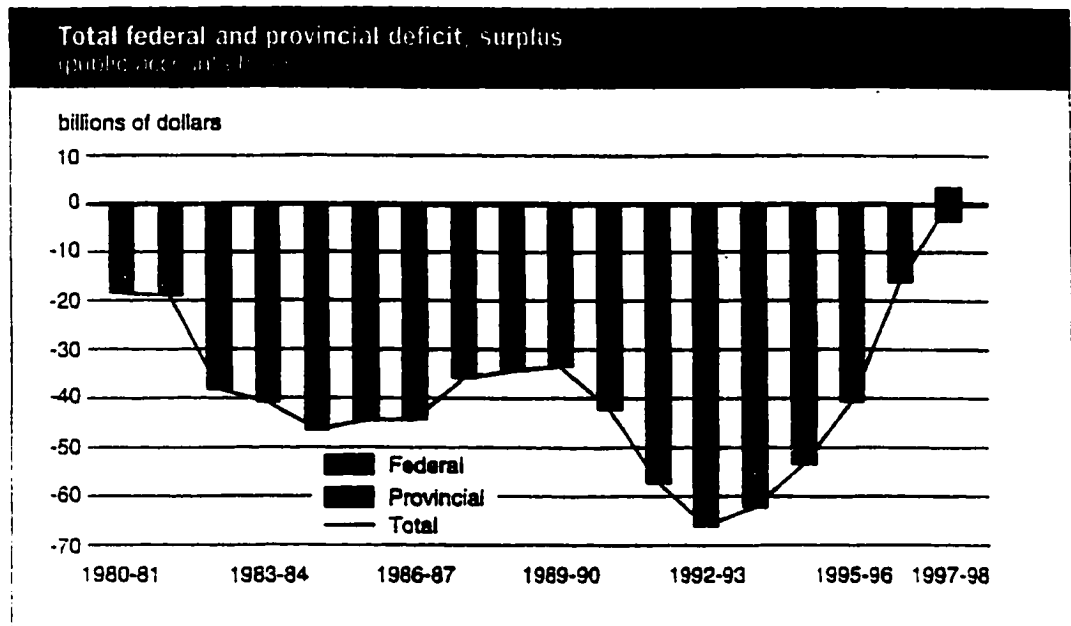
Figure 5



Source: Department of Finance data.

Source: Canada: House of Commons Standing Committee on Finance. Facing the Future: Challenges and Choices for a New Era, December 1998, p. 7.

Figure 6



Source: *Economic and Fiscal Update, October 14, 1998.*

Source: Canada: House of Commons Standing Committee on Finance. Facing the Future: Challenges and Choices for a New Era, December 1998, p. 8.

change. Pressures continue to increase for incremental, not comprehensive, change. The policy field might get more static than ever.

The Politics of Retrenchment

The fiscal crisis (and hence political crisis) of the welfare state has been well documented.⁴⁴ In Canada, in the 1980s and early to mid 1990s, unmanageable deficits and debt, lack of economic growth and high rates of unemployment forced many governments to commit themselves to exercising fiscal restraint and pursuing policies of retrenchment. This meant significant reductions in funding for health care at both federal and provincial levels at a time when medical technology is advancing rapidly and the population is aging. However, it is unlikely that with the recommitment of federal funding for health care the "crisis" of the universal health system is over.⁴⁵ In fact, governments that have successfully balanced their budgets and injected surpluses into the health system have already demonstrated that demands on the health system outpace governments' ability to provide funding. The clocks cannot be turned back for social rights defenders.

⁴⁴ See, for example, Paul Pierson. *Dismantling the Welfare State? Reagan, Thatcher and the Politics of Retrenchment*. Cambridge: Cambridge University Press, 1994. Also: Ramesh Mishra. *The Welfare State in Crisis: Social Thought and Social Change*. Sussex: Wheatsheaf Books Ltd., 1984.

⁴⁵ See Martin's 1999 Budget.

The Political Implications of Federalism: Social Policy Stasis

The fiscal "crisis" as it pertains to health care can be discerned in federal-provincial fiscal relations. Federal contributions to provincial health programmes were established, at the outset (1966), on a cost-sharing basis, whereby the federal government matched provincial spending in the health field conditionally upon provincial compliance with certain requirements. The arrangements for public medical insurance established that the federal government would pay 50% "of the national per capita cost of insured services, multiplied by the insured population of the province"⁶ and the provinces were required to operate programmes in accordance with federally determined standards.

With the implementation of Established Programs Financing (EPF) in 1977, the federal government was able to assume a greater degree of control over spending on health care (under the former cost-sharing arrangements the provinces held the balance of power). The new fiscal arrangements spelled the end of cost matching for health care, and replaced the conditional scheme with a block funding arrangement. There were three components to the EPF arrangements: a block grant, a tax point transfer, and an equalization component. Block funding arrangements are

⁶ Paul Barker, "The development of major shared-cost programmes in Canada." In R.D. Olling and M.W. Westmacott (eds.), *Perspectives on Canadian Federalism*. Scarborough: Prentice-Hall Canada, 1988, p. 205.

essentially unconditional in nature, which meant that with EPF the provinces were granted a significant degree of autonomy. However, the degree to which this was actually the case is a matter of perception. Some provinces considered the new fiscal arrangements for the established programs to be a victory: there was no longer any requirement that the funds be spent on the designated programmes, and there was no penalty indicated for permitting authorized charges, such as user charges and facility fees.⁴⁷ However, other provinces were suspicious of the arrangements and believed that the federal contribution would not be sufficient to cover escalating costs.

Although the federal government's use of its spending power to direct provincial action has generated great controversy, much of the intergovernmental tension in the field of health is the result of normative and symbolic disputes. For example, one of the most contentious "illusions" of federal-provincial relations is the transfer of tax points provided for in the EPF arrangements. The federal government underestimated the yield of the tax points (13.5% personal income tax and 1% corporate income tax), which meant that the cash component remained a substantial portion of the total contribution much longer than expected. However, the cash component secured federal visibility in this important policy field, which was politically desirable

⁴⁷ Ibid, p. 210.

for the federal government. To most Canadians it appeared that in intergovernmental conflict regarding health care, the federal government was on moral high ground; the provinces seemed to be concerned only about the funding arrangements, while the federal government protected the integrity of the system by insisting on provincial compliance with national standards. This, however, was (and is) not quite the case. Thomas Courchene explains that the tax transfer is "notional" in that "the provinces are assumed to have taken up this vacated federal tax room."⁴⁸ In other words, the revenue yielded by those tax points is provincial revenue, and not a federal contribution, although the federal government indicates otherwise. In the first year of the EPF arrangements the tax point transfer constituted a federal contribution of funds. But, after the initial transfer the tax room created is properly considered to be within the provincial realm of taxing prerogatives. In federal calculations of EPF and CHST transfers, the tax points are included as part of the yearly transfer of funds for social programmes. Hence, it appears in federal accounts that the federal government is transferring much more revenue to the provinces for health services than is actually the case. This practice is what Stefan Dupre considers to be "at the top of my list of the Big Lies of Canadian public finance."⁴⁹

⁴⁸ Thomas Courchene, *Social Canada in the Millennium: Reform Imperatives and Restructuring Principles*. Toronto: CD Howe Institute, 1994, p. 113.

⁴⁹ From J. S. Dupre, "Comment: the promise of procurement

In 1982 the federal government began reducing the EPF escalator, which caused the cash component of the transfer to decline steadily. This also meant that federal visibility and programme conditionality were declining. Because the transfer of tax points is inherently unconditional, and cannot easily be withheld, the federal government devised a new set of financial arrangements to secure the conditional cash portion. It is symbolically important that the federal government maintain the perception that national standards are being upheld. Miriam Smith explains the implications of the declining cash component of EPF: "As the federal cash funding declines as a proportion of total federal expenditure, the federal government's ability to enforce the conditions of the Canada Health Act also declines."⁵⁰ Or, in the words of Thomas Courchene: "Ottawa's version of the "golden rule" is becoming less and less sustainable: as it

federalism." In Keith Banting, Douglas Brown and Thomas Courchene (eds.), *The Future of Fiscal Federalism*. Kingston: Queen's Univ. School of Policy Studies, 1994, p. 250.

Courchene explores the (likely) possibility that as the federal government continues to adjust EPF/[CHST] transfers unilaterally, the provinces will ask for the same abatement as Quebec. Ottawa would not be able to refuse such a request. In this case, transfers for social programmes would consist only of tax points, and therefore would be completely unconditional in nature (Thomas Courchene, *Social Canada in the Millennium: Reform Imperatives and Restructuring Principles*. Toronto: CD Howe Institute, 1994, p. 117).

⁵⁰. Miriam Smith, "Retrenching the sacred trust: Medicare and Canadian federalism." In Francois Rocher and Miriam Smith (eds.), *New Trends in Canadian Federalism*. Peterborough: Broadview Press, 1995, p. 328.

stops supplying the gold, it is also losing its moral authority to make the rules."⁵¹

The federal government addressed these problems with the fiscal arrangements in the 1995 budget. The Canada Health and Social Transfer (CHST) (implemented the following year) collapsed funding for health, post secondary education and social assistance into a single transfer. This allowed the federal government to increase and maintain the cash component, which was expected to run out in 2010 under the EPF arrangements.⁵² The CHST does not make any distinctions among the three areas -- provinces are free (read obligated) to set priorities and allocate funds as they deem appropriate. Under the new arrangements, it seems that health care has fared, and is likely to continue to fare the best of all three programmes. Health care is Canada's success story. The country's record in the field of income maintenance, by way of comparison, is very poor. And it is the latter that accounts for relatively low levels of social spending: "It is Canada's relatively niggardly approach to income maintenance (other than unemployment insurance, or UI) that accounts for these relatively low social spending levels."⁵³

⁵¹. Thomas Courchene, *Social Canada in the Millennium* , p. 181.

⁵². Miriam Smith, *Retrenching the sacred trust* , p. 328.

⁵³. The strength of the medical profession in the health arena and the absence of a similarly powerful interest group in the field of income maintenance might account for the sharp difference between the two areas of social spending (Carolyn Tuohy, "Social policy: Two Worlds " in Michael Atkinson (ed.), *Governing Canada: Institutions and Public Policy* . Toronto: Harcourt Brace Jovanovich, 1993).

In other words, Canada's low levels of social spending (relative to other OECD countries) is due not to low levels in all three areas, but generous levels of health care spending and extremely low levels of spending on income maintenance programs.⁵⁴

The implications of these "two worlds" of social policy⁵⁵ will likely be discerned in future restructuring agenda. For example, the population health model, which is an integrated framework that focuses on the determinants of health (socio-economic status, education, and so on⁵⁶) was adopted by all Canadian governments in 1994. Like the CHST, the population health framework amalgamates, in theory, all major social programmes so that important connections can be made among them. However, in spite of explicit recognition of the importance of income maintenance spending and policy development in relation to health, it seems that governments have not channeled sufficient resources into these areas. Looking ahead, it is not likely that the priorities of social policy will change. Health care will remain the cornerstone

⁵⁴ When Esping-Andersen's "welfare worlds" model is applied to Canada, it is evident that health care fits into the social democratic world, and income maintenance programmes fit into the liberal world (Gregg M. Olsen. "Locating the Canadian welfare state: family policy and health care in Canada, Sweden and the United States." *Canadian Journal of Sociology*, vol. 19, no. 1, 1994, 1-20).

⁵⁵ Carolyn Tuohy, "Social policy: two worlds." In Michael Atkinson (ed.), *Governing Canada: Institutions and Public Policy*. Toronto: Harcourt Brace Jovanovich, 1993, pp. 275-305.

⁵⁶ See R.G. Evans, M.L. Barer and T.R. Marmor. *Why are Some People Healthy and Others Not? Determinants of Health of Populations*. New York: Aldine De Gruyter, 1994.

of Canadian citizenship, and therefore command the attention of governments, while income maintenance/ welfare assistance programmes will further diminish as priorities. Governments in New Brunswick and Ontario are already considering "contracting out" welfare services to private firms in order to save money.⁵⁷ The use of this (rather sharp) policy instrument hardly represents a commitment to seriously addressing the socio-economic determinants of health.

The 1999 federal budget seems to have called an end to retrenchment in health care. With the infusion of 11.5 billion dollars, the federal government has renewed its commitment to social equity and universality, and seems to have fulfilled its promise that deficit reduction strategies would only put temporary strain on health care.⁵⁸

In addition, the social union accord, ratified in 1998, indicates that there is still political consensus that health care ought to be a priority, and thereby delivered as a public good, a social right of citizenship.

⁵⁷ Maurice Simms. "Marketing takes new tacks." *Globe and Mail*, Aug. 12, 1997.

⁵⁸ However, the provinces await the 2000 federal budget with consternation; provinces hope that the federal government will continue to inject funds into the health system and make good on the promise that it will not create any new social programmes (a national, shared-cost child care programme is now on the agenda).

Reinforcing the Medical Model

That consensus looks a lot like the status quo, although there is allegedly to be renegotiation of the balance of federal and provincial authority for health care. For politicians, re-establishing or saving a revered social programme from feared changes will almost always be a sound move to garner public support. In Nova Scotia, for example, the newly elected PC government campaigned on a platform that included commitment to undo major changes made to the health system in the last ten years (namely, regionalization). This tendency, to promise reversing unpopular reform, even if much needed, and then to be compelled to deliver on it (governments), coupled with social rights defences (citizens), is likely to create policy stasis.

Stasis, caused in part by social rights claiming, is problematic, in the main, because it reinforces medical and institutional models of care. This presents a paradox because at the same time that defenders of the social rights thesis criticize medical and institutional models, their defences of the right to health care actually serve to maintain those models. As explained in chapter two, citizens' expectations are rising; citizens expect that the health care system will keep pace with their demands and hence provide the latest medical technology, access to pharmaceuticals and alternative medicines and services. At first glance, these expectations seem to be inconsistent with the medical model because they identify patterns of entitlement outside of the

existing terrain (the current model of provision does not make universally available pharmaceuticals, alternative medications, and services provided outside of usual institutional settings). In fact, it would seem to be the case that citizens' expectations repudiate rather than perpetuate the medical model. However, citizens' expectations also remain constant over time. To take these points together, it is evident that citizens' expectations rise incrementally, meaning that expectations build on existing expectations rather than replace them. In addition, social rights claiming reinforces the medical model because the political importance of the right to health care is used or distorted by organized medicine in order to resist changes to its privileged position in the health care arena. For example, the CMA can provide resistance to health care reform by claiming that reform efforts will compromise the ability of medical doctors to act in accordance with their professional ethics. Also, many physicians have an interest in maintaining the status quo because their incomes and careers are dependent on it.

What is the Medical Model and Why Ought it be Changed?

Physicians are often identified as the "gatekeepers" to the Canadian health system. In other words, patients must consult a general practitioner (GP) as their primary caregiver in order to gain access to specialists. This system ensures that GPs will continue to be the primary point

of contact for patients in the system, regardless of the increasing popularity of other practitioners as primary caregivers (OB/GYNs for women, nurse practitioners, chiropractors, physiotherapists, nutritionists, massage therapists and so on).

In many cases, however, patients can opt for other caregivers, such as chiropractors and physiotherapists, without being referred through their GP, but are not covered for those "alternative" services under the public insurance plan. Private access to OB/GYNs, periodontists or dermatologists, however, is not regularly granted without GP referral.

This pattern of consultation and referral is definitive of the medical model for three reasons. First, it perpetuates the dominance of medical doctors. Consequently, it is difficult for alternative patterns to be established. Nurse practitioners, nutritionists, and herbalists, for instance, remain subordinate to medical authority, because referrals to such caregivers are contingent on the disposition of GPs. Second, the medical profession tends not to be focused on preventive care. Although there might be a culture change beginning as GPs demonstrate greater willingness to advise patients on nutrition, exercise and alternative medications, physicians are trained to diagnose and treat disease, not prevent it. In short, medical doctors are trained to focus on managing disease and illness (with surgery and pharmaceuticals) rather than managing patients.

And third, such trends reinforce institutional patterns of care. Hospital and clinical settings are deemed most appropriate for treatment or cure.

However, the GP gatekeeping function is not without its benefits. Such a mechanism provides for good coordination of care, and it is cost effective because control can be exercised at the initial point of access. Consequently, it would not be wise to eliminate altogether the GP gatekeeping function. Rather, it might be necessary to examine possibilities for complementary avenues for alternative service provision, given that there is greater need for other types of health care provision, (while physicians and hospitals consume vast amount of resources).

Expenditures for hospitals and physicians' services account for approximately 75%, of total provincial health budgets, clearly, the lion's share of health care resources. When governments make adjustments in these areas, physicians respond by recategorizing services and reallocating their time in order to maintain desired income levels. The autonomy of the profession, in addition to the fee-for-service method of payment, seems to make containment of supply practically impossible.⁵⁹ In simple terms, the problem is that the incentive structure allows physicians to control levels of consumption of health resources, which means that momentum for change in the system builds toward expansion of medical

⁵⁹ Geoffrey York. *The High Price of Health: A Patient's Guide to the Hazards of Medical Politics*. Toronto: James Lorimer and Company, 1987.

services delivered in clinical settings and away from more holistic approaches to health care.⁶⁰ George Bernard Shaw once remarked:

that any sane nation, having observed that you could provide for the supply of bread by giving bakers a pecuniary interest in baking for you, should go on to give a surgeon a pecuniary interest in cutting off your leg, is enough to make one despair of political humanity. . . Scandalised voices murmur that these operations are necessary. They may be. It may also be necessary to hang a man or pull down a house. But we take care not to make the hangman and the house-breaker the judges of that. If we did, no man's neck would be safe and no man's house stable.⁶¹

The increase in rates of service growth, believed to be the result of raised citizens' expectations, positive political feedback for expanding health programmes, changing demographics, and availability of new medical technologies, is due in large part to the way in which physicians are remunerated. Until pressures for growth of supply-side costs are removed, fundamental change will not likely be achieved. The remarkable stability of physicians' and institutional care costs (as proportion of expenditures), difficulty in establishing incentives for physicians to practice in rural locations, and the renegotiation of collective agreements for health care workers according to equity criteria, leaves provincial governments tinkering with health care reform on the budgetary margins.

⁶⁰ See Pat and Hugh Armstrong , *Wasting Away*.

⁶¹ George Bernard Shaw quoted in Geoffrey York , *The High Price of Health*.

The Resilient Medical Model

Inauguration into the medical profession involves physicians making pledges of non-maleficence and beneficence to their profession. The Hippocratic oath, often translated as the promise to "first, do no harm," and the commitment to beneficence (kindness, goodness, compassion) apply on a case-by-case basis. These commitments are understood to be deontological rather than consequential⁶²; each patient is treated as an end in her/ himself, and not as a means to achieving a larger goal, such as that of population health. Trust in the medical profession is contingent on physicians' freedom to act in accordance with these categorical imperatives.

It is not surprising, then, that when governments begin to alter or reform the ways in which health services are provided, physicians delegitimize the process by claiming that the proposed changes threaten to seriously restrict their ability to act in accordance with their professional commitments, which will impoverish quality of service. As a matter of strategy, physicians label government encroachments on their financial autonomy as threats to professional ethics. Such defenses by physicians and their medical associations of the freedom to determine fee schedules, location of practice and income level, serve to undermine

⁶² Ian Harvey. "Philosophical perspectives on priority setting." In Joanna Coast et al eds ., *Priority Setting: The Health Care Debate* . John Wiley and Sons Ltd., 1996.

public confidence in government reform initiatives. They also serve to further strengthen their own position, and, consequently, citizens' defences of their rights to health care.

The Population Health Model

In 1994, all of the provinces agreed to structure their health care reform agenda according to the population health model⁶³. This means that, to the dismay of many physicians caring for individual patients, governments have adopted an approach to health care provision that promotes a broadened focus: social determinants of health, such as socio-economic status, are considered to be of foremost importance within this framework. The problem, as identified by (medical) Dr. T.L. Guidotti, is that "the model provided for the relationship between social and individual factors in health does not distinguish between the individual and the "population," and thus confuses individual "health and function" with population health status."⁶⁴ For medical

⁶³. The health promotion model requires citizens to take responsibility for their health and the health of their communities, which makes necessary some mechanism for assessing community needs and determinants of health. This means that, on the one hand, citizens must choose to adopt healthier lifestyles in order that their need for medical care is reduced, and on the other hand that because resources are scarce and rationing involves distributing health services according to values, citizens and communities must be consulted in order to determine which values will direct the process.

⁶⁴. Tee L. Guidotti, "Why are some People Healthy and Others Not? A critique of the population health model." *Annals RCPSC* (Royal College of Physicians and Surgeons of Canada),

doctors, who deal with individual patients (with various conditions) on a daily basis, the population health model is an abstraction that fails to recognize the roles and experiences of service providers.

In addition, and perhaps more troubling, there is a serious imbalance between federal spending commitments for social programmes and provincial policy agenda. The policy directives of the social determinants of health framework necessitate strengthened financial and moral commitments to income maintenance spending. This clearly has not been achieved with the Canada Health and Social Transfer, the funding arrangement that seemingly broadened the social policy focus in the country but in reality, has significantly reduced the total amount of the transfer and forced difficult allocation decisions onto provincial governments (provinces must now set priorities among three areas rather than two).

The CHST was implemented at the same time that there was a public policy paradigm shift in the field of health. The amalgamated transfer collapsed funding for health, post-secondary education and social assistance and, not coincidentally, the population health framework, which recognizes socio-economic status and level of education as determinants of health, was adopted by all Canadian governments.⁶⁵ The population health approach (also referred

vol. 30, no. 4, June 1997, p. 204.

⁶⁵. For a comprehensive examination of the population health model, see R.G. Evans, M.L. Barer and T.R. Marmor, *Why are Some People Healthy and Others Not ?*; also see Federal,

to as the determinants of health) differs from the traditional medical model in at least two ways:

1. Population health strategies address the entire range of factors that determine health. Traditional health care focuses on risks and clinical factors related to particular diseases.
2. Population health strategies are designed to affect the entire population. Health care deals with individuals one at a time, usually individuals who already have a health problem or are at significant risk of developing one.⁶⁶

The single most important determinant of health, according to the framework document, is income and social status. People of low socio-economic status (SES) have poorer health than those who are further up the social and income hierarchy. At one time it was believed that this difference in health was attributable to higher rates of smoking and alcohol consumption, poor diet and higher levels of stress in the lower strata of the population.⁶⁷ However, research shows that when these factors are controlled in both high and low SES populations, the result is that people in the lower SES groupings still have poorer health. The data suggest "some underlying general causal process, correlated with hierarchy, which expresses itself through different diseases. But the particular diseases that carry people off may then simply be

Provincial and Territorial Advisory Committee on Population Health, *Strategies for Population Health: Investing in the Health of Canadians*. Prepared for the meeting of the Ministers of Health, Halifax, Nova Scotia, September 14-15, 1994.

⁶⁶ Federal, Provincial and Territorial Advisory Committee on Population Health, *Strategies for Population Health: Investing in the Health of Canadians*.

⁶⁷ R. G. Evans, "Introduction" in *Why are Some People Healthy and Others Not?* p. 5.

alternative pathways or mechanisms rather than "causes" of illness and death; the essential factor is something else."⁶⁸ And it is this "something else" on which current public policy agenda ought to be focused.

Thus, public policy has been rhetorically reoriented to target certain disadvantaged populations in order that the entire Canadian population will become healthier.⁶⁹ Essential to this program is recognition of the differences among various ethnic, cultural and socio-economic populations, as well as important linkages between several policy areas: health, education, labour, income assistance, environment, and the economy.⁷⁰ The population health strategy cannot be pursued solely within health portfolios; virtually all departments of the state must engage to achieve population health goals.

This integrated approach also includes increased emphasis on health promotion for all citizens. If people exercise more, eat a low-fat diet, smoke less and learn to cope effectively with stress, then the overall demand for medical treatment will be diminished. But clearly, the

⁶⁸. Ibid, p. 7.

⁶⁹ For instance, programmes to improve Native health, health of children.

⁷⁰ See "Health Impacts of Social and Economic Conditions: Implications for Public Policy." Canadian Public Health Association, Board of Directors Discussion Paper. March, 1997.

Anton E. Kunst and Johan P. Mackenbach. "Measuring Socioeconomic Inequalities in Health." World Health Organization Regional Office for Europe, Copenhagen, 1995.

research suggests that the first component of the strategy (recognizing socio-economic determinants) is the more important. If levels of status and income are positively correlated with health, then governments should be committed to eradicating poverty and increasing the standard of living for all Canadians. However, Canada's record for income maintenance spending and program development for recipients of welfare is quite poor, and is likely not to improve under the current funding arrangements.⁷¹ Therefore, although federal and provincial governments remain committed to the rhetoric of the population health model, it is not clear the extent to which governments are committed to implementing an integrated approach to social policy-making and service provision.

What would this approach mean for social rights? On the one hand, it reasserts the profundity of social class, and on the other hand, it verifies the need for public policy to address and incorporate other sources of inequality. The constraining effect of federalism, observable in the reduction in federal funding for health care at the same time that the population health model was endorsed, makes the approach difficult to implement. The gap between rhetoric (of both social rights claiming and reform) and action seems to be widening.

What is needed, then is an approach that serves not to dismantle the medical model, but recognize and

⁷¹. See Carolyn Tuohy, *Social Policy: Two Worlds*.

institutionalize health promotion strategies. However, this broad, population-based approach needs to constitute only one element of a health policy reorientation. Dr. Guidotti's concerns about subordinating individual patients and their care to community health (a series of health indicators that amalgamate and dissolve the experiences of individuals and their particular relationships with physicians), are substantial. Therefore, there must be attempts, through public policy, to achieve balance. To continue with the AIDS example (again, the most notable exception to the trend from communicable to non-communicable disease), it is clear that health promotion strategies are crucial (i.e. public health campaigns re: safe sex, clean needles), and need to target certain segments of the population. But public health needs have to be balanced with individual concerns, like privacy, treatment and choice.

Health Indicators and the Changing Contours of Disease

This lack of clarity of objectives and political capacity for implementation pose significant problems. A population health approach, with careful focus on social determinants of health, is likely what is needed in Canada, given the dynamics of the epidemiological transition. The WHO finds that, "non-communicable diseases are expected to account for an increasing share of the disease burden, rising from 43% in 1998 to 73% by 2020, assuming a continuation of recent

downward trends in overall mortality."⁷² This shift in main causes of death from communicable to non-communicable diseases has consequences for 1. health, and 2. equity and entitlement.

According to the WHO document:

The steep projected increase in the burden of noncommunicable diseases worldwide -- the epidemiological transition -- is largely driven by population ageing, augmented by the rapidly increasing numbers of people who are at present exposed to tobacco and other risk factors, such as obesity, physical inactivity and heavy alcohol consumption... Health systems must adjust to deal effectively and efficiently with the globally changing nature of illness, and health policy-makers will be challenged to find the most cost-effective uses of their limited resources to control the rising epidemics of noncommunicable diseases.

At the same time, health policy-makers will need to respond to the unexpectedly persistent inequalities in health status within countries... Recent studies have revealed surprisingly large inequalities within developed nations, and they highlight the need for policies that focus on disadvantaged populations throughout the world.⁷³

1. Health

Two clear directives can be gleaned from this transition. The first is that individuals must take greater responsibility for their health by eating well, exercising more, reducing consumption of tobacco and alcohol, and taking precautions to reduce the spread of communicable diseases, namely HIV/AIDS. The second is that governments must, through redistributive measures, provide resistance to the

⁷² WHO 1999, p. 16.

⁷³ WHO 1999, p. 16-17.

increasing polarization of the wealthy and the poor in society, so that overall health will improve, thus addressing non-communicable disease. This would also necessitate health promotion campaigns and programs that will fill the widening gaps in entitlement, such as well developed home care and pharmacare programs. It seems to be the case that those with the most limited resources have the greatest difficulty obtaining home care services and expensive pharmaceuticals.

2. Equity and Patterns of Entitlement

By addressing the social component of health, governments achieve equity, meaning fairness, rather than strict equality or sameness. And, while attention still ought to be paid to reducing inequalities in status and income, consonant with Marshall's analysis, it should no longer be the sole lens through which inequality is examined in society.

Differences in income, health status, gender, race, sexuality, and so on, intersect with one another and, as will be explained in chapter four, effectively create "communities" that fall into marginal entitlement zones. Patients with AIDS, for example, not only need prohibitively expensive medication, but often need extensive home care services. While all Canadians have the same access to meager pharmaceutical and home care benefits, some will be disadvantaged to a greater extent. That is to say that Canadians do not have access to a comprehensive range of health services, but a limited range of medical and hospital-

based services. The standard of expected service gets higher with improvements in medical technology which, paradoxically, make many medical and hospital-based services unnecessary.

It is likely that traditional patterns of health service provision and utilization will continue to be replaced with a variety of new options, for which the state might be unwilling or unable to provide funding. The point to be made is that this challenge cannot be addressed with what the World Health Organization calls "classical universalism". Rather, "new universalism", that recognizes diversity and "governments' limits but retains government responsibility for the leadership and finance of health systems,"⁷⁴ should replace Marshall's welfare state citizenship model.

These directives concerning health, and statements about equity and entitlement, are indications of a new blend of individual responsibility-taking (individual health and choice) and collective entitlement (health distributed 'universally' as a public good). The right to health care, as an essential component of Canadian citizenship, manifests this new blend, even if defenders of the right do not recognize the subtleties or complexities of their claims. The substance of these claims, however, needs to be clarified, so that governments can implement reforms that

⁷⁴ See WHO 1999, p. 33. These statements are meant to indicate broad agreement with the approach of the "new universalism," and not an endorsement of the specifics of the WHO approach.

will improve health in accordance with the changing contours of disease.

Health and Empowerment

But how new is the concept of individual empowerment for health care? And was it really absent from "passive" welfare state arrangements? It might be argued that there has always been care work done by friends and family members (often the burden has fallen disproportionately on women). While this is certainly true, the argument presented in the next chapter concerning the development of a more active, duty-bound citizenry, bolsters the claim made in this chapter, namely that citizens are becoming more active in providing care as a means of adjusting to shorter patient stays, day surgeries and outpatient services with meager homecare support. Of course, to say that citizens *ought* to be more active in decision making regarding health care is much different from saying that citizens are taking more and more responsibility in the acquiring of services (either by providing services "free" for family members or paying for them to be provided by other care workers). In the paragraphs that follow I will explain how these claims are very different yet connected.

Citizens are taking more responsibility for their own health care and the health of family members for two reasons. First, reduction in services provided in hospitals means that many services will be provided in the home. This includes preparation for surgery, and treatment for recovery. And

second, evidence shows that lifestyle is a main determinant in health, therefore it is necessary for individuals to try to improve the conditions that may make them prone to disease as defined by the epidemiological transition. Both of these reasons for increased individual responsibility taking for health require state action. In the first instance, the state needs to adequately support family caregivers through well-developed homecare programmes. The second reason necessitates action in the direction of reducing income disparity within society.⁷⁵

In determining how to distribute resources in society, it is necessary to define the communities among which public goods will be allocated. As argued, the universal distribution of health services is being challenged by rising expectations, cost containment policies, and differentiated citizenship claims. Strictly equal health care benefits are neither consistently valued by Canadians⁷⁶, nor affordable, nor desirable in the current stage of citizenship development.

But identifying communities is important not only because, if different "communities" need to be taken into account, as I have argued, then there needs to be some mechanism for identifying and consulting these communities. Engaging

⁷⁵ See R.G. Evans, M.L. Barer and T.L. Marmor (eds.). *Why are Some People Healthy and Others Not? Determinants of Health of Populations*. New York: Aldine de Gruyter, 1994.

⁷⁶ See "75% of Canadians in favour of health care user fees, poll finds." *National Post*, January 12, 2000; Jeff Heinrich, "Quebec poll finds support for private health care."

communities in decision making for health care is also potentially empowering and edifying for citizens, meaning that participation enables them to impact health policy and restructuring efforts, as well as identify with the goals of reform. Taken together, citizen engagement can lead out of stasis because empowerment and consultation can provide some balance to the power of the medical profession. However, the argument presented is not that citizen or community authority should replace that of organized medicine, but rather that more effective citizen or community influence upon the state could ensure that the state itself acts as a more effective counterbalance to organized medicine.

Conclusion

Citizens' resistance to the increased commodification of health services, in addition to the politics of federalism, and the entrenched medical model, institutionalize and strengthen the political potency of the right to health care. In other words, social rights, as popularly conceived, are reinforced by the political interpretation of entitlement and social equity, and interest group accommodation. This is somewhat troubling because, as explained in the introduction, and as evidenced by the discussion of Keynes-inspired approaches to budgeting in this chapter, the social rights thesis is outmoded, and needs to be revised, not further defended and entrenched in the national psyche.

In the next chapter, I will further examine the implications of the stasis that has resulted from failure to revise Marshall's thesis. As explained, social rights stasis has perpetuated existing (traditional) patterns of medical authority and service provision. Therein I will argue that one main component of provincial reform agenda, the creation of community governance structures within regionalized systems, provides additional evidence of the changing mix of individual responsibility-taking and collective entitlement, and has the potential to change the essential quality of social citizenship with more active modes of health care decision making.

CHAPTER FOUR

Citizenship, Entitlement, "Community": Evaluating Community Governance Structures as Mechanisms for Moving Beyond Classical Universalism

Introduction¹

The social rights thesis, coincident with the development of the welfare state, protects (as it was designed to) a certain relationship between citizens and the state. In Canada, this relationship can best be discerned in debates concerning the universal health system. Two general comments can be made about the relationship. The first is that the relationship serves to ensure equality. Citizens have come to expect that government will maintain commitments to universality in health care, and governments continue to promise that they will do so. And the second is that the relationship is defined by passivity (which is reinforced by the executive system of government). Because it was the entitlement side of Marshall's citizenship equation that became institutionalized in Canada, the right to health care came to identify a virtually unlimited set of expectations, with no corresponding, well developed, notion of duty. To be sure, it might be the case that citizens have fulfilled obligations (have paid for health care through their taxes), and that it is the entitlement side that is thin.

¹ Another version of this chapter was published as: Candace Johnson Redden, "Rationing care in the community: engaging citizens in health care decision making." *Journal of Health Politics, Policy and Law*, vol. 24, no. 6, Dec. 1999.

Regardless, paying taxes in return for social programmes is a relatively passive exchange. Marshall's theorizing might have engendered such passivity, although originally intended in much different (postwar) circumstances. Marshall also believed that citizenship was an evolving concept, but did not speculate about the configuration of citizenship beyond the period of social rights development. How might duty be conceived at the turn of the twenty-first century?

Provincial exercises in community engagement for health care decision-making might provide important opportunities for citizens to fulfill their duties of citizenship. Citizens can become more active in determining the ways in which health care is delivered in the context of technological advancement, alternative service provision, changing demographics and epidemiological patterns, and finite resources. The problem is that such opportunities might be undermined by social rights expectations, which perpetuate the existing welfare state model.

In this chapter, I examine the creation of community governance structures in Nova Scotia and Saskatchewan against the Medicaid rationing process undertaken in Oregon, in order to determine the possibilities for such exercises in the Canadian context. I have chosen Nova Scotia and Saskatchewan as case studies because each is an example of a different model of citizen involvement. The former illustrates the process of citizen input, and the latter represents structures that have been created for citizen

governance.² The Oregon experiment is an important example of transparent and community-level rationing. It provides lessons for countries such as Canada that, due to complex political factors, are being forced to recognize that (1) priority setting for health care is a value laden process that might necessitate citizen involvement, (2) shifting difficult decisions onto citizens and their communities (under the guise of democracy) lets governments deflect some political "heat" in this volatile policy area, and (3) prospects for public debate are contingent on institutional and structural factors, and might not always achieve desired effects.

In the Canadian case it seems that community participation has the potential to contribute to the construction of an active conception of citizenship, a major departure from the passive conception that is endemic to the existing welfare state programmes in that country. However, it is unclear the degree to which the much needed debate concerning the future of universal health care can produce viable or useful results in community governance structures, regardless of their conceptual compatibility or incompatibility with social rights.

² Jonathan Lomas, John Woods and Gerry Veenstra. "Devolving authority for health care in Canada's provinces: An introduction to the issues." *CMAJ*, 1997, vol. 156, no. 3, 371-377.

Social Rights Versus Participation

It seems to be the case that social rights are in conflict with participation. Social rights, seemingly requiring very little in exchange for benefits (viz., the very idea of social rights is that a modicum of social services ought to be granted to all citizens, on the same terms, and not contingent on need, wealth or income), are, at first glance, at odds with participatory expressions of citizenship. In a context in which participation is valued, and either directly or indirectly affects the decisions that are made, the bargain struck, or guarantee provided with social rights, is overridden. However, it will be explained later in this chapter that social rights and participatory modes of citizenship might be complementary rather than contradictory.

Yet despite possibilities for the compatibility of "competing" approaches, at some point it will be necessary to decide which conception of citizenship will guide health policy decisions. The social rights conception seems to be implicit in many of the significant scholarly contributions in the field. For instance, the compelling work of Hugh and Pat Armstrong seems to rest on the assumption that health care ought to continue to be distributed as a public good, a social right of citizenship, although they clearly "reject the notion of simple choices between such alternatives as prevention and cure; promotion and intervention,"³ which might

³ Hugh Armstrong and Pat Armstrong. *Wasting Away: The Undermining of Canadian Health Care*. Toronto: Oxford, 1996, p. 13.

also logically extend to the social rights -- participation dichotomy. In addition, the work of Miriam Smith (which focuses on health care as an issue of federalism)⁴, and Robert Evans (which focuses on the economic viability or rationality of universal health care)⁵, while not squarely addressing the question of entitlement, lend support to uncritical defences of the social rights thesis. In neglecting the question of the validity or benefit of the entrenched right to health care, their analyses, building on unexamined or flawed assumptions, contribute to further misinterpretation.

In addition, those who are concerned with participation (Jonathan Lomas⁶, Michael Rachlis⁷), seem to be uninterested

⁴ See Miriam Smith, "Retrenching the Sacred Trust: Medicare and Canadian Federalism." In Francois Rocher and Miriam Smith (eds.), *New Trends in Canadian Federalism*. Peterborough: Broadview, 1995.

⁵ See Robert G. Evans. "Hang Together or Hang Separately: The Viability of a Universal Health Care System in an Aging Society." *Canadian Public Policy*, 1987, vol. 13, no. 2, 165-180;
Robert G. Evans. "Canada: The Real Issues." *Journal of Health Politics, Policy and Law*, 1992, vol. 17, no.2, 739-762.

⁶ See Jonathan Lomas, John Woods and Gerry Veenstra. "Devolving Authority for Health Care in Canada's Provinces: 1. An Introduction to the Issues." *CMAJ*, 1997, vol. 156, no. 3, 371-7;
Jonathan Lomas, Gerry Veenstra, and John Woods. "Devolving Authority for Health Care in Canada's Provinces: 2. Backgrounds, Resources and Activities of Board Members." *CMAJ*, 1997, vol. 156, 513-20;
Jonathan Lomas, Gerry Veenstra and John Woods. "Devolving Authority for Health Care in Canada's Provinces: 3. Motivations, Attitudes and Approaches of Board Members." *CMAJ*, 1997, vol. 156, 669-76;
Jonathan Lomas. "Devolving Authority for Health Care in Canada's Provinces: 4. Emerging Issues and Prospects." *CMAJ*, 1997, vol. 156, 817-23.

in the symbolic value of health care, social rights, or citizenship. While all of these scholars raise important questions concerning citizen engagement and regionalization strategies, none of them employs a framework that can directly address the larger questions, namely, entitlement. I will try to bridge this gap by considering both health care as social right of citizenship and citizen participation in health care decision-making.

Changing Health Care Decision-Making Structures in Canada

In the Canadian context it can be argued that federal-provincial maneuvering in the field of health, policy paradigm shifts, and structural reform are components of a larger strategy of cutback management. Public health insurance is guaranteed to all Canadians as a social right of citizenship, therefore any attempts to redesign the health system can be perceived as violations of that right. Further, governments proceed with caution in order to avoid inflaming public sentiment; because public health insurance is universally available, the middle class (which constitutes the largest group of voters) benefits greatly from the programme.⁸ In other words, while it is important to

⁷ See Jonathan Lomas and Michael Rachlis. "Moving Rocks: Block-Funding in PEI as an Incentive for Cross-Sectoral Reallocations Among Human Services." *Canadian Public Administration*, 1996, vol. 39, no. 4, 581-600.

⁸ Gosta Esping-Andersen. "Citizenship and Socialism: De-Commodification and Solidarity in the Welfare State." In *Stagnation and Renewal in Social Policy*, ed., Martin Rein and Lee Rainwater. New York: M.E. Sharpe, 1987.

recognize that health care in Canada is perceived to be a right, it is clearly valued by a majority of citizens because of the tangible benefits that it provides.⁹ With this in mind, it is tempting to dismiss the development of fora for citizen and community participation as a political mechanism for deflecting criticism and avoiding making difficult decisions publicly in order to avoid alienating the majority of voters. However, this position is not entirely accurate. The creation of regional and community health boards in many of the Canadian provinces is the result of citizen demands for inclusion, political commitments to more openness and transparency in health care decision-making, and provides citizens with unique opportunities to fulfill their duties of citizenship.

Governments in Canada are committed to formally engaging communities in decision-making processes concerning issues of distributional equity. In part, this initiative is an attempt to connect with international trends toward greater transparency and community involvement in health care decisions¹⁰ and recognition that priority setting for health

⁹ Carolyn Hughes Tuohy. "Conflict and Accommodation in the Canadian Health Care System." In Robert Evans and G.L. Stoddart (eds.), *Medicare at Maturity*. Calgary: Univ. of Calgary Press, 1986; Tuohy. "Health Care in Canada." In William M. Chandler and Christian W. Zollner (eds.), *Challenges to Federalism: Policy-Making in Canada and the Federal Republic of Germany*. Kingston: Institute of Intergovernmental Relations, 1989; Tuohy. *Policy and Politics in Canada: Institutionalized Ambivalence*. Philadelphia: Temple University Press, 1992.

¹⁰ In developing countries, regionalization and community engagement strategies are being employed as a means to

services is a value-laden process. It is also part of a larger governmental strategy of cutback management, whereby difficult decisions that involve the limiting or removal of health services will seemingly be made by citizens and their communities. The rhetoric of this strategy mimics closely the reforms undertaken in Oregon (which will be considered in a subsequent section): the literature that outlines plans for regionalization and reform in Nova Scotia, for example, makes frequent mention of the need to define those services, and involve citizens in decision-making processes concerning the definition of core services. However, virtually every attempt to distinguish core from non-core services has failed to achieve intended results.¹¹ In the Oregon case, the decision to fund line item 565 and not 566 is based solely on fiscal criteria, and is arbitrary from either a moral or clinical point of view.¹² It is not clear what Canadian

poverty reduction. In developed countries, such strategies are aimed at the elusive goals of cost containment, efficiency, effectiveness, and equity. See for example: Richard Saltman and Josep Figueras. *European Health Care Reform: Analysis of Current Strategies*. WHO Regional Publications, European Series no. 72, 1997.
 David J. Hunter. *Desperately Seeking Solutions: Rationing Health Care*. New York: Longman, 1997.
 PAHO. *Community Participation in Health and Development in the Americas*, 1984.
 Meredith Minkler (ed.). *Community Organizing and Community Building for Health*. Rutgers University Press, 1997.

¹¹ Joanna Coast. "Core Services: Pluralistic Bargaining in New Zealand. In J. Coast, J. Donovan and S. Frankel (eds.), *Priority Setting: The Health Care Debate*. New York: John Wiley and Sons, 1996; Jonathan Lomas and Michael Rachlis 1996, p.586

¹² On February 1, 1994, the Oregon Plan took effect; 565 out of the 696 treatment/condition pairs were funded. Joanna Coast. "The Oregon Plan: Technical Priority Setting in the

reformers hope to achieve by making similar distinctions. And, it will be argued, both the outcomes and the opportunities for engagement are important, therefore, attention should be focused on decision-making processes and, coincidentally, on what can realistically be achieved through community engagement exercises.

The degree to which the rationing experiment in Oregon has had an impact on Canadian reform efforts is difficult to determine.¹³ On the one hand, there is no tangible evidence of a causal relationship; Canadian reformers did not simply import the Oregon model and map it onto their political landscape, nor do they refer explicitly to it as a point of reference. On the other hand, the rhetoric that makes buoyant the creation of community governance structures in Canada is remarkably similar to that of the Oregon process (in contradistinction to that of European health care reform, for example). The American penetration of Canadian political discourse is an historical regularity, and the prevailing view is that North-South economic and political influences and relations are increasing in strength.¹⁴ This is also

USA." In J. Coast, J. Donovan and S. Frankel (eds.), *Priority Setting: The Health Care Debate*. John Wiley and Sons Ltd., 1996, p. 47.

¹³ However, it is likely that reformers in Canada's western provinces (if not in other provinces) were well educated about the Oregon experiment.

¹⁴ Thomas Courchene. "ACCESS: A Convention on the Canadian Economic and Social Systems." In *Assessing ACCESS: Proceedings of the Symposium on the Courchene Proposal*. Kingston: Queen's University, Institute of Intergovernmental Relations, 1997, p. 81.

evidenced by the market-driven approach to health care that has long been the signature of the American health care system, discernible in the creation of private clinics in Canada in which physicians participate in for-profit health care business, as well as the large migration of Canadian health care practitioners to the U.S.

When reform efforts began in the Canadian provinces almost a decade ago, many academics and practitioners insisted that primary care reform precede structural reform. However, due to many complex political factors¹⁵, provincial governments (based on the recommendations of provincial royal commissions and committees created to consider reform agenda) decided to pursue agenda of structural reform which included (in all provinces save Ontario) the creation of regional and community health boards. That restructuring became the priority in provincial reform efforts meant that health care decision-making systems were being redesigned (decisions regarding the distribution of health resources will be made in the community) prior to the reconsideration or reevaluation of the role of General Practitioners (GPs), hospitals and home care programmes in the health care system. In other words, whether GPs should perform different functions as the "gatekeepers" to the health system (or whether GPs should in fact be the gatekeepers), or whether home care should

¹⁵ For example, the creation of community-based governance structures is visible and immediate and makes the community "accountable" for difficult decisions. Moreover, the decision to pursue structural reform was not dependent on the quiescence of the medical profession.

completely replace certain acute care services (and be funded accordingly) were not decided prior to the implementation of the new community structures; on the contrary, in Nova Scotia, for example, it will (seemingly) be the community health boards that will have to make difficult decisions concerning issues of distributional equity (i.e. rationing). The extent to which community health boards will be able to make such decisions has not yet been determined. Those decisions are inevitable, and will likely require strong political leadership in addition to citizen input.

Engaging the Community: the Case of Nova Scotia

In the late 1980s and early 1990s, provincial governments were beginning to come to terms with health care as a fiscal issue in its own right, rather than as the by-product of intergovernmental discord. The federal government had been consistently reducing transfer payments to the provinces for social programmes since 1977, although such adjustments in the fiscal arrangements were related more to the budgetary planning themes that were in vogue at the time than to any long-term understanding of the demographic and technological developments that would expand health care budgets beyond fiscal capacity.

The fiscal conservatism of the federal Progressive Conservative government (1984-1993) had profound effects in Nova Scotia, a province that is dependent on federal

equalization payments and social policy transfers for economic stability. Reductions in transfer payments, in the context of turbulent and frequent changes in government,¹⁶ resulted in well intentioned, but never fully implemented, health reform agenda.

Groundwork for health care reform was set in 1989 with the Report of the Nova Scotia Royal Commission on Health Care, which recommended that citizens be included and thereby empowered in decisions regarding health issues. The Commission envisioned an expanded information network so that citizens would have access to information on health status, health costs and the like, which would compel them to take more responsibility for their health choices. This conception of citizen empowerment would be mobilized with decentralization of decision-making and the creation of regional structures for service delivery. These recommendations were reiterated and elaborated in the 1994 report of the Blueprint Committee on Health System Reform. The creation of Nova Scotia's "blueprint" was itself an open and inclusive process; the substance of the report was based on extensive community interaction. According to the report,

nearly 200 written submissions were received from individuals, municipal governments, health planning groups and a wide range of care providers. The vast majority supported the reform process and offered valuable suggestions for improving the

¹⁶ In 1991, PC Premier Buchanan left office in wake of scandal, and was replaced by Donald Cameron. The 1993 election was won in a landslide by the Liberal Party, led by John Savage, who promised to reduce the budget deficit accrued by the Buchanan Tories (1978-1991).

health system. Many submissions highlighted the need for communities and consumers to have access to, and control over, health care services.¹⁷

The government's response to this public sentiment was to create community governance structures within the regionalized health system. The mandate for the new institutional design included the following: "to allow for effective community input into decision-making about health care resource allocation".¹⁸ More specifically, and prior to regionalization, the Blueprint Committee recommended that regional health boards be created to establish, in consultation with the Department of Health, a list of core services that will be provided and funded categorically in all regions:

The government's health policy included a commitment to establish core services. These are defined as essential health care services that must be provided throughout the province at a consistent standard. The Blueprint recommended that the RHBS and the Department of Health work together to identify core services at the community, regional and provincial levels and to develop a mechanism for funding these services.¹⁹

This ambitious mandate would be supported by several community health boards in each region. According to the Blueprint Committee these would be responsible for:

¹⁷ Nova Scotia, The Minister's Action Committee on Health System Reform. *Nova Scotia's Blueprint For Health System Reform*. Halifax: Dept. of Health, 1994, p. 17.

¹⁸ Nova Scotia 1994, p.26

¹⁹ Nova Scotia, The Minister's Action Committee on Health System Reform. *From Blueprint to Building: Renovating Nova Scotia's Health System*. Halifax: Department of Health, 1995, p. 6.

planning, coordinating, and authorizing the funding for primary health care in their area. To do this, an allocation for primary health care will be developed for each CHB by the RHB. Some examples of primary health care include outpatient clinics, physiotherapy services, nutrition programs, and well-baby clinics. Local primary health care providers, such as community health centres, will work with their local CHB by identifying the programs and services they can deliver most efficiently, effectively, and affordably.²⁰

Clearly, in Nova Scotia the original and enduring *de jure* mandate of RHBs and CHBs is to set priorities among health care spending areas. The rhetoric indicates that citizens and their communities, via these new community governance structures, would be the source of any new allocative decisions for health care, if not the primary decision-makers in priority setting exercises, with the Department of Health in a formal supervisory role. Daily political debate includes discussion of community involvement in setting priorities for health, and publications from the Department of Health regarding the reforms are littered with references to grassroots decision-making and community empowerment, which seem to indicate a strong political commitment to engaging communities in difficult decision-making processes. This engagement can also be considered as an attempt by the state to deflect or download difficult decision-making responsibilities onto those who are least well-equipped to make them. However, at this stage in the reform process there is need for neither praise nor alarm.

²⁰ Nova Scotia 1995, p.7

In Nova Scotia four regional health boards (RHBs) were created (the implementation process began in 1996) which were intended to organize all of the province's health care facilities and resources into four distinct regional entities, each reporting to the province on behalf of hospitals, clinics, etc.²¹ This would have meant four bodies reporting to and making demands on the department of health rather than the 36 individual hospital boards that effectively performed these functions prior to regionalization. However, at approximately the same time that the Dept. of Health was regionalized, several hospitals merged into larger regional entities and replaced a number of smaller institutions.²² These new regional hospitals²³, in addition to two other major hospitals in Halifax²⁴, did not want to channel their efforts through the new health boards - - there are obvious advantages in having direct access to government. Therefore, the province's four major health care complexes chose to remain outside the regional structure, effectively undermining the province's restructuring effort,

²¹ The process of regionalization in Nova Scotia has created four Regional Health Boards, with a total of 67 members (all appointed by government -- some salaried, some on a volunteer basis), and 30 Community Health Boards with a total of approximately 420 members. Nova Scotia: Department of Health. *Health Care Update -- Regionalization*. December, 1997, p. 10.

²² Nova Scotia 1997

²³ These are the Queen Elizabeth the II Health Sciences Centre in Halifax and the Cape Breton Regional Hospital.

²⁴ The IWK-Grace and the Nova Scotia Hospital ; both are located in Halifax.

and depriving the regional and community health boards of institutional support. In fact, the defiance of these four hospitals (non-designated organizations -- NDOs) is frustrating for the Department of Health's entire reform agenda in that the NDOs direct and consume a significant portion of the health care budget, yet remain outside the regional configuration. In this context, it is unlikely that RHBS and CHBS will be of much force or effect in the reorganized departmental structure, which is unfortunate because passivity will continue to tacitly endorse the medical model (through which physicians and hospitals were able to mount resistance to the regionalization scheme in the first place).

The Case of Saskatchewan

Saskatchewan, distinguished as the birthplace of public health insurance in Canada, consistently draws attention in the social policy arena. The province's cooperative political culture, resource based economy (volatile to "boom and bust" cycles), and commitment to social progress, as these have translated into health policy, make it exceptional from other provinces. In 1995 Saskatchewan became the first province to balance its budget, and remains the only province to have done so before beginning health system reform. That the NDP government eliminated the budget deficit while it remained dedicated to social democracy in a politically, socially and

economically conservative context, is particularly impressive.

The most significant differences between community engagement in health care decision-making in Nova Scotia and Saskatchewan are briefly explained in the paragraphs that follow. First of all, in Saskatchewan, legislation compelled all providers to operate within the regionalized structure, which prevented the undermining of the reform process that characterized the Nova Scotia experience. Second, budgeting decisions have been devolved to the districts in Saskatchewan (there are 32 districts; each district board includes some members that have been appointed by the Department of Health (one third) and some that have been elected by the district constituency (two thirds))²⁵, whereas in Nova Scotia full decision-making authority for budgetary allocations rests with the Department of Health. Third, in Saskatchewan, there was clear agreement among decision-makers that deficit reduction was not health care reform, therefore the provincial budget was balanced before health system reform was undertaken. The fourth important difference that accounts for Saskatchewan's success in regionalizing its health system and encouraging citizen participation was the political stability in that province during the policy planning and implementation phases. The Romanow NDP

²⁵ For a detailed account of implementation of health districts in Saskatchewan, see HealNet: Health Services Utilization and Research Commission. *Regionalization at Age Five: Views of Saskatchewan Health Care Decision-Makers*. December 1997.

government has enjoyed a firm hold on power from 1991 to present, during which time there have been relatively few administrative rearrangements. In that same period in Nova Scotia there were three different governments, continuous reshuffling of cabinet and senior levels of the public service, and departmental reorganizations. According to one official who attended the meetings of health ministers, there was a completely different group (Deputy Minister and other senior officials) from Nova Scotia each year.

The fifth and final difference is that the Saskatchewan Government began with principles for reform, rather than a detailed blueprint, because those involved in policy planning realized that such a blueprint would be inaccurate well in advance of the implementation stage. This decision effectively prevented a situation wherein government becomes inflexible throughout the reform process because it committed at the outset to unachievable goals. Health care reform was properly realized as an evolutionary process through which compromises would have to be made in accordance with a consistent set of principles.

Thus, the planning and implementation of district health boards in Saskatchewan has been a success relative to other provincial experiences. This is further evidenced by the fact that in Saskatchewan district health board members are elected, a stated goal of most other provincial regionalization plans. However, there are two major problems

that have not yet been adequately addressed in evaluation of regionalization in Saskatchewan. The first involves the distribution of health care resources. In times of retrenchment, when there is no money to spend, allocation is rather simple: cuts are made to areas and agencies that will have the least negative political impact. However, when there is a budget surplus and a small amount of money to be spent, which is now the case, decision-making becomes soberingly difficult. And the second problem is the potential power imbalance that will eventuate among communities, the state and organized medicine.²⁶ As American experience warns, the displacement of state dominion by community authority, in conjunction with the diminution of the influence of organized medicine, makes for a relatively unstable, and ultimately impotent, tripartite relationship.²⁷

Medicaid Reform in Oregon: Rationing Resources

Medicaid is a joint federal-state programme that was developed in the United States in the 1960s to assist disadvantaged groups such as the poor and the disabled. Guidelines for the entitlement programme are set federally, but eligibility for the programme is determined by individual states. Consequently, there is enormous variation in

²⁶ The challenge that community engagement presents is also positive in that there is potential for disruption of the medical model of health care. See chapter 3 of this thesis.

²⁷ James Morone. *The Democratic Wish: Popular Participation and the Limits of American Government*. New Haven: Yale Univ. Press, 1990 p. 285.

eligibility requirements among states although the range of services available to those who are eligible is comprehensive and consistent. Prior to 1996, federal law required that all Aid to Families with Dependent Children (AFDC) eligible persons, blind or disabled persons whose income falls below the level determined by the state, and those women and children covered by the federal Poverty Level Medical Program (states cannot adjust the eligibility threshold for this programme) were the intended recipients of Medicaid support.

²⁸ AFDC eligible persons constituted the largest group of Medicaid recipients. Each state was responsible for determining the eligibility threshold for AFDC and hence Medicaid. In 1995, the federal poverty level for a single adult was US\$6620 per year; and for a family of four it was US\$12000. That same year Oregon had set its requirement for AFDC at 58% of the federal poverty level; therefore, a family that made over US\$6960 per year was ineligible for public funding.²⁹ In Alabama the income threshold for AFDC had been set at 14% of the federal poverty level.³⁰ In order to deal effectively with escalating health costs and heavy resistance

²⁸ In 1996 AFDC was replaced with a block grant. See Gary Bryner. *Politics and Public Morality: The Great American Welfare Reform Debate*. New York: WW Norton and Co., 1998.

²⁹ Michael Brannigan. "Oregon's Experiment." In David Seedhouse (ed.), *Reforming Health Care: The Philosophy and Practice of International Health Reform*. New York: John Wiley, 1995, p. 27.

³⁰ David Eddy. "Clinical Decision-Making: From Theory to Practice. What's Going on in Oregon?" *JAMA*, 1991, vol. 266, no. 3, p. 419.

of citizens to increased taxation in the 1980s, state governments had few instruments available to them to deal with the fiscal situation. Indeed, the Oregon Health Services Commission recognized at the outset of the reform process that "society's expectations are on an inevitable collision course with its resources, and that something must be done".³¹ The most common response by state legislatures to uncontrollably expanding expenditures was to further reduce the eligibility threshold for AFDC; "unfortunately this [was] often the easiest solution politically, and the effects can be extreme".³² The state of Oregon, led in its boldness by Senator Kitzhaber, decided that exercising fiscal restraint by penalizing the most disadvantaged persons in society was neither politically nor morally viable. Something different would have to be done.

In September 1988 the Oregon Medicaid Priority-Setting Project was established to consider and rank a variety of health care benefits for Medicaid recipients. In addition, the legislature "established an 11-member Health Services Commission (HSC) whose goal was two-fold: expand Medicaid coverage and establish a list of prioritised health care services, to be periodically reviewed".³³ The basic premise

³¹ Harvey Klevit, Alan Bates, Tina Castanares, Paul Kirk, Paige Sipes-Metzler, and Richard Wopat. "Prioritization of Health Care Services: A Progress Report by the Oregon Health Services Commission." *Archives of Internal Medicine*, 1991, vol. 151, no. 5, p. 913.

³² Eddy 1991, p. 419

³³ Brannigan 1995, p. 29

on which this group was given its mandate was that the state should guarantee at least a basic set of publicly insured services to all citizens who cannot afford or are not eligible for private insurance or Medicaid. At that time, only certain low-income groups were eligible for public funding under Medicaid, which consisted of a virtually unlimited range of health services. This left an estimated 400 000 Oregonians uninsured.³⁴ The state decided that the federal programme should be restructured so that all individuals and families whose income was below the federal poverty line would be entitled to public insurance. In other words, the system was to be transformed from one that distributed benefits according to a person's eligibility, to one that distributed or rationed services.

From 1989 through 1993 the HSC worked at drafting a comprehensive and viable list of health services, ranked from most important to least important. The final list (approved in 1993) was considerably different from the first attempt which (as result of counterintuitive ranking) was dismissed outright.³⁵ Yet despite many fundamental changes in methodology and orientation throughout the process, the commitment to recognizing and incorporating community values

³⁴ Theodore Ganiats and Robert Kaplan. "Priority Setting: The Oregon Example." In F. Schwartz, H. Glennerster and R. Saltman (eds.) , *Fixing Health Budgets: Experience from Europe and North America* . New York: John Wiley, 1996, p. 21.

³⁵ Daniel Fox and Howard Leichter. "Rationing Health Care in Oregon: The New Accountability." *Health Affairs* , 1991, vol. 10, no. 2, p. 22.

in the priority setting exercise remained constant. Citizen participation was indispensable partially by virtue of that state's political culture³⁶, and partially the manifestation of the current international trend toward more transparency and openness in restructuring health systems.³⁷

Community Matters

The forerunner to and impetus for the Oregon Plan, was Oregon Health Decisions (OHD), "a network of citizens aiming to

³⁶ Fox and Leichter explain that: "Oregonians, ever mindful of the history of the Oregon Trail and of courageous pioneers, take pride in their innovative social policy. More recently, the *Almanac of American Politics* described Oregon as "a culturally liberal state on many issues, with many young and single voters, and one that is proud of being the first state to ban throwaway bottles and among the first to allow abortions." The popular image that Oregonians have of themselves has been called a "moralistic" political subculture, in which "both the general public and politicians conceive of politics as a public activity centered on some notion of the public good and properly devoted to the advancement of the public interest"."(16)
Oregon is exceptional in many respects, but citizen participation or community engagement is a feature of many other state political cultures. To be sure, "associations" are an important component of American identity (Tocqueville).

³⁷ This trend is also observable in countries with universal health care systems, such as Canada and Great Britain (parallel system). As governments grapple with the cross-pressures of fixed budgets and increasing need for health services, it is inevitable that moral issues of equity, inclusion and fairness become political questions. These issues, as they pertain to the role of the citizen and the role of the state, are interpreted differently in each system. In the United States, the dominance of individualistic principles often precludes consideration of collective identities (as rights bearers), which means that debates concerning of health system reform bring to the table questions about the flexibility of fundamental American values.

raise awareness of bioethical problems among the public".³⁸ In 1987 OHD began a project called "Oregon health priorities for the 1990s," which involved 19 community meetings (which were widely advertised with radio announcements, television advertisement and direct mailings) across the state of Oregon.³⁹ The set of criteria (for rationing health services) that was devised through this process of citizen interaction did not reflect an unquestionably fair distribution of health services, although it was consistent with trends that were emerging elsewhere that focus on preventive strategies. The most important outcome of the community meetings organized by OHD was that a debate on social values and health care priorities was opened; "following the community meetings, in September 1988, 50 delegates (including 24 participants from the community meetings) met as a Citizen's Health Care Parliament".⁴⁰ Delegates to the Citizen's Health Care Parliament tabled 15 resolutions, the most important of which was that "allocation of health resources should be based, in part, on a scale of public attitudes that quantifies the trade-off between length of life and quality of life. The full set of principles was then published and sent to all state legislators. Many of the principles established by the Health Care Parliament are now reflected in Oregon's Senate

³⁸ Joanna Coast. "The Oregon Plan: Technical Priority Setting in the USA." In *Priority Setting: The Health Care Debate*, 1996, p. 38.

³⁹ Ibid, p. 38

⁴⁰ Ibid.

Bills 27 and 935".⁴¹ These examples of citizen initiative would guide the development and implementation of the Oregon Health Plan through several stages to its finalized form.

The first stage of the reform process involved ranking 1600 condition/treatment pairs according to citizens' values (ascertained through a telephone survey) and technical criteria. The primary method used in the priority setting exercise was cost-benefit analysis, which proved to be ineffective. This method of analysis led to a counterintuitive ordering of condition/treatment pairs; for example, crooked teeth received a higher ranking than early treatment for Hodgkin's disease, and dealing with thumb sucking ranked higher than hospitalization of a child for starvation".⁴² Members of the Commission, however, were not surprised, claiming that the first exercise was merely a test of the method. Cost-benefit analysis was quickly abandoned, as was the first list: the Chair of the Commission, Harvey Klevit, is reported to have said, "I looked at the first two pages of that list and threw it in the trash can".⁴³

In the next attempt to rank order condition/treatment pairs, the Commission relied more heavily on public values and clinical judgment. For example, Fox and Leichter explain that:

⁴¹ Ibid.

⁴² Fox and Leichter 1991, p. 22

⁴³ Ibid.

One widely debated issue. . . was the relative priority assigned to various preventive medical and dental services. While some members of the commission. . . felt that the high value assigned to preventive services by Oregonians in the community forums dictated that such services receive a high priority, some of the physician members were less convinced about the relative utility of, say, nutritional supplements and dental check-ups. In the end, however, the force of expressed community values prevailed, and preventive health services received a high priority on the list.⁴⁴

However, the degree to which "community values" ultimately prevailed remains an open question. The Bush administration rejected Oregon's application for Medicaid waivers on the grounds that the process of community decision-making generated discriminatory results. Specifically, the administration was urged by the National Legal Center for the Medically Dependent and Disabled to reject the proposals because "only some of the people surveyed were disabled [which meant that] the responses were likely to be prejudicial and reflect negative stereotypes about people with disabilities".⁴⁵ Medicaid waivers were eventually granted by the Clinton administration, but only after clinical judgment had mitigated the effects of the community consultations.

While system reform was not addressed directly during the Medicaid reform process (the private insurance, multi-payer system remains firmly in place), institutional reforms

⁴⁴ Ibid.

⁴⁵ Gail McBride. "Bush Vetoes Health care Rationing in Oregon." *BMJ*, 1992, vol. 305, no. 6851, p. 437.

were implemented, which might eventually lead, through incremental change, to a more equitable system. The engagement of citizens in the rationing exercise served to justify and legitimize the process, which was criticized for its lack of diversity, and its underrepresentation of low socio-economic status groups. [As noted, it was such participation that led, ultimately, to the rejection of Medicaid waivers by the Bush administration.] Those who attended the community meetings tended to be employed, educated, privately insured, middle-aged white women. Michael Brannigan explains that:

Over 69% of the participants were either health care or mental health workers; over 63% were women; an overwhelming number were insured (90.6%), and of these 4.4% were Medicaid recipients; 67% were college (university) graduates; 93% were white (the proportion of white adult Oregonians in the general population was 92%); and 34% had annual incomes of over UD\$50 000 (the average household income in the state was between US\$24 000 and US\$34 000).⁴⁶

By engaging the community in the Medicaid reform process in Oregon, legislators recognized that determining which services to fund and which citizens to include in the plan were value-laden decisions that ought to be made through a process of community-guided clinical judgment, rather than by technical experts, and in so doing were able to accord a significant degree of legitimacy to the rationing exercise. Moreover, the Oregon experiment demonstrates the nature of the political culture, and institutional logic, that define American community. And while no other state has yet followed

⁴⁶ Brannigan 1995, p. 32.

Oregon's lead in engaging citizens in a rationing experiment, there are Health Decisions organizations in many states, as well as a national umbrella organization (American Health Decisions). Engaging citizens in decision-making is simply becoming part of the health policy landscape in North America.

The Politics of Participation

With these North American experiences in mind, then, what is it hoped that the community governance structures will achieve? With neither the full capacity for community decision-making nor the support of the major health care institutions in the province of Nova Scotia⁴⁷, somewhat greater although limited success with the participatory exercise in Saskatchewan, and a community rationing exercise in Oregon that was marred by the discriminatory effects of citizen deliberation, there must be a strong political rationale for continuing to make community governance structures a priority on health care reform agenda. In some estimations, greater citizen inclusion in decision-making is "a laudable goal in itself," regardless of its institutional capabilities.⁴⁸ That community participation is inherently

⁴⁷ It might be argued that it is precisely because the most powerful institutional actors are not accommodated within the new structure that RHBs are appealing in Nova Scotia. In other words, RHBs might provide an effective counterweight to the medical profession, which might not continue to dominate in the regionalized system.

⁴⁸ Lomas and Rachlis 1996, p. 586.

good is a claim that is, most likely, based on democratic appeal.

Democracy, Distribution, and Citizenship

One significant element of appeal for community governance structures is that, because they are included in health services redistribution decision-making processes, citizens can actively protect their perceived rights. The right to health care has been protected by the state in Canada for more than three decades, which means that citizens might have been well served, but not *empowered*, by such protection. And the possibilities for empowerment, in the context of current reform strategies, are questionable. As explained, the balance of power in the reorganized departmental structure in Nova Scotia will be held by the non-designated organizations and, despite the political rhetoric, real decision-making authority concerning the allocation of scarce resources will not be made at the community level. Thus, although citizens in Nova Scotia (as well as citizens in other provinces that have merely solicited citizen input) have been included in community decision making processes, they will not necessarily be empowered. In other words, citizen input is not equivalent to citizen governance,⁴⁹ and it is the latter that has the potential to empower citizens by enabling them to actively protect their own rights and

⁴⁹ Lomas, Woods, Veenstra 1997.

fulfill duties. Reform agenda for such initiatives in Saskatchewan, which has created citizen governance structures, are therefore more promising in that the type of engagement promises to protect rights, aggregate interests and empower citizens.

The question of whether community participation resulted in protection of rights and empowerment is somewhat less relevant in the Oregon case. In the United States, health care is not universally provided as a social right of citizenship, which means that community-based decision-making is not directed at protecting health care as a right, viz., a symbol of national identity *in addition to* a set of important services. And the degree to which citizens were empowered through the process is, perhaps, a matter of perception. Citizens were invited to open political fora to share their opinions, ideas and recommendations, which were tabled in reports that were frequently consulted by key decision-makers. That is to say, while citizens formally played only an advisory role, their advice provided the foundation for the reformed system.

According to Lawrence Jacobs, Theodore Marmor and Jonathan Oberlander, the most important function of democratic deliberation in the Oregon case was that of consensus-building.⁵⁰ Made possible by the state's participatory culture, the process

⁵⁰ This analysis is consistent with proponents of deliberative democracy who explain that free and open communication among the citizenry is an essential component of democratic public

offered reformers a political opportunity. Instead of experts designing OHP in a closed room, policy entrepreneurs chose a process that methodically sought out the attention of everyday Oregonians and sparked a very public debate across the state. Reformers solicited public participation as a part of a genuine effort to incorporate the public's "substantive input on the relative importance of health care services." But they also recognized the political benefits of public participation.⁵¹

Citizens, through participating, came to understand the complexities of the process, and could identify with the goals of reform. Surprisingly, the political justifications for, and developmental effects of, citizen deliberation might constitute the most important innovations and subsequent lessons of the Oregon rationing exercise, despite the attention attracted by "the list".⁵² Community engagement as consensus building was important because it provided a basis for political agreement among Democrats, Republicans, the Oregon Medical Association, and citizens' groups. Such broad agreement was instrumental in implementing the reforms and moving toward the goal of universal coverage (although the

policy making. In general terms, more citizen participation means greater diversity of opinion. By inviting everyone to the discursive forum, politics becomes less elitist and exclusive and, ultimately, better decisions will result. At the very least, decisions will be more legitimate in that the process through which they were deliberated was open, and dissenting voices were heard.

⁵¹ Lawrence Jacobs, Theodore Marmor and Jonathan Oberlander. "The Oregon Health Plan and the political paradox of rationing: what advocates and critics have claimed and what Oregon did." *Journal of Health Politics, Policy and Law* , 1999, vol. 24, no. 1, February, p. 172.

⁵² Jacobs, Marmor, Oberlander 1999.

most important and ambitious step on the road to universality, the employer mandate, was repealed).⁵³

But how is this analysis relevant to Canadian experiences with community engagement in health care decision-making? How can Canadian reform efforts be evaluated within the well-developed debates⁵⁴ concerning deliberative democracy? As mentioned, universally available health services have become institutionalized as social rights of citizenship in Canada, which means that citizens expect that the right to health care will be protected by the state. Canadians seem to be well beyond the need for deliberative processes of the sort that Susan Goold identifies.⁵⁵ That is, those engaged in health care debate in Canada are arguing from an unoriginal position (to twist Rawls' words), meaning that proposals for reform are considered (almost exclusively) within defences for maintaining the existing (universal) arrangements. It has

⁵³ Ibid.

⁵⁴ See Also John Dryzek. *Discursive Democracy: Politics, Policy and Political Science*. Cambridge University Press, 1994. Amy Bartholomew. "Democratic citizenship, social rights and the "reflexive continuation" of the welfare state." *Studies in Political Economy*, 1993, vol. 42, Autumn. Lynn Sanders. "Against deliberation." *Political Theory*, 1997, vol. 25, no. 3.

⁵⁵ For an interesting and insightful analysis of deliberative prospects for decision-making concerning distributional equity, see Susan Goold, "Allocating health care: cost-utility analysis, informed democratic decision-making, or the veil of ignorance?" *Journal of Health Politics, Policy and Law*, 1996, vol. 21, no. 1, Spring. Goold argues that various applications of the veil of ignorance might be more useful than cost-utility analysis in devising principles to guide rationing decisions in the U.S. health system.

already been determined that justice requires an equal distribution of health resources in society. However, implicit rationing efforts in Canada threaten to undermine commitments to universality. It is worth considering whether citizen participation can help reinforce these commitments that are purported to be essential not only for the health of the Canadian population, but for maintaining national identity.

Democratic Deliberation in Canada

It is most likely that deliberative democracy for health care is aimed at developmental effects, or consensus-building. However, the development of a certain civic-mindedness among the citizenry, (in the Canadian context this translates as social rights identity, which indicates a sense of national pride and shared values), has already been achieved in the Canadian context. Health care is Canada's most unifying national symbol: Canadians seem to agree that, as a matter of citizenship, each individual is entitled to a comprehensive range of health services. Throughout the incremental process that resulted in the current health system, citizens came to consider universal health care to be a right. In other words, social rights identity was developed during the creation and expansion of the system with strong political commitments. Hence, it seems counterintuitive to posit that the *dismantling* of hospital and medical insurance programmes

will further develop this type of civic mindedness among Canadians.

Moreover, both the development and maintenance of social rights, and participation in decision-making, are directed at the goal of political equality. Health care in Canada is being transformed to embody competing theoretical justifications. On the one hand, health care in Canada is a social right, and as such, seems to require nothing (other than proof of citizenship) from the claimant. On the other hand, Canadian provinces have created, or are in the process of creating, community governance structures in order to include citizens in decisions regarding distributional equity. It will no longer be the case that Canadians are passively entitled to health services. To be sure, public health coverage will not be contingent on participation, but, as the structures develop, those who do participate will be responsible (either morally responsible, professionally responsible, or both) for their decisions.

It was stated above that social rights seem to require nothing from the citizen-claimant. For the sake of theoretical clarity, it needs to be explained that this is not an entirely reliable assessment. The social rights thesis, advanced by T.H. Marshall, is well known, yet misinterpreted, as explained in the introduction to this thesis. Social rights, meaning a range of benefits to which each member of the political community is entitled as a matter of citizenship, are important not simply because

governments ought to provide universal health care, subsidized education and housing, and the like, to mitigate the harsh effects of markets, but because the provision of these benefits enables citizens, regardless of social class, to fulfill certain duties, although the entitlement side was the more important.

In Marshall's social rights thesis, then, equality was defined relatively *passively*: all citizens were equally entitled to receive benefits. Participation, also directed at the goal of political equality, clearly requires active citizenship. Thus, it seems that there are now two competing theoretical justifications for equality in the Canadian health system, which should be thoroughly examined before reformers invest much more time, effort and public resources into citizen engagement exercises.

In spite of theoretical inconsistencies, however, it is possible that the competing theoretical justifications for equality are compatible, if not reinforcing. If the social rights thesis, as originally formulated, contains a reciprocal relationship between citizens and the state, a mutual exchange of entitlements and duties, then community engagement exercises for health care might provide opportunities for citizens to fulfill their obligations of citizenship. Of course, the degree to which such

participation could achieve substantive equality, is debatable.⁵⁶

The Value of Participation

On the question of whether participation is inclusive or exclusive, there is no consensus. At first glance, it seems that participatory governance must be, by its very nature, more inclusive, empowering and edifying than representative forms. This view, expounded by Jean-Jacques Rousseau, J.S. Mill and Carole Pateman, posits that by deliberating in their own affairs, citizens develop as human beings. In other words, "the goal of politics is the transformation and education of the participants."⁵⁷ Rousseau explains, in, *Social Contract*, that freedom in society is contingent on the participation of each individual in political, cultural and economic affairs. Deliberation in the public sphere is necessary in order that humans can cast off their chains and become citizens. In his *Letter to M. D'Alembert on the Theatre*, Rousseau explains that the theatre will lead to the degeneration of society in Geneva: "It is there that they go to forget their friends, neighbors, and relations in order to concern themselves with fables, in order to cry for the

⁵⁶ See Jane Mansbridge. "The Limits of Friendship." In John Arthur (ed.), *Democracy: Theory and Practice*. Belmont: Wadsworth, 1991 ; and Lynn Sanders 1997.

⁵⁷ Jon Elster. "Three Varieties of Political Theory." In James Bohman and William Rehg (eds.), *Deliberative Democracy: Essays on Reason and Politics*. Cambridge: MIT Press, 1997, p. 3.

misfortunes of the dead, or to laugh at the expense of the living".⁵⁸ This removal of the individual from the immediate, collective concerns and duties of daily life is particularly troubling for Rousseau. He asks: "What then does he go to see at the theatre? Precisely what he wants to find everywhere: lessons of virtue for the public, from which he excepts himself, and people sacrificing everything to their duty while nothing is exacted from him" (25). Full democratic citizenship consists of rights (namely some secured freedom) and responsibilities or civic duties. In such an arrangement, participation in public affairs is essential. To be clear, for Rousseau, citizens' participation in the community includes engagement in cultural as well as political activities. The theatre is threatening because it distracts people not only from matters of governance, and hence from gaining a civic education, but also from cultivating their own talents (playing music, telling stories).

Similarly, Carole Pateman explains that democratic deliberation serves an important developmental or educative function: "The major function of participation in the theory of participatory democracy is therefore an educative one, educative in the very widest sense, including both the psychological aspect and the gaining of practice in

⁵⁸ Jean-Jacques Rousseau. "Letter to M. D'Alembert on the Theatre." In Allan Bloom (trans.), *Politics and the Arts*, New York: Free Press, 1960, p. 17.

democratic skills and procedures".⁵⁹ The indispensability of participation to a democracy affirms the alienability of human beings from their ideas and interests. And recreating discursive fora in advanced democracies is particularly important, given the unparalleled distractions and alienating effects of the technological age.

However, notwithstanding the practical difficulties in encouraging and supporting participation, even in the widest sense, it is not a foregone conclusion that participatory or "active" citizenship translates into positive political inclusion. Jane Mansbridge explains that by insisting on equality in participatory fora, diversity is not adequately respected and the creative process is impoverished:

Beyond a certain point in any process, attempts to ensure absolutely equal power in every decision will reduce output. The higher the value one puts on the benefits of equal respect, political education and equal protection, the higher the price one will be willing to pay in output. Many participatory democrats are willing to reduce the quantity and perhaps also the quality of production quite dramatically in order to increase equality. Responding to Isaiah Berlin's example of a symphony, some participatory democrats would certainly argue that if the roles of conductor and players could not be rotated or the prestige of the jobs made more equal, the musicians should consider playing music that does not require a conductor, such as chamber music or some forms of jazz.⁶⁰

⁵⁹ Carole Pateman. "A Participatory Theory of Democracy." In John Arthur (ed.), *Democracy: Theory and Practice*. Belmont: Wadsworth, 1991, p. 118.

⁶⁰ Mansbridge, p. 125.

Thus, decision-making by lay participants tends to level-down the quality of diverse experiences and skills that each participant brings to the deliberative forum.

Lynn Sanders goes on to argue "against deliberation" for similar reasons.⁶¹ Taking aim at advocates of deliberation⁶², Sanders argues that the internal dynamics of mutual respect and equality that are necessary preconditions for legitimate deliberation, cannot be achieved. Yet Sanders seems to gloss over the most obvious problem with deliberative fora, namely that not all citizens will choose to, or be able to, participate.

This most obvious problem, recognized by Joshua Cohen and Joel Rogers, suggests that mere possibilities for participation are not sufficient.⁶³ However, the argument might be made that opportunities for participation are akin to voting: not everyone votes, although every eligible citizen has the right to do so (therefore "the vote" itself is positive and empowering, regardless of who actually votes). Similarly, opportunities for participation would change the nature of politics, afford greater possibilities

⁶¹ Sanders.

⁶² See Cass Sunstein. "Beyond the Republican Revival." *Yale Law Review*, 1988, vol. 97, 1539-90 ; Bruce Ackerman. *Social Justice in the Liberal State*, New Haven: Yale UP, 1980; and James S. Fishkin. *Democracy and Deliberation*, New Haven: Yale UP, 1991.

⁶³ Cohen and Rogers argue that differences in social class will serve as barriers to equal opportunities for deliberation.

Joshua Cohen and Joel Rogers. *On Democracy*, New York: Penguin, 1983.

for inclusion or diversity, regardless of who actually participates in meetings. But, far fewer people will participate in community governance structures than will vote. Moreover, the current constitution and rationale for structures do not foster proper dynamics for inclusion. In sum, until further consideration is given to the competing justifications (which is beyond the scope of this thesis), it will be theoretically and practically difficult, to say the least, to square social rights (passive) with participatory (active) citizenship. More will be said about this problem, and what might be done to remedy it, in a subsequent section.

Parliamentary Governance and Democracy

There is another factor that contributes to stasis. Executive domination of policy processes in a parliamentary system of government results in relatively small public sphere. Because governmental authority is concentrated in a single decision-making body (cabinet), possibilities are diminished for competing domains of popular authority. In contradistinction, the congressional system of government allows for, and perhaps necessitates, a considerable degree of citizen involvement in political decision-making, which greatly increases the size of the public sphere.

The incongruence of an open deliberative forum (many voices) and a parliamentary system of government (two voices, government and opposition), indicates the theoretical difficulty of the former in the context of the latter.

However, the limitations of the executive system make participation all the more important. As the primary cause of death has changed from communicable to non-communicable disease, the responsibility of each individual for his or her own health is magnified (this was explained in greater detail in chapters 2 and 3). It is no longer the case that state action in health care (exclusively) can significantly contribute to better overall health indicators. Responsibility-taking is not merely a right-wing strategy for cost containment, but a matter of practical importance, and consonant with Marshall's citizenship equation (rights+duties=citizenship).

Evaluation

If debate is necessary as part of a plan to move beyond stasis (other elements of a possible plan will be discussed in the concluding chapter), can purposeful debate take place in community governance structures for health care? The lesson to be taken from the Oregon experience is that citizen participation does shape public policy, and that such participation can be both empowering and discriminatory. On the one hand, citizen engagement (either as *input* or *governance*) might be important in the Canadian case to build consensus (as in Oregon), at least in recognition of problems. The degree to which viable solutions can be drafted, on the other hand, is much more doubtful. As in the Oregon case, members of community governance structures in

Canadian provinces are "largely middle-aged, well educated and well off."⁶⁴ (See table 4). The potential for such an unrepresentative group to make unrepresentative (if not discriminatory) decisions, is great.

It is also necessary to revisit the question that was set in the introductory chapter: Is this what Marshall had in mind? Is it consistent with his vision of citizenship? To the former, the answer is likely no, Marshall did not envision that citizens would help to determine their own social rights. This was the responsibility of the state. However, the answer to the latter is affirmative. Participation is consistent with his conception of citizenship as a reciprocal arrangement between citizens and the state, and might be best employed to build consensus regarding problems and limitations, rather than to set priorities for health reform.

A Solution? Citizenship, Entitlement and Differentiation

The promise of community governance structures is that communities will be able, through the process of deliberation and decision-making, to build-up their own identities and have these identities reflected in patterns of entitlement and service delivery. If the community health board in North Halifax, for example, is representative of a large proportion

⁶⁴ Jonathan Lomas, Gerry Veenstra and John Woods. "Devolving Authority for Health Care in Canada's Provinces: 2. Backgrounds, resources and Activities of Board Members." *CMAJ*, 1997, vol. 156, p. 513-20.

Table # 4

Characteristics of members of boards of devolved authorities

Characteristic	Provinces with established boards				Provinces with immature boards	
	All boards n=514	Alberta n=106	Sask. n=200	PEI n=22	B.C. n=152	N.S n=34
Length of appointment, months	15	13	21	16	9	10
Mean no. of Board meetings attended	26	31	39	221	12	9
Mean time spent on board activities, hours per month	34.6	52.5	29.2	10.5	33.9	28.4
Sex, % female	52	52	49	41	57	55
Age group % of members						
<35	4	3	2	14	3	12
35-64	83	84	85	77	81	76
65 and over	14	13	13	9	16	12
Education level, % of members						
<high school graduation	8	5	9	9	9	3
High school or college graduation	45	51	52	32	39	24
Unviersity degree	47	44	39	59	53	73
Annual income level, % of members						
<\$20 000	3	2	2	5	5	3
\$20 000-50 000	34	37	40	42	26	23
>\$50 000	63	61	59	53	69	74
Employment status % of members*						
Employed full time	36					
Employed part time	15					
Self employed	13					
Homemaker	20					
Retired	22					
Other**	9					
% from a minority ethnic group	10	11	7	9	12	9
% employed in health or social services	18	6	25	27	12	36

* Total is more than 100 because respondents checked all categories that applied.
Data by province were not readily available.
**Other+unemployed and full-time and part-time students.

Source: Jonathan Lomas, Gerry Veenstra, and John Woods (1997).
"Devolving Authority for Health Care in Canada's Provinces:
2. Backgrounds, Resources and Activities of Board Members." *CMAJ*, 156:513:20.

of people of colour, or elderly persons suffering with respiratory disorders, then suggestions can be made so that policy is responsive to those needs.

The problem, however, is finding ways to have the community health board reflect the community it represents. As Oregon experience shows, and is revealed by the information gathered by Lomas et al on regional governance structures in Canada, not all segments of a community are "represented," and those who do participate tend to be from particular cohorts.⁶⁵ Not to mention that even if "communities" were fully representative, they are geographically determined, and do not reflect the "communities" of people that a differentiated approach ought to address. Simon Watney, building on Ralf Dahrendorf's ideas, explains that in the British context, it needs to be recognized that:

entitlements must be sufficiently flexible to be able to respond to the emergence of new social identities and constituencies. Citizenship thus stands to unite the overlapping interests of individuals and groups whose self-conscious identities are specific to the postwar period, whether in relation to race, gender, sexuality, disability, or whatever. The concept of citizenship is sensitive to the fact that our identities are multiple and mobile, that we all increasingly identify ourselves with aspects of race, class, sexuality and so on, in ways that are idiosyncratic and subject to frequent change over time.⁶⁶

⁶⁵ Ibid.

⁶⁶ Simon Watney. "Practices of Freedom: 'Citizenship' and the Politics of Identity in the Age of AIDS. In Jonathan Rutherford (ed.), *Identity: Community Culture Difference* . New York: NYU Press, 1990.

The inability of the party system in Britain to recognize these multiple identities, rather than dissolve them, presents a serious obstacle to reform, and an affront to citizenship (this critique also applies to Canada). Marshall's caveat that citizenship is an evolving concept, would support this movement toward reconceptualizing citizenship.

So, community governance structures, as currently constituted, are problematic in that they are likely to reproduce discriminatory effects as in Oregon. Stigmatized groups, such as HIV/AIDS patients, might be worse off with community governance structures. Yet, it also seems that they are an important component of provincial reform agenda, and have great potential for addressing the gaps in electoral/party politics (rather than replicating them). What, then, are the options?

There are two changes that can be made to harness the positive potential of community governance structures. The first is that community meetings could be organized to address narrow and well-defined issues. For example, one open public meeting might address HIV/AIDS issues, another might address seniors and pharmaceuticals, or home care options. This would bring interested and affected parties to the meetings, who might not attend the general community meetings. But the problem, again, as evidenced in Oregon with Medicaid reform, is that affected parties do not always

choose to become involved in community decision-making exercises, even when the issues clearly affect them.

The second is to establish ad hoc representative boards. Some balance has been achieved in most provinces with provincial appointments to regional health boards. However, the diversity that can be reflected in these permanent boards, is limited. Thus, regional and community health boards might have their mandates changed and clarified so that they function as advisory boards whose only duty is to assemble ad hoc representative groups from the community to attend issue-oriented meetings. This second option would actually blend both suggestions, remedy the existing problems of improper representation of "communities," and eliminate the current practice of regional and community health boards producing unfocused "wish lists" for reform.⁶⁷

Conclusion

The rhetoric of "grassroots" initiatives, citizen inclusion and community participation, in addition to the actual changes heralded by community engagement exercises, have begun to adjust citizens' expectations regarding the role of the state, which allows governments in Canada to indirectly address issues of distributional equity at the same time that they dodge politically charged issues. Such developments are problematic in that they demonstrate a glaring disregard for

⁶⁷ See Halifax Peninsula Community Health Board. *Halifax Peninsula Community Health Plan*. Condensed Version of the Issues and Recommendations Sections Only.

the theoretical and practical difficulties that result from competing theoretical justifications concerning equality (social rights versus participation), and introducing fora for the exercise of popular authority in an executive-driven system.

However, to dismiss community engagement exercises in this way is to misconstrue the full intention of the social rights thesis and the unique opportunities that community governance structures potentially afford. Duties are not just preserve of new right theorizing.⁶⁸ As explained in the preceding chapters, Canada is entering a fourth stage of social citizenship development that requires a new blend of individual responsibility-taking and collective entitlement. The social rights thesis asserts the latter, while some aspects of provincial reform agenda, notably community governance structures, have the potential to institutionalize the former. Unfortunately, it seems to be the case that the social rights thesis, at the same time that it protects collective entitlement, precludes important political initiatives aimed at individual responsibility-taking. The

⁶⁸ See Will Kymlicka and Wayne Norman "Return of the Citizen: a Survey of Recent Work on Citizenship Theory." In Ronald Beiner (ed.), *Theorizing Citizenship*. Albany: SUNY Press, 1995. The authors explain that "the New Right believes that the model of passive citizenship underestimated the extent to which fulfilling certain obligations is a precondition for being accepted as a full member of society."(p. 287) And "most people on the left continue to defend the principle that full citizenship requires social rights."(p. 288).

question that remains is: How can the right to health care be protected at the same time that stasis is attenuated?

CHAPTER FIVE

Conclusion: Evaluating Health Care, Social Rights, and Citizenship Development

To the question posed at the end of the last chapter, viz., how to attenuate stasis and protect entitlement, there is no definitive answer. However, the analysis of this dissertation provides some foundational support for understanding the right to health care and the need for moving beyond stasis. The evolution of rights discourse over the postwar decades, as it pertains to health care, reveals both individual and collective elements of social entitlement. The enduring collective element is distinctly premodern, within the normative realm of discourse. The individualistic trend can be attributed to several forces pulling in the same direction: the Charter of Rights and Freedoms, the New Public Management, the Canada Health Act, the epidemiological transition, and, as always, the increasingly frequent penetration of American culture into Canadian political, economic and social life.

The result, the beginning of a new blend of individual responsibility-taking and collective entitlement, might indicate that Canada is entering a fourth stage of citizenship development. The period of social rights development, of particular importance in the Canadian context, enabled the institutionalization of relatively generous patterns of entitlement to public health care. The practical benefits and symbolic value of such entitlement

have resulted in the popular assertion that health care is a right of citizenship, and, as such, ought not be significantly altered by governments trying to balance budgets. However, as demonstrated throughout the thesis, such defences of the right to health care have led to untenable positions and static conditions, which have presented serious problems.

The problems that are particular to Canadian health care are endemic, on a larger scale, to social rights theorizing. Such problems were the focus of this thesis. In chapters two and three arguments were presented to establish that the social rights thesis was outmoded. The changing nature of "rights" in addition to macroeconomic policy trends, in accordance with T.H. Marshall's caveat that citizenship is an evolving concept, require vigilant reconsideration and revision.

Health care, Canada's most revered social entitlement programme, was certainly one of Marshall's intended components of full social citizenship. However, his analysis pertained directly to issues of education and poverty in Britain, and modifications and specifications needed to be made in order to import social rights analysis into the specific case of health care in Canada. Further, Marshall's analysis was intended to address a specific temporal period, and, necessarily, a certain set of circumstances that were characteristic of that period.

One characteristic, social class as the main source of social inequality, has deflated currency in multicultural, turn of the century Canada. Citizenship in Canada requires respect for multiple sources of inequality, as they intersect with socio-economic status (social class). Differences based on language, gender, sexuality, ability, and "race", make necessary increasingly flexible policy responses. Of course, on one level, the reason for universal health care coverage is to make certain that poor people will have access to medical services. But there are other, more complex reasons.

The epidemiological transition, the problem explored in some detail in chapters two and three, reveals that health ought to be a priority not just of individuals, but of their societies. The shift in main causes of death, from communicable to noncommunicable diseases, implicates social factors. This means that in contrast to the public health measures that were necessary to stem the epidemics of the last century, a new type of collective concern for health is needed to address diseases linked to the distribution of income and status within societies. The right to health care in the 1940s translated as the expectation that communicable diseases would be brought under control, and that a range of advanced medical services would be available for private consumption. In the 1950s and 60s the right to health care began to indicate an expectation that health services would be distributed as public goods. By the end of the next decade, health care had become part of Canada's collective

conscience, and protecting the right against retrenchment was a matter of practical concern, as well as national identity.

Defences of the right to health care say something about how Canadians treat one another (with a spirit of generosity). And in good liberal fashion, people might understand that their own socio-economic position is tenuous, and distribution patterns are required so that if they were to become poor, and unable to pay for health benefits, they would have access to medical services.

Further, how Canadians consent to provide health services to one another says something about how they believe they ought to treat one another in different situations, social, political, even constitutional matters, and in other parts of the globe. Yet in other areas of Canadian social policy, this spirit of generosity is replaced with a chary disposition. So, health care demands scholarly attention because of the puzzle that it presents: the right to health care in Canada is paradigmatic of Canadian culture, but is also an enigmatic social democratic covenant. In other words, universal health care seems to be definitive of Canadian identity at the same time that it is a special case.

Beyond Stasis: Identity Rights as Citizenship Development

The foregoing analysis might indicate that Canada has entered a fourth stage of citizenship development. This assertion has clear links to, and implications for, legal rights claiming. The Charter's commitments to "categorical equity" have been

able to protect, if not assert, differences based on gender, sexuality, language, ability and so on. Such commitments provide evidence for a more active and inclusive era of citizenship.

This new era of identity rights as citizenship has implications for health care. As demonstrated in chapter two, health care is increasingly defended in the language of rights. The right to health care, as an essential component of citizenship, has come to embody a new blend of individual responsibility-taking and collective entitlement that might be relevant to other areas of concern, even if the dynamics of health policy (and the apparent generosity that they engender) are not emblematic of other policy fields.

To be clear, the arguments about identity rights and health care, while both reveal similar dynamics of citizenship development, are offered as parallel arguments. While it might or might not be the case that identity rights, won or lost through charter litigation, and increased diversity, as the result of more open or tolerant society, or patterns of immigration, have directly affected patterns of need for health services, the conclusion to both arguments is one and the same: citizenship in Canada has developed beyond the postwar need for simple unity, as promised by universal social programmes.

This movement beyond stasis and toward more active and inclusive models of citizenship can already be discerned in provincial health care reform agenda. As argued in chapter

five, community governance fora give structure to a reciprocal arrangement between citizens and the state. As the state continues to deal with, and fund accordingly, new patterns of disease, care, and entitlement, citizens can fulfill their obligations by engaging in decision-making processes. The flexibility that is potentially afforded by these models is great. However, the possibility that they will become institutionalized or effective, is, at best, indistinct.

It is essential to find approaches to dealing with general issues of health and entitlement so that prospects might be better for dealing with more acute dynamics of inequality, epidemiology and citizenship. In particular, it is important to understand the meaning of the right to health care and the direction of citizenship development as it pertains to health care, in order to deal with those in groups that have much different experiences with access to medically necessary services (stigmatized populations, including AIDS patients and the mentally-ill), i.e., groups that are differentially entitled and particularly dependent on services that fall outside the parameters of the public plan.

Such an approach should include a commitment to what the World Health Organization (WHO) calls "new universalism". Contemporary WHO values "lead away from a form of universalism that has governments attempting to provide and finance everything for everybody. This "classical"

universalism, although seldom advanced in extreme form, shaped the formation of many European health systems. It achieved important successes. But classical universalism fails to recognize both resource limits and the limits of government."¹ In its place the WHO advocates a "'new universalism', that recognizes governments' limits but retains government responsibility for the leadership and finance of health systems."² Under this rubric it might be possible to develop ancillary programmes like pharmacare and homecare, although the mercurial dynamics of federal-provincial relations will be the more important factor in determining the viability of any new programmes.

It is also imperative that such an approach address citizen engagement. The decline of the welfare state and the unreliability of the social rights thesis make necessary the consideration of the inclusion of citizens in decision-making processes, even if prospects in some if not all Canadian contexts seem to be less than ideal. However, clarifications will have to be made regarding the goals of participatory exercises. Will citizens be making decisions or merely advising? Are the issues to be negotiated discrete and well defined, or will participants be contemplating the most broad issues at hand? Although the evidence thus far indicates that the effects of citizen governance in health care are

¹ World Health Organization. *The World Health Report 1999. Making a Difference*, 1999, p. 33.

² Ibid.

negligible in most cases, these initiatives are still in their infancy, and it is expected that the road will continue to be bumpy, especially when the political environment is not amenable to cooperative policy change.

Of course, it is much too late to question whether there is a universal, inalienable right to health care. The main assumption of the thesis is that there is such an entitlement in the Canadian context. But can this right be imported to other countries? It is an impositional claim, I think, to posit that this is a human right that exists beyond borders and time. While states ought to provide and fund health services, whether or not they do might say more about their values or character than their human rights record.

And that, in short, has been for Canada both a source of pride and stasis. Health care is a vital social programme, but, despite its popularity as a symbol of Canada's social superiority to the United States, is not beyond reproach. As citizenship develops beyond the social rights stage, there is increasing dissonance in rights claiming for health care (expectations), the nature of entitlement (public good) and service provision (universal, but eroding on the margins with little or no thorough reevaluation of the feasibility of existing models). The complexity of the burgeoning range of pressures for change, makes solutions to "crises" of funding and entitlement both pressing and elusive. Defending the right to health care against all encroachments does not seem

to be an appropriate or sophisticated response to complex problems.

Recommendations for Change

The argument that I have presented in this thesis suggests that there needs to be greater diversity and flexibility in health care service delivery, although I also believe that whatever changes are made, decision-making authority should continue to rest primarily with caregivers and the state. The Canada Health Act (CHA) makes arrangements for health care to be provided by medical doctors and practitioners in institutional settings. It might be advisable to change the language of the Act so that "medical doctors" are replaced with "caregivers", and then have the definition of "caregiver" expanded in the Act. Such a change might be effective in establishing viable home care programmes. That said, most of the Act, including the conditions of payment, should remain as it is, because I believe that national standards are important.

Another option for moving beyond stasis would be to change the manner in which federal transfer payments for social programs are disbursed to the provinces. It might be possible to adopt the model used in the United States for the Children's Health Insurance Program (CHIP) whereby the states must apply for federal money, proving that they have met the conditions of the programme, and are in compliance with national standards before they receive the money. This might

give the federal government more control over funding and programme conditionality, at the same time that provinces are given increased latitude for experimentation because provincial plans are made public and approved at the outset (no hidden agenda). Further, public debate on the applications might bring out more voices, thereby contributing to and expanding "active" citizenship.

Beyond these recommendations for Canadian politicians and health care administrators, there is a message in the thesis for health care reformers in the United States. The Canadian health system is not perfect, and requires more than just additional funding to secure its long-term viability. Changes in economic, political and social realms indicate that substantive definitions of citizenship in Canada, North America, and in other advanced liberal democracies, have developed beyond the social rights stage. Thus, it makes little sense to discuss the construction of new welfare state programs in post-social rights contexts.

In terms of citizenship development and possibilities for universal health care program development, Canada and the US might be converging. As progress is made toward the goal of universality in the US, the challenge of difference will facilitate the movement toward health care coverage for the entire population (although this is likely to be done in a very piecemeal way), rather than stymie it (as was the case in the 1960s; the tumultuous civil rights era effectively preempted the development of social rights). In Canada, the

challenge of difference offers a way out of social rights stasis, at the same time that it offers to secure universality.

The point of convergence will be, somewhat paradoxically, differentiation. In this new stage of citizenship development, health care reform in the U.S. might be conceptually consistent. The incrementalism of health care reform (and the frustrating pace that it takes) is an appropriate approach (provided that it is supplemented with some deliberateness or strategy) for including different "communities" in entitlement programs. As noted, CHIP might be the thin edge of this wedge (coupled with the flagging economic viability of many managed care corporations). Of course, there are many other complex changes that will have to be made before the goal of universality can be achieved through the construction of various entitlement programs. And there is no consensus on that goal, only consensus that there needs to be change, and that the 45 million Americans that currently have no insurance ought to have coverage.

In Canada, the perennial model for North American health care reform, the universal health care system has become, in a sense, the emperor with no clothes. Continued defences of the right to health care cannot by themselves secure access and entitlement for all Canadians. What is needed, instead, is recognition of the multiplicity of differentiated citizenship claims across the country, an understanding of how these claims can be expressed and accommodated in public

policy, and a strategy for identity based communities informing and interacting with geographically based entities.

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