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The Canada Health Act and the Future of Health Care Systems in Canada

by

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The views expressed herein are solely those of the author and do not necessarily reflect those of the Commission on the Future of Health Care in Canada.

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Highlights

The role of the *Canada Health Act* within public health systems in Canada must be examined on the basis of the core issues that it raises. Discussions of constitutional and legal technicalities no longer suffice, for the latter serve only to confront us with the impasse of the deep division that exists between those who support the constitutional validity of the *Act* and those who contest the constitutionality of the federal government's spending power in fields of provincial jurisdiction.

Basically, the public authorities can orient their interventions in the health sector along two main lines: that of the *Canada Health Act*, which prescribes the public service rules for ensuring that all citizens have the same right to access health care based on need; or that of erecting conditions favourable to the delivery and funding of services by private enterprise, the terms of which can notably be found in the plans and proposals for "modernizing" the *Act* that are emanating from Alberta and Quebec. This second option translates into a division of services and individuals into different categories, where right of access, coverage or the basket of services can be modulated according to a multitude of criteria for market segmentation. Under this second policy approach, the delivery and funding of health care services by private enterprise also require a substantial input of public funds in order to guarantee that the business' areas of operation remain profitable.

The principles of the federal *Act*, which are in blunt opposition to the principles that regulate the market, work to support the equality of all in the face of illness. For reasons peculiar to the Canadian legal structure and federal and provincial occupation of the taxation field, the *Canada Health Act* today serves as the keystone of the legal guarantee of health care funded and provided in accordance with the rules applicable to public services, in the face of the calls for its "modernization," which would reorient public intervention along the second line of policy, which is more favourable to private enterprise and acts to the detriment of the public interest.

Executive Summary

The role of the *Canada Health Act* within public health systems in Canada must be examined on the basis of the core issues that it raises. Discussions of constitutional and legal technicalities no longer suffice, for the latter serve only to confront us with the impasse of the deep division that exists between those who support the constitutional validity of the *Act* and those who contest the constitutionality of the federal government's spending power in fields of provincial jurisdiction.

The principles of the *Canada Health Act* have helped establish and maintain a health care system based on the concept of public service. They are of critical importance in ensuring the survival of health care as a public service within our market economy, which if not for targeted legislated protection would occupy all areas where a profit is to be made and abandon those where it is not.

A balance must be struck between the areas that respond to the rules of the marketplace and the public service areas whose active principles are opposed to them. The market economy is humanly tolerable and acceptable only by incorporating solid spheres of public service, at once tangible, meaningful and symbolic, where democracy and equality among citizens can be lived and experienced.

There are basically two main avenues that are open to Parliament in the health care sector. The first, that of the *Canada Health Act*, is the road on which Canada and each of the provinces have been travelling for some 30 years, where efforts are directed toward delivering health care based solely on the criterion of the need of patients, without regard for their ability to pay or their socio-economic status. In addition to their obvious recognition of the equality of citizens in the face of illness, the five principles of the *Act* also offer the best guarantees of the cost-effectiveness of the system.

The second possible avenue for public intervention in health care is that characterized by repeated calls for the "modernization" of the *Canada Health Act*, notably by Alberta and Quebec. Here, priority is placed on putting the public authorities at the service of private enterprise, whose viability and profitability require major public funding support in order to compensate for the economic reality of health care, which is that 4 percent of the population incur 50 percent of the costs. This option is based on certain principles that are contrary to the principles of public service, and translates into a segmentation of markets and coverages where it is the mission of the public sector to provide basic services or to assist the most vulnerable segment of the population.

The structure of the taxation system in a jurisdiction is another indicator of the orientation of public programs. A public service program such as health care, which is characterized by a substantial redistribution of wealth, can only be supported by progressive taxation measures. The recent trend to a regressive taxation system, observed at both the federal and provincial levels, raises a good deal of uncertainty as to the future directions of the health system.

The introduction of a public service program has never received unanimous approval. When delivery of a good or service is removed from the market rules that drive the profitability of an

industry, it is normal for the excluded industry to act in its own interest and promote reform of that sector so that it can reoccupy potentially lucrative outlets.

The reform programs originating in Alberta and Quebec are firmly based on this second avenue of public support for the funding and private delivery of health care. Not only do these projects jeopardize the concept of public service protected by the *Canada Health Act*, they also put health dollars at the service of the profitability of the health industry, which primarily consists of for-profit insurers, health care delivery and management firms, and information and telecommunications management firms.

Alberta has made its policies clear with the *Health Care Protection Act*, while the Mazankowski report goes even further in pursuing the methodical dismantling of the Medicare system to the benefit of for-profit enterprise.

Although it has not yet formalized its policies in legislation, Quebec shows every sign of taking a similar direction, in light of the Arpin and Clair reports as well as the introduction of the prescription drug insurance plan, whose principles are contrary to the concept of public service. These orientations are confirmed by the text of the draft bill on the *Québec Health Card Act*, discussed by a parliamentary commission in winter 2002.

In the face of these calls for “modernization,” the federal government’s role in maintaining public service principles for all health care could well be critical to the future of health systems and Canadian society.

I. The Meaning and Relevance of the *Canada Health Act*: One of the Great Achievements in Public Service

Introduction: Targeting the Core Issues

It is important at this stage in the history of Medicare to target the core issues of the *Canada Health Act*, which are to be distinguished from the technical legal issues or political strategy issues that have marked its course. There is no question that there have been sharp constitutional disputes between the provincial and federal powers since the very first talks about introducing a health and hospital insurance program, and that they persist today. No program of such social importance could forego the debates, oppositions and struggles that move any democratic society forward. The main thing is to correctly define the issues and interests favoured by the various opposing arguments.

Health law, in its technical specifics of a legal and even constitutional nature, cannot give us the whole story. The history of the establishment of public health care systems in Canada is characterized by political competition between the two levels of government in which the political strategy of both camps has often prevailed over orderly co-ordination in the best interest of the public. This has been skilfully described elsewhere (Taylor, 1987, 1990; Maioni, 1998). The situation at this dawn of the 21st century urges us, rather, to analyse the core issues facing the *Canada Health Act*, too often relegated to the background by constitutional debate, so as to press an agenda that deserves to be discussed more openly instead of being kept enclosed in its technical legal dimension. In short, the constitutional issues proper to Canadian health law will not be covered in this essay, except in the next section, to situate them summarily in their current context. This text will be concerned with the basic issues that emerge from the complex relationship between health care as a public service and the market economy, so as to better understand the role now played by the *Canada Health Act* at the heart of this dialectic.

Constitutional Jurisdictions Over Health

The Canada established with the *British North America Act* was a newly industrializing society of the 19th century that had little in common with the society that would gradually take shape a half century later in the wake of the Great Depression of the 1930s and two world wars. The *Constitution Act, 1867* is a faithful representation of accepted theory and practice on the role of the State in the second half of the 19th century, as can be seen from its total silence on spheres of jurisdiction that would later require constitutional amendments (such as unemployment insurance in 1940) or federal-provincial agreements (such as the agricultural products marketing framework). The 1867 text has nothing to say about the funding and organization of the health care system as we know it today. A legal or constitutional text cannot deal with what does not exist, either in fact or in its authors' imaginations. In 1867, health care could not be conceived apart from the strictly private sphere of the family, the intimate relationship between doctor and patient or, on its largest scale, as the business of religious or charitable organizations. It was as inconceivable for the Fathers of Confederation to anticipate the role that the State would play in

the health field as to predict the radical changes to the tax system that would come with the 20th century.

In fact, the 20th century dramatically altered this limited conception of the State's role which informed the text of 1867. In the face of a constitutional document designed for another age, the wave of social change succeeded in reformulating relations between citizens and the operation of the economy. The emergence of social law, culminating after a lengthy process in the introduction of Medicare, had to be worked out through various arrangements, all of which were the subject of lively political, social and legal debate and opposition.

One cannot help but notice today how difficult it is to correlate the constitutional jurisdictions over health as prescribed in the *Constitution Act, 1867* with the legal structure of the system that was set up in the 20th century. The federal government has intervened in the field of health primarily on the basis of its spending power and the criminal law, while the provinces' interventions are attached to their jurisdiction over hospitals, property and civil rights, and more generally, matters of a local and private nature (Jackman, 2000).

While there is consensus regarding the constitutional bases for the intervention of each level, there is deep division over the validity of those jurisdictions (Lajoie, Molinari and Auby, 1981, chap. 1; Hogg, 1988). For proof, we have the findings of Quebec's recent Commission sur le déséquilibre fiscal [commission on fiscal imbalance], which concludes in one of its research reports that the constitutional validity of the federal spending power in matters of provincial legislative jurisdiction remains contentious (Quebec, 2002). It must be recognized that constitutional law experts are divided on the significance of the key rulings on this subject (*Winterhaven*, 1988; *Reference Re the Canada Assistance Plan*, 1991; *Eldridge*, 1997): some see them as supporting the federal jurisdiction that underlies the *Canada Health Act*, while others firmly challenge their constitutionality.

Co-existence of Public Services and the Market Economy

Every legislature in the country is faced today with the huge challenge of maintaining the areas of public service set up in the course of the 20th century. Every sphere of public service requires legislative intervention to provide for both its principles and its articulation. It is a peculiarity of the *Canada Health Act* that it can be limited to principles alone, on account of the structure of Canadian federalism and its characteristic fiscal imbalance. This means that it is the provinces that must see to its articulation, in all of its complexity.

Here it is revealing to compare two sectors of public service where federal transfers make up a significant share of funding: health and higher education. Unlike the health sector where federal transfers are conditional upon compliance with the conditions prescribed in the *Canada Health Act*, federal transfers in higher education are not subject to similar conditions to protect universal accessibility regardless of socio-economic status. In the 1990s, a number of provinces adopted a policy of deregulation or authorization of tuition fee increases that resulted in a hike in university tuition fees not seen in 30 years, particularly in professional faculties or those with strict quotas. Wide disparities in tuition fees can now be found in the different parts of Canada

and in universities across the country. For example, a university education in law for the academic year 2002-03 will demand of students a mandatory annual expenditure (tuition plus related costs) of \$2,050 at Laval University compared with \$14,800 at the University of Toronto. At the same time, the marked increase in tuition across the country shows how much ground the concept of public service as applied to university education has lost across Canada over the past decade.

The provincial jurisdiction over education that is clearly set forth in section 93 of the *Constitution Act, 1867* has prohibited the imposition of legislative conditions on federal transfers. The conservative policy agendas of certain governing provincial political parties have been evident in a gradual and steady increase in tuition fees, with no possible curb from the federal financial backer. Meanwhile, being confronted with an overall reduction in federal social transfers, provincial health care systems have undergone certain organizational reconfigurations (hospital closures and institutional consolidations), without the provinces being able to jettison the principles of public service underlying those systems. This comparison between health and university education does not allow us to conclude that the federal legislative presence in the health sector is the reason why the concept of public service is being maintained in that sector across the country. The corollary to such a conclusion would be that the absence of any conditions on federal transfers in university education is the reason why accessibility is dwindling in many Canadian provinces. Such conclusions are inappropriate because they fail to consider other actions of the federal government that are also promoting the reduced provision of health care along public service lines. The drastic and unilateral reduction of federal transfers and the consolidation of social programs under the CHST (Canada Health and Social Transfer) in 1996, which at the same time became a tool for fighting the federal deficit, remind us that the federal government, no less than the provinces, often pursues an equivocal policy where measures that support the delivery of public services stand cheek by jowl with measures that weaken its very foundations or objectives. In short, it is important not to simplify our analysis of the situation by ascribing to one level of government or one party in power all the virtues or all the sins of promoting public service rules or market rules.

Given the expression by certain provinces of intentions to undertake health reforms that are contrary to the principles of the *Canada Health Act*, we can posit the hypothesis that the *Act* has become key to maintaining the principles of public service in the health sector.

The core issues of the *Canada Health Act* are highlighted by its five central principles (public administration, comprehensiveness, universality, portability and accessibility), which form the framework for the concept of public service as applied to health care services in a powerful market economy. To analyse the history surrounding the *Canada Health Act* is in fact to read a capsule version of how capitalism evolves in a democratic system. The slow development of Medicare is the result of democratic debate regarding powers conceded and then wrested from market forces in order to determine how a population is allocated health care products and services. There are two crucial aspects to the co-existence of a public service and a market economy. The first is that their active principles are fundamentally opposed. Whereas public service has to honour the equality of all citizens, delivery of goods and services on the market takes place on the contrary by segmenting the various market niches so as to better profit from their differentiation. The second aspect of this co-existence, now too often forgotten, is that each

sphere is dependent on the other. The funding of public services depends on a sound economy, just as the social viability of the market economy depends on respect for areas of public service. Hence the stability of the entire democratic, market-economy system rests upon the fragile but vital balance between these two active principles. Try to eliminate one and you will put the other at peril. The market economy is humanly tolerable and acceptable only by incorporating solid spheres of public service, at once tangible, meaningful and symbolic, where democracy and equality among citizens can be lived and experienced.

The *Canada Health Act* presides over an interjurisdictional legal structure with remarkable simplicity and legislative efficiency. With its 26 sections, the *Act* states the fundamental principles of public service that the provinces must respect in organizing services within their borders in order to benefit from federal transfers. The structural intersection effected between the taxes collected by the two levels of government, the federal legislation and provincial responsibilities for health is such that the *Canada Health Act* can ensure that the entire Canadian population is provided with health care that is available outside the rules of the marketplace, which in any case have demonstrated their patent inability to guarantee all citizens equitable access to health care at the lowest cost.

The contemporary importance of the *Act* can be measured by the convergence and the force with which it is now being contested not only by business communities but by a series of reports or policies originating in the various Canadian provinces as well as the federal apparatus itself. Far from indicating that it is outmoded, analysis of the reasons for opposition to the *Canada Health Act* (Section II) demonstrates on the contrary how fully relevant it is. The main arguments for scrapping the concept of public service – such as the panic generated about the ageing population, which is said to be liable to jeopardize the system's sustainability – have to be put in perspective (Lefebvre and Soderstrom, 2000; Frankman, 1998). It is primarily by analysing the alternative programs emanating from Alberta and Quebec, which present some substantive objections to the *Act* (as opposed to objections based on constitutional legal technicalities, as alluded to earlier), that we propose to demonstrate how crucial the *Canada Health Act* is at this stage in the evolution of Canadian health care systems.

Not only does the *Canada Health Act* hold a central, symbolic place on the Canadian scene, but it is equally relevant in terms of the current planet-wide campaign for democratic values and human rights against the globalizing thrust of the rules of a marketplace whose most lucrative and most significant segment is controlled by big multinational corporations. Objections to legislated public service enactments such as the *Canada Health Act* have been picking up since the last decade. We are seeing more and more attempts to occupy and transform areas of public service created by hard-fought struggle in the 20th century, and more and more positions from which such attempts are launched. This movement has generated a wave of massive privatizations from which few countries have been spared (Collier, 1997) and against which the populations affected are beginning to openly express resistance. It is in this general contemporary context that the meaning of the *Canada Health Act* must be understood.

The State's Role in Health Care

At the Crossroads of Two Options

Contrary to widespread opinion, minimum State intervention is not a distinctive characteristic of a market economy. Quite the opposite: the advance of market economies has necessitated abundant and elaborate State regulation in all fields, including those where work emblematic of free enterprise is carried out, such as industrial production. To give an example from the health sector, the *free* exercise of the health care industry in the United States requires inextricable regulations of greater quantity and complexity than the equivalent Canadian regulations (Morone, 1992). The difference between the legal spheres for the exercise of free enterprise and for the exercise of a public service lies not in the presence or absence of State regulation but in the different nature of the regulation. In the free enterprise context, the main object of public intervention is to promote the profitability of business (while protecting citizens from the most flagrant abuses), particularly through measures of direct and indirect support in a multitude of forms. In the public service context, the main object is to ensure the equitable distribution of a good or service to all citizens without distinction as to their socio-economic status.

For the consumer in a market economy, ability to pay plays a decisive role in the accessibility of certain goods and services. For instance, family incomes are largely responsible for the value of the houses where those families live, the class of restaurants they patronize, or the type of vacations they can take. The legal system grants commercial enterprises the freedom to exploit the financial capacities of the various market segments, thereby sanctioning the social acceptability of the marked differences in consumption of those segments. To maintain the acceptability of these disparities in consumption, the legal system provides for minimum targeted and temporary assistance to persons whose income falls below a certain threshold. This is the form taken by social regimes such as welfare, unemployment insurance or the Canada Pension Plan. It is the function of these social security programs, which act as a lifebuoy, to maintain the acceptability of the rules of the marketplace by taking over if the system should fail certain persons at certain times. This safety net protecting individuals from an unacceptable failure serves as a buffer to the full exercise of economic and legal freedoms in the market economy.

After testing the rules of the marketplace in all sectors, a strong majority of countries have agreed that the minimum financial safety net was insufficient on its own to meet certain specific categories of essential human needs. These are goods or services that the social sciences recognize as falling within the class of public service, or *public good* (or *merit good*), depending on one's particular tradition or discipline. For reasons that have as much to do with economics as human behaviour, it is recognized that effectiveness is substantially increased when these goods are offered to all in kind according to need, instead of as advance payments in order to procure them on the market. Education and health fall into this category. The financial safety net cannot prevent human failure caused by ignorance or illness, because the rules of the marketplace are structurally incapable of adequately responding to such things. The great majority of OECD countries have effectively established a legal system for education and health that is distinct from those rules. The organization of health care services in the countries of the European Union partakes overall of a public service perspective (Berthod-Wurmser, 1994). Individuals' ability to

pay must not dictate the right to access a higher education or health care. A corollary to this is that it is considered unacceptable for one segment of society to be able to profit from the suffering of others, especially when misfortune confronts a person with a terrible choice such as paying for medical treatment or the family's food and housing.

Although the triumph of public service within market economies is too seldom recognized for its true worth, its entrenchment in our modern legal systems represents one of the greatest achievements of the last century, on a par with the adoption of the charters of human rights. In short, the essence of the *Canada Health Act* derives from its entrenchment in the Canadian legal structure of the principle of public service for health care. In that sense, the *Act* is a democratic monument to human dignity, which has the immense and rare quality of taking tangible, eloquent shape in the life of every citizen. The contribution of the health care system to social cohesion in each of the Canadian provinces and territories is inestimable.

From the economic perspective, there is near unanimity on the fact that the rules of the marketplace are in themselves inadequate to meet the health needs of an entire population. Even the fiercest supporters of the liberal economy acknowledge that the public authorities have a role to play. Where the consensus fails is on defining the nature and scope of the role of public intervention. There are two main options before us. The first is the route taken by the *Canada Health Act*, and the second is typified in the repeated calls to "modernize" that piece of legislation. It is therefore important to sketch these two main options for public intervention in the health care field.

The Public Service Option and the Canada Health Act

The first option for intervention by the public authority, the one that has been adopted by Canada and its provinces, is based on two axioms: the legal equality of persons confronted with illness and death, and pursuit of the cost-effectiveness of the health care system.

In legal terms, through its five principles, the Canadian *Act* posits for each Canadian the same right to access medically necessary health care services. Cumulatively and in interaction, those principles say that access to health care must be based solely on need for medical treatment, regardless of the citizen's status or ability to pay. At the same time, they favour the *scientific* character of the decision on medical treatment, as opposed to an arbitrary determination based on the individual's membership in one group or another. The disregarding of socio-economic status as a criterion for access to care means that the decision will not be made arbitrarily on the basis of the patient's insurance coverage or influenced by the profit motives of an organization in charge of health care management or delivery. In short, according to the *Canada Health Act*, the determination of the medical treatment that a patient's condition requires is totally divorced from the person's financial capacity or social position. The key element in deciding on health care is the professional judgment of the physician, in discussion with the patient, structurally sheltered from all interference with the latter's socio-economic status. The level of decision making on care is brought as close as possible to delivery of the care, that is, to who directly provides and receives it. At a more macro level, the budget cuts to health over the past decade have contributed to the emergence of another level of service allocation based on the

limiting and rationing of the services offered. Waiting lists and treatment delays have served as a reminder that appropriate funding and organization of services also have a central role to play in determining the accessibility of services. The problems of prompt accessibility to health care experienced in recent years call for adequate correction before they render the Medicare system even more fragile.

The public service concept as applied to health care makes a very important contribution to the still-fragile balance between, on the one hand, the requirements of democracy, which seeks expression of the principle of the equality of citizens, and on the other, the precepts of the marketplace, which in a constant quest for profit operates according to a different logic that must look to the economic disparities between market segments for its structural foundations. Canada, in concert with the Canadian provinces, which have often been the driving force or catalyst in devising solutions, has found this balance by removing health care funding from the dictates of the market and attaching it to the tax system. The result is a fiscalization of health care funding, where the principle of contributions commensurate with ability to pay must govern the collection of funds.

In economic terms, the superiority of a universal public health care system as the most effective possible provider of quality care for an entire population no longer needs to be demonstrated (Deber, 2000; National Forum on Health, 1997). The economic arguments that break with the public service principles of the *Act* are being advanced in defence of interests likely to be served by them (Frankman, 1998).

If one had to identify which of the five principles of the *Canada Health Act* is its real nucleus, one would have to opt for universality, which guarantees the same conditions of access to health services for every citizen. This principle is in direct opposition to any form of variable coverage based on the risk posed by the patient, or on the patient's employment or employability, age, income or membership in a given group, to name just a few examples of the criteria of differentiation. Universality is also incompatible with all impulses to administer means tests to patients or to consider criteria other than those of the patient's medical needs in guiding a decision on medical treatment.

The *Canada Health Act* offers the most efficient principles for preventing health dollars from being spent on purposes other than delivery of health care to patients. The administrative costs of the Canadian health system are among the lowest in the world, whereas the American system has the highest administrative costs among the OECD countries. One comparison put the annual figures at US\$18 per capita in Canada versus US\$95 in the United States (D'Intignano, 1992). As to the medical care costs themselves, the Canadian regime embodies an integrated system of cost control in establishing a balance of power between the single funding source and the providers, as represented in particular by the physicians who have organized within powerful bargaining units.

The Option of Support for the Health Care Industry

The second option for public intervention in health gives priority to the State's role in supporting business. Here the State acts both as arbitrator and facilitator so as to promote the

cost-effectiveness of the health sector, but also intervenes as financial backer. As a counterbalance to promotion of the private sector's cost-effectiveness, a range of auxiliary measures must be implemented in order to contain the system within limits that are tolerable for the populace, and particularly for that segment likely to have substantial health care needs.

The characteristics of the health-care economy are known and recognized (Evans, 2000). The unpredictability and exorbitant cost of certain treatments place the health risks beyond the scope of most families and individuals. Patients' options in the face of the complexity of illness are limited, and require them to rely to a very large degree on the scientific expertise of the health care professional. The state of need and powerlessness in which they find themselves puts them in an exceptionally vulnerable position. Because of these characteristics, health care falls into a special economic category. Furthermore, countrywide, about 4 percent of the population incurs 50 percent of health care costs (D'Intignano, 1992), which represent roughly 10 percent of the GDP of industrialized nations, making this one of the biggest sectors in developed economies.

Under these conditions, it is clear that maximizing the health care industry's profit opportunities requires substantial intervention by the public authorities, both through their regulatory power, which must be placed at the service of a business-friendly system, and through public monetary contribution to the industry's operations. For the moment, however, both the *Canada Health Act* and provincial health legislation prohibit such direct and indirect public subsidies to the health care industry (Flood and Archibald, 2001). Moreover, developing areas of profitability for business in the health sector requires that the public authorities take charge of depressed areas of the market concentrated in disadvantaged segments of the population.

A Close Relationship between Public Services and the Tax System

The major public services fields that emerged in the 20th century were supported by a profound reform of the tax system of those nation-states that decided to take this route (Ardant, 1972; Bouvier and Wolff, 1973). The structure of the taxation system is closely connected to the viability of the services it finances. For 30 years, the tax revenues of both levels of government have successfully provided every citizen with access to health care without regard for socio-economic status, serving as the vehicle for substantial redistribution of wealth.

The fairness of a health care system must be based on a taxation system that is likewise characterized by its fairness. The federal and provincial taxation system in Canada has been considerably modified over the past decade, notably insofar as it has suffered certain blows to its progressive nature (Lareau, 1998). As it has become more fragile, the tax structure has transmitted these effects to the health system which it funds. Numerous indicators of a fragmentation of the taxation system have manifested: there has been a substantial falling-off in corporate contributions to the income tax class (Sargent et al., 1998), which has been offset in part by the introduction of a regressive commodity tax at the federal level (the GST). Quebec has introduced a business tax exemption policy that affects much of its industry, whose economic growth can now be tax-sheltered – including tax contributions to the provincial health care services fund. The “free zone” mechanism has emerged, whereby industry can pursue its

activities while sheltering its revenues, or a portion of them, from taxes, while certain individuals are now entitled to regimes that exempt them from tax contributions (APFF, 2001).

As the war on public deficits has been accompanied by major changes to the structure of the Canadian tax system, the trend toward fiscal division and fragmentation can only have a negative impact on the funding of the health system. The State-endorsed race of economic agents to become internationally competitive has translated into major changes in the tax system which have reduced the fiscal resources that can be allocated to social services, while subsidies to private enterprise accelerate.

One has to acknowledge the close relationship that exists between the principles of the taxation system and those that govern such an important program as the health care system. It has been possible to set up the Medicare system only by working in step with a progressive taxation system that shares the same principles of solidarity as Medicare. The recent tendencies toward fragmentation taking shape within the country's taxation systems can only raise fears for the preservation of the principles of solidarity of the health care system that are protected by the *Canada Health Act*.

The Relevance of the *Canada Health Act* in Light of Some Historical Opponents of Its Principles

The provincial health care programs have not been installed with the blessing of all sectors of society. The insurance industry and professional corporations of physicians, whose practices were liable to see radical change, were especially active in mounting an organized opposition throughout the discussions that preceded introduction of the public plans. The insurance industry saw a market sector that was escaping its grasp, while the physicians – who could see some personal interest by dint of the income security resulting from the plans but were afraid of tighter control over their financial arrangements – refused to become employees of the government, and opposed the ban on soliciting more substantial fees from their more well-off clientele (Fuller, 1998). An alliance was created between the insurance industry and the professional physicians' corporations in order to better organize opposition to Medicare – an opposition that had every appearance of a call to a crusade in the name of free enterprise.

The opposition strategy that was quickly put in place by this alliance was to militate in favour of a form of regulation that worked like a public subsidy for private insurance, so as to allow the most disadvantaged to obtain private coverage by means of public funds. The work of the Hall Commission had shown that between 54 and 76 percent of the population needed public assistance to purchase private insurance coverage on the market (Canada, 1964). Given its fear of government regulatory intervention, the alliance also tried to minimize the crudest defects of the system. A number of physicians' associations, in concert with certain hospitals, set up not-for-profit health insurance programs to meet the glaring needs of a clientele unable to pay regular market premiums. The Hall Commission, after carefully analysing the situation, noted the relevance and superiority of the tax-funded model in correcting the many distortions, major inequities and high costs of the consequences of segmentation of health risks by private insurance, for both the government treasury and the patient (Canada, 1964). The haste in

preparing for the worst was captured well by the president of the Ontario Medical Association when he said in 1939: “If we do not socialize ourselves and develop proper techniques of service, governments will be forced to try their hand” (Fuller, 1998, p. 32). This pre-emptive strategy temporarily bore fruit when Alberta adopted in 1963 a subsidy plan so the poor could buy private insurance (*Manningcare*). The method was used again 30 years later, to counter demands to extend the field of application of the *Canada Health Act*, with the 1996 passage in Quebec of a prescription drug plan based on risk segmentation (*Act respecting prescription drug insurance*, 1996; Soderstrom, 1996). It must not be forgotten that the adoption of public health care plans represented a defeat for the insurance industry.

II. Current Status of the *Canada Health Act* in Light of the Alternatives Proposed Today

The Complaints against the *Act*

Now that the federal government finds itself on the defensive before the barrage of calls to amend or “modernize” the *Canada Health Act*, it is important to analyse the content of the alternatives being advanced. First it must be noted that the tone is becoming shriller. Critics no longer hesitate to openly ridicule the principles of the *Act* by comparing them, for example, to the *Ten commandments* (Leblanc, 2002b) or an *open bar* (Leblanc, 2002a). The ideological confrontation between public service and market dogma at this dawn of the 21st century is once again proving as highly charged as ever.

The *Canada Health Act* has a clearly defined purpose: to ensure that health care is delivered to all Canadians in accordance with the principles of public service. The *Act* poses certain major obstacles to any project that would stray from public service principles, obstacles which have thus far proven effective. It is precisely this that testifies to the *Act*'s effectiveness.

It is important to remember that not only is the provision of services by the private sector not prohibited by the *Canada Health Act* or provincial legislation, but that, on the contrary, the private sector already plays a predominant role here with a significant share (data which unfortunately are not collected by the Canadian Institute for Health Information [CIHI]) of public health care funding, which goes to pay private providers of medical goods or services. Physicians in private practice account for a large part of the health budgets administered by their recipients, according to the rules of the entrepreneur who manages his own time and organizes his own work. Prescription drugs, which account for a growing share of health costs, are sold by companies whose profit margins are among the highest in any industrial sector. Private laboratories supported by public budgets are also seeing their market share grow. To talk about a public monopoly in the health field is misleading when the private sector is already channelling a large chunk of the 70 percent of public health spending, while at the same time representing 30 percent of total health spending (CIHI, 2001). As Professor Evans says: “The Canadian form of Medicare is not ‘socialized medicine’ but rather ‘socialized insurance’” (Evans, 2000).

So it is necessary to clearly identify the nature of the obstacles raised by the *Canada Health Act*. This can be facilitated by examining certain current provincial projects. The proposals emanating from Quebec and Alberta call for the *Act* to be “modernized” or made more flexible; basically they aim to compel greater participation by the private sector, not just in terms of total sales, but chiefly in order to modify its role and function. In short, although the private sector is currently an important player in health care delivery in Canada, for the moment it operates in a manner compatible with the *Act*. The exhortations to “modernize” the *Canada Health Act* would introduce a mode of operation for the private sector that has little in common with what we now know, and which would be contrary to the prescriptions of the *Act*.

Three distinct levels of transformation of the health system are being pursued: increased privatization of health care delivery (delivery by companies), privatization of the funding of

health care, and privatization of the mechanisms for integrating these two dimensions. To employ a shortcut, if we take “privatization” to mean increased participation of the for-profit private sector in areas of public services, the most frequent mechanism for this is private-public partnerships.

The Avenues Pursued by the Detractors of the *Canada Health Act*

The political agendas of Alberta and Ontario (Ontario, 2000*a* and *b*) leave no doubt as to the desire to reduce the areas of public service (Leduc Browne, 2000). The situation in Quebec is harder to decipher, in that the orientations proposed and followed often contradict official statements, which themselves are difficult to reconcile with certain emerging political plans.

To illustrate the central role played by the *Canada Health Act* in protecting health care as a public service, the plans in Alberta and Quebec will be examined.

Alberta

With the passage in May 2000 of the *Health Care Protection Act* (2000), (Bill 11, c. H-1), the Ralph Klein government made known its directions for the future of the health care system in Alberta. While the complex drafting of the statute might leave some doubts as to longer-term objectives, the recent government-approved report of the Advisory Council, chaired by D. Mazankowski (Alberta, 2001), removes those doubts completely.

The Alberta *Act* is of great interest in analysing the crossroads at which the federal government today finds itself. It reflects a fairly radical ideological opposition to the *Canada Health Act*, yet at the same time it has to aspire to respecting the principles of the *Act* so as to avoid too obvious a contravention of its prescriptions, for fear of sharp opposition to the project being expressed by the people of Alberta and of triggering the sanctions prescribed in cases of non-compliance.

The Alberta *Health Care Protection Act* opens the door to a thorough remodelling of the Albertan health care system and its fundamental social principles, by straying from the concept of public service entrenched in the *Canada Health Act*. Both the funding and the delivery of health care are converted and diverted to the benefit of for-profit enterprise. Contrary to the Canadian *Act*, which guarantees an airtight separation of funding and care delivery, the Alberta statute integrates and links these two functions.

In the area of care delivery, we see the emergence of a new player: the for-profit “surgical facility,” which can simultaneously provide publicly funded and market-funded care. Furthermore, public hospitals providing insured and uninsured care must open their facilities to for-profit operations.

In the area of funding, the full fiscalization of health care funding comes to an end, since the statute creates the concept of the “enhanced medical good or service,” which must be purchased

on the market while at the same time qualifying for a substantial public subsidy to the facility via two mechanisms provided for in the statute. The first mechanism is the co-existence of insured and uninsured services in the same institutions, in the public hospital and surgical facility alike, with managers given full discretion to have uninsured services funded by insured services, not to mention the structural exposure to abuse and cross-subsidizing or to discounts that elude public control thanks to the flexibility of the contract, whose terms and conditions can vary as the negotiating parties see fit. The second mechanism is “facility services,” which the statute defines as “medically necessary” [s. 29(g)] and which could therefore receive public funds even when provided for uninsured care, while also permitting extra billing of the patient, who is now a consumer. What the Alberta statute creates, then, is a plan for subsidizing the for-profit surgical facility with public health care funds.

The “enhanced medical good or service” serves as a basis for this new structure where health dollars are used to fund profit-making businesses. Section 5 of the *Act* gives a glimpse of the abyss into which this notion threatens to cast the health care system. The physician must, of course, inform the patient that the enhanced service generates certain charges, but above all he must explain that the service is not medically required, even though it is suggested all the same. One may wonder why a physician would recommend a good or service that is not medically required. There is obviously nothing scientific about such a notion, it has nothing to do with overall control of health costs, and it does not aim to improve patient services. Its object is to ensure the profitability of the for-profit surgical facility with the assistance of a constant flow of public health dollars. The distinction that is made between enhanced medical care and necessary care as determined on a case-by-case basis by the physician [s. 29 (f)], subject to any announced regulations [s. 25(1)(h)], is open to the worst abuses observed in the American health care system. This structure fosters situations of conflict of interest for a physician caught between his professional role as an advisor in the best interest of the patient and his role as member of a business concern. The *Act* recognizes this danger, since it provides in paragraph 8(3)(g) that mechanisms for monitoring conflicts of interest and ethical issues are among the many criteria by which the Minister must be guided when approving an agreement signed between a facility and the Health Authority. The broad discretionary power in designating surgical facilities that is conferred upon the Minister [sections 7, 8, 13, 14 and 15], protected by a privative clause [section 23], augurs nothing worthwhile. This is an example of public administration that has reverted to its classic 19th-century role, which exerts its power by ratifying a plethora of contracts negotiated one-by-one.

Basic, publicly funded services serve to provide constant funding for profit-making facilities that will be able to recover their expenses as they deal with a public administration that is reduced to the status of a mere partner that negotiates by contract. The same facilities will subsequently be able to make their profit on uninsured services all of whose fixed expenses have already been covered by public funding. The scenario raised by the Alberta statute is most disturbing in terms of both the effectiveness and the sound management of public funds, not to mention the perversion of the concept of public service that it ushers in.

While a superficial reading of other provisions of this statute might suggest that their purpose is to protect the population of Alberta, these too are powerful mechanisms for subsidizing the

surgical facility. For example, subsection 5(6) of the *Act* states that when the standard medical service is not available, a patient who has previously refused the enhanced service will have access to it without having to pay. The contractual agreements will not fail to stipulate that the Health Authority will then pick up the bill of the facility, in whose interest it will be to reduce the availability of standard goods or services to the minimum in order to force the public funding of enhanced services. In reading section 2, which restricts major surgical operations to public hospitals, one must keep in mind that the for-profit surgical facility is free to select by contract the insured procedures of its choice, taking the opportunity to direct the most lucrative operations to the private sector.

The co-existence within the same institutions of insured and uninsured services, with the mechanisms described above, offers a structure that is not only conducive to but inherent in the two-tier system, in which one client's money and private insurance coverage give him or her priority over another whose coverage is limited to public insurance. The prohibition of queue jumping in section 3 and its maximum penalty of \$100,000 could prove entirely futile when the distinction between insured and uninsured service is based on the physician's offer to the patient to take advantage of an enhanced medical service that is not medically required, which is not an insured service within the meaning of section 3. Who could then argue a violation of section 3?

The program of the *Health Care Protection Act* would doubtless be sufficient in itself to endanger the sustainability of the Medicare system, as it lays the legal foundations for the cost-effectiveness of the for-profit surgical facility. But the Premier's Advisory Council on Health for Alberta, which is provided for in that statute [sections 27 and 28] and whose report was released on January 8, 2002 (Alberta, 2001, hereafter the Mazankowski report), takes the structural and legal proposals promoting the profitability of the health care industry even further. Mr. Klein has been quick in announcing his firm intention to take action on this report.

In the same spirit as the statute from which it proceeds, the Mazankowski report is even more clearly in opposition to the fundamental principles of the *Canada Health Act*. It brushes aside the central principle of socialization of health care costs, even for the portion of care maintained in the public system. The thrust of the Mazankowski report is to complement the measures provided for in the *Health Care Protection Act* with another spectrum of mechanisms for ensuring the viability of the health industry and its public funding. The authors of the report acknowledge that their proposals will not reduce health costs in the short (or long) term. The report clearly sets forth its proposal to distinguish two categories of health services: essential services for those who cannot afford them and who remain insured by the public system; and new treatments and services, which will be offered only to those who can procure additional insurance or can pay for them directly.

The members of the Advisory Council have undoubtedly recognized the thorny nature of the notion of "enhanced medical service," which the *Act* describes as medically unnecessary. They have repeated the approach proposed by the Clair report in Quebec with the rationing of the basket of services, so as to exclude from it the latest treatments or services using a race-to-the-bottom mechanism where the services covered are under constant threat of removal depending on whether provincial tax resources are available.

The report acknowledges opting for a health care system in which the citizen's ability to pay becomes a criterion for segregating access to services. However, it evades the fact that public funds are used to consolidate that part of the system that will be accessible only to the smallest segment of citizens. The strategic measures in the report can be organized into four categories.

Subsidize Private Insurers and Other For-profit Enterprises

The Mazankowski report puts back on the table the old measures and proposals typical of opposition to the public health system in the first half of the last century, that is, use of public measures to subsidize the purchase of private insurance coverage (p. 54-56). In using favourable tax measures to support private health care savings, the report encourages greater disparities among individuals and the channelling of profits to the financial systems that receive individuals' deposits. The report also suggests that the Medical Savings Account (MSA) can be used to purchase supplemental private coverage. The creation of the MSA, which keeps a record of the citizen's health care costs on an individual basis, represents a total misinterpretation of the principles of the *Canada Health Act*, which prescribes the socialization of funding. The MSA project, which sees an equal amount of public funds paid annually to every citizen, is totally at odds with the distribution of health care costs throughout the population.

The dizzying increase in administrative costs generated by these proposals is indicated several times in the report, but the solution proposed is always the same: have the necessary facilities financed by public funds in order to keep this increase favourable to the private sector. The report points out that massive investment in new information technologies, including the health debit card, will be needed to manage the measures proposed.

Force the Public Funding of Private Services

The guarantee of service within 90 days is a measure which, contrary to all appearance, primarily favours the for-profit service providers to whom the Health Authority must turn and whose costs it is forced to pay. In addition, the report suggests that the portion of the MSA that is not spent at year end can be used to purchase private services. This dubious measure once again channels public funds into the coffers of profit-making companies.

Perversion of the Taxation System

The authors of the Mazankowski report have fully grasped the close ties that exist between the philosophy of the tax system and the vision underlying the services it finances. It is, in fact, by modifying the fiscal rules for funding health care that the Alberta project intends to bring about a transformation of the principles of health insurance, while at the same time minimizing open confrontation with the principles of the *Canada Health Act*. The report suggests a public funding of health care that, on the one hand, increasingly copies its practices from those of private insurance companies (variable premiums and the Alberta Health Care Account), and on the other, accentuates the regressive character of tax collection (MSA and the increase in health

care premiums). The report also proposes a regional taxation power for the Health Authorities, granting a total exemption for industry and businesses, on the grounds of avoiding inequities among regions (p. 30).

The Albertan initiative to “modernize” the *Canada Health Act* demonstrates a direction that should mislead no-one as to its clear desire to break with the concept of public service in the health sector in order to develop a sphere of profitability for the health industry, which can only have harmful effects in segregating the population in terms of health care needs.

Quebec

Quebec was the last province of Canada to adopt a public insurance plan for medical services in 1970. However, it took advantage of this late entry to draw the appropriate lessons and adopt a plan that would become a model for Canada in explicitly prohibiting user fees and extra billing. The federal *Act* was amended in 1984 to include these principles already in effect in Quebec for over 15 years. Quebec was also the Canadian province that was first off the mark in introducing effective measures to control health costs, while fully respecting the independence of health care professionals – measures that were subsequently adopted by other provinces (Tuohy, 1999).

However, it is quite a different orientation that emerges today from the most recent Quebec programs, as articulated in the Arpin report (Quebec, 1999), the Clair report (Quebec, 2000), the prescription drug insurance plan (*Act respecting prescription drug insurance*, 1996; Quebec, 2001 [Montmarquette report], the *Act to amend the Act respecting prescription drug insurance*, 2002) and the draft bill on the smart card (*Québec Health Card Act*, 2001). Instead of working toward a consolidation of the public system and increasing public control measures on health spending, like Alberta, Quebec is taking the second approach outlined in the first chapter, which is to abandon or dilute the concept of public service so as to open the door to private insurers, by employing measures that support private enterprise and by integrating public services with services provided and insured by private enterprise.

I have outlined elsewhere my understanding of the program that emerges from the recommendations of the Clair report, which also calls for the “modernization” of the *Canada Health Act* (Prémont, 2001*a* and *b*) by rationing the basket of public services. The Quebec prescription drug insurance program, which has already demonstrated its inability to control the plan’s rising costs and recurring deficits, must be understood as a measure that is basically designed to occupy the drug insurance sector to the joint profit of private insurers, pharmaceutical companies and information management firms, which then benefit from the system put in place. The recent Montmarquette report and the bill amending the plan confirm that this is the favoured model (Quebec, 2001).

Far from complying with the five principles of the *Canada Health Act*, the health care reform program that is taking shape requires the opening up of the basket of insured services and the introduction of an improved health care regime whose revenues are directed to business and private insurers.

The project of introducing a smart card into the health system is another indication that Quebec is moving toward a radical modification of public service principles for health care. The meaning of the draft bill called the *Québec Health Card Act* becomes clearer when read in the context of the three memorandums of the Ministers of Health and Social Services that were submitted to the Quebec Cabinet between June 2000 and December 2001 (Marois, 2000; Trudel, 2001a and b). It then becomes apparent that the objective of the draft bill is to lay the foundations of an information infrastructure that can allow for a thorough transformation of the Quebec health care system, toward a “future evolution” with “restrictions on insured services coverage” and “new service modulations that can incorporate complementarity between public and private partners” resulting in a “complex of specific situations which are negotiated.” The draft bill distinguishes between insurance eligibility based on citizenship criteria and insurance coverage that can vary from one person to another, in flagrant contradiction of the principle of universality (s. 8(2) of the draft bill). The ministerial memorandums and the construction of the draft bill pave the way for implementation of an infrastructure that is justified in a plan that is contrary to the current principles of the public health and hospitalization insurance program (Prémont, 2002). A very large percentage of the memorandums submitted to the parliamentary commission raised substantive objections to the bill (Centre for Bioethics, 2002 – see Web Site, p. 23).

The objective that emerges from all of these measures, plans and projects is well described by the father of Quebec’s drug insurance plan who, adopting one of the key recommendations of the Clair report, urges the public authorities of Quebec to extend the prescriptions of the drug insurance plan, contrary to the principles of the *Canada Health Act*, to the entire health care system (Castonguay, 2001). Whereas Quebec at one time provided inspiration for the federal *Act*, the plans outlined here see that legislation rather as an obstacle.

Conclusion

Historically, physicians played an important role in fighting the introduction of Medicare in Canada. This opposition has left some major marks on our present-day systems, as witness the fee-for-service system. The incentive effect of this mode of payment on health care delivery is well known, and many countries have tried to make adjustments to it, notably by introducing capitation and comprehensive fixed envelopes for medical procedures (Germany). These methods of controlling health spending, like the reorganization of front-line care with the introduction of family medicine groups, are legitimate and worthy of the attention of our provincial leaders. All of them can be employed in compliance with the principles of the *Canada Health Act*, which poses them no obstacle. In calling for the “modernization” of the *Act*, the demands coming from Quebec and Alberta are intended not to control total health care spending, but rather to have that spending transferred to the benefit of for-profit enterprise.

The professional health corporations were the historical ally of the insurance industry during the discussions that preceded adoption of the public system. On account of the modification of health care, technological development and the increased role of drugs in health care plans, the insurance industry today has new allies in its battle against the Canadian public systems, those being the pharmaceutical and information and telecommunications management sectors.

Reluctance to be subjected to government regulation is normal and longstanding, since such regulation alters the scope of the privileges enjoyed by certain economic sectors. For instance, in the late 19th century Quebec physicians opposed the obligation imposed on them to certify causes of death, regarding this as interference in their professional practice. They also opposed the mandatory reporting of certain contagious diseases, arguing the principle of doctor-patient privilege (Guérard, 1996). Yet history has confirmed for us the social usefulness of these measures. It is the role of the public authority to analyse such complaints so as to better define their substance.

Analysis of the proposed alternatives demonstrates that they all converge upon the same objective: to reformulate the legal principles of Canadian health care systems to ensure that there are areas of profitability for the health industry. These transformative proposals necessarily lead to abandonment of the principle of universality of health services, the key nucleus of the *Canada Health Act*. The alternatives proposed by Alberta and Quebec target the methodical dismantling of the most important public service accomplishment in the provinces of Canada. One comment by the late French sociologist Pierre Bourdieu is appropriate to the situation now facing the public authorities and the Canadian population:

[translation] It is characteristic of conservative revolutions, those of the thirties in Germany, those of Thatcher, Reagan and others, to present restorations as if they were revolutions. The conservative revolution of today is taking an unprecedented form (...). This new brand of conservative revolution is calling upon progress, reason and science (economics, in this case) to justify the restoration, thereby attempting to dismiss progressive thought and action as archaic. (Bourdieu, 1998)

In this brief overview of the Alberta and Quebec programs – which are banking on challenging the public service principles of the *Canada Health Act* in order to introduce a system contrary to the public interest, a system that would see the serious equity problems of the first half of the 20th century return to Canadian society – the federal government is called upon to play a critical role in not yielding to these conservative recriminations.

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