

Commission on the
Future of Health Care
in Canada



Commission sur
l'avenir des soins de santé
au Canada

DISCUSSION PAPER NO. 21

Health Care Politics and the Intergovernmental Framework in Canada

by

Candace Johnson Redden

Brock University



September 2002

Catalogue No. CP32-79/21-2002E-IN
ISBN 0-662-32794-2

Although the views expressed in the paper are those of the author(s), each of the papers was subjected to an independent peer-review process. The Commission would like to thank the Institute of Health Services and Policy Research (IHSPR) of the Canadian Institute of Health Research for their oversight and administration of the peer-review process for these papers. The work of the authors, the reviewers and IHSPR will serve to make these papers an important contribution to the Commission's work and its legacy.

Contents

Highlights	iv
Executive Summary	v
Introduction	1
The Creation of a Health Care System	2
Rights Reorientation	3
Problems and Patterns: Fiscal Federalism	5
Social Rights and the Challenge of Difference	8
Health and Difference	10
Strengthening Civil Society	13
Bioethical Reflection	15
Conclusion	18
References	19

Highlights

- The federal-provincial relationship has effected a stable and efficient set of arrangements for health care, but has not been completely successful in developing an effective system. In fact, the stability and efficiency of the system might undermine its effectiveness. On the one hand, Medicare is effective because it embodies and makes tangible the five principles of the *Canada Health Act* (CHA) – universality, accessibility, comprehensiveness, portability, and public administration. On the other hand, the stability of government-group relations and the efficiency that those relations produce are not conducive to dynamic policy change. Further, many reforms and improvements, namely macro-level policy discussions, do not get done because of federal-provincial disagreement and deadlock. This is a significant problem given the new challenges to health systems around the globe.
- As currently understood and applied, the intergovernmental perspective is inappropriately narrow. The process of federal-provincial decision making for health care overshadows many issues relevant to health care and eclipses substantive policy issues.
- Health care as a citizenship right is made tangible through intergovernmental and constitutional politics. The *Canada Health Act* (1984) increased provincial responsibility for health care by enumerating the conditions for disbursement of federal funds and, more importantly, identifying the penalties for failure to comply with those conditions. It should be noted that the problem with the CHA is not the stringency and unreasonableness of federal conditions but that it allows the federal government to claim a shared vision as its own.
- Recent tensions between the federal and provincial governments concerning health care are consistent with historical patterns. One of the most significant factors that affects the intergovernmental relationship is funding and the uncertainty created by changes in the structure of federal transfer payments. Because health care is a field of exclusive provincial jurisdiction and the federal government is involved in most health care policy only to the extent that it can convince the provinces to comply with national standards, much about the federal-provincial relationship can be understood through an investigation of fiscal federalism.
- In the paper, I explore three issues that cannot easily be accommodated by the federal-provincial framework that is under examination. The first is social rights and the development of policies aimed at diversity. These issues exemplify the conception of health and equality as transcendent of geographical spaces. The second is civil society – realization through public policy and structural change of the need to engage citizens and their communities in decision making. Such engagement might alter the structure of intergovernmental politics. And the third is bioethical reflection. Deliberation about distribution, what states ought to provide for citizens, and how humans ought to treat one another, constitute the substance and essence of health care debates.

Executive Summary

The idea of citizenship is expressed in many ways. Citizens and states exchange duties and services, rights and responsibilities, in order to create workable, sustainable political communities. In Canada, as in other countries, this exchange is made visible through social policy. Benefits are accorded through pensions, education, housing, and health care as compensation for, or to enable, participation in the military, the economy, and society. Such an exchange reflects, reinforces, and generates beliefs about the Good Society and delineates patterns of social inclusion and exclusion. For Canadians, some of the substance of citizenship is revealed in the health care policy arena. Canadians are proud of their universal health system and hold that it is a feature that distinguishes them from Americans. Further, Canadian citizens understand the citizenship bargain through which they exchange taxes for health insurance and have come to communicate this exchange in the language of rights. This “rights talk” has developed in tandem with, or perhaps as a result of, loss of confidence in the state’s ability or willingness to maintain existing health care programmes and develop new ones.

Thus it is critically important to evaluate the state’s role in health care and the ways in which it has enriched or diminished hospital and medical services insurance (commonly referred to as Medicare). In the Canadian context the evaluation focuses, inevitably, on questions of federalism. I argue that the federal-provincial relationship has effected a stable and efficient set of arrangements for health care, but has not been completely successful in developing an effective system. In fact, the stability and efficiency of the system might undermine its effectiveness. On the one hand, Medicare is effective because it embodies and makes tangible the five principles of the *Canada Health Act* – universality, accessibility, comprehensiveness, portability, and public administration. On the other hand, the stability of government-group relations and the efficiency that those relations produce are not conducive to dynamic policy change. Further, many reforms and improvements, namely macro-level policy discussions, do not get done because of federal-provincial disagreement and deadlock. This is a significant problem given the new challenges to health systems around the globe.

Recent tensions between the federal and provincial governments concerning health care are consistent with historical patterns. One of the most significant factors that affects the intergovernmental relationship is funding and the uncertainty created by changes in the structure of federal transfer payments. Because health care is a field of exclusive provincial jurisdiction and the federal government is involved in most health care policy only to the extent that it can convince the provinces to comply with national standards, much about the federal-provincial relationship can be understood through an investigation of fiscal federalism.

The story of fiscal federalism indicates that harmony and discord in federal-provincial relations for health care are linked, first and foremost, to funding issues. The provinces are concerned with autonomy in policymaking and securing enough money to adequately fund health care, and the federal government is concerned with cost control and compliance with national standards. The *Canada Health Act*, to some extent, ensures effectiveness through the stated conditions of payment. Efficiency in decision making, although impaired by two layers of governmental authority, is achieved, somewhat facetiously, through federal unilateralism. And stability in funding levels (although there has been slow decline, which has caused greater

uncertainty for the provinces) is secured through negotiated funding arrangements, public opinion, and medical profession-state relations. Thus, as Carolyn Tuohy argues in *Accidental Logics*, the Canadian health system has remained relatively stable through turbulent times. However, the other side of the efficiency coin is this: stability can be a constraint to much needed change. Federal-provincial disagreement in the field of health care consumes a significant amount of creative energy. This means that there are many reforms, improvements, and innovations that do not receive adequate consideration. With an inordinate amount of attention devoted to intergovernmental processes, disputes, and historical patterns and grievances, many macro-level discussions, through which policy is created and understood, are rendered irrelevant by more immediate concerns. A more harmonious federal-provincial relationship might be more supportive of such discussions and thereby lead to more widespread and successful innovation in the system.

In the second half of the paper, I explore three issues that cannot easily be accommodated by the federal-provincial framework that is under examination here. The first is social rights and the development of policies aimed at diversity. These issues exemplify the conception of health and equality as transcendent of geographical spaces. The second is civil society – realization through public policy and structural change of the need to engage citizens and their communities in decision making. Such engagement might alter the structure of intergovernmental politics. And the third is bioethical reflection. Deliberation about distribution, what states ought to provide for citizens, and how humans ought to treat one another, constitute the substance and essence of health care debates.

My purpose in raising issues concerning rights, civil society, and bioethics, is to demonstrate that health care is an incredibly dynamic policy field that is often rendered static by the limitations of the intergovernmental framework. While it is important to maintain respect for intergovernmental arrangements for health care, it should be recognized that the inertia of federal-provincial relations constrains policy change. Discussions of citizenship rights (in the form of entitlements to health care) transcend questions of jurisdiction and funding. Bioethical concerns are both universal and particular and will need to be addressed at the global level, in communities, and in hospitals. Change in medical technology, citizenship, and domestic politics alters the delicate balance of obligations and commitments in a federal state. And, in the case of health care in Canada, the provinces are left to create new understandings, bargains, and programmes for citizens.

It is possible that by acknowledging this imbalance of rights and responsibilities among the federal and provincial governments and citizens, clarity can be established, and from this clarity a new intergovernmental relationship can be built. To be sure, intergovernmental politics can accommodate (and has accommodated) issues of distributional equity. Intergovernmental politics has addressed problems concerning allocation of health resources and might be able to provide a model for future negotiation on the terrains of bioethics and rights. However, as currently understood and applied, the intergovernmental perspective is inappropriately narrow. The process of federal-provincial decision making for health care overshadows many issues relevant to health care and eclipses substantive policy issues.

Introduction

The idea of citizenship is expressed in many ways. Citizens and states exchange duties and services, rights and responsibilities, in order to create workable, sustainable political communities. In Canada, as in other countries, this exchange is made visible through social policy. Benefits are accorded through pensions, education, housing, and health care as compensation for, or to enable, participation in the military, the economy, and society. Such an exchange reflects, reinforces, and generates beliefs about the Good Society and delineates patterns of social inclusion and exclusion. For Canadians, some of the substance of citizenship is revealed in the health care policy arena. Canadians are proud of their universal health system and hold that it is a feature that distinguishes them from Americans. Further, Canadian citizens understand the citizenship bargain through which they exchange taxes for health insurance and have come to communicate this exchange in the language of rights. This “rights talk” has developed in tandem with, or perhaps as a result of, loss of confidence in the state’s ability or willingness to maintain existing health care programmes and develop new ones.

Thus it is critically important to evaluate the state’s role in health care and the ways in which it has enriched or diminished hospital and medical services insurance (commonly referred to as Medicare). In the Canadian context the evaluation focuses, inevitably, on questions of federalism. I will argue that the federal-provincial relationship has effected a stable and efficient set of arrangements for health care, but has not been completely successful in developing an effective system. In fact, the stability and efficiency of the system might undermine its effectiveness. On the one hand, Medicare is effective because it embodies and makes tangible the five principles of the *Canada Health Act* – universality, accessibility, comprehensiveness, portability, and public administration. On the other hand, the stability of government-group relations and the efficiency that those relations produce are not conducive to dynamic policy change. Further, many reforms and improvements, namely macro-level policy discussions, do not get done because of federal-provincial disagreement and deadlock. This is a significant problem given the new challenges to health systems around the globe.

The Creation of a Health Care System

The historical record shows that federalism has facilitated health care policy development in Canada. After a few “false starts” in some of the Canadian provinces in the 1930s and 1940s, the Saskatchewan Government implemented a public hospital insurance plan in 1947 (Maioni 1998: 73-77). It might have been the case that the provinces had no choice but to develop health programmes on their own. In 1937, Prime Minister Bennett’s New Deal Legislation, a national policy proposal to provide relief in the aftermath of depression, was declared *ultra vires*. The Judicial Committee of the Privy Council (JCPC) protected the provincial terrain of social policy from federal encroachment. Thus a federal government willing to act in response to economic adversity and social decline was prohibited from doing so. The question might be asked: Would a different JCPC decision have created a different social policy landscape in Canada? Would the federal government have acted earlier to develop public health insurance programmes without the inspiration of innovative provincial forerunners? But who knows? These questions cannot be answered. The provinces *did* lead the way in terms of progressive health policy. What remains to be seen is whether, in the face of much needed reforms, the provinces can be entrusted with the national vision that has been shaped, nurtured and institutionalized over the past four or five decades and whether the provinces can implement reforms consistent with that vision.

In order to evaluate federal-provincial relations in the health care arena, it is necessary to identify the sources of tension in the relationship and determine the relevance of the intergovernmental framework. It is clear that the federal government has developed, in conjunction with the provinces, a national vision that reflects and comports with public sentiment. This vision is the product of a number of forces. First, it was evident following the Second World War that the existing federal grants-in-aid for specific purposes (such as tuberculosis control and hospital construction) were piecemeal and insufficient.¹ Furthermore, the war effort was a demonstration of citizenship and responsibility, and the state was compelled to respond with a cadre of rights. Thus federal action in 1957 and 1966 (national hospital insurance and national medical insurance, respectively) provided citizens with tangible health benefits and also declared the social dimensions of Canadian nationalism.

Such pan-Canadian action in a field of provincial jurisdiction was made possible through the federal spending power. The Canadian Constitution authorizes the federal government to spend in all policy areas, even those of exclusive provincial domain. Given the tangible benefits of universal health care, the national dimensions of the programme, and the federal financial contribution to a policy area outside of its ambit, it was inevitable that health care would become a hotly contested intergovernmental issue.

¹ The inadequate approach to the health of the nation was indicated by the Report of the Royal Commission on Health Services (the Hall Commission, 1964).

Rights Reorientation

The *Charter of Rights and Freedoms* and the *Canada Health Act* inspired a new rights orientation in the field of health care (Redden 2002; Manfredi and Maioni 2002; and Flood 1999). The authority of full judicial review moved debate concerning constitutional matters beyond mere questions of jurisdiction. Thus it no longer makes sense to consider health care as an exclusively intergovernmental issue. It is important to recognize that the federal-provincial perspective is narrow, process-focused, and that the intergovernmental dimensions of health care intersect with debates related to rights, civil societies, and bioethical reflection. In my estimation, one of the most serious problems concerning the federal-provincial framework for health care is that the process of intergovernmentalism has crowded-out many issues relevant to health care (such as rights, bioethics, and global distribution). The process, in some cases, seems to engulf the substance of the debate. Moreover, questions about the impact of federal-provincial relations on the sustainability of Medicare are, to a certain degree, wrong-headed. The Canadian health care system is a creature of intergovernmental politics. Federal-provincial relations, both harmonious and discordant, have facilitated *and* constrained policy change.

Evidence of significant change in the Canadian health system comes in many forms. One of the most profound and interesting is the rights orientation that has developed over the past two decades. It is commonplace for people to speak of rights to various things, both fundamental and frivolous. To claim that one has a right to something is not to indicate its value. For example, one might believe that one has a right to smoke on the street, although such behaviour has been prohibited in many communities. The maker of this claim might feel strongly about his or her asseveration, but likely would not believe that this “right” is equivalent to the right to life, liberty or free speech (although the right to smoke might follow from more fundamental rights). Thus rights talk is important because it delineates not value but cultural expressions of sentimentality and attachment. To be sure, the claiming of rights is, in large part, the expression of societal values. However, the daily rubric of rights reveals emotional excursions into citizenship, sentimental attachments to objects, services, and familiar patterns. In fact, instead of the proliferation of rights discourse further entrenching cold enlightenment rationality, it liberates it. Profuse rights claiming might transcend rationality and serve as evidence of a postmodern configuration of citizenship.

For example, some people feel violated when their range of choices is impinged in any way. Like not being able to buy a Coke on a university campus that has a contract with Pepsi. It is plausible that this is a violation of the right to freedom of expression. And while that seems to be stretching the boundaries of fundamental rights, it might not be possible to separate the irrelevant from the relevant. Similarly, the debate concerning health care rights requires the assessment of primary versus luxury services, values and sentiments. On an intuitive level, health care convincingly follows from more fundamental rights. I have argued elsewhere that the right to health care is properly understood (philosophically and politically) to be a citizenship right rather than a human right (Redden 2002). The right to public health insurance in advanced industrialized democracies is not equivalent to rights to basic health services like immunizations, clean drinking water and shelter.

Health care as a citizenship right is made tangible through intergovernmental and constitutional politics. The *Canada Health Act* (CHA) (1984) increased provincial responsibility for health care by enumerating the conditions for disbursement of federal funds and, more importantly, identifying the penalties for failure to comply with those conditions. It should be noted that the problem with the CHA is not the stringency and unreasonableness of federal conditions, but that it allows the federal government to claim a shared vision as its own.

The *Charter* (1982) has inspired more (and different) litigation concerning health care. Whereas in the pre-*Charter* era most litigation concerning health care focused on physician-patient relationships (Flood 1999), in the post-*Charter* era the focus of litigation turned to matters relating to fundamental rights, equality, and access (see the *Eldridge* and *Waldman* cases in British Columbia, and the *Cameron* case in Nova Scotia). This reflected and further inspired change in the nature of rights claims. On the one hand, citizen-patients came to expect services delivered in absolute terms. After all, the language of rights is unequivocal. And the gravity of health care issues could not be denied by the state. On the other hand, the CHA and the *Charter* seriously altered the provincial role in health care by increasing the level of provincial responsibility in both symbolic-political and constitutional realms. Citizen-patients direct their rights claims against provincial governments, which bear sole constitutional responsibility for health care. Moreover, provinces have assumed greater financial responsibility for health care; they are carrying more of the fiscal burden as the proportion of federal government funding declines.

It is not possible to determine with any degree of certainty whether this increase in degree of provincial responsibility is positive or negative. And it is not as simple as deciding whether the federal role is illegitimate or whether the provinces are fatally constrained by federal legislation, constitutional arrangements, and an increasingly litigious society. To be sure, public opinion polls show that Canadians want the federal government to continue to play a role in health care and uphold national standards (Merck Frosst Canada & Co. et al. 2000: 26). It is clear, however, that the provincial role has changed as a result of the CHA and the *Charter* (as well as other factors) while the federal role has remained, more or less, constant. This is problematic because it creates an imbalance of rights and responsibilities, which diminishes possibilities for reform. As provinces assume more financial and moral responsibility for health care policy, the federal role becomes questionable, which presents a serious constraint to necessary change.

Problems and Patterns: Fiscal Federalism

Recent tensions between the federal and provincial governments concerning health care are consistent with historical patterns. One of the most significant factors that affects the intergovernmental relationship is funding and the uncertainty created by changes in the structure of federal transfer payments. Because health care is a field of exclusive provincial jurisdiction and the federal government is involved in most health care policy only to the extent that it can convince the provinces to comply with national standards, much about the federal-provincial relationship can be understood through an investigation of fiscal federalism.

Hospital and medical insurance programmes were funded initially through cost-matching grants. The federal government contributed approximately 50 cents for every provincial dollar spent on health care (for details see Barker 1988). The provinces were free to spend as they wished, provided that they spent on designated programmes (like hospital construction). Thus the process was established at the outset whereby the federal government established priorities and made funding available to provinces so that those priorities could be operationalized. As health care programmes developed and provincial expenditure budgets expanded, concerns arose about sustainability of the health care system and fiscal capacity. The turbulent economic environment of the 1970s, precipitated by the OPEC price shocks in 1973, inspired serious change in all policy areas. For health care this meant renegotiation of funding arrangements.

In 1977, the federal government replaced cost-sharing for health care with a block grant system called Established Programs Financing (EPF). The new grant combined two policy areas – health care and postsecondary education – and set limits for transfers to provinces in both areas. This new arrangement ostensibly relaxed programme conditionality – provinces had to spend on health care and postsecondary education, and uphold the spirit of the universal system, but could now set their own priorities. The provinces viewed the change with guarded optimism, if not suspicion. While the increase in discretion was regarded as a victory for the provinces, it was feared that the new transfer payments, which allowed the federal government more control over spending, would not be sufficient to cover escalating costs.

Ultimately, and predictably, the federal government would determine spending levels by adjusting the EPF escalator against inflation. Beginning in 1986, the federal government applied the EPF escalator to the entire transfer, which set the increase in annual payments at GNP -2%. The EPF transfer, which consisted of a block grant (cash component), a tax point transfer (13.5 personal income tax points and 1 corporate income tax point), and an equalization component, was initially intended to become sustained through the tax points. In other words, as the yield of the tax points increased, it was estimated, the cash component would be reduced and eventually eliminated. However, the tax yield was much lower than expected and the cash component diminished but remained.

This worked well for the federal government. Although the block component required outlays of (federal) cash, it would effectively secure adherence to national standards. This meant that the federal government could reduce the EPF escalator and thereby reduce the cash component, and continue to insist on its conditions. The provinces, of course, felt aggrieved by

this arrangement and complained that the federal government should either increase funding for health care or relax conditions and broaden the idea of national standards.

This was a period of great tension in federal-provincial relations. The provinces would lose the battle over funding and national standards in two episodes of major policy change. Both are components of the trend of federal unilateral decision making in health care policy, which explains, in large part, intergovernmental discord. The first was the *Canada Health Act* (CHA), 1984, which reiterated the five principles of Medicare that were identified in the EPF legislation and attached provincial compliance with these principles to financial penalties. That is to say that, prior to 1984, the provinces were expected to adhere to national standards but it was not clear what recourse the federal government would have if they failed to do so. In the context of ongoing funding disputes and extra-billing by physicians, which were symbolically damaging to Canada's most revered social programme (Tuohy 1988), the CHA was the federal government's attempt to champion universal health care in the face of mounting challenges.

The second episode of policy change came in 1995 when the federal government replaced EPF with the Canada Health and Social Transfer (CHST). The CHST amalgamated funding for health care and postsecondary education (EPF) with funding for welfare programmes (the Canada Assistance Plan [CAP]). The CAP was Canada's last major shared-cost programme and as such required substantial federal cash payments. The cash component of EPF, to which conditions are tied, was decreasing and was expected to run out completely by 2010 (Smith 1995: 328), which would have left only the tax point portion of the transfer. While tax points are part of the transfer, they cannot easily be withheld. This means that the financial penalties for contravention of the CHA would be virtually impossible to impose. By combining EPF with CAP, the federal government increased the cash component of the CHST while it reduced the overall amount of the transfer by approximately six billion dollars (Canada 1999: 15). This posed serious challenges to the provinces that now had to establish priorities among three policy areas rather than two and meet growing demands in the social policy arena with fewer resources.

The story of fiscal federalism indicates that harmony and discord in federal-provincial relations for health care are linked, first and foremost, to funding issues. The provinces are concerned with autonomy in policymaking and securing enough money to adequately fund health care, and the federal government is concerned with cost control and compliance with national standards. The *Canada Health Act*, to some extent, ensures effectiveness through the stated conditions of payment. Efficiency in decision making, although impaired by two layers of governmental authority, is achieved, somewhat facetiously, through federal unilateralism. And stability in funding levels (although there has been slow decline, which has caused greater uncertainty for the provinces) is secured through negotiated funding arrangements, public opinion, and medical profession-state relations. Thus, as Carolyn Tuohy argues in *Accidental Logics*, the Canadian health system has remained relatively stable through turbulent times. However, the other side of the efficiency coin is this: stability can be a constraint to much needed change. As noted in the introduction, federal-provincial disagreement in the field of health care consumes a significant amount of creative energy. This means that there are many reforms, improvements, and innovations that do not receive adequate consideration. With an inordinate amount of attention devoted to intergovernmental processes, disputes, and historical patterns and grievances, many macro-level discussions, through which policy is created and understood, are

rendered irrelevant by more immediate concerns. A more harmonious federal-provincial relationship might be more supportive of such discussions and thereby lead to more widespread and successful innovation in the system.

In the pages that follow, I will explore three issues that cannot easily be accommodated by the federal-provincial framework that is under examination here. The first is social rights and the development of policies aimed at diversity. These issues exemplify the conception of health and equality as transcendent of geographical spaces. The second is civil society – realization through public policy and structural change of the need to engage citizens and their communities in decision making. Such engagement might alter the structure of intergovernmental politics. And the third is bioethical reflection. Deliberation about distribution, what states ought to provide for citizens and how humans ought to treat one another, constitutes the substance and essence of health care debates. In this section, I explore four main conceptual distinctions. Some of these distinctions or deliberative fields can be accommodated by existing federal-provincial structures, while others are non-spatial in that they transcend borders.

Social Rights and the Challenge of Difference

Canada's health care system has undergone a number of substantial changes throughout the late twentieth and early twenty-first centuries in each of the provinces. Many of the reforms have (1) attempted to reconcile commitments to universality with challenges of difference and diversity, (2) engaged citizens and their communities in health care decision making (and thereby strengthened civil society), and (3) recognized the global impact and universality of bioethical and human rights issues. Such developments are clear examples of the decline in relevancy of T. H. Marshall's social rights thesis and the need to define new relationships among the government, the economy and society. All three of these dimensions intersect with intergovernmental arrangements.

T. H. Marshall explains in *Citizenship and Social Class* that social rights developed in Britain in the twentieth century in response to the extant inequalities and the needs of the state following the Second World War (Marshall 1964). The development of civil and political rights in the eighteenth and nineteenth centuries, respectively, guaranteed formal procedural equality for British citizens. However, it became abundantly clear that the substance of British citizenship was plagued with inequality (largely tied to economic factors) and that national security was best served by enabling citizens to fulfil their duties to country. Well-functioning military and industrial sectors were dependent upon a healthy and educated populace. Social rights in the form of welfare schemes, health services and education provisions that were distributed equally among all British citizens regardless of social class or income level (i.e., welfare state programmes) would guarantee "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" (Marshall 1964: 78).

The main benefit of social rights development is that equality is established and maintained through social programmes that go beyond rhetoric to deliver tangible benefits. In Canada, economic inequality, combined with patterns of urbanization and advancements in medical technology, declared the need (in the early decades of the twentieth century) for state action in health care (Dickinson 1993). Such action began at the local level with municipal doctor plans (Taylor 1987). Communities paid a doctor a stipend to commit to practice within their area. By the time that people were experiencing serious economic hardship in the 1930s, it was clear that this patchwork approach was insufficient. The grassroots initiative was assumed by some provincial governments and the Canadian Medical Association (CMA). It was in the interests of provincial governments (which had constitutional jurisdiction for health care) and doctors (who needed to get paid for their services) that public health plans were created.

The history of public health insurance in Canada was well documented and explained elsewhere (Taylor 1987; Maioni 1998). The point that I would like to make here, and I will return to it in the next section, is that grassroots participation – the engagement of civil society – is only possible when it is authentic, that is, when it reflects a genuine set of needs and interests and not a manufactured one. Pre-welfare state grassroots mobilization was very different in that action was imperative, whereas in the post-welfare state era citizens have already decided or accepted that federal and provincial governments are responsible for health care decision making.

In the literature, the current defenders of social rights and the welfare state tend to be convincing (Armstrong and Armstrong 1996; King and Waldron 1988). However, the choices that governments face are much more complex than the binary option of statist or market approaches. It is practically inarguable that welfare state programmes have brought about a measure of equality in many advanced capitalist democracies. Yet while social class and socio-economic status remain central to analyses of inequality, governments and their societies must find ways to deal with a much broader, sometimes overlapping and sometimes competing, range of inequalities. Differences based on gender, sexuality, race, and ability, in short ascription and identity, complicate the welfare state's promise to deliver unity through universal social programmes.

The possibility of a "third way" (Giddens) that cuts a hopeful path between the welfare state and the postmodern angst of seemingly irreconcilable differences, market forces and globalization, is intriguing. In fact, it might continue the tradition in Canada, which began with the *Charter of Rights and Freedoms* in 1982, of understanding rights and entitlement to social services to affect both individuals and groups. The *Charter* recognizes that while equality among individuals is a priority for any liberal democracy, the basis for claiming equality might be difference or that equality might not be possible without respect for difference. As such, the *Charter*, in theory, resists the trend that has plagued American social policy: realization in practice of formal commitments to individual equality with recognition for group marginalization and difference only insofar as those groups are excluded from the formal commitments. Canada, by contrast, includes as part and parcel of its formal commitments, recognition for group difference. Michael Ignatieff explains that "[c]onstitutional change might have begun with Prime Minister Trudeau's desire to anchor Canadian equality in the equality of individual rights. But by the time the process had finished, Canadians had insisted that individual rights were not enough: guarantees for collective language rights, women's equality, multicultural heritage, and Aboriginal land claims had been forced into the Charter..." (Ignatieff 2000: 7).

Health and Difference

It is generally accepted that differences such as gender, language and age have varying and significant impacts on health. The issues presented by the realities of increased life expectancy are new and complex. Life extending technologies raise difficult questions about length of life – quality of life trade-offs. The need for home care and pharmacare options is pressing for this population. And the bioethical dimensions of organ transplants, end-of-life issues (distribution of scarce resources to terminal patients, do not resuscitate orders and euthanasia) and family restructuring (to care for aging relatives) make impossible simple responses in the form of the usual appeals to universality.

Governments have developed limited pharmacare programmes and have increased spending on home care, although there is little coordinated policy for the latter initiative. In 1998, public home care expenditures reached the \$2.1 billion mark, an increase of \$1.1 billion or 104% from 1990-91 (Health Canada 1998). The National Forum on Health (NFOH)(1997), recommended that Canada adopt a more deliberate and coordinated approach to ethical reflection. The Values Working Group of the NFOH found that there are few well-developed research networks among organizations and institutions concerned with bioethics (Canada 1997: 21). However, many of the (federal) recommendations of the NFOH have not been implemented, and it remains to be seen whether a more systematic discussion concerning health care ethics will ensue. (The Canadian Institutes for Health Research might provide some structure for this objective.)

In addition, there has been much attention at all levels given to the distinct challenges and concerns of women's health. Since 1996, the federal government has sponsored the creation of five national centres for excellence in women's health. These centres, located in different parts of the country, reflect the federal government's commitment to exploring health issues for women and to implement its gender-based analysis policy (Health Canada 2000). The need for policies and perspectives that recognize women's sex and gender differences as they affect health encompasses medical research, health services distribution, bioethics, and lifestyle factors. Thus it is a step beyond universality as sameness of treatment and provision for all patients regardless of difference.

Different individual Canadian citizens and different groups of Canadian citizens experience access to health care in different ways. For example, the English-speaking population in Quebec found its access to health services seriously affected by the closing of many English hospitals and the reducing or removing of bilingual services from many others in the province. While hospital closures have been a staple of most provincial reform agendas, the Quebec Government's decision to close English hospitals presented a distinct affront to access. Closing a hospital in a rural area might mean that patients must drive to the nearest urban centre to receive care. But closing English hospitals that provide service in English not only compromises access, it eliminates it (Commissioner of Official Languages 1998: section 2).

Similarly, in 1997 in British Columbia, the provincial government decided to discontinue funding for interpretation services for patients with hearing disabilities (the *Eldridge* case). The *Canada Health Act* (1984) stipulates that:

12. (1) In order to satisfy the criterion respecting accessibility, the health care insurance plan of a province
- (a) must provide for insured health services on uniform terms and conditions and on a basis that does not impede or preclude, either directly or indirectly whether by charges made to insured persons or otherwise, reasonable access to those services by insured persons (*The Canada Health Act*, Chapter C-6).

However, prior to *Eldridge*, accessibility had only been enforced to prohibit user fees and extra-billing practices. That is to say that the federal government has withheld from its transfer payments to provinces user fees levied by clinics or monies extra-billed by physicians. The penalties for other transgressions are more difficult to exact. How much can be withheld from a province that fails to provide the means to access, such as interpretation services? What are the other punitive options?

This difficulty of reconciling national standards with provincial policy prerogatives is nothing new in the Canadian health care arena. However, this case is unique because it was not argued on the terrain of federal legislation (i.e., the issue was not whether the B.C. Government's decision contravened the *Canada Health Act*), but as a constitutional matter. Colleen Flood explains that:

Prior to *Eldridge*, the existing case law was clear that the *Charter* did not apply to hospitals on the grounds that the government did not exert sufficient control over these institutions to qualify them as "government..." However, in *Eldridge*, the Supreme Court of Canada found that the *Charter* did apply to a hospital's decision not to fund translation services for deaf patients (Flood 1999: 36).

Thus the *Eldridge* case is significant because the appeal to the *Charter* expands notions of health care rights to formally include individuals and groups, equality and difference. It also signifies a new era of legal reinforcement of provincial responsibility and increased rights claiming by citizen-patients (see Rioux 1999). It also demonstrates that public policy issues can become formal rights issues and, as such, acquire status not alterable by either federal or provincial governments.

The study of inequality as it relates to health has been the concern of epidemiologists (see, for example Wilkinson 1994; Farmer 1999). However, there has been very little consideration given to the intersection of health and inequality by those interested in political questions (with the major exceptions of Evans, Barer and Marmor 1994; Daniels, Kennedy and Kawachi 2000). This is surprising because the study of politics is the study of power and resources and how each are distributed among groups and individuals in a given population. Perhaps because formal political commitments to political equality have been the hallmark of modern liberal democracies, issues concerning inequality have not been fully recognized or addressed. However, the postwar commitments to social rights and the securing of political equality through social programmes are somewhat outdated. The challenges of difference and inequality cannot be appropriately met by the existing intergovernmental arrangements in Canada.

Of course, there have always been policies in place to deal with diversity and marginality. The federal government recognizes its responsibility for Native populations and the health needs

that are unique to those populations through the Non-Insured Health Benefits Program. Despite the appearance of a single, universal health system in Canada, each province has created, and continues to develop, its own health system. As the population ages, provincial governments make arrangements for health services for seniors that are not available to the general population. And the changing dynamics of disease and treatment have prompted governments to provide drug benefits for patients who require prohibitively expensive medications (pharmaceuticals administered outside of hospitals are not covered by provincial health insurance plans). Finally, the entire system, or network of systems, is built on the notion that physicians will provide individual patients with whatever programme of care they deem to be “medically necessary.” In all of these ways, the Canadian health system already recognizes diversity and difference. However, the centrality of the intergovernmental framework contributes to static patterns. While the processes and products of fiscal federalism have created a stable health system, they have, at the same time, reduced most policy questions to intergovernmental ones. To be sure, health policy is made in an intergovernmental context of federal-provincial negotiation. But questions about the future of health care in Canada go (and ought to go) far beyond the mechanics of transfer payments.

Strengthening Civil Society

In the 1990s, provincial governments in Canada undertook various reform efforts. One feature that most of them (all, with the exception of Ontario) had in common was the decentralization of health care decision making. Provinces created regional or community level units (called regional health authorities or regional and community health boards) through which citizens could participate directly in the shaping of health policy for their area. In Saskatchewan, these community governance structures became exercises in democracy – some of the board members were elected by their constituents – and in other provinces, such as Nova Scotia, board members were appointed by officials in the Department of Health (for a full examination of devolution in the Canadian provinces see Lomas, Woods and Veenstra 1997a; 1997b; 1997c; 1997d). The goals of this type of reform initiative were diverse, and have been realized to widely varying extents. However, it can be concluded that one of the main aims of community governance structures was to strengthen civil society.

Although there is no consensus on what “civil society” means, and provincial governments did not describe their populations as “civil societies” in the reform literature, the term is applicable to evaluations of citizen engagement in health care decision making. The main question surrounding the term “civil society” seems to be the degree to which citizens’ groups and communities are distinct from the activities of government. Civil society organizations are assumed to be somewhat autonomous and provide views from “outside” the state. These organizations include non-profit and community service organizations, such as HIV/AIDS activist and service groups. Although the definition of civil society remains elusive, the term has been used generally in recent literatures to stand for the ideas of autonomy, outside perspectives, citizen engagement, and community empowerment (see Cohen and Arato 1994; Keane 1999). Community governance structures in reorganized health care systems present opportunities (again, to varying extents) for citizen participation and representation of community needs. Thus they promise to lead to better-informed policy decisions, as well as to stronger civil societies. They were also important components of the trend (in the 1980s and 1990s) toward democratic administration (Albo 1993) increased “consumer” awareness, and empowerment in regard to public policy (Pierre 1995).

Notions about civil society fit into the intergovernmental framework in that they are created and sustained by provincial governments. Citizen engagement through community governance structures was (and, to varying degrees, still is) a popular policy tool. Provincial governments can employ community health authorities to provide information, solicit input, and make decisions. However, the people who are empowered through these structures are both federal and provincial citizens. They are not public servants of one order of government or another, nor are they trained to negotiate policy in the context of fiscal federalism. Rather, they are members of deliberative bodies, moral agents, makers of claims, raisers of questions, and purveyors of expectations. As a layer of government they are, at the same time, meta- and sub-provincial.

One of the most promising or potentially transformative effects of engaging citizens in health care decision making is that a strengthened civil society with institutional support can provide some counterbalance to the dominance of the medical profession. Elite decision making for health care in Canada accounts for much of the stability of the health care system. Carolyn

Tuohy explains that “through the 1970s and 1980s, the playing out of the logic of the single-payer system gave the Canadian system extraordinary structural and institutional stability” (Tuohy 1999: 204). While this stability is favourable in many ways, it might have the negative effect of developing patterns of policy decisions that are resistant to change. Exercises on community engagement might provide opportunities for alternative or excluded visions and create new avenues for policy explorations.

While it is difficult to evaluate Canada’s health system against health systems in other countries, an opportunity for comparison might be afforded by the United States. In 1997, the U.S. federal government introduced the Children’s Health Insurance Program (CHIP). As in Canada, health care is the responsibility of the states, and the federal government may establish funding for programs and the conditions upon which that funding is disbursed. The U.S. federal government produced guidelines for the CHIP but realized that each state would necessarily implement a very different version of the program. To recognize this in practice, but maintain national standards, the federal government solicited formal proposals from each state. These proposals included details about program goals, spending targets, additional funding sources, the profile of low-income, uninsured children in the state, and justifications in cases where a state’s plan diverged from the federal prescriptions. Hence each state had to formally apply for federal money and prove that it had met the conditions of the programme and was in compliance with national standards *before* it received the money (see www.cms.hhs.gov/schip/chpa-map.asp). A similar process might give the Canadian federal government more control over funding and programme conditionality at the same time that it might give the provinces increased latitude for experimentation and innovation because provincial plans or proposals are made public and approved at the outset. Further, public debate on the applications might bring out more voices, thereby contributing to and expanding “active” or participatory modes of citizenship.

While this suggestion might inspire rethinking of Canadian funding mechanisms for health care, it needs to be stated that cross-country comparisons (in search of reform possibilities) are limited and difficult. The United States does not have a universal health system. Entitlement to health insurance is linked to employment rather than citizenship. Many people acquire insurance through their employers. Those who meet their state’s eligibility requirements for social assistance also qualify for federal health coverage (Medicaid). Senior citizens are entitled to health insurance through another federal program (Medicare). And approximately 45 million Americans have no health insurance coverage. Social policy in each country, and health care in particular, reflects very different values concerning citizenship (the obligations of the state and the rights of citizens) and the Good Society.

Bioethical Reflection

The foregoing discussions of diversity and civil society intersect with intergovernmental debates (historical patterns of negotiation and tension, fiscal federalism), but the former cannot be understood fully within the context of the latter. That is to say that federal-provincial decision making for health care has been able to accommodate diversity while maintaining universality and has, to some degree, successfully institutionalized competing voices through community governance structures. However, the federal-provincial relationship, mainly conceived as a set of formal fiscal arrangements, is focused on the process of health care debates, not their substance. This renders an efficient and stable set of arrangements somewhat ineffective.

This is particularly problematic for the final issue to be considered: bioethical reflection. In this section I will explore four models or sets of compatible ideas. The first two fit within spatial models, which means that deliberation is contingent upon an understanding of geographical spaces: citizens and strangers, and bodies, states, and universals. The third makes a distinction between political priorities and international human rights imperatives and as such begins to move beyond the spatial model and into the realm of normative discourse. The fourth is a non-spatial model that considers the complex ethical terrain of medical technology. All four address important substantive health care issues as they relate to access, distribution, and citizenship.

The relationships among medicine, public health, ethics, and human rights are now evolving rapidly, in response to a series of events, experiences, and struggles. These include the shock of the worldwide epidemic of human immunodeficiency virus and AIDS, continuing work on diverse aspects of women's health, and challenges exemplified by the complex humanitarian emergencies of Somalia, Iraq, Bosnia, Rwanda, and Zaire (Mann 1999: 439).

The events, experiences, and struggles noted above indicate that health can no longer be conceived as only a domestic social policy issue. The new realities of infection and inequality implicate all populations and call for global action. Health can be conceived as a human rights issue in many ways, all of which are related to the basic human right to dignity (Mann et al. 1999). As will be explained below, the understanding of health as human right depends on the definition of human rights – what is deemed fundamental to humanity and what is considered to be a “perk” of membership to one political community or another.

Bioethical discussions are linked to human rights discourse. Both are concerned with questions of “ought.” As a global community, what ought we to respect about one another by virtue of our shared humanity? What offenses are so egregious that they ought to be labeled human rights violations? What ought to be done for a particular patient in a particular circumstance? What options ought to be available for terminally ill patients? What health services ought to be provided by the state for its citizens? Bioethical questions range from particular, patient-specific concerns to broad issues concerning distributional equity.

By focusing attention on health care and bioethics as issues for both citizenship and global human rights action, several important distinctions can be made. The first is the distinction between populations “inside” the state (citizens) and populations “outside” the state (refugees,

migrant or temporary workers). All nation-states distinguish between citizens and non-citizens for the purpose of allocating resources. In Canada, all citizens, landed immigrants and convention refugees are entitled to public health insurance whereas non-citizens must secure private insurance. However, there is another layer of inclusion and exclusion. Among the citizens of a state, some have entitlements that are not made available to others. In the United States, senior citizens are entitled to public health insurance (Medicare), but for all other citizens health insurance is linked to employment. And in both Canada and the United States, many citizen-patients are marginalized due to their difference, regardless of their formal entitlements. For example, such reproductive rights issues as birth control, abortion and new reproductive technologies (like in vitro fertilization) reveal patterns of inequality within societies. Dorothy Roberts explains (regarding race and regulation) that:

Even though there are restrictions on white mothers, it's a fundamentally different kind of regulation... A perfect example is sterilization. In the seventies, a group of feminists opposed to waiting periods and rigid informed consent procedures for sterilization. Women of color said, "Let's put limits on sterilization because doctors are guilty of abuse." But this just didn't register with some of the mainstream reproductive rights groups that had been pushing for greater access to sterilization for white, middle-class women. While poor black women were, in some cases, forcibly sterilized, sometimes without their knowledge, let alone consent, white women had a hard time getting sterilized (Roberts 1997: 78).

The point to be made is that bioethical issues, and hence health as a human rights issue, are complex indicators of inequality. And that human rights abuses (such as forced sterilization) can be hidden by freedom-enhancing rights claims (access to abortion and NRTs) of relatively privileged segments of society (white women).

The second is the distinction between particular (patient-specific), domestic (state specific) and universal bioethical deliberation. Bioethics, as the field of ethical questions as they relate to the body, is sometimes very narrowly applicable and sometimes very widely applicable. For example, the decision of a particular hospital to provide an expensive and complicated lung transplant to an elderly cancer patient will take into consideration all information and ideas relevant to that particular case. And the decision will not necessarily establish policy concerning all future transplant patients. The next patient to require a lung transplant will be considered on the merits of his or her own case. Domestic or state-specific deliberation concerns the distribution of health resources in a state. Thus this type of deliberation is the substance of citizenship. Should all citizens be entitled to publicly funded cosmetic surgery, as in Argentina, should all citizens be entitled to a comprehensive range of "medically necessary" services, as in Canada, or should citizens be responsible for securing their own insurance, as in the United States?

And the third is the distinction between negotiation concerning political priorities and international human rights imperatives. Human rights issues for health care include matters pertaining to provision, access and bioethics. The first matter, provision, is the most basic. In many developing countries, public health services such as clean drinking water and immunizations are not made widely available. And in wartime, disaster and refugee situations many people go without adequate food and shelter. Because these matters are linked to the issues

of development and war, it is practically inarguable that they constitute human rights violations (they are clearly human security issues). It seems fundamental that every human being has access to the most basic medications and services. International humanitarian organizations such as Doctors Without Borders (DWB) and the International Red Cross are committed to the promotion of health as a human rights issue and provide support for populations in need. For example, DWB had been working in Afghanistan to ensure that marginalized sections of the population had access to health services. Such a project involves sensitivity to cultural and political factors that affect health. Women in Afghanistan were forbidden to receive care from a male practitioner, yet in many areas there were no female physicians or nurses. DWB placed female practitioners in such underserviced areas so that women could receive care.

The issue of access covers everything from user charges for health services in Canada to the 45 million people in the United States with no health insurance coverage to the legacy of Apartheid in South Africa (Chapman and Rubenstein 1998). These “violations” might be more appropriately labeled citizenship breaches because they are directly linked to citizen-state relationships in each country. However, these violations or infringements or gaps in coverage may also be conceived as human rights issues. While in each of the three countries mentioned above most people have access to clean drinking water and childhood immunizations, the rights to life and liberty are seriously impaired if citizens are too ill to access them. Health is central and not adjunct to social, political and cultural life. All three of these distinctions can be conceived as borders that are policed and transgressed by diverse populations.

Finally, the issue of modern bioethics (as it relates to the applications of medical technology rather than basic access and allocation) is relevant to advanced industrialized democracies. There is great distance between the need for or right to clean drinking water and the right to doctor assisted suicide or in-vitro fertilization. The language of rights has been invoked to bolster all three claims, yet there seems to be an intuitive ordering of each claim as a human rights issue. That is to say that the first passes as a human rights issue quite easily due to the immediacy of the need and its direct effect on quality of life. The two bioethical issues noted subsequently are more complex and reflect higher order “needs.” Whether the issues of provision, access and bioethics are different in degree or substance remains an open question. Do all noted patterns of inequality count as human rights violations? Is the person who cannot gain access to an abortion in the United States (because she is a recipient of Medicaid or has no health insurance and cannot afford it) equal in terms of disadvantage, loss of dignity and quality of life, to the person in earthquake-shattered Columbia who has no clean drinking water and no option for medical care? Do these claims have to be equivalent in order to constitute human rights issues?

Conclusion

My purpose in raising issues concerning rights, civil society, and bioethics is to demonstrate that health care is an incredibly dynamic policy field that is often rendered static by the limitations of the intergovernmental framework. While it is important to maintain respect for intergovernmental arrangements for health care, it should be recognized that the inertia of federal-provincial relations constrains policy change. Discussions of citizenship rights (in the form of entitlements to health care) transcend questions of jurisdiction and funding. Bioethical concerns are both universal and particular, and will need to be addressed at the global level, in communities, and in hospitals. Change in medical technology, citizenship, and domestic politics alters the delicate balance of obligations and commitments in a federal state. And, in the case of health care in Canada, the provinces are left to create new understandings, bargains, and programmes for citizens.

It is possible that by acknowledging this imbalance of rights and responsibilities among federal and provincial governments and citizens, clarity can be established, and from this clarity a new intergovernmental relationship can be built. To be sure, intergovernmental politics can accommodate (and has accommodated) issues of distributional equity. Intergovernmental politics has addressed problems concerning allocation of health resources and might be able to provide a model for future negotiation on the terrains of bioethics and rights. However, as currently understood and applied, the intergovernmental perspective is inappropriately narrow. The process of federal-provincial decision making for health care overshadows many issues relevant to health care and eclipses substantive policy issues.

References

- Albo, Gregory, David Langille and Leo Panitch. 1993. *A Different Kind of State? Popular Power and Democratic Administration*. Toronto: Oxford University Press.
- Appiah, K. Anthony. 1996. "Race, Culture, Identity: Misunderstood Connections." In *Color Conscious: The Political Morality of Race*, edited by K. Anthony Appiah and Amy Gutmann. Princeton: Princeton University Press.
- Armstrong, Pat and Hugh Armstrong. 1996. *Wasting Away: The Undermining of Canadian Health Care*. Toronto: Oxford University Press.
- Barker, Paul. 1988. "The Development of the Major Shared-Cost Programs in Canada." In *Perspectives on Canadian Federalism*, edited by R. D. Olling and M. W. Westmacott. Scarborough: Prentice-Hall, p. 195-219.
- Canada. 1999. Department of Finance. Budget 1999. *Building Today for a Better Tomorrow: Federal Financial Support for the Provinces and Territories*. February.
- Canada. National Forum on Health. 1997. *Canada Health Action: Building on the Legacy*. Synthesis Reports and Issues Papers, Volume 2. Ottawa: National Forum on Health.
- Chapman, Audrey R. and Leonard S. Rubenstein (eds). 1998. *Human Rights and Health: The Legacy of Apartheid*. Washington, DC: American Association for the Advancement of Science.
- Cohen, Jean-Louis and Andrew Arato. 1994. *Civil Society and Political Theory*. Cambridge (MA): MIT Press.
- Commissioner of Official Languages. 1998. *Annual Report 1997*. Part IV, The Official Language Community. Minister of Public Works and Government Services, Canada. www.ocolclo.gc.ca/e4.html (site visited December 24, 2001).
- Daniels, Norman, Bruce Kennedy and Ichiro Kawachi. 2000. *Is Inequality Bad for our Health?* Boston: Beacon Press.
- Dickinson, Harley. 1993. "The Struggle for State Health Insurance: Reconsidering the Role of Saskatchewan Farmers," *Studies in Political Economy* 41 (Summer): 137-138.
- Evans, Robert G., Morris L. Barer and Theodore R. Marmor (eds). 1994. *Why Are Some People Healthy and Others Not? Determinants of Health of Populations*. New York: Aldine De Gruyter.
- Farmer, Paul. 1999. *Infections and Inequalities: The Modern Plagues*. Berkeley and Los Angeles: University of California Press.
- Flood, Colleen. 1999. "The Structure and Dynamics of Canada's Health Care System." In *Canadian Health Law and Policy*, edited by J. Downie and T. Caulfield. Toronto: Butterworth, 5-50.
- Fox, Renée. 1999. "Medical Humanitarianism and Human Rights: Reflections on Doctors Without Borders and Doctors of the World." In *Health and Human Rights: A Reader*, edited by Jonathan M. Mann, Sofia Gruskin, Michael A. Grodin and George J. Annas. New York: Routledge, p. 417-435.

- Giddens, Anthony. 2000a. *The Third Way and Its Critics*. Cambridge (UK): Polity Press.
- . 2000b. *The Third Way: The Renewal of Social Democracy*. Cambridge (UK): Polity Press.
- Hall, Emmett. 1964. *The Royal Commission on Health Services (Report)*. Ottawa: R. Duhamel, Queen's Printer.
- Health Canada. 2000. *Health Canada's Gender-based Analysis Policy*. Ottawa: Health Canada.
- . Policy and Consultation Branch. 1998. *Public Home Care Expenditures in Canada 1975-76 to 1997-98*. Ottawa: Health Canada, March.
- Ignatieff, Michael. 2000. *The Rights Revolution*. Toronto: The House of Anansi Press.
- Keane, John. 1999. *Civil Society: Old Images, New Visions*. Princeton: Princeton University Press.
- King, Desmond and Jeremy Waldron. 1988. "Citizenship, Social Citizenship and the Defence of Welfare Provision," *British Journal of Political Science* 18, 415-443.
- Lomas, Jonathan, John Woods and Gerry Veenstra. 1997a. "Devolving Authority for Health Care in Canada's Provinces. 1. An Introduction to the Issues," *Canadian Medical Association Journal* 156(3).
- . 1997b. "Devolving Authority for Health Care in Canada's Provinces. 2. Backgrounds, Resources and Activities of Board Members," *Canadian Medical Association Journal* 156(4).
- . 1997c. "Devolving Authority for Health Care in Canada's Provinces. 3. Motivations, Attitudes and Approaches of Board Members," *Canadian Medical Association Journal* 156(5).
- . 1997d. "Devolving Authority for Health Care in Canada's Provinces. 4. Emerging Issues and Prospects," *Canadian Medical Association Journal* 156(6).
- Maioni, Antonia. 1998. *Parting at the Crossroads: The Emergence of Health Insurance in the United States and Canada*. Princeton: Princeton University Press.
- Manfredi, Christopher and Antonia Maioni. 2002. "Courts and Health Policy: Judicial Policy Making and Publicly Funded Health Care in Canada." *Journal of Health Politics, Policy, and Law* 27 (2): 213-240.
- Mann, Jonathan M. 1999. "Medicine and Public Health, Ethics and Human Rights." In *Health and Human Rights: A Reader*, edited by Jonathan M. Mann, Sofia Gruskin, Michael A. Grodin and George J. Annas. New York: Routledge, p. 439-452.
- Mann, Jonathan M. et al. 1999. "Health and Human Rights." In *Health and Human Rights: A Reader*, edited by Jonathan M. Mann, Sofia Gruskin, Michael A. Grodin and George J. Annas. New York: Routledge, p. 7-20.
- Marshall, T. H. 1964. *Class, Citizenship and Social Development*. New York: Doubleday.

- Merck Frosst Canada & Co., POLLARA Research, Coalition of National Voluntary Organizations, Canadian Medical Association, Canadian Nurses Association, Canadian Association of Community Care, Canadian Home Care Association. 2000.
- Pierre, Jon. 1995. "The Marketization of the State." In *Governance in a Changing Environment*, edited by Guy Peters and Donald Savoie. Montreal: McGill-Queen's University Press.
- Putnam, Robert. 2000. *Bowling Alone: The Collapse and Revival of American Community*. Simon and Schuster.
- Redden, Candace Johnson. 2002. "Health Care as Citizenship Development: Examining Social Rights and Entitlement," *Canadian Journal of Political Science* 35(1): 103-125.
- _____. 1999. "Rationing Care in the Community: Engaging Citizens in Health Care Decision Making." *Journal of Health Politics, Policy, and Law* 24(6): 1363-1389.
- Rioux, Marcia. 1999. "An Appeal to the Charter of Rights and Freedoms." In *Do We Care? Renewing Canada's Commitment to Health*, edited by Margaret A. Somerville. Montreal: McGill-Queen's University Press, p. 144-147.
- Roberts, Dorothy. 1997. *Killing the Black Body*. Pantheon. Excerpt reprinted in *Ms. Magazine*, April/May 2001.
- Smith, Miriam. 1995. "Retrenching the Sacred Trust: Medicare and Canadian Federalism." In *New Trends in Canadian Federalism*, edited by François Rocher and Miriam Smith. Peterborough: Broadview Press.
- Taylor, Malcolm. 1987. *Health Insurance and Canadian Public Policy: The Seven Decisions that Created The Canadian Health Insurance System*. Montreal: McGill-Queen's University Press.
- Tuohy, Carolyn Hughes. 1999. *Accidental Logics: The Dynamics of Change in the Health Care Arena in the United States, Britain, and Canada*. New York: Oxford University Press.
- _____. 1988. "Medicine and the State in Canada: the Extra-Billing Issue in Perspective." *Canadian Journal of Political Science* 21(2).
- Wilkinson, Richard G. 1994. "The Epidemiological Transition: From Material Scarcity to Social Disadvantage," *Daedalus* (Fall): 61-78.