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**Discourse, Institutions, and Identit(ies): The Creation and Transformation of the
Canadian Health System**

**Charles Conrad
c-conrad@tamu.edu
Chris Cudahy
cmcudahy@yahoo.ca
Department of Communication
Mail Stop 4234
Texas A&M University
College Station, TX 77843-4234****

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**Beginning in the fall, 2008 term Mr. Cudahy will join the faculty of Atlantic Baptist
University, Moncton, NB

This project started with two observations. The first was that Canadian academics, political operatives, and the general populace, almost universally assert that there is something special about Canadian Medicare and the institutions that created it. The system is pragmatically important for the vast majority of Canadians who would be unable to afford high quality health care if delivered via a mixed system such as that in the U.S. and for primary care physicians who are provided a stable if not luxurious income. But, it also is a critically important symbol, an institution that simultaneously reflects and reproduces a uniquely Canadian identity.¹

For example, Feldberg, et al. (2003) note that "popular opinion and the press often link Canada's health-care system to the very fabric of Canadian national identity" (p. 3).

Robert Evans (1993) provides a more detailed summary:

Our system of universal public insurance for health care is, by a considerable margin, Canada's most successful and popular public program. We think of it, not just as an administrative mechanism for paying bills, but as an important symbol of community, a concrete representation of mutual support and concern. It expresses a fundamental equality of Canadians in the face of disease and death, and a commitment that the rest of us will help as far as we can. Perhaps as important for our national identity, the Canadian approach to health insurance also

clearly distinguishes us from the United States. The fact that we have developed such a different system suggests that, despite outward appearance, we really are a separate people with different political and cultural values (p. 21).²

A decade later (2002), Candace Redden noted that

The political importance of health care in Canada is remarkable. The Canadian health care system as a social policy experiment has proved to be a successful redistributive programme. It is also a potent political symbol that distinguishes Cda from the United States and, as such, transforms Canadian identity. . . . On a more conceptual plane it can be observed that symbolic disputes over health care are no longer exclusively intergovernmental affairs, but involve citizens directly and evoke from them passionate responses in the language of rights (p. 103).

Echoing both positions in terms that articulate the theoretical frame of this pre-conference, Margaret Somerville (1999) observes that:

[H]ealth care [policy debate] is never simply about health care, and certainly not in Canada. Our health care system defines us as communities, as a society, and as a nation. What Canadians are prepared to do, and more importantly, what we are not prepared to do, for each other when we are sick, vulnerable, and most in need, says a great deal about Canada, our basic values, and the values that we want to hand on to future generations of Canadians. Health care is a major force in determining what can be referred to as the ethical and legal tone of a society. For Canada, as for many societies at the end of the 20th century, it is also an extraordinarily important forum in which to work out the principles, attitudes, beliefs, myths, and values that will together constitute a new societal paradigm for the decades ahead. This is the 'shared story' on which a society is based; the story we narrated, heed, and contribute to in order to form a society" (p. xi-xii; also see Armstrong & Armstrong, 1996; Tuohy, 1993).

However, if one looks more closely at the Canadian health care system, the complex relationships among institutions, ideologies, identities, and discourse are more ambiguous and more conflicted. Redden continues that

the terrain of social rights in Canada, of which the right to health care is a subset, is largely unfamiliar territory. . . . [H]ealth care in Canada presents a puzzle. The right to health care is paradigmatic of Canadian culture, but is also an enigmatic social democratic covenant. In other words, universal health care seems to be definitive of Canadian identity at the same time that it presents a special case (p. 106).

This conclusion is supported by a number of empirical and historical observations. For example, health care is the only social service program in Canada that is grounded in a "deep-rooted suspicion of class-based systems of any kind" (Evans, 1985) and a desire to provide "Canadians with a protective barrier against aggressive corporate strategies that aimed to open up the . . . sector to private investment and profit making" (Fuller, 1998, p. 74; also see Flood, Stabile, & Tuohy, 2006). The scope of Canadian pension programs, both the CPP and the QPP, is smaller than the U.S. social security system and the benefits are more limited, although the funding mechanism is more progressive (Perry, 1993). Similarly, efforts to equalize tax burdens and social services across provinces "do not bring poorer provinces close to the national average" (Finbow, 2005, p. 97), even if Canada Health and Social Transfers are included in the equalization equation. Indeed, the gap has grown significantly since Alberta's oil revenues were removed from the equalization formula in 1982 and payments started to be adjusted for provincial GDP growth in the late 1980s. Indeed, if Department of Defense funds are included in the equation, the U.S. does more to equalize burdens and social services across regions than Canada does. Finbow concludes:

Canadian federalism is inequitable, with inadequate redistribution that fails to provide for comparable services at comparable tax burdens. . . . Equalization is a cheap alternative to a more equitable dispersion of national spending. These imbalances are worse than in the U.S., making Canada's poorer regions vulnerable if redistribution is decreased" (p.98)

Although sociologist Joel Bakan's conclusion that "despite all of the rhetoric about Canada being a caring and compassionate society, its social welfare system has done little to address economic maldistribution, even at the worst end of the scale" (1997, p. 139)

seems harsh, there does seem to be a tension among Canada's communitarian ideology, its political discourse, and its institutional realities.

Canadian scholars have offered similar observations about Medicare. The system "was instituted only very late in the development of this [Canadian] welfare state, and then only in the limited form of a government health insurance scheme to pay for the private provision of medical care on a fee-for-service basis" (Ornstein & Stevenson, 1999, p. 421). It has developed incrementally over time, and the claim that the system embodies and enacts "Canadian values/identity" was made not made explicit until the passage of the Canadian Health Act in 1984. In addition, the program has been hotly contested throughout its history on both ideological and economic grounds (Boase, 1996; Flood, Stabile & Tuohy, 2006) and there are wide variations in the structure, operation, and benefits across provinces (Blackwell, 2007). As a result, Yale's Theodore Marmor and his associates (1990) have observed that health care policy in the western provinces is more like that of the U.S. states of Washington and Oregon than of the Maritime Provinces, and Quebec's system is more like Europe than any of the other Canadian Provinces. Even in Quebec a number of class-based differences exist. For example, Quebec's recent reform of prescription drug coverage is regressive in the financial burden that it creates, and has had significant adverse health effects for poorer Quebeckers (Kapur & Basu, 2005; Tamblyn, et al., 2007).

Finally, recent decisions by appellate courts (e.g., the Supreme Court of Canada's *Chaoulli vs. Quebec* wait times decision and the British Columbia Court of Appeals' 1988 *Wilson vs. B.C.* reversal of provincial efforts to encourage physicians to locate in underserved areas), and decisions by Alberta (Bennett, 2008), British Columbia (Bains,

2007), and Quebec (Rakobowchuk, 2008) all seem to be a move away from the core principles of the Canada Health Act.

Theoretical Framework

In both the humanities and social sciences there now is widespread acceptance of the theoretical relationship among discourse, ideas/ideologies, and materials conditions/structures. Unlike James Taylor and his associates, who have produced literally thousands of pages of texts exploring the complexities and nuances of these inter-relationships, we will operate from a relatively simple perspective.³ Like Karen Orren we begin with *ideas*, which through praxis coalesce into *ideologies*, with all of the attendant class differences, social and political inequities, and power imbalances. Ideologies need not be internally consistent; indeed their stability often lies in their contradictions. And they have impact because of their links to actions and institutions. In his discussion of the development of the Peuple Quebecois, Maurice Charland (borrowing from the ideas of Kenneth Burke) explains that "an 'ideology' is like a spirit taking up its abode in a body: it makes that body hop around in certain ways; and that same body would have hopped around in different ways had a different ideology happened to inhabit it (1987, p.143). But, contradictory ideologies can lead bodies to dance in the same ways, and similar ideologies can generate very different patterns of action. For example, in the case of Canadian health care,

Ideologues in all three philosophic traditions may endorse Medicare on the basis of three quite different motivations. A classical or Tory conservative underpinning for medicare might be *noblesse oblige*, a sense that society's privileged classes should help underwrite it, via the state. The idea is to maintain the fabric of the entire community, including its desperately needy classes. A liberal may support medicare due to the belief that all individuals require equal opportunity to prove themselves and get ahead, something tragically impossible if one is stricken by illness. A socialist might embrace Medicare because it

manifests our care for one another as equal members of a community in solidarity (Wiseman, 2007, p. 17).

Ideologies, and conflicts among them, are simultaneously obscured and revealed by related discourse, and are concretized in *institutions*--recurring practices or seemingly stable structures. Wiseman extends these assumptions to encompass processes of public policy formation:

Culture is an abstraction. So too is ideology. . . . Culture is an ordered system of symbols; ideology is an ordering of symbolic terms. . . . Culture is a big idea, one with many facets. It may be looked at in terms of three levels: fundamental abstract values or *ideology*, time-honored *policies*, and ritualized *practices*. . . . Examples of now time-honoured Canadian policies are medicare and equalization payments to 'have-not' provinces. . . . Ideology is employed to legitimate established and new policies. Ideas may also be used to justify emerging practices." (Wiseman, 2007, pp. 14-15) Culture and institutions have a symbiotic relationship. Like cultures, institutions are customary structures and practices. Constitutions provide for formal institutional structures; they contain a collection of rules and principles according to which an organization is governed. . . . To see culture as determining institutional form is too one-sided. The cause arrow points both ways b/c culture is a response learned from living under certain institutions. In this light, institutions help to shape culture (Wiseman, 2007, pp. 59-60).

Although discourse is central to our perspective, institutions are important because they provide important elements of order and continuity to political systems, create and/or restrict discourse opportunities, and guide and constrain health policy rhetoric. Institutions are sets of relationships that persist over time and space, although in an inherently conflictual and tension filled way. Institutions may be formal organizations or informal networks or both. They have shared interactions and relatively stable sets of resources attached to them. They are both actual patterns of communication and activity and abstractions such as values, norms, ideas, or official rules (Skocpol, 1995).

Institutions are "path dependent" in that current decisions are guided and constrained by previous responses to political situations and environmental conditions (Burke, 1931), which means that "political culture and political action are interdependent and mutually reinforcing, for 'politics must be invoked not merely as the outcome of political socialization but a cause thereof, as well" (Cook, quoted by Wildavsky, p. 40). In spite of recent announcements of the "death of the state," the most important formal institutions still are governments: the state still is

the site of class conflict, and the arena in which hegemonic relations are produced. . . . [S]tate policies must satisfy the interests of the dominant class while at the same time appearing to be in the universal interest of the society as a whole. The creation of hegemony, or attempts at it, therefore involves the relative autonomy of politics and ideology as realms of discourse and institutional activity that cannot be reduced to the interests and determination of singular classes" (Ornstein & Stevenson, 1999, p. 6).

This does not suggest that formal organizations are unimportant; indeed the merger of multinational corporations and state apparatuses is *the* defining characteristic of globalization (Stiglitz, 2002). It does suggest that each dimension of human symbolic action--ideas, ideologies, and institutions--simultaneous and recursively influence one another, supporting their mutual continuation and/or facilitating their transformation: "All political cultures contain contradictions, and the way in which these are resolved will either support the status quo or lead to cultural change (Berger, 1989, p. 100)" (also see Boase, 1996, pp. 9-10; Orren, 1995).

Perhaps the most sophisticated application of institutional perspectives to health care policymaking is Carolyn Tuohy's "accidental logics" perspective. Tuohy combines an "historical institutionalist" view with contemporary concepts of "bounded rationality" to argue that the distinctive combinations of political and economic structures (Banting &

Corbett, 2001)-- ideas, ideologies, patterns of resource use and distribution, discourse, and discourse opportunities--existing at key moments in the development of public policies create complex webs of incentives to which decision-makers respond by crafting boundedly-rational policies. These situations are both a function of the ongoing dynamics of health care innovations, needs, and inadequacies, and broader social/political processes. It is not accidental, for example, that the expansive government and rapid economic growth of the 1960s led to significant health policy changes in each of the nations Tuohy studied (the U.K., U.S., and Canada), or that the politics of the Reagan-Thatcher-Mulroney era led to modifications of those systems, or that the 1990s dawned with a consensus view among health policy experts that fundamental changes were in the offing (Marmor, 1994).⁴

However, once institutions are established, they are resistant to change. As Robert Putnam observes, "history matters . . . What comes first (even if it was in some sense 'accidental') conditions what comes later. Individuals [policy makers] may 'choose' these institutions, but they do not choose them under circumstances of their own making, and their choices in turn influence the rules within which their successors choose" (1993, p. 8). The overall "logics" of all three nations--Britain's "hierarchical corporatist" model, the U.S. "mixed model" of market forces for most citizens combined with national health insurance for select groups; and Canada's national health insurance approach remained essentially the same in spite of a flurry of reform efforts and change rhetoric (Tuohy, 1993, 1998). Politics develop health policies that are filled with tensions, contradictions, ironies, and paradoxes (Light, 2004), all of which persist over time.

Our goal in the remainder of this paper is to examine the discourse that simultaneously constituted the Canadian health insurance system and was guided and constrained by existing ideas, ideologies, and institutions. We have chosen to focus on three foundational "moments" in the development of the program--the 1964 Hall Commission Report, the "resolution" of the "extra billing" issue in the 1984 Canada Health Act, and the 2003 *Chaoulli vs. Quebec* "wait times" decision by the Supreme Court of Canada. We will suggest that each moment can only be understood within the broader political context created by the enactment of the institutional history of health care in Canada.

The Hall Commission

There is no disagreement about the impact that the Hall Commission had on the development of Canadian Medicare, or of the irony surrounding the commission's report. The development and success of early moves toward universal health insurance in select provinces, notably Saskatchewan and British Columbia, had generated a heated debate between proponents of a similar systems in other provinces and/or at a national level and defenders of private, free-market systems (Fuller, 1998; Rachilis & Kushner, 1994; Tuohy, 1993). In 1961 the Canada Medical Association (CMA), which then supported a program of government-funded insurance for the poor but strongly opposed broader efforts like the "British Columbia and Saskatchewan freaks" (Fuller, 1998, chp. 2), asked the Conservative Prime Minister to appoint a committee to support the issue. The Royal Commission on Health Services, chaired by a well-known and respected libertarian Supreme Court Justice Emmett Hall, was in place and conducting hearings by June, 1961. While the Commission was doing its work, two provinces, Alberta and Ontario,

established governmental insurance plans for the poor of the type advocated by the CMA. However, when the Hall Commission presented its report three years later, "it astounded the coalition of medical and insurance interests that had urged its establishment by recommending a Saskatchewan-style universal, comprehensive government-sponsored plan as the model to be cost-shared by the federal government" (Tuohy, 1993, p. 53). The rationale for the Commission's recommendations reflects a distinctively Canadian set of values and modes of decision-making, and the report itself had a major effect on the ideas, ideologies, and institutions that would follow.

The Rhetoric of the Hall Commission Report

The rhetoric of the Hall Commission Report is notable in two respects. First, it consistently rejects ideologically-driven policymaking, instead focusing on devising pragmatic strategies for confronting the complex issues facing Canada's health care system (see Tuohy, 1993). Second, the Commission's goal was to produce a "conservative" or "moderate" outcome in the sense that it sought to change only those parts of the current system that undermined its goals of providing high-quality health care, in an optimally efficient manner, that interfered with patient-provider relationships as little as necessary, and that respected the country's Constitutional mandate to make health care a responsibility of the provinces rather than the federal government.

The key term "freedom" permeated the Hall Commission report. Chief among these freedoms is the need to ensure that the physician-patient relationship to be unencumbered by any undue influence from government:

[The physician] renders the service which, in his judgment, his diagnosis indicates. The state does not interfere in any way with his professional management of the patient's condition, not with the confidential nature of the

physician-patient relationship. Only the manner of receiving payment is altered. No one can seriously suggest that any one method of receiving payment is sacrosanct or that it has any therapeutic value. In fact, there is good reason to believe that eliminating the financial element at time of receiving service does have a salutary effect on the patients and on the physician-patient relationship. Moreover, any physician is free to practice independently of the programme (RCHS 11).

However, maintaining the sanctity of the provider-patient relationship is meaningless if financial barriers preclude access to health care. Both advocates of U.S.-style free-market healthcare for all but the poorest Canadians and advocates of U.K.-style government employment of providers typically couched their arguments in a rhetoric of quality. After viewing the available data, the Commission drew a different conclusion. Early in their report, the authors denied that there was any inevitable link between the mode of financing health care and its quality:

There has been no suggestion that deterioration of quality will ensue if Canadians are universally insured through physician-sponsored prepayment plans and commercial insurance. Accordingly, we conclude that there is no more reason to assume that quality will deteriorate if universal coverage is achieved through government-sponsored prepayment (RCHS 7).

Here again, In short, they questioned the link between method of payment and the quality of services provided. Moreover, free-market ideology violates the core values of modern Canadians:

No one can seriously suggest that any one method of receiving payment is sacrosanct or that it has any therapeutic value. In fact, there is good reason to believe that eliminating the financial element at time of receiving service does have a salutary effect on the patients and on the physician-patient relationship... The notion held by some that the physician has an absolute right to fix his fees as he sees fit is incorrect and unrelated to the mores of our times. This nineteenth century laissez-faire concept has no validity in the twentieth century in its application to medicine, dentistry, law, or to any other profession, or, in fact, to any other organized group (RCHS 11).

Conversely, the Commission argued, its goals could be met without the creation of the kind of national healthcare system that characterized the United Kingdom, one that

did impinge on the clinical freedom implicit in the provider-patient relationship. The Commission recognized that free market processes can have a positive effect on creativity and innovation within health care delivery. In two lengthy sections, the authors argue for a diversified, decentralized health care system that would encourage technological growth and new discovery:

The essence of our position is that in the provinces there should be freedom of choice in the type of institution responsible for sponsoring health services. Diversity, with its possibility of experiment, innovation and improvement, is preferable to a completely uniform or centralized programme. Since each province is free to develop its own pattern for providing services there is ample room for experimentation in the search for the best ways of providing those health services that will best meet the needs of the community... The Commission has recognized that diversity and decentralization are essential to encourage and permit experiment and improvement. If individual initiative is stifled or regimented then any organization becomes ineffective. The recommended health programmes for Canadians leave individual professional practitioners free to continue their practice as 'independent contractors' as is the case for other health organizations. Moreover, with ten provinces each developing its own institutional structure, within that structure is room for diversity, for different solutions to the problems of organizing regional hospital systems, or providing medical services, and all the other programmes and services (212; 234).

Thus, by addressing some of the objections of both market oriented lobby groups and more socially inclined entities, the Commission adopted the persona of arbiter or 'referee' – a reasoned voice in the midst of emotionally and ideologically charged arguments--that would render its decision based on a careful assessment of the available evidence. After assessing that evidence the Commission developed an outline of a pragmatic alternative to a privatized system that had created a practical barrier of affordability. It would alter the nature of the money flow from the provider of a service and recipient. At the same time, it was recommended that many of the features of a market based system continue to be embraced as a valuable mechanism for encouraging, growth, creativity, and innovation.

The Commission also argued that with these efforts to maximize provider, patient, and provincial freedom came responsibility. For the citizen, freedom meant exercising control over their lifestyles:

The commission believes that the individual's responsibility for his personal health and that of the members of his or her family is paramount to the extent of the individual's capacities. Briefs from the health professions and other experts, and studies by our research staff emphasize the wide scope that the individual has for the determination of his own health and well-being. With the near-disappearance of most communicable diseases, that range of self-determination has increased. Personal hygiene, cleanliness in the home, balanced diets, precautions against accidents, adequate rest, regular exercise, wise use of time for leisure and recreation; in short, temperate living – all of these are not only of first importance in the maintenance of health but are largely under the control of the individual, and in our opinion, are clearly his responsibility (RCHS 11).

For health care providers, freedom carried a responsibility to be accountable to his or her “moral and social obligations [as a citizen], as well as self-interest to do well in his profession” (RCHS 11). In a system that retained as high a level of freedom as the one envisioned in the Hall Commission report, both quality of care and control of costs depended on the provider and his or her decisions.

In sum, the Hall Commission did not attempt to meet all of Canada's health care needs. Instead they sought a "pragmatic alternative" that would ensure that “the best possible health care is available to all Canadians” (1), healthcare that is accessible and "of the highest possible quality” (RCHS 1). The authors of the commission laid out rational, thorough, and compelling evidence that provided good reasons for such a system to come into being. They sought an impartial middle ground – an intermediary of sorts – between free market fundamentalism and a reactionary socialist response to the current system. Their discourse is striking in its ‘rhetoric of objectivity’ or ‘impartiality’ and it's assertion, both overtly and covertly, that making well-reasoned policy decisions even in

the face of highly charged historical and political moments was "the Canadian way".

Their avowed the motive for the recommendations/decision did not appear to be based on what was popular or politically expedient. Instead, the rationale was to tackle a pressing problem in a way that was perceived to benefit all Canadians, and its rhetoric established new parameters--a new rhetorical situation--for health care institutions.

Ideas, Values, and the Hall Commission Report

In spite of the initial "shock and awe" that accompanied the Hall Commission's report, the path to implementation of its primary recommendations in the 1966 Medical Care Act was surprisingly smooth. Still, a coalition of private insurance companies, big business, and the CMA (all of whom felt a little betrayed by a Commission that was created through their efforts and chaired by a hand-picked libertarian judge) fought this move toward "compulsory, government-run, socialized medicine," and/or attempted to delay its implementation until the late 1960s when many economists predicted an economic downturn that would make it difficult for Ottawa to fulfill its funding commitments for the program (Fuller, 1998). In spite of their efforts, the bill passed with only a handful of dissenting votes and each province moved to implement its provisions.

Although individual negotiations with Ottawa varied substantially across provinces, and the resulting systems differed in ways that reflected local political, economic, historical, and institutional constraints, every province adopted some form of Medicare. Initially, private sector insurers extracted concessions that allowed them to administer the provincial programs, but within a decade these programs ceased operations save "medigap" policies that covered care that was not included in the provincial plans. This relative peace during the implementation phase stemmed from two factors. First,

accommodations were reached between provincial governments and providers that allowed them to retain almost complete *clinical* autonomy in exchange for sacrificing a degree of entrepreneurial/economic control to the government (Tuohy, 1998, p. 56; chps. 3 & 7), precisely the kind of balance that the Hall Commission had desired.⁵ Second, providers' economic fears turned out to be vastly exaggerated. Physicians had learned from the Saskatchewan experiment that their incomes would not fall; indeed, the universal program made it much easier for them to obtain payment for their services, and gave them a degree of income stability that they had never before experienced (Naylor, 1986).⁶ As important, providers quickly learned to "game the systems," the cost-control problem that the Commission had anticipated, but to a smaller degree than it had feared. Overall, fees that providers were allowed to charge increased during the 1960s, fell during the 1970s, and increased again during the early 1980s (Barer & Evans, 1986). But, physician incomes were much less volatile, and increased steadily. This was in part because they learned to increase the volume of their practices, in part because they shifted to more lucrative treatment regimes, and in part because they started charging additional fees for administrative activities such as photocopying patient records and charging for changes in appointment times (Tuohy, 1988), all of which contradicted the "care without regard to wealth" goal of the Hall Commission.

The "Extra Billing" Issue and the Canada Health Act

While Canadian popular opinion was mixed during the early stages of implementation of Medicare, support for the program increased rather rapidly, and health care soon began to be widely discussed as a "right" of all Canadians, one that defined Canadian society and differentiated it from its southern neighbor.⁷ The concept of a

"right to health care" was not new to Canada--even before World War II the Canadian Federation of Agriculture observed officially that "the people are thinking of health as a right of citizenship, of even greater importance than education or police protection, which are taken for granted" (cited in Taylor, 1987). But, *institutionalizing* the idea in a national act, and *implementing* it through a pattern of provincial *practices* solidified its place in Canadians' self-conceptions. While this pattern of discourse elevated communitarian, group-oriented values it did not resolve the tension between individualism and socialism that long had characterized Canadian political culture.⁸ As long as economic growth continued, the tension stayed in the background. But the economic dislocations of the late 1970s and 1980s strained commitment to the welfare state implemented throughout the developed world during the 1960s and early 1970s. Canada was no exception. Established institutions were placed under increased stress, and citizens' commitment to core values was tested.

Canadian Values during Times of Political and Economic Stress

Based on extensive surveys conducted between 1979 and 1981, Ornstein & Stevenson (1999) argue that during this era of economic and cultural stress, Canadians' values were much more complex than a simple dichotomy between individualism and communitarianism. On the one hand there was widespread opposition to all forms of large, politically powerful institutions--big (federal) government, big business, *and* big labour (p. 179; also see Kluegel, Mason, & Wegener, 1985). Conversely, large majorities felt that small businesses and farmers had too little power (p. 152), and popular opinion was split on the degree of power that is (and should be) afforded doctors, lawyers, and religious leaders. Even during these challenging times, Canadians were happy with their

quality of life, and while they complained about government economic policy, there was almost no support for changing the political system or for any form of public protest. As the popular contrast between Canada and the U.S. suggests, Canadians retained a popular ideology that "favours the maintenance and extension of the postwar welfare state" and a belief that the state is "the proper locus of responsibility for social and economic welfare" (p. 12, also 18). This part of Canadian ideology is "conservative" in that it supports the institutions that have been constructed in the past (p. 181).

But, Canadian values also are "conservative" in a second sense. Progressive, communitarian values are subordinated to less progressive beliefs that tend to favor dominant over subordinate classes and favor individualistic, free market social and economic policies, structures, and practices (pp. 175, 179; also see Kluegel, Mason, and Wegener, 1985). The relative importance of progressive and free market approaches also depended on the specific topic. Strong support existed for generally applicable social programs like health care, education, and day care (in spite of ongoing budget cuts by both provincial governments and Ottawa). There also was very "little public support for the operation of free markets in essential services" such as health care (p. 148), but significant support for programs designed to aid "special groups" such as retirees. In addition, large majorities supported using tax policy to reduce the gap between rich and poor (p. 147). Ornstein and Stevenson conclude:

public opinion in Canada, though strongly in favour of institutional commitments to social insurance and economic equity, remained heavily petty bourgeois in its support for private, capitalist, as opposed to public, state-directed, arrangements for the organization of economic life, and substantially uncommitted to institutional aspects of the welfare state that protected labour against capital" (p. 19, also p. 149)..

These results do not support Michael Mann's characterization of working class ideology as composed of "rather confused values with surprisingly conservative biases" (1970, p. 426), but instead evidence an

economistic view of the 'rights' of individuals and communities that equates equality with identical treatment, and so does not conceive of collective rights or culture. . . . There was indeed a hegemonic order built around public support for the institutions of the Canadian welfare state, and this order survived, more or less intact ideologically, through the early 1980s. It was a limited hegemony, however . . . and the limitations help explain why an attack on the welfare state could be mobilized from the political right (Ornstein & Stevenson, 1999, p. 427, 433).⁹

Ornstein and Stevenson's results hold important implications for the rhetorical strategies that will become available to the advocates of free market approaches to health care who would become increasingly vocal during the 1980s and 1990s:

these findings suggest that the success of selling cutbacks to the public in the face of strong public commitment to social programs depends on convincing people that the continuation of social programs endangers the economic health of the country. The power of these appeals is heightened by the finding that the economic concerns that are translated into a lack of confidence in government are as likely to be impersonal estimates of national economic problems as they are to be reports of personal economic difficulty (Johnston, 1986, 62-4) (p. 148) .

The so-called "right-wing free market challenge" to the Canadian healthcare system is not a simple conflict between a collective "'right to health care' . . . [and] . . . possessive, individualistic rights claims" (Redden, 2002, p. 104). Canadian values are far more complex, and far more ironic than this simple Manichean view would suggest. *Because* Canadians value community, public policies that fail to meet the needs of their brother/sisters are suspect, *even if the systems are working for them as individuals. Because* large institutions, such as national governments are inherently suspect, local/provincial systems are more credible than national ones, and differences across provinces are objectionable only if they directly threaten core values. Free market

"solutions," if implemented through local institutions, developed incrementally, and justified on practical grounds are congruent with this set of "Canadian" values

The Symbolism of Extra-billing

However, the one practice that engendered a very public debate was "extra billing," the practice of charging patients fees over and above those reimbursed by provincial health plans. Extra-billing had been a central issue from the beginning of health reform in Canada. It was the key issue in Saskatchewan doctors' successful 1962 strike against that province's pioneering system in 1962, and in a largely unsuccessful strike by Quebec's doctors when its plan was introduced in 1970 (Tuohy, 1993, p. 279). By the early 1980s an inconsistent patchwork of provincial policies had developed. Extra-billing was allowed in Alberta, Saskatchewan, Manitoba, Ontario, Nova Scotia, and to a limited extent in New Brunswick. It was banned in Quebec, and largely irrelevant in Prince Edward Island and Newfoundland/Labrador because the economy was so weak that very few people could pay extra fees even if they were assessed. British Columbia managed the issue through "mystification"--it banned the practice, but negotiated such a high fee schedule for providers that it was not a serious issue. From a practical economic standpoint, the issue was much less important than public discourse suggested. There is no way to tell for sure how extensive the practice was because of a lack of systematic, nationwide data, but it appears that in 1982 extra-billing receipts equaled 1.3% of physician billings (ranging from a low of 0.1% in New Brunswick to 2.4% in Ontario) and involved only about 10% of providers, about the same percentage who chose to "opt out" of the provincial systems. Similarly, while the practice does seem to have had some regressive effects on the Canadian health care system, both

academic studies and polling data make it clear that its primary significance was *symbolic*, not substantive.¹⁰

Just as ideas and ideologies lead to institutionalized practices, institutions can become powerful symbols that crystalize ideas and link them to deeply-held identities. Identities function as "condensation symbols" (Burke, 1941; Edelman, 1985). Implementing the Medical Care Act elevated the *idea* that everyone should have equal access to medical services regardless of ability to pay to an article of faith, and in the process solidified Canadians' commitment to what health economist Robert Evans has described as a "deep-rooted suspicion of class-based systems" regarding health care (Fuller, 1998). Extra-billing quickly became *the* symbol of threat to that identity. In 1979 the short-lived Progressive Conservative administration of Joe Clark asked Judge Hall to revisit the Canadian health care system. Although the Tories were swept from power before the report was complete, Judge Hall's report to new Prime Minister Elliott Trudeau identified extra-billing as a "major potential distortion of universal health insurance," adding his substantial credibility to criticisms of the system (Taylor, 1987). Public opinion polls indicated that large majorities of Canadians opposed the practice (as high as 79%) and favored legislation against it (Tuohy, 1988, p. 283).

Faced with declining public support over other issues, the Liberal party jumped on extra billing as a powerful political issue, a threat to the vision of "Canada as a humane and caring society, a society that has undertaken to care for all its people through a comprehensive social security system program" (Government of Canada, 1983) that the party shared with the Canadian people. As a political strategy, the resulting Canada Health Act was a failure for the Grits--not wanting to hand them a potent issue in the

upcoming elections, Conservatives supported the proposal, just as they had supported the Medical Care Act. The CHA passed, robbing the Liberals of a key campaign issue, and the Tories won the election. Like the 1966 legislation, each province negotiated with providers to implement the provisions of the CHA (Heber & Deber, 1987):

At the end of these processes . . . generous tangible and "positional" gains for the medical profession in the form of fee schedule increases and binding arbitration mechanisms had been achieved in return for the sacrifice of extra-billing. These actions left Ontario, Alberta, and New Brunswick as the only provinces to be penalized by Ottawa for continuing to allow extra-billing. Ontario, with one-third of Canada's physicians, accounted for more than 80 per cent of the federal withholding penalties for extra billing and was to be the next major arena in which the extra-billing battle would next be engaged (Tuohy, 1988, pp. 286-287).

In Ontario the medical association (OMA) misread the provincial government's commitment to the act and overestimated the Liberal government's flexibility in light of very strong NDP opposition to the practice. In a classic case of how not to negotiate, the OMA dug in its heels, and embarked on a strike that both failed to force significant concessions and undermined its credibility with the general population (Tuohy, 1988). Eventually, even Ontario implemented the act, and

the Canada Health Act provided Ottawa with an effective 'no Typical compliance, no cash' lever with which to enforce national standards. It served to strengthen not only the legal framework within which the health sector function, but also the fight to defend longstanding principles held by the Canadian people. It weakened the 1980s push for free-market medicine and required doctors who wanted to bill patients over and above the fees negotiated with provincial governments to leave the public health plan, something that very few chose to do" (Fuller, 1998, pp. 74, 75).

Perhaps more important than the practical/legal effects of the CHA, was its impact on the symbolic environment surrounding health care in Canada. When combined with the 1966 act, it institutionalized a communitarian ideology and legitimized (even

federal)government action in the health care arena. At a more micro level, the *institution* of the Canada Health Act now "drives decision making about what is in and what is out of Canadian Medicare" (Flood, Stabile & Tuohy, 2006, p. 17). Negotiations about the meanings attributed to ambiguous parts of the legislation are largely conducted in private, outside of the public view, and in an incremental, non-systematic process that serves to perpetuate the status quo. The discursive opening provided advocates of private-sector health care by Canadians' complex set of primary and secondary values had been narrowed significantly, if not closed completely. Opponents of Medicare, who came to office immediately after the passage of the act, would have to find indirect ways to rein in the program and reduce its widespread public support.¹¹

The Road to *Chaoulli vs. Quebec*

The decades after the passage and implementation of the Canadian Health Act was characterized by two processes--the federal government reducing its financial support to the provinces, and increasing concern about the long-term viability of the program (Tuohy, 1993).

Manufacturing a "Crisis" in Canadian Health Care

By the end of the 1990s, physician John Ralston Saul responded, quite bluntly by Canadian stylistic norms, to the rhetoric of the growing "crisis" in Medicare:

I am not convinced that there is anything wrong with the fundamental ideas behind Canada's public health system. Medicare's current difficulties derive in part from people telling us that the system does not work, then taking actions to make sure that it will not work, then telling us again "See, we told you it didn't work." . . . Neither have I learned of anything to suggest that medicare's costs are spiraling out of control in a manner unforeseen in projections made at the time of its implementation. Cost figures which are, it is true, never entirely reliable, indicate that health care costs are about 20% under what Emmett Hall. . . thought they would be. . . [T]he medicare debate is in fact handicapped by the attitudes

and behaviors of politicians. To reassure us, they lie to us, and then treat us as idiots by insisting on things that we know are untrue. Not only does this prevent a reasonable debate from taking place, but it also creates a very unhealthy relationship between citizens and their elected representatives (cited in Somerville, 1999, pp. 3, 5).

Saul's analysis of cost increases is supported by the available data, which demonstrates that rapid increases in health care spending as a percentage of GDP were primarily the results of slowed economic growth, thus reducing the denominator of the ratio, and of rapid cost increases in unlisted services and prescription drugs (Fuller, 1998; Rachlis, 2000; Tuohy, 1993). Canadian Medicare itself was "doing quite well, thank you." Popular support for the program remained exceptionally high, even as citizens registered increased concern about its long-term prognosis. Some provinces incrementally cut back on Medicare funding, and in some cases re-introduced private care. But, the primary attack on Medicare did not come through legislation, it came from the courts.

The Charter of Rights and Freedoms and Healthcare Policy

There is no question that the enactment of the Canadian Charter of Rights and Freedoms has had a major transformative effect on Canadian society and culture. Fossum (2005) notes that "Charters or bills of rights are central ingredients in the constitutional makeup of modern democratic polities. They confer rights upon individuals and groups and evoke civic identities and collective self-conceptions" (p. 188). They also "change our civic self-conceptions" and "manipulate our psyches" (p. 149). Like the Canada Health Act, the Charter quickly became a "powerful symbol of national identity" (Wiseman, 2007, p. 86) and almost from the moment it was proposed by the Trudeau administration, poll after poll has indicated overwhelming popular

support for the idea of a charter of rights, even though Canadians knew very little about its actual contents (Russell, 1992, pp. 115-116).

However, the *Charter* and responses to it had two ironic dimensions. It is clear that Prime Minister Trudeau conceived of the *Charter* as a transformative exercise; his goal was to change Canadian identity by changing its institutions and its discourse:

constitutions establish pressures and limits that help shape the underlying conditions for effective civic speech. . . . [and] produces a corresponding authoritative civic language, which helps to amplify some claims and silence others. As Cairns puts it, Trudeau's attempt to furnish an official language of citizen rights, and thus to counter the provincializing effects of an unalloyed discourse of federalism, was not merely 'playing around with the externals of our existence.' [Cairns, 1991, p. 62] Rather, Trudeau sought to make Canadians a 'very different people' by setting in motion an institutional transformation that would help to change what they might say and hear [Ibid]" (James, 2005, pp 133-134).

But, the key to the Charter's impact lay in the "discursive foothold" that it created (James, 2005, p. 140), the "symbolic capital" (Bourdieu, 1986) that it provided various groups of citizens who could use it to legitimize their rights claims: "actors who can speak in institutionally authorized discourse are situated very differently in relation to power from those whose claims can be dismissed as idiosyncratic" (James, 2005, p. 137; also see Manfredi, 1993, p. 248). The "discourse opportunity" created by the *Charter* generated an outpouring of what U.S. scholars might call "identity politics" as "Charter Canadians" (those groups explicitly identified for legal protection), groups who were not named in the Charter but who believe that they are protected by its principles, and "Charter plus"-oriented aboriginal groups sought application of their newly-institutionalized rights to their everyday experiences. As Alan Cairns argues:

The Charter, designed as an integrating mechanism to transcend our cleavages in the future, elevated the status of equality as a constitutional principle and,

paradoxically, contributed to a transformed historical self-consciousness that underlined how badly we had treated each other in the past. . . . The past also exists as memory, as a key source of our identity, and as a contributor to whether we feel valued or unrecognized. The past is the raw material from which sense of pride or alienation derive or are fabricated. Definitions of who 'we' are and who are 'other' evolve from an infinity of past encounters in our own lives and in the lives of those with whom we are linked by such ties as kinship, gender, linguistic community, and ethnicity" (Cairns, 1995, pp. 20, 22, 25).¹²

The country was fragmented along the lines of identity politics, and, ironically the geographic-historical-linguistic tensions were exacerbated. As a result of the ensuing 13-month "constitutional crisis" regarding the Charter, the negotiations between the Trudeau administration and the provincial governments which insisted on the addition of the "notwithstanding" clause, Quebec's refusal to agree, and decades of Charter challenges in the courts, and tensions that were not directly related to the Charter, a "three nations" conception of Canadian citizenship developed--an ethnically heterogeneous English Canada, Quebec, and First Nations peoples.¹³

During the quarter-century since the Charter was ratified, it has had a minimal *direct* effect on the Canadian health care system, in spite of what media coverage often has suggested (Flood, Stabile, & Tuohy, 2006). Canadian courts have never ruled that the Charter provides citizens with a right to health care; even *Chaoulli v. Quebec* only guarantees a right to purchase private health insurance, not a right to publicly-funded care. Prior to the *Chaoulli v. Quebec* decision, the courts generally had affirmed the constitutionality of provincial health care systems, largely because those systems were based on the same principles as the *Charter*. Of the approximately fifty constitutional challenges to government policies filed between 1982 and 2002, plaintiffs were successful in around one-third of cases, a figure that compares to the success rate of

healthcare litigation in the U.S. Of the cases requesting the addition of particular services to provincial reimbursement schedules, only one, *Eldridge v. British Columbia* (1997) was successful. Even then, the case was about citizens gaining access to the existing system (in this case, through provision of an interpreter to deaf patients), not about expanding the scope of covered services (Greschner, 2006). However, as we shall argue in the remainder of this essay, the *Charter* has had a subtle-but-fundamental *indirect* effect, one that portends to be critically important in the future. In particular, we argue that the *institution* of the Charter has (1) changed the operant conception of "rights" and the nature of discourse about rights that characterize health policymaking; (2) legitimized the use of courts rather than elected legislatures as the locus of public policymaking on health care issues, and (3) created a new venue in which corporate influence can dominate the lifeworld that is related to Canadian healthcare.

Individualizing the Canadian Conception of "Rights." Perhaps the most haunting lines in Canada's history were written in 1858:

It will be observed that the basis of the Confederation now proposed differs from that of the United States in several important particulars [the most important of which is that] it does not profess to be derived from the people but would be the constitution provided by the imperial parliament thus remedying any defect.' These words are from a letter signed by the three Fathers of Confederation, George-Etienne Cartier, Alexander Gault, and John Ross" (Russell, 1992, p. 4).

In short, British constitutionalists simply did not accept the French-American/Enlightenment concept that rights are located in the essential humanness of each individual citizen, opting instead for a view that constitutions are the product of organic development in which a citizen's relationship to his or her community was of paramount importance. Their philosophical patron-saint was Edmund Burke, not John Locke:

Instead of abstract natural rights, Burke believed in the real rights and obligations which grow out of the social conventions and understandings that hold society together. For Burke, the social contract which formed the foundation of society was not between individuals here and now but from one generation to another, each handing on to the next the product of its collective wisdom (Russell, 1992, p. 10; also see Redden, 1992).

This does not mean that Canadian political history was devoid of Lockean ideas: a tension between individual and group-based rights has permeated Canadian political culture since the Confederation, and is clearly present in the debates surrounding the adoption and implementation of the *Charter of Rights and Freedoms* (Fossum, 2005, p. 157). But, conceptions of Canadian citizenship developed in two phases. The first was from approximately 1945 (the immediate postwar period) to 1982, the year that the constitution was patriated and to it was added *the Canadian Charter of Rights and Freedoms*. This period was marked by a concerted federal effort to create pan-Canadian social programs. The general consensus at this time was that it was legitimate, if not imperative, to use the state to achieve *collective* goals (Graham & Phillips, 1997). During this era the right to health care was conceived as a *collective* entitlement at the same time that "it indicated an area of individual entitlement" (Redden, 1992, p. 115) in a coherent balance. In this view "rights" were "just expectations," mutually expected responsibilities that Canadians have to one another, both as individuals and as members of groups and institutions. During that era, claiming a "right" meant, "I justly expect that the state will provide the social goods that are necessary to guarantee an adequate standard of living to members of my political community" (Redden, 1992, p. 113).

However, after 1980

the changes put in effect by the New Public Management, and, more significantly, the *Canadian Charter of Rights and Freedoms* and the *Canada Health Act*, redefined the meaning of rights claims for access to health care. The nature of

rights claims in the 1980s became more individualistic Citizens seem to have come to feel entitled to health services b/c they have paid for them in advance through their taxes, and the (inevitable) rationing of services is perceived as a rights violation. . . . The *Charter* entrenched individual rights and provided a reference point for the emerging philosophy of individual responsibility taking." (p. 116).¹⁴

Notions of the citizen-as-consumer and "rights" as grounded in the individual possession of property "came to replace earlier normative notions of right" (Redden, 1992, p. 115). In this new ideology, the state becomes just another provider of services, potentially in competition with the private sector, and the "political empowerment" that comes through social rights was replaced by "economic empowerment" which "changed the nature of the citizen-state exchange process from a traditional model . . . based on 'needs, obligations, and entitlements,' with a market-like exchange process" (Redden, 1992, p. 119). Charles Taylor concluded that the new era "promotes a procedural view of justice in which the commitment to treat all *individuals* equally and fairly takes precedence over any substantive shared end a society might favour" (cited in Bazowski, p. 105; also see Redden, 1992, pp. 117-118).¹⁵

Legitimizing the Courts as a Site of Public Health Policymaking. Not only did the charter transform the operant conception of "rights" in Canada, it also changed the processes and sites through which those rights are claimed. The issue is not just one of the legitimacy of "judicial review" of parliamentary actions, although by 1985, and clearly by 1988, the Canadian Supreme Court had taken a broad, U.S.-like view of its right to nullify legislation on *Charter* grounds. For example, in a crucial case on abortion rights, Chief Justice Dickson was explicit: "the Court now is charged with the crucial obligation of ensuring that the legislative initiative of our Parliament and legislatures conform to the democratic values expressed in the *Canadian Charter of Rights and*

Freedoms" (cited in Manfredi, 1993, p. 239). Although judges had been progressively less constrained by "legislative intent" during the decades prior to 1982 (Elliott, 2005), the *Charter* "enhanced the importance of the judiciary and judicial system at the expense of national or provincial parliaments" (Cooper, 2005). As a result, "today it is impossible to understand Canadian *politics* without taking postmaterialist interest-group [groups motivated by a cause rather than by shared interests with other Canadians] *litigation* into account" (Cooper, 2005, p. 111, citing Knopff & Morton, 1992, 2000 and Mandel, 1989).

However, the debate over judicial "activism" in Canada is more complex than the simple issue of "judicial legislation" because it is accompanied by a debate between individualist and communitarian theories of constitutional interpretation (Monahan, 1987). "'What ought to be done 'by society or for society?' is replaced with "what constitutes an illegal infringement on the moral space of an individual" (Redden, 1992, p. 12). In addition, judicial policymaking inherently takes a more narrow focus than parliamentary debate. Sociologist Joel Bakan observes that

the politics of *Charter* law are driven by ideological processes that narrow the range of meanings that lawyers and are likely to attribute to the *Charter's* otherwise open-ended words. . . . Consequently, constitutional rights have only a limited capacity to advance social justice--in relation, for example, to economic security, communications, and health. . . . [F]inally . . . judges tend to rely on conservative conceptions of society when interpreting the Charter, thus creating a further barrier to the *Charter's* having progressive effects (Bakan, 1997, pp. 143-144).¹⁶

As a result of the "legalizing" of public policy , "the right to health care is no longer merely a 'just expectation' or normative claim, but a serious legal matter" (Redden p. 115-116).

The Corporatization of Public Policymaking. The final effect of the *Charter* was to make a new venue available to organizational rhetors. The Canadian political

system presents a distinctive challenge to corporations and the non-governmental organizations that represent them. Elections campaigns are short by U.S. standards and come at irregular intervals, anti-corruption laws restrict corporate influence over campaigns and legislative action (Abelson, 2002), and popular suspicion regarding the power of large corporations combine to create especially challenging situations for organizational rhetors. As a result, corporate influence over legislative or executive branch policymaking in Canada generally needs to be indirect, through related but difficult-to-understand issues such as trade policy or media ownership (Abelson, 2002; Fuller, 1998; Grieshaber-Otto & Sinclair, 2004). However, *judicial* policymaking provides a much more promising venue for corporate actors. This is in part because corporations have far more extensive resources, both financial and expertise-related, to bring to bear during litigation than other social actors (Greschner, 2006), but it also because “business can enhance its power by using the *Charter* to deregulate its activities; [aided by] anti-union and pro-business attitudes among judges” (Bakan, 1997, p. 146; also see Chps. 6&7).

Still, current case law makes it more difficult for corporations to dominate the Canadian judicial system than in the United States. In his history of the development of the "American system" of large, weakly-regulated, and politically influential corporations, Charles Perrow has argued that court decisions were crucial. Three U.S. Supreme Court decisions in 1819 significantly increased the legal power of corporations vis-à-vis governments. The most important of these was the *Dartmouth* decision, which granted corporations the legal status of "persons" with all of the attendant Constitutional protections. *Dartmouth* was not an accident--it was the outcome of an extended

campaign by corporate interests whose primary goal was to protect corporations from "the rise and fall of popular [political] powers and the fluctuations of public opinion" (cited in Perrow, 2002, p. 41). More than a century later in *Buckley v. Valeo* the court ruled that campaign donations are "protected speech" under the First Amendment of the U.S. Bill of Rights, thereby making limits on political donations and/or political (or other) advertising virtually unenforceable (Cheney, 1992).

Although there has not yet been a Canadian equivalent to the *Dartmouth* and *Valeo* decisions (Manfredi, 1993, p. 243), there have been a number of incremental moves toward a "corporation as person" position. On the one hand, the courts have held that corporations are not directly protected by *Charter's* rights to life, liberty, security of the person (section 7), and freedom of religion (section 2a) because only human beings can have these rights. On the other hand, the Supreme Court has relied on *Charter* rights to acquit business corporations accused of criminal and regulatory offences. Moreover, it has held that *Charter* rights other than those stated in Sections 7 and 2a, including freedom of expression and some criminal-procedure rights, do provide direct protection to corporations.

While the *Charter* does not protect 'purely economic' interests, it (along with lower courts) has construed many economic interests as not purely economic, thus clearing the way for constitutional protection" (Bakan, 1997, p. 88). There are two ways around this "economic rights" limit. First, corporations can argue that regulations violate rights of individuals with whom they have a connection (e.g., an employee or customer). This interpretation started with the *Big M* case which declared Sunday sales restrictions to be unconstitutional violations of the *Charter*, but it also has been applied to liability

and regulation cases. In two 1991 cases, *Wholesale Travel* and *Motor Vehicle Act Reference*, the Court interpreted the burden of proof provisions of liability laws in ways that limit "the state's capacity to enforce legislative standards in relation to the environment, workers' safety, and consumer protection, among other areas, is now subject to judicial determination and may thus be substantially weakened" (Bakan, 1997, p. 90).

Second, the Supreme Court has ruled that where a *Charter* right is interpreted by a court to protect interests that a corporation *can* have, that right will be available. Freedom of expression is one such right. For example, although corporations cannot have or practice religion, they can, at least in the Court's view, express beliefs, opinions and ideas--just like humans (see Justice Stevenson's discussion in *Slaight Communications* (1989) and the court's decision in *CIP, Inc.* [1992]). All governmental regulation of advertising is put at risk by this precedent: restrictions on what can be advertized. . . . and how things can be advertized . . . now constitute prima facie breaches of section 2(b) and thus depend for their validity on judges/ willingness to uphold them under section 1." The same is true of other kinds of corporate communication, a point acknowledged, for example, in Justice L'Heureux-Dube's statement that 'the government's regulation of [all broadcasting] resources . . . constitute [*prima facie*] violations of s. 2(b) (*Committee for the Commonwealth* 1991). Legislation designed to level power imbalances in communications, such as the Canadian content and election-spending regimes . . . must also be justified" (Bakan, 1997, p. 90), with the burden of proof placed on the government, not the corporation.

These trends toward judicial protection of the rights and freedoms of corporations have directly influenced health care policy. For example, in order to require physicians to locate in underserved (primarily rural and inner-city) areas, British Columbia refused to provide new billing numbers for its provincial health plans unless the physicians requesting them met requirements regarding the place, time, and nature of their practice. In *Wilson* (1988) the Court of Appeals declared these policies unconstitutional because the issue was not *purely* economic, but also effected the provider's lifestyle, and therefore was prohibited by the Charter. A case with nationwide implications currently is being considered by the Canadian Supreme Court. Canwest Communications has sued to reverse the ban on prescription drug advertising in Canada:

Canwest spokespersons said company officials were unavailable for comment, but the firm contends the ban is a breach of the Canadian Charter of Rights and Freedoms. . . . If approved, direct-to-consumer advertising would increase drug use and drug prices in Canada, leading to more drug industry money in the country—much of which would be spent, as is the case south of the border, to influence the political process” (*Canadian Medical Association Journal*, 4/22/08, 1126).¹⁷

In sum, the passage of the *Canadian Charter of Rights and Freedoms* had two important effects on policymaking in Canada. First, it foregrounded a conception of rights as possessions of *individuals* by virtue of their nature as humans (an essentially Lockean position), rather than because of their membership in a larger community. Although both conceptions have been important parts of Canadian history, culture, and popular values, the community-rights (Burkean) doctrine has dominated legislation and popular opinion, and still does (Crane, 1994; Ornstein & Stevenson, 1999). While organizational rhetors still can advocate successfully for legislation that makes incremental or marginal changes in Canadian social welfare systems on the grounds that

they impinge on *individual* rights or favor large, powerful institutions, attacking the communitarian base of these programs in public policymaking venues is very risky. However, the *Canadian Charter of Rights and Freedoms* opened a second front for corporate rhetors, one that is far less favorable to their interests than the U.S. system, but which allows them to exploit their tactical advantages while minimizing problems created by popular attitudes and values. The significance of this new venue became crystal clear in the 2003 "wait times" decision.

Chaoulli vs. Quebec

Jacques Chaoulli is a physician who had tried for years to have his home-delivered health care officially recognized by the Quebec health care authority and to obtain a license to operate a private hospital that was independent of the public system. For some time he had searched for a patient who would join him in a lawsuit against the Quebec health care system. George Zeliotis, a patient who had experienced a number of health care problems, all of which were treated in the public system, but only after what he felt were objectionable delays, became that patient. Given past case law, the Supreme Court's first decision involved its jurisdiction: (1) is it proper in this case for appellate courts to overrule legislative actions; (2) since Quebec had never ratified the *Canadian Charter of Rights and Freedoms*, but had passed its own bill of rights, which document applied to this case; and (3) did the case involve sufficient non-economic considerations to avoid problems related to the economic effects limitation of the *Charter*?

The lower court had ruled, rather summarily, that the Canadian and Quebec *Charters* were sufficiently alike to allow the court to focus on the *Canadian Charter*, that the lawsuit involved economic rights that were "intimately connected with the right to

life, liberty, and security of the person" to be constitutionally relevant (p. 24),¹⁸ and that the plaintiffs' rights under section 7 of the Canadian Charter were deprived by the ban on private insurance. However, the court ruled that those individual rights had to be balanced against the province's right to establish an efficient and effective health care system that benefited all Quebecers, and that on balance, the ban on private insurance was "in accordance with the principles of fundamental justice" (p. 26).¹⁹

The majority Supreme Court decision affirmed the lower court's decision that sufficient non-economic considerations were present to allow the suit to continue, and that the Supreme Court had the right to review legislation to see if meets the terms of the *Quebec Charter* (p. 31). Provincial governments have a number of different options available about how they implement the provisions of the Canada Health Act, they argued, and there is no reason why

The Court must show deference to the government's choice of measure. The courts have a duty to rise above political debate. When . . . the courts are given the tools they need to make a decision, they should not hesitate to assume their responsibilities. Deference cannot lead the judicial branch to abdicate its role in favour of the legislative branch or the executive branch . . . given the tendency to focus the debate on a sociopolitical philosophy, it seems that governments have lost sight of the urgency to take concrete action. The courts are therefore the last line of defense for citizens" (pp. 7, 61).

A concurring opinion agreed with this assessment, and added that the Quebec legislature had confronted the wait time problem on multiple occasions, and had failed to take adequate remedial action (p. 62), making judicial intervention even more justifiable.

The Court also accepted the lower court's observation that section 7 of the Canadian Charter and section 1 of the Quebec Charter were almost identical. However they also found that the latter document established requirements that are independent of the Canadian Charter, and was broader in scope. Most important, the Quebec Charter

does not include "any reference to the principles of fundamental justice" (p. 33). As a result, claimants have an easier burden under Quebec law--instead of having to overcome a burden of proof regarding *both* the unconstitutionality of the law *and* the balance between individual and societal rights, they only have to demonstrate that the law violates individuals' constitutional rights.

With these legal principles in mind, the Court then turned its attention to the issue of surgical wait times and their effects. The plaintiffs argued that for urgent care patients on waiting lists, their lives were at risk and delays increased the risk that their "injuries will become irreparable," and for non-urgent patients, excessive wait times could cause unnecessary and constitutionally objectionable levels of pain and restrictions on their quality of life, including negative psychological effects related to delays (pp. 6, 37). The court noted that "it is common knowledge that the demand for health care is potentially unlimited and that waiting lists are a more or less implicit form of rationing" (p.37), a position that is consistent with the consensus opinion among health policy experts (Aaron, Schwartz, & Cox, 2005; Boase, 1996; Mechanic, 1994). However, there also is a consensus that wait lists also function to increase the efficiency of health care systems and thereby help control costs by ensuring that expensive surgical operations do not sit unused for extended periods of time (de Coster, et al., 1999; Hux & Naylor, 1995), encourage physicians to use less invasive (and less dangerous) procedures before resorting to surgery, and allow some conditions to improve without medical intervention (Edwards, 1997).²⁰ In short, "excess capacity will encourage higher rates of surgery, increasing the rate of unnecessary surgery, as well as the rate of post-surgical complications and death" (de Coster, et al., 1999, p. 190), which helps explain that

overall survival and surgical success rates are not significantly different across wait times. The issue of the compensating efficiencies associated with waiting lists is not raised in any of the opinions written by the judges. Although the concurring opinion noted that legislatures have the right to choose particular mechanisms for administering a public health care system (p. 27), it also declared that it was not necessary to use wait lists to do--a wide variety of alternative methods are available, as illustrated by cross-province comparisons within Canada, and cross-national comparisons between Quebec and other developed (OECD) countries.²¹ Hence, a ban on private insurance is not necessary for the government to fulfill its responsibilities to its citizenry.

The dissenting opinion questioned the court's interpretation of the Quebec bill of rights and its reading of the evidence presented to the lower courts. The legislature has a duty and the authority to establish the health care system that it prefers, and to protect it against modification unless there is a consensus among citizens that it should be changed. Not only was there no negative consensus, the dissenters argued, the current system also serves to control costs more effectively than a "mixed" system would, a legitimate purpose that is not denied (or even discussed) in the majority or consenting opinions (p. 10):

The Quebec health plan shares the policy objectives of the *Canada Health Act*, and the means adopted by Quebec to implement these objectives are not arbitrary. In principle Quebec wants a health system where access governed by need rather than wealth or status. To accomplish this objective, Quebec seeks to discourage the growth of private sector delivery of "insured" services based on wealth and insurability. The prohibition is thus rationally connected to Quebec's objective and is not inconsistent with it. In practical terms, Quebec bases the prohibition on the view that private insurance, and a consequent major expansion of private health services, would have a harmful effect on the public system. . . . The evidence indicates that a parallel private system will not reduce, and may worsen, the public waiting lists and will likely result in a decrease in government funding for the public system (p. 10).

Furthermore, the evidence presented to the trial judge on the extent and severity of the wait time "problem" was inadequate on its face. Finally, wealthy patients always can opt to obtain private sector care outside of the province if they find that waits are psychologically damaging (p. 12).²²

The dissent raises serious issues about the use of evidence in the majority decision, an issue that has generated an extensive criticism by both Canadian legal scholars and health policy experts.²³ With a stereotypically Canadian degree of tact, Greschner (2006) observes that "time and space preclude dissection of the majority opinion's deployment of evidence [in *Chaoulli*]; suffice it to say that the majority opinion has made judicial appreciation of evidence-based decision-making more urgent" (pp. 44-45). Morris Barer of the Canadian Institutes of Health Research was more direct, "One of the most unsettling aspects of this judgment was the selective use, misuse, and ignorance of researchers' evidence" (cited in Bueckert, 16 Sept., 2005). Although it is impossible to provide a comprehensive survey of the court's use of evidence in this essay, there is a good deal of evidence to support Dr. Barer's assessment. For example, using cardiac bypass surgery as his primary case study (because it and artificial hip replacements are the two procedures that appeared most often in the mass media prior to the *Chaoulli* decision), Evans found (1993, pp. 35-36) that wait lists are carefully managed by physicians in terms of individual patients' needs and the potential outcomes of each procedure. There is only a limited range of conditions for which by-pass surgery offers increased life expectancy. People with these problems are not kept on waiting lists in Canada, but receive immediate and high-quality treatment. Older people with limited life

expectancies, and for whom bypass surgery would have minimal positive effects, often are put on the lists for psychological reasons, "as a humane way to preserve hope." In this sense, "dying *while* on a waiting list is not the same thing as dying *because* one is on a list, rather than being operated on immediately" (p. 36). Finally, there is a consensus among cardiologists that by-pass surgery is over-used in the U.S. mixed private-public system with serious adverse effects: "more people die during

Similarly, there was high-quality data available to the majority on the issue of the potential impact of a mixed private-public system on wait times. A 1994 study of cataract surgery in Alberta, which allows both private and public facilities, found that wait times in public facilities were longer (2-8 weeks) than in private facilities (1-4 weeks), but the difference was largely isolated to surgeons who practiced in *both* public and private facilities: "if the surgeon operated both publicly and privately, the wait for surgery in the private system was up to a year" (Consumer's Association of Canada, cited in de Coster, et al., 1999, p. 195). Similar results appeared in studies of other procedures, e.g. cardiac procedures, in both Manitoba and the U.K. Although each of these studies was available to the majority in the *Chaoulli* case--indeed, they are cited in the bibliographies of the decision and/or are listed in their bibliographies--none is referenced in the majority opinion (or, surprisingly, by the dissenters). It appears that the kind of data the majority had excoriated Professor Marmor for omitting from his testimony--cross-province and cross-national research--was at their fingertips throughout the proceeding.

The issue of evidence-based policymaking is especially important for both pragmatic reasons and for what it suggests about processes of institutionalization in this very important case. Canadian policymakers, at least from the time of the Hall

Commission, have prided themselves on their data-based decision-making. For example, University of Toronto scholar Carolyn Tuohy argues that the primary institutional difference between Canadian and U.S. health policymaking is that the former is driven by evidence, while the latter is driven by ideology (1999). Deborah Stone (1997) explains the role that "numbers" play in ideologically-driven (U.S.) public policymaking. The collection and analysis of data is an inherently political act. Policymakers resist efforts to do so unless (1) they know the results ahead of time, and (2) know that those results will unambiguously favor the ideological position(s) they are advocating. The process of counting makes citizens pay attention to a topic and, often stimulate public demands for change. Collecting and discussing data can create political communities/alliances out of otherwise disconnected people who share the attribute(s) being measured.²⁴ Numbers *seem* to be objective and precise, so they can enhance the credibility of people who count and/or report the results of counting. But, numbers are inherently ambiguous, and can become the basis of multiple, contradictory narratives about societal conditions. When it comes to health policy, they are an attractive nuisance--policymakers are much more prone to tell health care "horror stories" (Conrad & Millay, 2000) than to deal with data. Stories capture media attention, arouse audience emotions, and can be presented in ways that are difficult to challenge. In short, the power to measure is the power to control policy debates

Ironically, at the time of the *Chouilli* decision, there was no systematic, nationwide data available regarding the extent or severity of the wait time "problem" in Canada. There still is none, either at the provincial level or the national level (Canadian Medical Association, 15 Jan., 2008). Horror stories abound, but by 2006, eighty percent

of Canadians were satisfied with the amount of time they waited to get a doctor's appointment, medical test, or non-urgent surgery (Montreal Gazette, 7 Dec., 2006). Canadians were and are concerned about emergency room wait times, but the medical significance of these delays has been exaggerated by the media and by critics of the Medicare--at the peak of the "crisis" most visits were non-urgent and most patients waited less than an hour to see a physician (Ubelacker, 14 Sept., 2005). Since the *Chaoulli* decision, surgery rates are up, especially in the five areas identified by the Harper administration as critically important--heart surgery, cancer treatment, hip and knee replacement, cataract surgery, and diagnostic imaging (Fitzpatrick, 5 Feb., 2007; Canada News, 5 Feb., 2007), but they may be down (and wait times up) for other procedures. This overall picture has led some critics of the government's response to *Chaoulli* to claim that recent efforts are more "gimmick" than substance (Blackwell, 6 April, 2007). But, the absence of reliable data allows policymakers to *claim* to be making progress on the issue (Bueckert, 3 April, 2007, 6 June, 2007), while independent policy experts argue that it is "impossible to tell if medical wait times are shrinking" (Bueckert, 26 June, 2007). Annual studies by right-wing "think tanks" such as the Fraser Institute can continue to claim that wait times are at an all-time high (CBC News, 16 October 2007), while critics decry the methodological sloppiness of their studies (*Medical Care* editorial board, cited in DeCoster, et al., 1999; Scott, 1994) and U.S. politicians decry Canadian rationing of health care (Rachlis & Kushner, 1994, chp. 7; Marmor, 1994).

Conclusion

From the inception of the Confederation, Canadian identity has been defined by the management of tensions and contradictions. Canadian cultural critic Bernard Ostry opined that

The unresolved conflict which Lord Durham perceived in the generation preceding Confederation and which he expressed so trenchantly in his famous report remains to haunt us all: 'I expected to find a contest between a government and a people: I found two nations warring in the bosom of a single state: I found a struggle, not of principles, but of races.' Yet one hundred and fifty years later, we possess even fewer unifying institutions: the influence of organized religion has changed dramatically, where it has not seriously declined; even Canadian political parties of the same stripe are often split between federal and provincial viewpoints (1978, pp. 4-5).

Canadians' shared experience has involved balancing pressures toward identification and division, in effect, the human experience writ large (Burke, 1941). It may be that the Canadian nation-state exists primarily as an *idea*, one sustained through core *institutions* and institutional discourse, which overcome competing *ideologies*. In its most extreme form, discourse about Canada's impending fragmentation has created and articulated fears that "Canadian identity and institutions are vulnerable, fragile, and open to attack by the American capitalist machine" (Grieshaber-Otto & Sinclair, 2004, p. 147). However

the language of 'crisis,' so pervasive and long-standing in assessments of Canada's political condition--the alarm bells are constantly ringing--has been cheapened and rendered meaningless. By comparative international measures, Canada is remarkably stable, tempered, and blessed with prosperity . . . The Canadian political cultural tradition is one of evolutionary change: gradual, incrementalist, and iterative" (Grieshaber-Otto & Sinclair, 2004, p. 148).

The Canadian health care system plays a central role in both the discourse of stability and continuity and the discourse of crisis and "inevitable" change. As an institution, it has enacted Canadians' shared ideas and identities, while being buffeted by ideological storms. It both reflects and reproduces those ideas and identities, and at the same time molds and directs them as social actors seek the optimal rhetorical strategies and sites for

efforts to achieve their individual goals. There is little doubt that the *Chaoulli* decision has transformed the ideas, ideologies, and institutions surround Canadian health care. But, there also is little doubt that this core institution continues to guide and constrain efforts to dismantle it, and efforts to save it.

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Notes

¹ We will try our best to avoid the entire set of issues regarding the existence, or even the potential, of a "Canadian identity." As Wiseman (2007) has observed:

The very notion of a Canadian nation is a highly contested one. NO region, with the possible exception of Quebec, could conceivably qualify as a nation. To assert the Canadian nation as one entity is to reject the plausible dualistic and multinational conceptions of the country that are held by many Canadians. . . . Defining Canadians' collective ethos is a profoundly more disputations and intractable matter (p. 6).

Russell is even more direct: "Canadians have not yet constituted themselves a sovereign people. So deep are their current differences on fundamental questions of political justice and collective identity that Canadians may now be incapable of acting together as a sovereign people" (Russell, 1992, p. 5).

Paradoxically, this may be Canada's unique identity:

Canadians have been less united than Americans in defining themselves and the principles that govern them. There has been greater uncertainty about what is 'Canadian' and 'un-Canadian,' a term appearing only recently in tentatively in the language of Canadian politics. . . This is b/c Canadians negotiated their collective identity in a non-declaratory manner. Canada's history is littered with messy and inarticulate but functional compromises of its elites rather than with ringing proclamations, as in the American Declaration of Independence. The Canadian way makes for ambiguity. The genius in the Canadian path of constitutional evolution has been to adapt, improvise, and muddle through" (p. 64).

² We also have been struck by the important role that comparisons to the United States have in the symbolic construction of Canadian identity, the process of "affirmation by negation" that Karlyn Kohrs Campbell has argued characterizes feminist rhetoric (????) and Kenneth Burke has suggested is a central element of the "dialectic of [national] constitutions" (1945). In fact, Nelson Wiseman argues (2007), "Canadians often, and sometimes smugly, contrast and compare themselves and their country to Americans and the United States. They spend less time comparing themselves regionally. . . Canadians may not share a consensus on who they are, but they are united on who they are not: Americans. America continues to serve as the requisite 'other' for Canadian self-definition and identity" (pp. 2, 75; also see p. 89). Although these processes are important, we have decided to follow Wiseman's suggestion and focus our attention on Canada.

³ The best evidence to support the simplicity of our approach comes in our "references" section--not a single European postmodernist, post-postmodernist, or high modernist philosopher or sociologist is included.

⁴ There is, however, no question that the different logics that develop at key transition points have major long-term effects. For example, in 1960 the U.S. and Canada had very similar employment-based health insurance systems covering a virtually identical proportion of the population, and very similar "horror stories" about the effects of being uninsured or underinsured (Heeney, 1995). "From this common point," Tuohy

concludes, "decisions taken in the late 1950s and 1960s would set these two nations on dramatically different courses" (p. 50). The differences accelerated again, especially in terms of cost of medical care, after 1980.

⁸Tuohy (1988, 1993) argues persuasively that this was true of all of the programs developed or expanded in the developed countries, including the United States. However, in the U.S. the negotiations were increasingly between providers and private-sector organizations--insurance companies, managed care organizations, and employers who purchase care for their employees--with adverse effects on physician autonomy: "These large corporate entities on the supply and demand sides are intervening much more directly into medical decision-making than governmentsIronically, in attempting to preserve its economic discretion by successfully opposing the introduction of national health insurance, the medical profession in the United State may have delivered itself into the hands of large corporate actors who are less sympathetic to professional autonomy than the state has elsewhere shown itself to be (1988, pp. 273, 274).

⁶ This also was true of the U.S. Medicare program (Marmor, 2000)

⁷ Of course, this concept pre-dated the act.

⁸ Since the end of World War II, this description of Canadian values has emerged as much from comparisons to the United States as from a systematic analysis of Canadians. The best known of these studies is Seymour Martin Lipset's *Continental Divide* (1990), which argues that the defining moment for the political cultures of both Canada and the United States was the American Revolution. Loyalists who relocated to Canada represented the conservative counter-movement to America's populist, egalitarian democracy.⁸ Canadians' value system was more elitist and less egalitarian; more focused on ascription and less on achievement; more deferential to state and ecclesiastical authority; more hierarchical and more likely to treat people as members of groups than as individuals (Wiseman, 2007, p. 25).

⁹ Wiseman (2007) critiques Ornstein and Stevenson's methodology (pp. 53-56) in that it exaggerates cross-geographical differences, especially in reference to "established national programs like health/medical care" (p. 199) and is atheoretical about why those differences have developed. However, he does not disagree with the overall conclusion regarding primary and secondary values (for ex., see p. 77)

¹⁰ Tuohy (1988) also notes that the providers did opt out or extra-bill did so for ideological reasons rather than financial ones, and that the relevant ideology was to "preserve private practice" rather than an anti-govt. ideology (p. 285). She cautions readers to remember that Canadian physicians have been split/ambivalent about "free market" descriptions of health care, which meant that justifying extra-billing in free market, ideological terms was rhetorically risky (p. 286).

¹¹ For an analysis of covert approaches to healthcare policymaking see Conrad & McIntush (2000); for a perspective on "tactical" strategies, see Conrad and Abbott (2007)

¹² There is an extended debate among political scientists regarding the origins of "Charter Rights." The most sophisticated, and most extensive, part of this debate involves Alan Cairns and his associates and Ian Brodie and his colleagues and students. The primary issue between the perspective of these two groups seems to be which came first, the assertion of group-related individual rights or the Charter (see Cooper, 2005).

¹³ Finbow (2005) argues that, with the decline in real dollar values exchanged through the equalizational formula Canada may now have four different forms of citizenship, with rich and poor English Canada becoming increasingly separated from one another.

¹⁴ Wiseman (2007) is even more direct: "An Americanizing cultural implication of the Charter is that core values of Canada's tory legacy--privileging certain *groups* or *collective interests* over those of self-seeking individuals--are being further overshadowed by the liberal values of individualism" (pp. 74-75, also pp. 84-85).

¹⁵ Both Seymour Martin Lipset (see the summary in Manfredi, p. 234) and Wiseman (2007, pp. 74-85) refer to this shift as the "Americanization" of Canadian political culture. Although we agree with the substance of the observation (see Manfredi, 1990), we do not think it is necessary to be insulting.

¹⁶ Also see Mandel (1994). Bakan's position on this issue is in one way different than that of the other Canadian legal scholars we have cited in this section--while they believe that returning to a broader conception of rights via the creation of additional legal structures such as a "social contract" can do much to return Canada to a Burkean orientation, Bakan believes that doing so would do nothing to address societal power inequalities, and thus can have little or no long-term effect:

How many times does one hear that Canada is now a free and equal society b/c of the Charter of Rights and Freedoms, w/o any analysis of the actual impact of its provisions? A similar disparity is possible with social rights [the rights of groups of individuals]. The ideals they articulate may be misinterpreted as descriptions of reality, and the effect may be to create an illusion of progressive social change when nothing has actually happened. Smart has noted that 'the acquisition of rights in a given area may create the impression that a power difference has been resolved' (Smart 1989). My concern is that social rights may be understood as themselves remedies for social inequality and thus obfuscate the continuing need for social change. 'Rather than providing a springboard to the future [a social charter might thus] trap the country in the past' (Myles, 1992, p. 62)." (Bakan, 1997, p. 140).

¹⁷ The Court's decision in this case is scheduled to be announced in June, 2008. This case is especially ironic because it comes on the heels of a great deal of self-congratulatory discourse by Canadian officials who celebrated Canada's ban on such advertising in the

wake of the Merck/Vioxx fiasco in the United State (see Baker, Conrad, Cudahy, & Willyard, In Press).

¹⁸ All citations are taken from the text of the Canadian Supreme Court decision, which is available at www.lexum.umontreal.ca/csc-scc/en/rec/html/2005scc035.wpd.html.

²⁰ For example, current Quebec Health Minister Philippe Couillard recently praised the opening of a private clinic in Montreal in response to the *Chaoulli* decision, while complaining that it took five years to implement the change. However, Dr. Amir Khadir noted that the operating room costs Quebec taxpayers more than "\$9000 per day just to cover the costs of maintaining the operating room with nurses" (Rakobowchuki, 6 Feb., 2008).

²¹ This position is developed in greatest detail in the concurring opinion. Although the judges did not indicate which alternative they preferred, the tone of their statement suggests a preference for the German or Dutch systems, where "people who opt for private insurance are not required to pay for the public plan. Only nine percent of Germans opt for private insurance" (p. 55). However, the Court did not discuss that role that stringent controls on insurance coverage and rates play in the success of the German and Dutch plans.

²² The majority and concurring opinions had attempted to pre-empt these arguments in two ways. First, it argued that being forced to leave the province for health care placed an excessive burden on wealthy Quebecers, and thus violated the principles of Canadian health care. Secondly, it argued that Canadians' strong support for its health care system would preclude the development of a private system of sufficient scope to threaten the public system (p. 49), and that predictions of adverse effects of a private system are inferences, not direct evidence. Yale University scholar Theodore Marmor's predictions were singled out for criticism in the majority and concurring opinions, while being praised by the trial judge and dissenting opinion.

²³ The use of evidence by Canadian appellate courts in *Charter*-related cases has been at issue for some time, both in general (see Martin, 2003; Mutttert, 2007; Ostberg & Wetslein, 2007) and in healthcare-related cases (see Downie & Gibson, 2007; Flood, Roach & Sossin, 2005). The *Chaoulli* decision heightened those criticisms (see *Catholic New Times*, 3 July, 2005 and Choudhry, 2005).

²⁴ For example, both U.S. and Canadian policymakers have resisted efforts to collect systematic data about the coming need for or cost of long-term care of an aging population. Because at this point there are no viable public policies available to meet those needs (Armstrong & Armstrong, 1996; Weissert & Weissert, 2006; Rachlis, 2004) it is unlikely that policymakers in either country will push to collect that information.