HEALTH CARE POLICY MAKING IN CANADA AS RHETORICAL TRANSCENDENCE: 1944-2014

A Dissertation

by

CHRISTOPHER MICHAEL CUDAHY

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Chair of Committee,	Charles Conrad
Committee Members,	Joel Iverson
	Jennifer Mercieca
	James Burk
Head of Department,	Kevin Barge

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ABSTRACT

Canada's national program for health services was conceived in the late 1960's after protracted advocacy on the provincial level – most notably from Tommy Douglas, premier of Saskatchewan. After insured services for both hospital and physician services had been secured in the province in 1961, the Government of Canada faced increasing pressure to nationalize universal health care. Largely in response to the advocacy of Mr. Justice Emmett Hall in his 1964 Commission Report, a national system was instituted into law in 1968 under Prime Minister Lester B. Pearson. Since that time, robust advocacy has waned and successive federal governments have instead focused on defending Medicare through the enactment of rigid legislation such as the *Canada Health Act*. This legislation and other advocacy has enshrined universal health care into the Canadian psyche making it highly resistant to change. I sought to assess the nature of the advocacy that has served to perpetuate the status quo at all costs and have suggested ways in which the rhetorical landscape could be altered to reinvigorate public discussion to keep Medicare up to date and to ultimately strengthen health care services in Canada. I employed rhetorical and communication theory as a lens for providing suggested pathways for clash and reform.

The following findings were noted in the dissertation. First, rhetorically induced value principles associated with Medicare have devolved into an institutionalized system that has been reinforced through its strong connection with Canadian identity. Second, there has been a marked de-emphasis of rhetoric which has been supplanted by a focus

on funding mechanisms and point of service delivery. Third, the more flexible argumentation associated with the legislative realm has been neglected and largely replaced by the more adversarial and rigid enforcement of perceived rights for health care through judicial review. Throughout the dissertation I argued for the need for rhetoric to be resurrected in Canada perhaps through the vehicle of egoistic charismatic political leaders. All in all, I envision a health care system that is more flexible, molded by rhetoric and allows for greater innovation while retaining core principles such as universality.

DEDICATION

To my Lord

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CHAPTER I

INTRODUCTION AND LITERATURE REVIEW

"Afoot and light-hearted I take to the open road,
Healthy, free, the world before me,
The long brown path before me, leading wherever I choose" (Whitman, qtd. in Bellah et al., 2007, p. 34).

"We must delight in each other, make others conditions our own, rejoyce together, mourn together, labor and suffer together, always having before our eyes our community as members of the same body" (Bellah et al., 2007, p. 28).

The above two quotes are reflective of two philosophies that can conceivably have a bearing on the nature of debate concerning health care and the kind of health care that is ultimately implemented in a particular nation state. The first quote illustrates one possible benefit associated with good health and having access to quality health care. Good health increases the potential of an individual to pursue their own interests and goals in life. However, those who subscribe to a more 'communitarian' perspective to life might highlight some of the pit falls associated with being so individually focused. Individualists miss out on both the promises and perils involved with living in a community.

The individual/community dialectic has certainly been an important factor in the inception, implementation, and continuation of Canada's universal system of medical care. The Canadian debate concerning the implementation and maintenance of what the Hall Commission termed health services programmes has been both complex and important to Canadians. In recent years, however, the health care debate has slipped in priority and been partially supplanted by other issues such as the economy, the environment, and the war in Afghanistan. This despite the fact that Medicare is

increasingly coming under attack by such free market oriented organizations like the Fraser Institute. Medicare has also been subject to increasing criticism from a variety of interest groups ranging from the Canadian Medical Association, to patients and most recently the Canadian Supreme Court. The stagnation concerning substantive policy discussion and the implementation of change within Canada's health care system was recently underscored by Justice Deschamps in the majority opinion in the recent Chaoulli decision:

> Ample evidence was presented. The government had plenty of time to act. Numerous commissions have been established. Governments have promised on numerous occasions to find a solution to the problem of waiting lists. 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. (*Chaoulli v. Quebec*, 2005, p. 61)

In light of the foregoing preliminary comments, this thesis will argue that with the considerable philosophical, theological, and policy related discussions and speculations relating to Canada's system of medical care, the patient has been lost in the fray. While it is true that the system has empowered patients in Canada by removing financial barriers to seeking medical care, this reality does not adequately inform and influence the patient's particular instances of visiting a physician or accessing and experiencing the medical system as a whole. The foregoing reality is exacerbated since the system provides a narcotizing dysfunction for the patient by inducing 'peace of

mind' concerning the resources at his/her disposal for maintaining health and managing suffering and illness. This thesis will seek to examine how the philosophical, theological, and policy related discourse influence and inform the patient's experience and sense of empowerment within the system. More generally, I will examine how key discourse relating to Canada's Health Services Programme contributes and influences the type or nature of care patients receive. The purpose of this thesis will be to attempt to reframe policy debate and decision in such a way as to focus rhetorical energy on empowering patients to the fullest extent that can be reasonably expected. I echo the sentiment made repeatedly throughout the formative Royal Commission on Health Services released in 1965: "In accordance with its Terms of Reference the Commission was directed to make recommendations to ensure 'that the best possible health care is available to all Canadians'" (RCHS, p. 1). They go on to elaborate on 'best possible' as to mean 'of the highest possible quality' (RCHS, 1965, p. 1). I will set up the discussion and analysis using rhetorical, philosophical, policy and theological literature to provide context and theory to the establishment of Medicare. Theory will be used as a means to evaluate the debate, implementation, and maintenance of health programmes services and to suggest ways that rhetorical and communication theory could be utilized to safe guard and improve a system that is so integral to Canadian identity along with the perception other countries have about Canada throughout the world.

With the above comments in mind, two things should be clear about the central position that will be taken in this thesis. First, my analysis will be based on the assumption of the centrality of patient care to any medical system. Second, I will

suggest that communication in general and rhetorical discourse specifically does matter in the sense that both have the ability to positively influence patient empowerment. Conversely, when the more visionary 'lofty' rhetorical communication is neglected, any system assumes the risk of falling prey to inert pragmatism that is recalcitrant to the malleability and adaptability that is so critical in the complex enterprise of managing disease, illness, suffering and death. This thesis will take an evolutionary approach to looking at Canada's universal system of medicine. Such an approach is valuable because it facilitates not only an analysis of key discourse relating to the movement but also provides opportunity to closely scrutinize the nature of the discourse at any particular moment within the history of a movement. I will argue that key discourse relating to Medicare falls into two basic philosophical categories. The first can be construed as ideologically based and be characterized by robust discussion, deliberation and widespread public debate. The second can be seen as discourse focused on pragmatism which seeks to create a system that will cement the ideas, and 'capture' the imagination and emotion upon which the system is based. The challenge in any well-conceived and complex system is to achieve an appropriate synthesis between pragmatism and ideology.

Through an analysis of key discourse relating to Canadian health care regarding the appropriateness of the aforementioned synthesis, I will argue that there has been and still is a disconnect between pragmatic oriented discourse and more robust policy deliberation and action. Specifically, I will attempt to provide an answer to the following questions: 1) To what extend is rhetoric needed to balance or 'temper' pure

pragmatism? Is achieving and cementing pragmatic ends or goals all that is required? 2) What role does or should 'agora style' rhetoric play in the implementation and maintenance of complex policies? Is there still an irreplaceable and indispensable value to the rhetoric of the market square? 3) What are some salient features that can be derived to help communication and rhetorical scholars make more subtle distinctions between pragmatic discourse and market place rhetoric? Can a typology be derived to help us to recognize degrees of hybridization between these two forms?

Proposed Critical Framework

First of all, it is important to note that my analysis of the debate and subsequent institutionalization of the Canadian health care system will take the form of 'applied' rhetorical criticism. Cheney & McMillan refer to several key thinkers in our field to justify this approach:

> As Crable (1986) observes, in examining Ehninger's (1968) 'systems of rhetoric,' the late twentieth century confronts the individual with rhetoric that is predominately organizational ('speaking for organizations') ; thus, the grammatical, psychological and social systems (as representing the classical period, the eighteenth century, and the first three quarters of the twentieth century, respectively) ought to be supplemented or at least reconsidered (1990, p. 107)

Having said so, I will use the thought of Burke, Weick, and Sproule as guidelines on my assessment of the nature of discourse emanating out of the health care debate in Canada. Sproule, for instance, recognizes the value of evaluating discourse in terms of its relative

public and private nature: "The distinction between the public and private spheres is a useful lens to begin a closer comparison of rhetorical action and organizational action" (Sproule, 1989, p. 258). To the extent that discourse on health care has become bureaucratized or overly focused on pragmatism, it should evidence characteristics of what Sproule would term 'expert rule':

> The knowledgeable leader acts for the best and is able to coolly make expert decisions while keeping prudently distant from the herd instincts of the crowd While not strictly democratic, the system has a benevolent utilitarian character in which the rule of the administrative expert assures the welfare of those less fit. (1989, p. 259)

To the extent that health care discourse adheres to some form of hybridization between the two extremes of pragmatism and ideology, it would then agree with Sproule's notion of 'second level' organizational rationality:

> Actors have a limited rationality owing to their less-than-complete private abilities to handle information and to respond to demands for decisions. The minimal structure of their dyads and triads are embodies in the reasons and rationales that become articulated when decisions are justified. This is clearly more of a Socratic or scientific view of rationality than a rhetorical one, since reason depends on actions of individuals instead of a judgment by a larger public which decides between advocates. A rhetorician might ask why we should limit organizational rationality to dyads loosely coupled:

> that is, is it not possible to develop a 'second level' or organizational enactment that might be more mutual and holistic. (Sproule, 1989, p. 261)

The foregoing notion of incorporating a scaled down version of town hall debates within the auspices of a complex and bureaucratized organization is also consistent with Weick's perspective on 'mini-publics' (Sproule, 1989, p. 264).

In drawing on the thought of Kenneth Burke, I will also use his concepts of hierarchy and mystery as a means to assess the nature of the discourse that has manifested itself in the debate and discussion of Canada's health care system. It has already been referenced that a focus on procedural 'fairness' in a utilitarian sense can nudge a system in the direction of rigidity to unique situations and individual concerns. Cheney & McMillan suggest that "bureaucracy ironically and necessarily suppresses concerns about individual needs, differences, and expressions… Even some apparently and intendedly non-bureaucratic forms of organization (such as lean, value centered high-tech firms) often manifest a technical-formal rationality that governs individual behavior in a thoroughgoing manner" (1990, p. 98). Taylor would label such a phenomenon as a slide towards 'procedural fairness' and Burke also speaks in his *Rhetoric of Motives* of the tendency of systems – once order has been established – to lapse into inflexibility:

> There is a 'universal' lesson here. But it is in the fact that we confront a 'hierarchic psychosis,' prevailing in all nations, but particularly sinister in nations which are largely ruled by the 'dead hand' of institutions developed from past situations and unsuited to the present. In one form or another, it

affects every rung on the social ladder, however imperceptible or roundabout its working may be. (Burke, 1969b, p. 281)

In sum, order and hierarchy can have a stifling effect on individuality, creativity, and imagination, so it stands to reason that documents that place a good deal of focus on the foregoing would more than likely swing to the 'pragmatism' side of the argumentation pendulum. Mystery, of course, is tied into hierarchy because it perpetuates order but can paradoxically foster what he would term 'pure persuasion' a type of courtship rhetoric. To the extent that a system is mysterious to its constituents, the situation can encourage communicative behavior to ameliorate uncertainty for the purposes of considering the partially acquired entity their own. So Burke's notion of mystery will be used as a key unit of analysis to both understand how uncertainty can empower and disempower those to whom it afflicts.

In short, I intend to take a historical approach to my analysis by starting at the discourse surrounding the genesis of Medicare and then to move on to other documents that have contributed to the debate and the perpetuation of the system since the beginning. The overall goal will be to use the ideas referenced above as a way to uncover the nature of the discourse and specifically, where each document or rhetorical event might sit on a pendulum that ranges from 'pure' agora style rhetoric and bureaucratized pragmatism.

Constitutional Influences on Canadian Health Care

Currently, two constitution acts inform and provide key guidance to the governing process within Canada. While there is no need for the purposes of our

discussion to describe either act exhaustively it is important to examine how elements within both acts relate to Canada's universalized single payer system of health care. In referring to the original Constitution Act of 1867, the historian William Stahl emphasizes:

> It is clear why the Fathers of Confederation spoke of 'peace, order, and good government' rather than life, liberty, and the pursuit of happiness. The virtues of monarchy subordinate the individual to the community. Instead of liberty and happiness, loyalty and responsibility are stressed. Freedom may be a watchword, but equality is not, and freedom is always tempered and circumscribed by obligations and the rights of others. (Lipset, 1990, p. 44)

There are several key points worth mentioning here. First, in the *Constitution Act of 1867* the values of 'order' and 'good government' were emphasized. As will be discussed in greater detail, Canadians tend to be more deferential to authority than their American counterparts which of course ties into how receptive they are to yielding to the judgment of government for a variety of issues. Second, a key feature that undergirds universal medicine in Canada is the value of equality. The system is set up to place all individuals on a level playing field when it comes to seeking medical assistance for a variety of illnesses and conditions. The constitutional justification of such an approach is clearly seen with the value the founding fathers placed on the importance and responsibility of government and the need to treat citizens fairly and equally. The *Constitution Act of 1982* was written as a byproduct of Canada's greater autonomy from Great Britain and also crafted with the intent purpose to enshrine what was seen as key

human rights that all of its citizens should be privy to. Otherwise known as the *Charter of Rights and Freedoms*, the document has since had a tremendous influence on such debates as the same-sex marriage issue and very recently the Canadian Supreme Court's decision to lift the ban on private health insurance in the province of Quebec. The Chaoulli decision originated from a physician and patient suing the Attorney General of Quebec for its prohibition on seeking care outside of the publicly funded system. The Charter of Rights and Freedoms became a key factor in the decision since the plaintiffs claimed that certain rights violated on account of the patient being forced to wait for over a year for hip replacement surgery. In a 4-3 decision, Canada's highest court accepted the argument. Section 7 of the charter formed the basis of the plaintiff's arguments and reads as follows: *"everyone has the right to life, liberty and security of the person and the right not to be deprived thereof except in accordance with principles of fundamental justice"* (*Canadian Charter*, 1982). Zeliotis and Chaoulli claimed that by being wait-listed for the procedure, the patients right to 'security of the person' was being violated and the Attorney General of Quebec asserted that the violations was justified on the grounds that the delay was in keeping with 'principles of fundamental justice.' So not only has the constitution influenced the genesis of Medicare but has also provided the basis for recent critiques of the system.

Our discussion would not be complete without reference being made to the *Canadian Multiculturalism Act* of 1985. Although the act was written after Medicare had been fully established, an examination of its contents expands on the value of equality and provides further illumination to the philosophical underpinnings of

universal medicine. The official Canadian policy concerning multiculturalism is spelled out quite clearly in the *Act* written in 1985. Among other things, this document states that it is the policy of the Government of Canada to a) recognize and promote the understanding that multiculturalism reflects the cultural and racial diversity of Canadian society and acknowledges the freedom of all members of Canadian society to preserve, enhance and share their cultural heritage; b) ensure that all individuals receive equal treatment and equal protection under the law, while respecting and valuing their diversity; and c) encourage and assist the social, cultural, economic and political institutions of Canada to be both respectful and inclusive of Canada's multicultural character (Canadian Multiculturalism Act). The philosophy of multiculturalism can be contrasted with the U.S. notion of the cultural melting pot where people from different ethnic backgrounds share the common foundation of being American. Dickinson and Dolmage sum up the distinction:

> In its crudest form, the debate is a contest between, on the one hand, melting down the citizenry into a nation of "Americans" or "Canadians," people who will largely share nationally defining characteristics and attributes, and, on the other hand, balkanizing them into officially structured units within the state, each with their own defining characteristics, attributes, and values. (1996, p. 364)

The Multiculturalism Act further cemented the value of equality that has become so important for Canadians. Granted, a melting pot doesn't necessarily promote inequality since the homogeneity involved in being American does create to an extent a level

playing field. The different view of equality between the two nations is more relating to degree than to kind. By virtue of being American, all U.S. citizens, at least in theory, enjoy equality of opportunity. Just because people have equal access to opportunity, however, does not mean that the condition of equality will actually be pervasive. The foregoing becomes obvious when one thinks of the term 'pursuit' of happiness enshrined in the U.S. constitution. Many people pursue things aggressively that they never acquire. In Canada, 'equality' pertains more to 'outcome' or the final product rather than an initial state of being. So at the end of the day, the way that Canadians experience their medical system should have less variance than is commonly seen in the United States.

The Canadian Cultural Philosophy

Building on our brief synopsis of elements within Canada's constitution that may have been influential for the implementation of its medical system and also central to subsequent challenges and debate, the discussion of Canadian values will be extended to include a wider look at cultural philosophy in general. In other words, how might some of these more formal elements actually play out in Canadian life? How can they be applied to day-to-day living in the social and political sphere? How do some of these constitutional considerations shape and morph into Canadian identity and policy in all of its complexity? And most importantly, what additional inferences might we make about these observations that would have a bearing on the implementation and maintenance of Canadian health care? Two major ideas can be further unpacked from the above discussion and applied to Canadians' perception and support of their system of health

care. The first idea is a natural outgrowth from the premium that our founding fathers placed on 'good government.' Trust in government implies a certain orientation toward hierarchy and authority in general. Of course as Burke would argue, human beings by nature are "goaded by the spirit of hierarchy" and "moved by a sense of order" (1966, p. 15) but several thinkers assert that Canadians are particularly deferential to authority and comfortable with the stability that the rule of law and good government can bring. They largely attribute this tendency to historical factors that served to differentiate the United States from its northern ally. In paraphrasing Bryce, Lipset brings forward the notion that:

> Canada did not exhibit the 'spirit of license, the contempt of authority, the negligence in enforcing the laws' found in the United States and other populist countries. He stressed the enduring adherence of both Canadian language groups to pre-Revolutionary values. Their concern with 'order and harmony' reflected 'the ideals of the authority and natural hierarchy. (1990, p. 54)

While recognizing the influence that liberal capitalism has had on Canada, a particular analyst of business behavior has suggested that it largely remained at its inception "an elitist, conservative, defensive colony" (Herschel Hardin, qtd. in Lipset, 1990, p. 120). One of the most significant ramifications of the foregoing difference between the United States in Canada is a greater tendency for the latter to rely on government to manage social concerns such as poverty and health. The U.S. in contrast is more likely to fall back on market oriented or individual mechanisms as a means by which people in need

are helped. It is a mistake however to assume that Canadians to not respect the market and saddle it with heavy regulations. Instead, the Canadian system appears to work off of a kind of hybrid scenario where the industrial and business sectors are market driven but in the realm of the social sphere government intervention is not only tolerated but expected:

> Many Canadians feel that a market economy works best with a minimum of government interference, but that the state should take responsibility for providing services in areas where it can do so more efficiently or humanely than the private sector. This viewpoint implies that government ownership occasionally may be a preferred solution, but regulation is less likely to be so. (Lipset, 1990, p. 133)

In short, Canadians believe that "government should take responsibility for the needy" and are more than willing "to use government power to redress the inequalities of the market place" (Lipset, 1990, pp. 141-142).

So in light of the foregoing discussion, what might be some of the implications of the Canadian orientation toward hierarchy for health care? More specifically, how could the above attitudes toward government and hierarchy conceivably influence patient empowerment in their experiences with the health care system? Clearly, the patient is required to interact with a hierarchy when they access the health care system. At the peak of this hierarchy is the physician who has the status, training, technical knowledge, education, and general expertise to manage a patient's health needs. Granted, business types often heavily populate hospital boards throughout the country.

But there is indication that even the system's political task masters rely on Doctors to fulfill a variety of functions. *The Royal Commission on Health Services* acknowledge this dependence with the following comments:

> Unlike many other goods and services the consumer as a rule is incapable of fully evaluating the health services he receives or even if he needs them… Hospital services, medical services, prescribed drugs and dental services can only be obtained through the decision of a physician or dentist and it is the practitioner generally who determined the amount, type and location of services received. In this area the recipient lacks the competence to judge what is appropriate… It follows then that for the majority of health services, the amount, the type and the location of health services must be decided by the practitioner on the grounds of medical or health needs. The judgment of the profession determines quality of care; the consumer generally does little more than accept the decision of the practitioner. (1965, p. 205)

So in addition to the tendency of Canadians to be more deferential to authority in general, physicians are also granted a significant amount of institutional credibility and responsibility as is illustrated from the above statement from RCHS. One possible consequence of this in terms of patient empowerment might be that patients will be less likely to fight for their rights from within the system. The technical nature of medicine and medical care can exacerbate a feeling of disempowerment since they often lack the 'language set' to employ as their own advocate. Second, although it is granted that many patients in Canada have their own family doctor they are still expected to navigate

through a complex system throughout the course of any sustained treatment for serious or chronic illness. In short, it is ultimately the 'system' that takes care of patients more so than an individual or a series of individuals. Ultimately, this increases the chances of the process being impersonal and somewhat rigid in responding to unique, individual tailored, personal concerns and issues. As Burke remarks, "an idea can seem impersonal because many men, or all men, may share in its personality (or partake of its substance, quite like communicants ritualistically eating the blood and body of their god)" (Burke, 1969b, p. 277). Burke also recognizes some of these elements as plausible consequences emanating out of a hierarchical system. He speaks of 'advantage' being gained not from rational or emotional appeals. Instead, it is grounded in a

> 'form,' in the persuasiveness of the hierarchic order itself. And considered dialectically, prayer, as pure beseechment, would be addressed not to an object (which might 'answer' the prayer by providing booty) but to the hierarchic principle itself, where the answer is implicit in the address. (Burke, 1969b, p. 276)

Here Burke suggests that the appeal of the 'system' and its complex hierarchy overshadows personal appeals directed to an identifiable and personal target in which a direct and individualized response can be expected. Finally, the issue of Canada's health system as being well-conceived but not particularly malleable to changing circumstances and historical contingencies has been briefly touched on earlier with the reference to the Supreme Court's intervention on behalf of citizens to address the exigence of wait times.

Interestingly, Burke connects stagnation and rigidity to hierarchy with his explication of what he terms a form of 'psychosis.':

> There is a 'universal' lesson here. But it is in the fact that we confront a 'hierarchic psychosis,' prevailing in all nations, but particularly sinister in nations which are largely ruled by the 'dead hand' of institutions developed from past situations and unsuited to the present. In one form or another, it affects every rung on the social ladder, however imperceptible or roundabout its working may be. (Burke, 1969b, p. 281)

Canada, as a nation of having a greater propensity to the acceptance and deference of hierarchy could certainly fall into the category of inactivity rather than proactively adjusting an originally well designed system that has served Canadians exceedingly well for several decades. Unfortunately, the void or routine and forward thinking maintenance has been filled by a series of less than helpful attacks and criticism from free market interest groups.

The second major idea that can be further unpacked from our preliminary discussion of constitutional influences on Canadian culture and more directly applied to Medicare is the notion of equality enshrined in the *Multiculturalism Act* of 1985. As referenced earlier, Canada differentiates itself from the United States on the grounds that it has established a cultural mosaic rather than a melting pot. The idea of a cultural mosaic is founded on the value of equality since citizens with differing ethnic, cultural, linguistic and religious backgrounds are allowed to hold fast to their identities. In a nut shell minority populations are encouraged to celebrate their uniqueness. In essence the

philosophy of a cultural mosaic follows the formula minority status + Canadian instead of American + minority status which is seen in a melting pot. The key thing to remember here is that a cultural mosaic is based off of the value of equality which reinforces one of the key premises of Medicare which provides equal access to medical services by removing financial barriers to care. Successive Liberal governments have repeatedly responded to suggestions of increasing privatization of the system with the refrain that such a change would create a 'two-tiered' system where public and private 'for profit' medical care would exist in parallel. Hence, the strong rhetorical implication here is that such a state of affairs would be patently *unequal.* In contrast, the clear presupposition behind the current U.S. system is that everyone has equal opportunity to acquire medical services either by mode of cash or insurance payments. The equality of *outcomes* however is far less equal with millions of Americans currently uninsured and without optimal access to health care. Few would argue that Medicare is unequal in scope but the question to be resolved here is whether the current system provides the 'best possible health care' that is 'of the highest possible quality'(RCHS, 1965, p. 1) for Canadians?

The ethicist Charles Taylor addresses some of the possible pit falls associated with the celebration of the value of equality. Recall Stahl's position that Canadian constitutional parameters set up a clash between the competing values of 'freedom' and 'equality' with the former being checked or diminished by the latter: "Freedom may be a watchword, but equality is not, and freedom is always tempered and circumscribed by obligations and the rights of others" (Qtd. in Lipset, 1990, p. 44). Taylor suggests that

the Canadian focus on equality creates a kind of argumentative deficiency when values are infused into public policy. It is in the realm of public policy, he says, that we often settle for 'procedural ethics' rather than constantly striving for the best possible policy based system which is what the Hall Commission advocated for. "In other words, we establish a neutral set of rights and liberties designed to allow maximal choice about what constitutes a good life or a proper end. Those rights do not reflect what is good – for that is individually determined – but rather, what is fair" (Bowers, 2002, p. 43). The foregoing reinforces our previous reference to the difference between 'equality of opportunity' and 'equality of outcomes' and also harkens back to some of Burke's comments on the sometimes impersonal less than malleable nature of embracing 'hierarchy' in an abstract and esoteric kind of way. It is also ironic that the recent challenge to the public system in Quebec by the Supreme Court of Canada was based on *individual* grounds something that Taylor would suggest can at times be sacrificed at the altar of equality.

A Bird's Eye View of Medicare

Now that some of the contextual and historical issues surrounding the implementation of a single payer universalized health care system in Canada have been addressed and a preliminary argument positing for the primacy of patient centered health services has been advanced, it is crucial to take a closer look on how theory might inform a critical look back and visionary look forward to the future of Canadian health services. A persistent theme that permeated the presentation of the Hall Commission was the desirability of not only implementing a plausible and logically defensible

alternative to privatized health care but also to establish a clear way by which the new system could be evaluated on a regular basis. Although it has been argued in this thesis that healthy debate and robust public discussion concerning health care has waned in recent years, this state of affairs was never the intent of those who authored the Royal Commission on Health Services:

> Evaluation procedures too must be built into the Health Services Programmes to facilitate a continuing assessment of the quality of care provided and the effectiveness with which this is accomplished. In carrying out its responsibilities at the local, provincial and federal levels the Health Sciences Research Council will be able to offer guidance to the Provincial Health Services Commissions in their evaluation of health services programmes (RCHS, 1965, p. 144).

And although it has been argued that historically Canada has tended to place the value of equality at the highest level of priority, the RCHS did not intend for this philosophy or orientation to culture to trickle down into their newly conceived publicly funded system. Freedom was certainly not a 'watchword' to the authors of this commission:

> [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, nor 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. (1965, p. 11)

So based on this it is worth the time to develop a theoretical scaffolding to reclaim some lost ground and to regenerate discussion on how our system can be critically assessed and based on this evaluation suggest a beneficial way forward. The remainder of this proposal will be geared towards these ends.

Mystery and Medicare

Linked to our discussion on hierarchy above is the notion of mystery. As Burke notes:

> Mystery in itself will not be without its usefulness in worldly governance. For, once a believer is brought to accept mysteries, he will be better minded to take orders without question from those persons whom he considers authoritative. In brief, mysteries are a good grounding for obedience, insofar as the acceptance of a mystery involves a person in abnegation of his own personal judgment. For in Earthy symbolicity, 'reason' will be closely associated with rule. So, if a man, in accepting a 'mystery,' accepts someone else's judgment in place of his own, by that same token he becomes subject willingly. That is, subjection is implicit in his act of belief. (1969b, p. 307)

While I might dispute the notion that Canadians have 'accepted' the mystery of Medicare, I would say that the system remains mysterious primarily resulting from a lack of knowledge concerning the way in which it 'works' (Burke, 1969b, p. 307). For instance, it remains unclear who or what exactly a physician bills for services rendered other than the ubiquitous and altogether general 'government.' Contrast this to the specificity of actually knowing the name and address of a particular private insurance company in a more market driven system. Neither is it obvious how the system is paid for other than the generic refrain 'tax dollars.' Is it even possible to make a determination on the percentage of an individual or family's gross pay that is designated to medical coverage? Of course, the answer, if attainable would vary depending on the individual (s) socio-economic status. In the United States citizens can calculate relatively easily how much they are paying for medical care by adding deductibles, co-pays etc. to whatever they pay out in insurance premiums. Even the costs of particular procedures, tests, and other medical services are readily discernable from statements received from doctor's offices and insurance companies. In Canada, since patients are not billed there is no need to be aware of these particulars. Burke would suggest in his *Rhetoric of Motives* that such incompleteness of understanding inevitably relegates one's perceptions of the 'system' or 'hierarchy' to the realm of 'hunch' or subjective feeling: "To the extent that he cannot reduce it to a mathematical formula he is in a state of 'infancy,' working with a kind of 'intuition' that overlaps upon the realm of the 'unconscious' in dreams" (Burke, 1969b, p. 175). All of this discussion of course could have an influence on a patient's ability to communicate with his or her physician in an

empowered way in regards to both the medical and economic rationale behind a suggested course of treatment. The same thing could be said when considering the logistics of navigating through a complex system. Rather than visiting one's doctor and presenting him or her with symptoms and then relying on that physician to operationalize the various human resources, equipment, and facilities available within a modern medical system, a patient could be empowered to be a more active participant in managing their case with a greater understanding of both the sum and parts of the services they require.

If one were to look at Canadian Health Services Programmes as a form of 'argument,' Burke's discussion of hierarchy and mystery again becomes relevant. He sees 'pure persuasion' as necessarily possessing an element of mystery to it. In using the metaphor of 'courtship' to explain what he means by the foregoing, he asserts that "standoffishness is necessary to the form, because without it the appeal could not be maintained" (Burke, 1969b, p. 271). The act of 'standoffishness' he says, can originate from either a person who is attempting to acquire something or from the object that is available for acquisition:

> At this stage we need only note that the indication of pure persuasion in any activity is in an element of 'standoffishness,' or perhaps better, self-interference, as judged by the tests of acquisition. Thus, while not essentially sacrificial, it looks sacrificial when matched against the acquisitive… For if union is complete, what incentive can there be for appeal? Rhetorically, there can be courtship only insofar as there is division.

> Hence, only through interference could one court continually, thereby perpetuating genuine 'freedom of rhetoric.' (Burke, 1969b, pp. 269-271)

In light of the foregoing, it is useful to ask, Is Medicare 'pure persuasion?' The answer would seem to be yes and no. On the one hand, Canadians have enjoyed universal health coverage for nearly four decades. So the 'attainment' of that service is complete. Hence the need for 'courtship' to gain health coverage is obsolete. Therefore pure persuasion is no longer occurring. But on the other hand, the patient is currently constrained by the system from accessing it at will or indiscriminately. Since this is true, the acquisition of health care on demand has not been achieved - keeping in motion the need for patients to 'court' or persuade the system to adapt and respond to their individual needs. Moreover, medical care is often postponed despite the fact that Canadians have essentially 'prepaid' for service. As a result, the patient finds themselves in an elaborate courtship with the health care system because there is not a one-to-one correlation between paying for service and receiving service. Consumption is 'controlled' or 'delayed.' So in this respect the relationship between the patient and the medical system reaches the highest levels of persuasion as outlined by Burke. The notion of having the benefit of already achieving a down payment for future health needs is in many ways consistent with the Canadian psyche when it comes to economic risk taking and managing personal finances (Adams, 2003, p. 94). In comparing Canada and the U.S. in this regard Lipset remarks as follows:

> From 1980 to 1988, the household savings rate in Canada was more than twice that in the United States for all years but two, when it was almost at

> that ratio… Canadians were more inclined to 'like to pay cash for everything I buy' (80 to 72 percent) and to say that 'to buy anything, other than a house, on credit is unwise' (61 to 50 percent). (Lipset, 1990, pp. 126-127)

Indeed, when grappling with the possibility of overusing a medical system in which prior financial barriers had been removed, the authors of the RCHS made a number of comments consistent with Burke's discussion of the nature of pure persuasion. After citing support for a system of prepayment for medical care by the Canadian Medical Association the commission report reads as follows:

> This however, raises the question whether a prepayment plan encourages or induces a substantial volume of demands for unnecessary medical care simply because of the removal of the economic barrier to a desirable service. Is the increased demand arising from the introduction of a universal prepaid programme a demand for unessential health services? (RCHS, 1965, p. 4)

Then, quoting *News & Views on the Economics of Medicine*, the commission speaks as follows regarding the underlying root causes of misusing medical services:

> We see every-day examples of the possibly insecure physician who in his enthusiasm, or for other reasons, overservices the majority of his patients… We also know that there has been a certain segment of the population which has always demanded a great deal of medical care and which will continue to make unreasonable demands if not brought under control by the medical profession. (RCHS, 1965, p. 5)

Focusing our discussion back unto Burke's notions of mystery and pure persuasion, the following comments can be made. So if the analogy of a courtship can be applied to a doctor-patient relationship, in order for this courtship to remain vibrant and reach the highest possible level of persuasion, a certain level of mystery needs to be maintained. If the physician is too 'enthusiastic' in his or her service or if the patient consumes an available service inappropriately, acquisition may be accomplished too easily. As a result, the system will lose some of its sausory value. As mentioned earlier, one of the factors that make Canada's universal health care so potent to Canadians is the peace of mind it induces. Canadian citizens know that if their health fails they have a government managed nest egg upon which to draw. Knowing that any future health care need has already been paid for in advance has the capacity to increase quality of life by empowering citizens to take risks and work toward a high quality of life with the assurance that they know that they will be taken care of during difficult times. So it appears that evaluating the Canadian health care system in terms of hierarchy and mystery reveals a social safety net that has both a narcotizing dysfunction and high degree of functionality that can also have a narcotizing effect. It appears that many problems that may be associated with a lack of knowledge or understanding of the system need not be confined to an unsolvable philosophical dilemma. Instead, an overabundance of mystery can be dealt with pragmatically with particular communication strategies employed by the government, medical professionals and patients.

Identification with Medicare and its link to Canadian identity

In a continued attempt to examine Canada's health services as an argumentative form, the discussion will turn to the extent that the system and its political masters tap into Canadian identity with the ultimate goal being to increase commitment toward the idea of universal health care that is funded on a pre-payment basis. In quoting a number of figures, Lipset encapsulates both the pervasiveness and unique nature of identity construction in Canada:

> National identity is the quintessential Canadian issue. Almost alone among modern developed countries, Canada has continued to debate its self-conception to the present day. One of its leading historians notes that it has suffered for more than a century from a somewhat more orthodox and less titillating version of Portnoy's complaint: the inability to develop a secure and unique identity. And so…intellectuals and politicians have attempted to play psychiatrist to the Canadian Portnoy, hoping to discover a national identity. As if to illustrate his point, Margaret Atwood comments ironically, 'If the national mental illness of the United States is megalomania, that of Canada is paranoid schizophrenia.' (Lipset, 1990, p. 42)

So the question that needs to be grappled with here is, To what extent does the distinctiveness of Canada's Health Services Programmes ameliorate the foregoing? Do Canadians see their system of health as particularly salient to their national identity? Cheney and Tompkins define identity "to be what is commonly taken as representative of a person or group either by the person/group in question or by observers" (1987, p. 5).

The term 'identification' is conceived as a more active construct that is more sender oriented. In other words, identification is more dependent on human agency:

> Identification will be broadly conceived by us as the appropriation of identity, either (1) by the individual or collective in question or (2) by others. (The term 'appropriation' is appropriate here because it subsumes both 'something acquired' and 'something invested.') Identification includes the development and maintenance of symbolic linkages salient for the individual/group, as well as less significant attachments which may be promoted by any rhetor (even the individual/group in question). (Cheney & Tompkins, 1987, p. 5)

Cheney and Tompkins continue their discussion by suggesting a link between identity/identification and commitment to a particular organization. They suggest that evidence of high commitment points toward an interaction between the organization and personal identity (Cheney & Tompkins, 1987, p. 7). In short, identity and identification form the substance of the relationship between an individual and organization and commitment is the form of this relationship (Cheney & Tompkins, 1987, p. 9). The appropriate management of the identity/identification and commitment relationship is important because high commitment to an organization that taps into perceived personal identity can become dogmatic, rigid, and even dangerous in the case of involvement with total institutions (Cheney & Tomkins, 1987, pp. 9-12). Conversely, low commitment or multiple commitments can cause confusion and at times paralysis as an individual's decisions and choices can clash with different facets of their identity. In the

case where there are too many options available for which to commit, an individual may simply choose not to choose – slipping into the realm if inaction and identity formation stagnation (Cheney & Tompkins, 1987, p. 12). Finally, Cheney and Tompkins discuss the importance of two particular identification behaviors for their influence on commitment to a specific target or organization:

> Both message *affect* (the way employees feel about the organization after communicating with others) and message *content* are predictive of organizational commitment, with those employees who send positive messages about the organization being the most committed. (1987, p. 11)

George Cheney draws on the thought of Burke to shed light on the suasory power of organizations to draw in desirable targets for their 'cause.' He terms the foregoing the 'rhetoric of identification' and ultimately elucidates three units of analysis upon which to evaluate the effectiveness of an organization to draw and retain target employees. The first strategic approach to achieving identification with a particular audience is through associating with the other. Identification "flowers in such usages as that of a politician who, though rich, tells humble constituents of his humble origins" (Burke, qtd. in Cheney, 1983, p. 148). The second strategy for inducing identification is to work toward unity in a disparate audience through emphasizing that though disagreements may exist, they pale in comparison to a particular adversary or rival. Burke describes the process as "the workings of antithesis, as when allies who would otherwise dispute among themselves join forces against a common enemy. This application also can serve to deflect criticism, as a politician can call any criticism of his

policies 'unpatriotic.' on the grounds that it reinforces the claims of the nation's enemies" (Qtd. in Cheney, 1983, p. 148). In paraphrasing Burke, Cheney reports that "the third identification indicates the mingling processes of association and dissociation, when very dissimilar interests are joined under the transcendent 'we'" (1983, p. 148).

Several comments can be made by way of application to our attempt to gain a greater understanding of what the best possible health care system for Canadians might look like. One of the suggestions for this thesis proposal is to siphon down esoteric discussion and speculation in regards to health and focus more on empowering patients within the system. First of all, as referenced earlier in our discussion on mystery there is certainly a gap in knowledge about and expertise within the system between physicians and other medical staff and lay patients. More active engagement of a rhetoric of identification could potentially assuage widespread ignorance or lack of clarity on the ins and outs of Medicare in Canada. In fact, one sees little evidence of direct to consumer marketing and public relations on behalf of Medicare, hospitals, or physicians. For future directions in research, it might be worthwhile to chart the breadth of advertisements in regards to our health care system in print, TV, radio, and electronic media. Second, it would make sense to explore the evolution of Canadian identity over the last twenty years. It would seem the days of our health care system being one of the most important contributors to Canadian's notion of themselves are past. On the one hand, it seems reasonable to suggest that the health care system enjoys a significant amount of presumption on account of it still being a deeply entrenched facet in the construction and reconstruction of Canadian identity. The perception that others have of

the quality of our system increases the foregoing. Cheney speaks of rhetorical techniques used to "encourage the employee to identify with the organization by representing the views of others. Implicit in the statements is the idea that employees should share the same positive view of their employer that actors in the environment do" (1983, p. 152). Canada has repeatedly been praised for its high quality of life by the United Nations and ranks above the United States on a variety of measures for effective health care as recorded by the World Health Organization (See Human Development Report Office, http://hdrstats.undp.org/countries/country_fact_sheets/cty_fs_CAN.html & http://www.paho.org/English/DD/AIS/cp_124.htm). On the other hand, Canadian identity is becoming more complex and less predictable in recent times. Once seen as a nation of peacekeepers, Canada has been involved in heavy combat in one of the most volatile areas of Afghanistan since 2002 (See Last, 1995, p. 204). Once known as primarily a 'hockey nation' Canada is now enjoying the highest levels of success in a wide range of sports such as Basketball, Baseball, and pro wrestling. Recently, Prime Minister Stephen Harper has been re-focusing attention on Canada's North as an issue of sovereignty and identity. In short, Medicare now competes with a wide range of other structures that mold and influence identity. Conceivably, this could leave the health care system more vulnerable to attack as new generations assume positions of prominence and influence in Canadian society who may not necessarily hold Medicare as sacrosanct. Finally, it makes sense to explore in greater depth to whether and to what extent the health care system is an 'organization.' If it is an organization, should this organization be considered all-encompassing or should Medicare be an umbrella term used to analyze

and look at multiple related entities such as medical staff, hospitals, patients, government, lobby groups such as the Canadian Medical Association, medical schools, and the media?

Concluding Remarks

This paper has attempted to set a research framework for making a contribution to the health care debate in Canada. Constitutional parameters that likely have had a bearing on the discussion, implementation, and perpetuation of Medicare have been explored. Additionally, particular cultural philosophies emanating from the foregoing were outlined. It was suggested that discussion centering around health has been dominated by discourse and contained within the symbolic realm and that debate should become more focused on empowering the patient when accessing and navigating through the system. Ultimately, the analysis pointed toward a number of tensions in need of being effectively managed. Burke's idea of mystery and hierarchy revealed that while a dim understanding of government and bureaucracy can be disempowering, some level of mysterious courtship behavior from one side or the other is required to keep a relationship persuasive and vibrant. It was also argued that the safety net provided by Canada's universal health care system can induce both a functional and dysfunctional state of being by ratcheting down incentive on the part of citizenry to be informed but at the same time enhancing quality of life through actually encouraging risk taking and the building of personal potential. The identity/identification dialectic and their relationship to commitment to a particular organization was a useful way of elucidating the inevitable need for the reform and maintenance of any system. While clearly Canadian

health care has been an integral part of the construction of identity, Scott, Corman & Cheney remind us that "identification is the process of emerging identity. Identification, especially as expressed in symbolic terms, represents the forging, maintenance, and alteration of linkages between persons and groups" (Scott et al., 1998, p. 304). Canadian identity is continually shifting and the debate surrounding the maintenance of the medical system should reflect that fact.

In light of the foregoing comments hopefully this thesis will help to illuminate an important issue in our field concerning the nature and function of rhetorical discourse. As Justice Deschamps argued, essentially there has been 'too much talk and not enough action' in dealing with the pragmatic issue of wait times.' But her comments beg the question as to whether a false dichotomy is being set up between discourse and material reality. Perhaps it is simply the case that more appropriate discourse needs to be generated to more effectively serve as a catalyst for addressing real problems and concerns. Bitzer, for example argued that rhetoric and pragmatism go hand in hand with one another:

> A work of rhetoric is pragmatic; it functions ultimately to produce action or change in the world; it performs some task. In short, rhetoric is a mode of altering reality by the creation of discourse, which changes reality through the mediation of thought and action. The rhetor alters reality by bringing into existence a discourse of such a character that the audience, in thought and action, is so engaged that it becomes a mediator of change. In this sense, rhetoric is always persuasive. (Bitzer, 1968, p. 8)

This proposal is by no means exhaustive as I would also like to explore other influences on the establishment and maintenance of Canadian health care. The importance of a plausible and useful theodicy, the liberal/conservative dialectic, the rhetoric of Tommy Douglas and the Saskatchewan project, and the nature and effectiveness of public policy advocacy are a few examples of how the argument will proceed. At the end of the day, though, I want to use these discussions as a starting point to going back to some key texts that have been manufactured in the intervening time frame between the RCHS and the Chaoulli decision. Source texts will include the *Kirby Report*, *Romanow Report* and the *Canadian Health Act*. The goal will be to set up some suggested criteria and then test their effectiveness at evaluating Medicare and adding a fresh communicative based perspective on a debate that has been an integral part of Canadian public policy related decision making for nearly forty years. This of course, is consistent with the spirit of the Hall Commission to facilitate the 'best possible' health care for all Canadians.

CHAPTER II

CONSTITUTIONAL PRECURSORS TO MEDICARE

It shall be lawful for the Queen, by and with the Advice and Consent of the Senate and House of Commons, to make Laws for the ***Peace, Order, and good Government of Canada****, in relation to all Matters not coming within the Classes of Subjects by this Act assigned exclusively to the Legislatures of the Provinces (Section 91, Constitution Act, 1867).* [Emphasis mine]

Before initiating my analysis of the rhetorical features of universal health care in Canada, it makes sense to briefly revisit my thesis. I will argue that as the considerable policy-related discussions and speculations relating to Canada's system of medical care developed over time, the patient has been lost in the fray. Reduced incentive for physicians operating out of a publically administered and not-for-profit system combined with an eliminated 'upfront payment' requirement for patients has the capacity of deemphasizing service and reducing expectations. Universal health care has empowered patients in Canada by removing financial barriers to seeking medical care, but the system also provides a ***narcotizing dysfunction*** for the patient by inducing 'peace of mind' concerning the resources at his/her disposal for maintaining health and managing suffering and illness: "It is not in the interest of a modern complex society to have large masses of the population politically apathetic and inert" (Lazarsfeld & Merton, 1948, p. 235). Nor is it in the interest of a modern and complex society or system for its adherents to only have a superficial knowledge of key issues important to the way in which said society or system functions (Lazarsfeld & Merton, 1948, p. 235). A narcotizing dysfunction does not facilitate meaningful social action (Lazarsfeld & Merton, 1948, p.235). In this thesis I will seek to examine how the policy links to health

care related discourse affect the patient's experience and sense of empowerment within the system. More generally, I will examine how key rhetorical acts relating to Medicare affects the type or nature of care that patients receive. Rhetorical and communication theory will be used as a means to evaluate the debate, implementation, and maintenance of health programmes services. A central assertion throughout this thesis is that initial rhetorical construction and engagement concerning health care in Canada has waned and crystallized into a rather entrenched bureaucracy. This bureaucracy is constantly being legitimized by rhetoric linking it to Canadian identity and a general socio-political ideology perpetuated by the liberal intelligentsia. Moreover, in order for Canadian Medicare to remain 'up to date' for our time and to allow for the importance of innovation, invention, and creativity, we need to find a way to resurrect the aforementioned rhetorical (re) engagement. A major goal of my analysis will be to show how the application of rhetorical principles can provide a clue for the way forward as our Health Care Services approaches its fifty year anniversary.

Canada's Health Services Programme was, at least to an extent, presaged by principles laid out in the *Constitution Acts* of 1867 and 1982 of which the latter includes the *Charter of Rights and Freedoms.* To put my analysis within a 'rhetorical frame,' I will be drawing from Kenneth Burke's discussion of the nature of constitutions in his *Grammar of Motives*. Additionally, I will sketch out some cultural features of the Canadian landscape, as articulated by Charles Taylor and finally provide a brief warrant to conceptualizing a 'system' as rhetorical from the ideas of Douglas Ehninger.

Constitutional History in Canada

While the precursors to universal health care in Canada can be seen in both the 1867 and 1982 versions of the constitution, the development of the key right of equality was a gradual process. Today, health care is commonly perceived as a right of citizenship but the constitutional evidence that supports this perception is complicated and indirect. Robert J. Sharpe does a good job of sketching out the rights and privileges of Canadian citizenship as they developed historically. What he presents is a minimalist picture of what constitutes federal jurisdiction within the *Constitution Act of 1867*. In general, Sharpe depicts the 1867 version of the constitution as trying to cope with and manage the complexity and diversity of Canada through the establishment of some pretty firm provincial rights, despite a history of limited judicial review that might have been used to challenge provincial jurisdiction within a general framework of some core federal protections for Canadian citizenship. Of course, the notion of citizenship did not mean much until midway through the 20th century because until that time, "Canadian nationals were British subjects only, and the status of Canadian citizenship did not emerge until the first Citizenship Act came into force in 1947" (Sharpe, 1993, p.222). But in general, citizenship has always been construed as a 'federal matter.' However, the application of the rights and privileges of being a Canadian citizen seemed to stem more from the provinces than from Ottawa. Therefore, the more current notion of citizenship conferring some key rights that needed to be respected across the board did not always hold true. More specifically, if a perceived right of citizenship was violated at the provincial level, it was the rare case that a citizen would have recourse to appeal

such violations on constitutional grounds. Historically, citizenship conferred some very general 'rights' that would be considered quite weak today. In short, the strength of the value of equality has grown gradually over many decades. In response to an allegation of provincial abuse of naturalized citizens in the late 19th Century, Lord Watson, a British lawyer and member of the Judicial Committee of the Privy Council, offered an opinion that hinted at a federalist position: "Between the lines of the terse and narrowly legalistic text of the opinion, one reads a determination to ensure that those admitted to the country were treated with the decency and respect due a subject of the British crown" (Sharpe, 1993, p.225).

Though federal jurisdiction for Canadian citizenship was loosely established from the *Constitution Act of 1867*, it was also clear from subsequent interpretation of this act that provincial rights were to be both acknowledged and protected. Going back to Lord Watson's opinion that established federal jurisdiction for conferral of limited rights of citizenship, an underlying purpose of the ruling was to respond to an 'anti-Chinese' sentiment in the early 20th Century from the province of BC. Legislation had been drafted "forbidding employment of 'Chinamen' below ground in a coal mine" (Sharpe, 1993, p.223). Though on the surface, the BC Government appealed to provincial jurisdiction in the area of employment as the grounds of the legislation, it was suspected that the actual intentions were more nefarious: "It was but one of a shockingly long list of legislative measures introduced in British Columbia to prevent or restrict settlement of Chinese immigrants in the province" (Sharpe, 1993, p.223). As a result, Lord Watson appealed to the federal power of citizenship in response to the

discriminatory legislation. However, the precedent that the ruling established was eventually overturned in another case that touched on the 'right' of naturalized citizens to vote in provincial elections. In this case, decided in 1903, provincial jurisdictional concerns were seen to outweigh the principle of equality for all citizens – whether Canadian born or naturalized: "The Privy Council swiftly abandoned the doctrine outlined by Lord Watson, adopting in its place an analysis that emphasized, to the exclusion of other values, the protection of provincial legislative authority. It accepted the characterization of the franchise as a privilege that the province was entitled to grant or withhold, as the legislature saw fit" (Sharpe, 1993, pp. 226-27). The tempering of federal protection for citizenship with provincial rights reflected a fear from the Privy Council that a broad dominion power to protect the rights and privileges of citizenship might swallow huge areas of provincial jurisdiction (Sharpe, 1993, p.227). So in sum, the now high value of equality was frequently weighed against provincial rights and jurisdictional concerns earlier in our history and the provision for judicial review of provincial ruling was very limited 'pre-Charter' (before 1982). While the precursors for equality as a 'right of citizenship' can be found in the Constitution Act of 1867, this key value had to be measured against flexibility on how it played out in practice from province-to-province. The tendency to interpret Canada's original constitution in a way that showed due deference to the provinces reflected a unique and early orientation to Canadian Constitutional Law:

> The failure of the courts to develop an expansive conception of basic rights of citizenship as implicit in the dominion power over 'naturalization of aliens' is

> hardly surprising. The language of the constitution hardly led inexorably to that conclusion, and the constitution embodies values and principles that run the other way. The very function of our constitution is to provide a structure within which diverse political communities may define themselves and pursue their own local aspirations within the sphere of legislative authority allocated to them. While some citizens will identify more closely with the federal power and wish to see Parliament have the most important role in defining our political communities, it cannot be denied that our citizenship is divided and that we are members of two communities. (Sharpe, 1993, p. 230).

Therefore, the early constitutional history of Canada was marked with some basic and limited rights of citizenship coupled with a strong focus on the provinces' right to parse these rights based off of local and historical contingency. In addition, the Constitution provided a very limited role for judicial review.

Over time, and particularly with the advent of the *1982 Constitution Act* otherwise known as the *Charter of Rights and Freedoms*, the rights associated with citizenship have been solidified and the value of equality has assumed increasing importance. The general significance of the 1982 version of our Constitution has been outlined by Brodie and Nevitte in an article that explores the relationship between civic engagement and Charter values. In their assessment of Cairns's Citizens' Constitution Theory, a very broad claim in respect to the cultural influence of the Charter is parsed out: "The Charter is 'transforming the psyche of the Canadian people' that 'contributes to a participant citizen ethic that applies to the whole written constitution'" (Brodie &

Nevitte, 1993, p. 236). Specifically, the Charter has promoted the value of equality through a privileging of minority rights. Discrimination is primarily discouraged in section 15 (1) and the text reads as follows: "Every individual is equal before and under the law and has the right to the equal protection and equal benefit of the law without discrimination and, in particular, without discrimination based on race, national or ethnic origin, colour, religion, sex, age or mental or physical disability." Despite the more explicit reference to the value of equality in this more recent constitutional text, Brodie & Nevitte (1993) explore whether increased civic engagement in Canada can be explained by alternative factors. They do so through comparing the Citizens' Constitution Theory with a 'New Politics Theory' promulgated by Ronald Inglehart. In general, a new politics theoretical perspective posits that greater level of civic activism is better explained through a 'post materialist' worldview that has become increasingly common in a postindustrial society. Though in the end Brodie and Nevitte seem to conclude that evidence for civic involvement cannot be explained by the Charter alone, a number of useful perspectives can be drawn out of their comparative analysis.

By way of summary, both post materialists and charter citizens demonstrate a lack of confidence in parliament and greater confidence in the legal system for social change. As Brodie and Nevitte note, this is likely symptomatic of a frustration with elites and tradition: "First, each claims that the new participant ethic is marked by the rise of unconventional and elite challenging political behavior which is symptomatic of growing disenchantment with traditional and hierarchically organized representative institutions" (1993, p. 240). Applying these ideas to health care is significant since

historically health care policymaking sought reform in the legislative realm in which pure rhetoric was employed. Preacher-turned-politician Tommy Douglas provides an exemplar for this type of rhetorical engagement. Since that time, rhetorical processes have played out primarily through the forum of Commissions and challenges within the courts. These shifting trends could be explained through looking directly at political and legislative processes, but also could simply be a reflection of emerging cultural trends. Again, drawing on Brodie and Nevitte:

> Canadians are more confident in the legal system than in Parliament. But the data do not support the prediction that non-Charter Canadians are more confident in Parliament than in the legal system. Charter Canadians are more confident than non-Charter Canadians in the legal system. Lastly, the data do not support the prediction that non-Charter Canadians are more confident than Charter Canadians in Parliament. (1993, p.247)

If one accepts the notion that legislative and judicial processes mirror cultural trends at least to some extent, a number of perspectives can emerge. First, the political realm can become bureaucratized. By this I mean that the absolute minimum for argumentation is played out for the invention of policy and once new policy emerges it is enacted in a rigid and inflexible way. This diminishes the inherent flexibility that the legislative realm should enjoy and presents judicial review as a more primary—though less effective—means for social change. As a case in point, I lost my driver's license a few years ago due to my experiencing an isolated seizure. This occurred because of the 'mandatory reporting law' of the Province of New Brunswick that stipulates that a

physician is required to report to the government any patient that they feel may be an 'unfit' driver. Initially, this legislation was mean to protect individuals and the public from harm only in the most severe of circumstances. One example that was referenced in the legislative debate leading up to the law being passed was the case of a suicidal person who announces to his/her family an intent to get behind the wheel and drive head on into oncoming traffic. It was clear from the debate preceding the bill's being passed that the intent behind the law was not to deprive citizens of their driving privileges unless absolutely necessary. Further, the main critique of the proposed law was the potential for a 'chilling effect' between patient and doctor that may create a situation whereby a patient would become reticent to seek needed service. Since the law has been passed it has become regimented and bureaucratized, with doctors frequently erring on the side of caution and reporting patients for the sake of protecting their career. The Department of Public Safety provides no means for internal review of decisions to revoke driving privileges; since the government 'relies' on the expertise of physicians, a revocation is a certainty if they receive a recommendation to that end. The patient's only recourse is either a recommendation for reinstatement from a treating physician or a judicial review of the department's decision. It would seem that some provision for internal review would be a more flexible and ongoing implementation of this legislation. This internal review could include a closer examination of the particulars of a doctor's expressed concern and allowance for an appeal process should a patient disagree with a doctor's reasoning in this respect.

So what can be learned from the foregoing analysis and discussion? Obviously, more vigorous and ongoing debate could be considered valuable for health care policymaking that would facilitate change, should it be desirable, and engage the wider population in a more meaningful and comprehensive way than judicial review. However, if the foregoing literature is right and the public is reluctant to engage issues in the legislative realm, a possible starting point to improve the situation could include a more flexible and less 'open-and-shut' implementation process. And at the grass roots level, it would not be a leap of logic to conclude that the 'post materialists' that encompass the theory of new politics could be encouraged to embrace a principle-based participant ethic that would interact more aggressively with the legislative and political realm.

The Dialectic of Constitutions

Very generally, Burke (1969a) defines a constitution as, "to place, set" (p. 323). The inevitable influence that such a foundational document can have on the business of any nation is borne out by the notion that the grammar of Constitutional wishes relates to the rhetoric of political manifestoes and promises (Burke, 1969a, p.323). The foregoing is of particular importance since it provides a plausible explanation of the rise of socialist rhetoric in Canada and the initial creation and implementation of our health care system, which would not be too far a stretch to label a miracle in North America.

Unlike the U.S. Constitution, Canada's resembles a hybrid of a formal written document and some informal traditions that are extended and applied into public policy concerns. Indeed, Burke justifies this type of flexibility philosophically by maintaining

that "the best example of human relations *in parvo* we could get would be one having a form sufficiently clear to be contemplated, yet sufficiently complex to defy simplistic description (Burke, 1969a, p. 324).

Additionally, Burke acknowledges that constitutions are representative of a nation's attempt to manage or cope with certain fundamental tensions that seem to surface within its psyche. For instance, Burke recognizes that a country's constitution can serve as both a constitutive and admonitory anecdote in the construction of identity. To the extent that Canada's constitution is admonitory, the "anecdote shaped about war would be designed not so much for stating what mankind substantially is as for emphatically pointing out what mankind is in danger of becoming" (Burke, 1969a, p. 330). Unfortunately however, constitutions that primarily serve as an admonitory anecdote would seem to be inherently limited in terms of providing a means by which a country can develop their identity and vision of reality fully:

> An anecdote about what one may become is hardly the most direct way of discussion of what one is. And it may be doubted whether a purely admonitory idiom can serve even the deterrent role for which it is designed; for it creates nothing but image of the enemy, and if men are to make themselves over in the image of the imagery, what other call but that of the enemy is there for them to answer? (Burke, 1969a, p.331)

Additionally, Burke makes it clear that there is some type of 'constitutional mark' on all public policy. After all, there are many general wishes that are found in constitutional documents. Burke also makes clear that constitutions are 'emerging'

entities in most cases. The wishes need to be actualized as history unfolds and individual cases present themselves. Of course in the judicial realm the emergence of constitutional principles into society occur through the setting of legal precedents. In the legislative realm, constitutions are enacted through the constitution of laws. Because a fixed document is gradually being enacted over time into fluid circumstances, there will inevitably be some tensions as to the extent that any single law is deemed to be 'constitutional.' Burke explains this tension with the following comments:

> Where there is a recipe of wishes, variously related to one another, existing as sovereign states in the ideality and generality of the constitutional document, but requiring the partial exclusion of one another when they are applied to particular cases, then note that specific measures could not properly be called either Constitutional or un-Constitutional. That is, they would not be wholly and unambiguously one or the other. But in being Constitutional from the standpoint of some one Constitutional principle, they would by the same token be un-Constitutional is considered solely in terms of some opposing principle. (1969a, p. 379)

The inevitable tensions that arise from actualizing a permanent document into the contingencies of history and specific situations necessarily apply when laws or 'measures' are tested against constitutional wishes. Burke submits that two main approaches can be used when the constitutionality of a law is being tested. Essentializing involves selecting *one* clause in the constitution and judging *a single* measure by reference to it. Taking a proportional approach to assessing the

constitutionality of laws involves testing a measure by reference to *all* the wishes in the constitution. In other words, the tension arises through evaluating laws in terms of the spirit of the entire constitution, versus assessing them in terms of a single clause within the constitution. Interestingly, Burke also references that there is no explicit hierarchy amongst wishes in a constitutional document. Therefore, judicial rhetoric becomes paramount as a way of arbitrating between these competing values: "And since the Constitution itself does not specify priority among the wishes, does not state which among these equals shall be 'foremost,' then the Court must make these decisions for itself, its judgment being a 'new act,' so far as the Constitution is concerned" (Burke, 1969a, p. 380). So in arbitrating between competing values such as equality and freedom, as one case in point, the courts would need to look at the specifics of the situation in which the clash was occurring and either place a priority of one over the other or, depending on the circumstances surrounding the clash of values, maintain that both values can apply. In fact, there are times when situations go beyond modifying constitutional principles. Sometimes wishes can be suspended or new laws declared 'constitutional' in light of extenuating circumstances. Quoting from Arthur Krock in an article published in the *New York Times* in 1941, Burke elaborates on this phenomena: "The Constitution means what the high justices say it means… If public opinion should be favorable, or the President determine – as Lincoln did concerning habeas corpus—that the emergency required it, made-to-order means could be produced and solemnly called legal" (1969a, p. 381). In short, when the 'scene' is dominant, some kind of intervention outside of the constitution can be justified. Of course, this raises the

interesting question as to what type of situation would justify a significant modification or even a bypassing of constitutional principles.

Further to the above, the delicate act of applying and interpreting a Constitution could be construed as a type of balancing between maintaining the unity of the foundational document while at the same time taking in account political diversity. Political trends and policy platforms are largely dependent on the perception of human motivation during a particular time. Constitutions may be able to account, at least in part, for human motivation in general. However, certain motivations will inevitably become more prominent with the institution of new socio-political legislation. For instance, though health care is sometimes conceptualized as a 'right' in the political realm based off of the perception of widespread support of the system, neither the *Constitution Act of 1867* nor the *Charter of Rights and Freedoms of 1982* explicitly state that this is the case. Clearly, the notion of 'health-care-as-a-right' is an emerging inference that the Canadian people have made based off of the historical development of Medicare. In short, constitutional principles are required to interact with time sensitive human motivations and the historical 'scene' in general. As Burke succinctly states, "every single day has been a day in which the particularities of the scene required some manner of new decision involving motivational ingredients not treated in the Constitutional calculus" (Burke, 1969a, p. 389).

In general, Burke conceives of political rhetoric as 'secular prayer.' Political rhetoric would of course include the foundational Constitutional documents of a nation. But as the above discussion has made clear, it can and does encompass the application

and actualization of constitutional principles into history on a day-by-day basis. These applications could include the development of new legislation, establishing legal precedents, and the judicial function of evaluating law in terms of its constitutionality. Burke advocates that Constitutional and historical wishes should be managed rhetorically through a focus on the canon of style. Otherwise put, the rhetor should employ the "prayerful use of language, to sharpen up the pointless and blunt the too sharply pointed" (Burke, 1969a, p. 393). In order to deal effectively with the tensions inherent in Constitutional wishes and their appropriation into time and circumstance, Burke would argue for the necessity of using language as a 'corrective instrument' (1969a, p. 393). Invariably socio-political policy involves compromise. But Burke implies that it would be difficult to get anything done in the messy realm of the human without either 'playing up' or 'playing down' controversial measures. In a sense, therefore, rhetoric is elevated over actual policy. If a rhetor feels that a particular policy initiative would be perceived as too drastic, he or she would need to compensate for this perception stylistically: "The more drastic the measure is in actuality, the more natural it would be for the politician to present it in a way that would allay fears and resentment" (Burke, 1969a, p. 393). Conversely, if a political initiative is suspected as being not drastic enough, the rhetor would "make up the difference stylistically by thundering about its startling scope" (Burke, 1969a, p. 393). With all of this discussion, Burke would seem to infer that to do nothing and say nothing is not an option in the realm of policy development, maintenance or reform. Instead, Burke would advocate for the strategic use of rhetoric being employed to manage peculiar historical exigencies and

situations. If the public wants change, yet change is ill advised or a threat to Party interests, some action is still advised even if the proposed policy is far below what is clamored for. This way, a politician can take into account the views of some key internal stakeholders through the endorsement of a more modest proposal. At the same time, they can alleviate public pressure by rhetorically inducing the perception that significant change has been accomplished. If there is a palpable fear of change even in the face of an urgent need for change, a politician can still move forward cautiously in a way that rhetorically manages this paranoia. The avoidance of rhetoric and inaction would seem here to be an enemy to be avoided. In short, rhetorical action is conceived as the appropriation of Constitution, historical precedents, and current wishes into unique issues emanating out of very specific historical circumstances. In so doing, politicians can avoid inaction or negative action based off of 'admonitory' grounds and instead engage and account for peculiar national cultures in a way that is 'constitutive' (Burke, 1969a, p. 394).

Burke and The Canadian Constitution

Hints of socialist rhetoric

As was articulated in the opening remarks of this thesis, much of the debate surrounding health care service programmes in Canada can be couched in terms of working out the tension between individualism and communitarianism. Or some might frame the foregoing debate in terms of adhering to blind ideology versus striving to initiate and implement good sound public policy that is practical and demonstrates utility for the good of the many. Regardless, Burke insists that the formulation of a

constitution serves to 'tame' or 'temper' the values of individuals into a framework that can better serve the collective good: "Men have developed from a competitive situation in nature; hence they are naturally competitive; but their essential competitiveness may, by various economic and/or psychological transformations, be sublimated into cooperation" (Burke, 1969a, p. 330). In going back to the primary 'text' that will be analyzed in this section, a close assessment of the Constitution Act of 1867 and 1982 should provide a clue to how the framers articulated and conceptualized the foregoing referenced tension.

The first element of the Canadian constitution that seems to hint at a 'biasse' toward socialism occurs in section 91: "It shall be lawful for the Queen, by and with the Advice and Consent of the Senate and House of Commons, to make Laws for the ***Peace, Order, and good Government of Canada***, in relation to all Matters not coming within the Classes of Subjects by this Act assigned exclusively to the Legislatures of the Provinces" (Section 91, Constitution Act, 1867) [Emphasis mine]. The foundational values of peace and order seem to have been preserved in the Constitution Act of 1982 but the articulation of these values are couched in a more specific way: "Whereas Canada is founded upon principles that recognize the *supremacy of God and the rule of law"* (Preamble) [Emphasis mine]. While the *Charter of Rights and Freedoms*, certainly is more oriented towards the individual in a more explicit or literal way, the preamble clearly indicates that our individual rights need to be placed within certain parameters justified by God, or His representative, and the law. Seymour Martin Lipset, a foundational sociologist who specialized in a close comparison between U.S. and

Canadian culture saw this phrase as significant in terms of the tendency of Canadians to show deference to order, or the desirability of legislative bodies developing good law.

Second, it is important to underscore that Canada is a *constitutional monarchy*. There is no question that this reality has a significant influence on how Canada as a country manages the dialectic or tension between individualism and communitarianism. It is clearly stated in the Constitution Act of 1867 that 'supreme power' in Canada rests within the monarchy: "The Executive Government and Authority of and over Canada is hereby declared to continue and be vested in the Queen…carrying on the Government of Canada on behalf and in the Name of the Queen, by whatever Title he is designated" (III 9&10). Even the legislative body in Canada remains, in the final analysis, subject to the monarchy. *The Constitution Act of 1867* prescribes that elected members of the House of Commons along with other key government employees such as military personnel are required to swear an oath to the figure that represents the monarchy:

> Every Member of the Senate or House of Commons of Canada shall before taking his Seat therein take and subscribe before the Governor General or some Person authorized by him, and every Member of a Legislative Council or Legislative Assembly of any Province shall before taking his Seat therein take and subscribe before the Lieutenant Governor of the Province or some Person authorized by him, the *Oath of Allegiance* contained in the Fifth Schedule to this Act; and every Member of the Senate of Canada and every Member of the Legislative Council of Quebec shall also, before taking his Seat therein, take and

> subscribe before the Governor General, or some Person authorized by him, the Declaration of Qualification contained in the same Schedule. (1867, IX 128)

The oath of allegiance to a monarchical figure is actualized by government employees and elected officials making the following statement: "I do swear that I will be faithful and bear true Allegiance to Her Majesty Queen Victoria" (*The Constitution Act*, 1867, The Fifth Schedule, I a&b). Furthermore, while the formulation of legislation is not in the direct purview of the monarchy, all federal and provincial laws in Canada need to be approved by them. This approval is commonly referred to as 'royal ascent:'

> Where a Bill passed by the Houses of the Parliament is presented to the Governor General for the Queen's Assent, he shall declare according to his Discretion, but subject to the Provisions of this Act and to her Majesty's Instructions, either that he assents thereto in the Queen's Name or that he withholds the Queen's Assent, or that he reserves the Bill for the Signification of the Queen's Pleasure. (*The Constitution Act*, 1867, IV 55)

In sum, political power in Canada still remains firmly entrenched in British tradition. While government leaders are no longer required to journey to London to get constitutional provisions approved by The House of Lords, there is an expectation that powers and privileges mandated to elected officials remain consistent with those conferred on elected counterparts in other commonwealth countries:

> The privileges, immunities, and powers to be held, enjoyed, and exercised by the Senate and the House of Commons, and by members thereof respectively, shall be such as are from time to time defined by Act of the Parliament of Canada, but

> so that any Act of the Parliament of Canada defining such privileges, immunities, and powers shall not confer any privileges, immunities, or powers exceeding those at the passing of such Act held, enjoyed, and exercised by the Commons House of Parliament of the United Kingdom of Great Britain and Ireland, and by members thereof. (*The Constitution Act*, 1867, IV 18)

In short, although there is a separation of powers to an extent in Canada, the legislative bodies, their elected officials including Prime Minister's, First Ministers of Provinces, and all members of the crown appointed by government leaders do not operate independently from British monarchy. Instead, there is a check placed on legislative authority.

So what does all of this have to do with the rhetorical precursors to the establishment of universal health care in Canada? What does our constitutional monarchy say about how the tensions between individualism and communitarianism are managed in Canada? First, in allowing legislative bodies to do all of the 'wrangling' associated with policy development yet submitting to the Crown for final approval – at least in theory – for any proposed legislation, there is a perception that ultimate authority is 'above the fray.' This feel of 'objectivity' can also filter down into the elected government as ministers of the crown, including the Prime Minister are expected to be impartial. One example of this would be the appointing of Justices to the Canadian Supreme Court. Traditionally Prime Ministers have selected justices based on their ability to do the job and their legal credentials. Ideological stances are a distant second, if they are considered at all, for these types of appointments. To extend this analogy a

bit further, policy developments of systems, such as Medicare, would presumably be based off of the principles of practicality, effectiveness, and quality control rather than being grounded in particular socio-political philosophies. Also, it is important to emphasize that having to seek approval from an elite and separate body for legislative assent can serve to remove or distance policy development from the people of Canada. A deference to an elite representative such as the Governor General or Lieutenant Governor or the Queen herself as possessing supreme authority can create a kind of 'big brother mentality' that the Government knows what is best for the people. This could conceivably encourage policies to be made and systems to be put in place in such a way that it limits grass roots rhetorical processes. Furthermore, systems can become bureaucratized or 'entrenched' once established making reform difficult and disempowering rank and file citizens' social policy development or reform advocacy. So in short, Canada's status as a constitutional monarchy would seem to be tilted on the side of the communitarian spectrum as it can limit grass roots or individual engagement related to personal rights, freedoms, and interests.

The third element of the Canadian constitution that seems to hint at a biasse toward socialism or communitarian values over individualism and their oft attendant ideological concerns, is its focus on equality. The value of equality as supreme or at least dominant in Canada can be seen in both the Constitution Acts of 1867 and 1982 and the *Canada Health Act*, which of course is more directly germane to Medicare. Further, there is philosophical warrant that speaks to equality as a value of critical importance to Canada that can be sketched out through the ideas of Charles Taylor. In

the *Constitution Act of 1867*, the value of equality is expressed in terms of striving to provide services of quality to all Canadians while at the same time committing to reducing economic disparity between the 'have' and the 'have not' provinces in Canada:

> Parliament and the legislatures, together with the government of Canada and the provincial governments, are committed to
>
> (a) Promoting equal opportunities for the well-being of Canadians;
>
> (b) Furthering economic development to reduce disparity in opportunities; and
>
> (c) Providing essential public services of reasonable equality to all Canadians
>
> Parliament and the government of Canada are committed to the principle of making equalization payments to ensure that provincial governments have sufficient revenues to provide reasonably comparable levels of public services at reasonably comparable levels of taxation. (*Constitution Act, 1982* – "Canadian Charter of Rights and Freedoms, 36 (1); a-c)

Of course equality is also connected to Canadian diversity – particularly our linguistic diversity. Although French remains a minority language in Canada, both English and French are our official languages and constitutional measures are in place to ensure that one language – minority or otherwise – is not privileged over the other. This specifically applies in the federal realm and in the province of New Brunswick: "English and French are the official languages of New Brunswick and have equality of status and equal rights and privileges as to their use in all institutions of the legislature and government of New Brunswick" (*Constitution Act, 1982* – "Canadian Charter of

Rights and Freedoms, 16 (1)). Although the *Constitution Act of 1982*, otherwise referred to as the *Charter of Rights and Freedoms*, is commonly seen to be a more literate/literal based focus on the individual, equality can still be seen as a prevailing sentiment or overarching principle for Canadian society, even in this document: "Everyone has the right to life, liberty and security of the person and the right not to be deprived thereof ***except in accordance with the principles of fundamental justice***" (*Constitution Act, 1982* – Canadian Charter of Rights and Freedoms, 7) [Emphasis mine]. This clause came to be important in the recent Chaoulli decision of the Canadian Supreme Court where a patient and his doctor challenged Quebec law which prohibited the purchase of private health insurance for services covered by the public plan. While they won the case in a split 4/3 vote, the appellants were challenged effectively by the Attorney General of Quebec on the grounds that delay in needed surgery can be justified if they are "in accordance with the principles of fundamental justice" which can be inferred in this case to mean universal and equal access by Quebecers to needed health care services.

Much of the *Canada Health Act*, which is a document that governs and controls federal assistance in the form of transfer payments to the provinces, is also based off of the value of equality. The objective for health care services in Canada is outlined in the CHA as to "protect, promote and restore the physical and mental well-being of residents of Canada to facilitate reasonable access to health services without financial or other barriers." The 'without financial barriers' clause is once again an attempt to provide for a service that costs, in such a way that Canadians of all financial backgrounds can take

part independent of their personal resources. In other words, removing financial barriers has a substantial leveling effect in the wherewithal to attain needed health care. In fact, one of the explicit criteria laid out in the CHA as a condition for individual provinces to qualify for transfer payments, is that each provincial health care system has to be 'universal' in nature. In short, each provincial plan "must entitle one hundred per cent of the insured persons of the province to the insured health services provided for by the plan on uniform terms and conditions," in order to be eligible for transfer payments from the federal government. Obviously, the term 'universality' strongly implies 'equality.' So in summary, while the federal government does not have constitutional jurisdiction over provincial health plans, they can certainly exercise influence through exercising their power of the purse. It is through this power of the purse that the federal government encourages equality in health care services nationwide. The principle of universality is monitored by the federal government and penalties are imposed if this principle is not adhered to:

> The Minister shall, as soon as possible after the termination of each fiscal year and in any event not later than December 31 of the next fiscal year, make a report respecting the administration and operation of this Act for that fiscal year, including all relevant information on the extent to which provincial health care insurance plans have satisfied the criteria, and the extent to which the provinces have satisfied the conditions, for payment under this Act and shall cause the report to be laid before each House of Parliament on any of the first fifteen days on which that House is sitting after the report is completed.

Analyzing the value of equality as an integral part of Canadian culture more globally, it is helpful to draw on some of the idea of Charles Taylor. Taylor is a Canadian philosopher who, not only taught at McGill University for many years but also ran for office as an NDP candidate – a party that traditionally has been known for its socialist outlook on culture. In articulating a potential weakness associated with a focus on pragmatism, instrumentalism and its attendant 'bureaucratization,' Taylor writes about a concept he labels as 'procedural ethics.' "In other words, we establish a neutral set of rights and liberties designed to allow maximal choice about what constitutes a good life or a proper end. Those rights do not reflect what is good – for that is individually determined – but rather, *what is fair*" (Taylor, qtd. in Bowers, 2002, p.43). Procedural ethics allows for maximal choice, not in terms of the nature of medical care, but in terms of its accessibility to the greatest number of people. To summarize, Medicare provides maximum amount of choice for Canadian society and not necessarily individuals. So when applying Taylor's argument to Health Services Programmes in Canada, it can reasonably be deduced that once again we can see a bias or slant towards a communitarian perspective.

An informal/formal hybrid

In comparison to the U.S. Constitution and the *Declaration of Independence*, The Canadian Constitution, particularly the *Constitution Act of 1867*, can best be described as a formal and informal hybrid. There is also a degree to which legislative bodies rely on tradition and long established protocol as a supplement to what has been written. But even the written portions reflect the informal nature of our constitutional parameters.

For example, the guidelines in the *Constitution Act of 1867* concerning logistical principles for the convening of various legislative bodies are quite general in nature: The presence of at least Twenty Members of the House of Commons shall be necessary to constitute a Meeting of the House for the Exercise of its Powers, and for that Purpose the Speaker shall be reckoned as a Member" (*Constitution Act,* 1867**, s** 48). And a little later on… "There shall be a Session of the Legislature of Ontario and that of Quebec once at least in every Year, so that Twelve Months shall not intervene between the last sitting of the Legislature in each Province in One Session and its first Sitting in the next Session" (*Constitution Act,* 1867**, s** 85). In regards to the first case in point, as of 2011, there are 308 possible seats for elected members in the federal House of Commons in Ottawa. Even in the 1st Canadian Parliament, elected in 1872, there were still 180 seats for elected members to fill. So when the constitution only stipulates that 20 members need to be present during meetings, this leaves an enormous gap between what might reasonably be expected for attendance in order for parliament to be 'functional.' In the second case in point, which obviously refers to two separate provincial legislatures, again there seems to be a large gap between the minimum frequency for meetings as prescribed by the constitution and what would seem to be reasonable and customary from the vantage point of the electorate. So if the foregoing examples of guidelines give us a clue, the Canadian constitution has a tendency at being quite vague and general in nature – hence making its application to actual governing and policy development as very *pliable*.

So what might the 'text' of the Canadian constitution say about the nature of policy development? It suggests again a bias toward practicality, implementation, and bureaucracy over an explicit and written ideological framework. So once again, a reasonable argument can be put forward that indicates that constitutional prescriptions in Canada are slanted toward policy development that benefits the greatest number of people or the collective and is less geared towards individual values and interests. For example, Walter Ong extrapolated a number of characteristics associated with 'orality' which is generally a more traditional, less formal and precise mode of communication. At least two of these characteristics that apply to our current discussion would be his notion that oral/informal communication tends to be *conservative or traditionalist* and *close to the human lifeworld*. In the case of the former characteristic, Walter Ong (1982) suggests that stories are not so much evaluated in terms of their freshness, novelty, or originality per se, but rather in terms of the storyteller's ability to introduce them uniquely into a specific situation (p. 41). He further states that old formulas and themes for narratives "have to be made to interact with new and often complicated political situations" (Ong, 1982, p. 42). However, "the formulas and themes are reshuffled rather than supplanted with new materials" (Ong, 1982, p. 42). In the case of the latter characteristic, Ong explains how skills and practices are learned not by explicit written instruction such as in a formally written constitution. Rather, they are learned "from observation and practice with only minimal verbalized expression." He concludes by stating that a "primary oral culture is little concerned with preserving knowledge of skills as an abstract, self-subsistent corpus" (Ong, 1982, p. 43). So in short a more

informal or unwritten constitution tends to lend more to a conservative approach to human relations that are sensitive to and actualized from current or up-to-date experiences and practices. In other words, it is flexible to society but not necessarily to individual concerns or circumstances.

The admonitory anecdote

It is important to understand that Burke frames human relations firmly within the context of *struggle or war*: "You may, if you will, imagine a spectrum with war at one end and absolute peace at the other, and with all acts in time considered to be lying somewhere along the intervening series of gradations, according to the varying proportions of the two ingredients" (1969a, p.332). The admonitory anecdote provides warnings on what a particular culture is in danger of becoming which of course is action that can lead to some kind of change or 'war.' Once action is taken as a means by which to avoid assuming the 'face of the enemy,' the peace or condition that follows based on these actions can be recalcitrant to adaptation. The status quo, achieved through a war to resist or avoid an undesirable state can be resistant to change. The establishment of Canadian Medicare can be construed as a hard fought victory to achieve the best quality of health care for the greatest number of citizens in such a way that financial barriers were eased and personal hardship associated with disease or illness was addressed, in a relatively efficient way that reduced inequality and restrained unfettered spending. Hence, it is easy to envision a reluctance to 're-engage' in the health care debate for fear of slipping back to the unequal, expensive and value neutral market driven system that proceeded it. While direct evidence of admonitory features of the *Constitution Act of*

1867 are not explicitly evident, inferences can still be made that would support the organization of Canadian culture in such a way as to avoid war and maintain the status quo, even in the face of having a neighbor that seemed to be oriented quite differently in these regards. Further, evidence supporting admonitory principles of our constitution becomes more explicit with the advent of the *Charter of Rights and Freedoms* and especially the constructing of the *Canada Health Act*.

In the preliminary comments of the CHA, the writers show admonitory features by articulating what has already been accomplished with the advent of a universal and single payer health care system. At the same time, however, the authors emphasize the importance of maintaining some of the key principles associated with Medicare moving forward:

> "That Canadians, through their system of insured health services, have made outstanding progress in treating sickness and alleviating the consequences of disease and disability among all income groups… That continued access to *quality* health care without financial or other barriers will be critical to maintaining and improving the health and well-being of Canadians." (1985, c. C-6)

In the foregoing statements, the key admonitory feature is relating to what is commonly understood to be a key difference between the Canadian and American systems. Unlike in the U.S., health care in Canada is provided 'without financial or other barriers' to 'all income groups.' One can see how this distinction is admonitory in light of the many horror stories from Canadians that experienced financial poverty as a result of medical

bills before the implementation of our current system. This, coupled with the reality that the number one cause of personal bankruptcy in the U.S. is *still* health related expenses, provides strong incentive for the maintenance of the 'new normal' which allows *all* Canadians to have access to the 'best possible quality' of health care. Furthermore, admonitory features can be seen quite explicitly in at least two of the five federally articulated 'benchmarks' that provincial health care systems are required to meet in order to be eligible for transfer payments. The first of these two benchmarks stipulate that provincial systems are required to adhere to the principle of public administration which is defined in the CHA as being "administered and operated on a non-profit basis by a public authority appointed or designated by the government of the province" (1984, c. 6, s. 8). It is important to stress how distinct this feature of Canadian Medicare is from most American iterations. In fact, even the reference to a 'public option' in the recently passed *Affordable Care Act* in the United States, nearly derailed the legislation initiated by President Obama. The second benchmark concerns the requirement of *universality* which stipulates that provincial systems "must entitle one hundred per cent of the insured persons of the province to the insured health services provided by the plan on uniform terms and conditions" (1984, c. 6, s. 10). The aforementioned benchmark is admonitory for two reasons. First, 100% coverage once again distinguishes Canadian care from the U.S. health care system as it has been common knowledge that upwards of 20% of Americans are not insured for health care. Even with the full implementation of *Obama Care*, as modified by the U.S. Supreme Court, it is unlikely that the U.S. will see even 80% of its citizens insured. Second, the phrase indicating that provincial plans

must be provided '*on uniform terms and conditions'* would be anathema to many Americans who would perceive such a leveling as socialism at best and communism at worst.

In summary, while there are no direct references either in the *Constitution Acts of 1867* and 1982, or the *Canada Health Act* to the 'face of the enemy,' it can be inferred through the textual evidence that admonishments are implied to maintain the 'outstanding progress' that has been made to ameliorate conditions that still persist in the United States. And as a reminder, these federal principles are enforced and monitored on a regular basis by the Minister of Health. In short, the underlying 'story' that seems to be conveyed through constitutional documents in Canada, is one of 'tempered individuality' in comparison to the 'unrestrained individuality' that is perceived to be a hallmark value for our southern neighbors.

The Textual Nature of The Canadian Constitution

So what is the nature of the Canadian constitution that has been illuminated by this analysis? It demonstrates a biased toward the collective over the individual. This is borne out through its articulation of the roles our legislative and judicial branches play in relation to the monarchy. Our constitution is also informal in nature which seems to privilege policy development, implementation, and bureaucracy over creativity, policy innovation and reform. It is admonitory in the sense that it celebrates what has already been accomplished and also implies certain consequences to taking a step back from these accomplishments. But what general principles can be gleaned from this analysis that can philosophically sketch out, what about Canadian culture, is germane to

Medicare? How can these principles support the argument for a rhetorical (re) engagement with the goal being to promote sustainability and encourage the formulation of fresh ideas and needed reform? For starters, I think it can be said that the system itself, and the values it represents such as efficiency, instrumentalism, and pragmatism, is *relentless*. What was true in the mid 60's when Canadian Medicare was established is largely true today. Medicare tends to privilege the community or society over the individual by striving to produce the 'greatest good for the greatest number of people.' Individual rights, people with unique circumstances, exceptions, and extraordinary situations face an uphill battle when the weight of society has worked to establish, bureaucratize and entrench universal health care. However, it must be said that Canada has seen a shift of sorts back in the direction of individuality with the formulation of the literal and written rights based *Charter of Rights and Freedoms* of 1982. Subsequent court challenges to the existing system by physicians and patients have continued to advance this trend. It would appear that there is a window of opportunity for the rhetorically engaged citizen, politicians and academic thinkers to flavor the argument for change and reform in such a way as to see revitalization in argumentation concerning health care in the public arena. As this thesis progresses, and through a close textual analysis of a variety of rhetorical artifacts such as key speeches from Tommy Douglas and other political figures, commission reports, legal discourse, academic inquiry, and bardic resources from newspapers, magazines etc., I will search for rhetorical clues that may point to a way forward for future constructions of reality. Of course there is always the objection favoring the status quo or simply leaving things the way that they are. The

old adage, 'if it isn't broke don't fix it' is particularly potent when combined with some of the admonitory features in some of our founding documents as has been referenced in this chapter. However, rhetorical (re) engagement can be justified as an inevitable reality if Burke's notion of the 'permanence of change' has any merit. Simply recognizing that reality is subject to this permanence of change – not so much in the ideological sense but as a philosophical inevitability might provide the impetus needed to actively discuss and enact change within the Canadian health care system.

A System's Approach to Rhetorical Criticism

Since this thesis is focusing on 'applied rhetoric' that is non-traditional in the sense that my analysis is not concerned necessarily with your classic one-to-many oratorical address to a legislative assembly that Plato and Aristotle placed much of their inquiry for rhetoric. Nor is this analysis primarily concerned with your commonly seen rhetorical addresses by political figures that are, more often than not, mediated and transferred to a mass audience. Rather, a key central assertion to this thesis is that 'systems' are capable of being persuasive. After all, Canadians rarely hear mass appeals in defense of Medicare these days. Tommy Douglas and Lester B. Pearson are no longer with us, and universal health care in Canada has been established and entrenched bureaucratically. What we have seen by way of advocacy since Medicare has been established in the form of Royal Commissions, court rulings, government statements, input from medical societies, think tank analysis, and commentary and op-eds in a variety of bardic sources. Hence, the nature of the debate right now does not lend well to traditional classical approaches for rhetorical criticism. So with this in mind, some

orientation on what some key thinkers have brought forward regarding the rhetorical analysis of systems is in order.

In his essay that outlines the differing system of western rhetoric, Ehninger (1975) rightly underscores the current complexity of rhetorical studies, offers a few insights on the evolution of rhetoric as such and sketches out a few implications associated with this reality. Due to the voluminous amounts of information available to us currently along with the multiplicity of forums or media by which this information may be obtained, its dissemination has changed the nature of the audience: "Today the burden has, in a sense, shifted to the listener, who by passing and repassing through cubes of exposure, gradually pieces together for himself messages composed of innumerable bits or scraps strewn broadcast by the media" (Ehninger, 1975, p. 449). In other words, rhetoric is no longer black and white. These cubes of exposure and the piecing together of messages can require and certainly justify the analysis of text from a variety of sources to gain a sufficient understanding of complex socio-political issues. Furthermore, rhetoric is commonly understood in our field to be 'reality constructive' in nature and hence opens up the domains of rhetorical theory and criticism to a wide range of human relations and symbolic action: "Today, under the influence of such writers as Susanne Langer, Kenneth Burke, Richard Weaver, and Georges Gusdorf, this view is giving way to the assumption that rhetoric informs all human communicative activity" (Ehninger, 1975, p. 452). Of course, as referenced earlier, the theory development and criticism of rhetoric has not always been so all-encompassing. The current perspective has evolved over time. As Ehninger notes, "the seeds of a rhetoric dedicated to the

promotion of healthy and productive human relations rather than to the cultivation of the arts of persuasion were sown in the early decades of this century (20th century) by such writers as Charles Beard, John Dewey, Mary Follett, and Graham Wallas" (1975, p. 449).

As a result of this evolution of rhetorical inquiry in the direction of the dissemination and understanding of complex political and social policy discussion, the rhetorician has become an 'engaged citizen' and is capable of applying his or her craft, not only to the aesthetics of rhetoric but to the betterment of society. In quoting Burke, Ehninger argues that "rhetoric, at bottom, is an instrument for bridging the conditions of estrangement natural to man" (1975, p. 450). He goes on to state that "by pursuing these and similar interests, the rhetorician, who has traditionally played the part of detached observer of human events, has in recent years taken on a new role and become an active participant in shaping their course" (Ehninger, 1975, p. 450). The foregoing goes a way to validate the major thrust of this thesis, which is not only to disseminate some of the discourse surrounding the implementation and maintenance of health care services in Canada, but also to suggest a way in which an understanding and application of rhetoric can move debate and policy development forward for the improvement of a system that already enjoys a great deal of assent in Canada and a certain degree of deference beyond.

Implications

The foregoing perspective and analysis suggest several implications concerning the benefits of applying cultural and constitutional concerns into health care

policymaking. First, Burke's notion that constitutions are emerging documents might allow for different orientations towards the relationship between the federal government and the provinces for health care. There seems to be little doubt from the above explication that the delivery of health care falls under provincial jurisdiction. A majority of the Canadian Supreme Court in the Chaoulli ruling affirmed provincial jurisdiction for health as prescribed by the *Constitution Act of 1867*. However, Roy Romanow laid out a case in his Commission Report for greater federal leadership and even intervention for reinforcing the core national values of Medicare that are outlined in the *Canada Health Act.* If we are to derive a clue from Burke's thought, unique circumstances and distinct situations should interact with the Constitution Act's seemingly explicit verdict for this jurisdictional question. If the system is truly in crisis, federal intervention might be justified despite what is in the text of this particular act. Second, it would seem that Burke's notion of a proportional approach to measuring legislation against constitutional principles could be useful for health care policymaking. Going back again to the Chaoulli ruling that stipulated that Quebec's ban on the purchase of private health care was unconstitutional, in order to appreciate the depths of the constitutional complexity of this decision, a thorough assessment of both majority and dissenting views would be required. Further, judicial rulings concerning issues of health care could profit from being proportional in nature. In so doing judicial rulings could be more sensitive to the importance of context and avoid the narrow decisions that are often the hallmark of legal deliberations. The Chaoulli ruling, far from offering solutions to problems that had surfaced in Medicare such as the wait time issue, instead sought to provide a legal

answer to a very specific question on whether a particular Charter right had been impinged. Third, Burke makes very clear that a Constitutional document is limited in its ability to account for human motivation. For instance a perception has developed in respect to Medicare that health care should be a sort of 'right' of citizenship by virtue of what it means to be Canadian and that this right should be based on need and not ability to pay. This perceived right is based on the understanding that it is the Canadian way to be fair. Fairness implies that all citizens should have access to a reasonably high quality of health care. In short, health care coverage should be universal and based off of the value of equity. The problem with this perception is that neither the *Constitution Acts of 1867* nor the *Constitution Act of 1982* prescribe for 'financial equality.' Additionally, it is clear that any rights of citizenship have tended to be weighed against the rights of the provinces to apply benefits of citizenship into particular situations. Hence, though it may not be ideal, a decentralized approach to creating universality for health care coverage would seem to fit better into the cultural and political history of Canada. Emmett Hall makes a compelling case for a decentralized yet universal health care system in his *1964 Commission Report*. Finally, Burke's explication of the tensions inherent in Constitutions, points to the value of a thorough analysis of the current historical context for Medicare, followed by a crafting of something 'new' or 'constitutive' as opposed to the admonitory and reactionist approach for molding a country and/or a system as a type of 'corrective' to prevent us from becoming what we might be. As one case in point, the perception that Medicare is, perhaps most significantly, 'not American' will be addressed in more depth in a later chapter.

CHAPTER III

TOMMY DOUGLAS – PRAGMATIC REFORM

> *I think your greatest and enduring accomplishment was the introduction and putting into effect of Medicare in Saskatchewan. Without your program as a successful one in being, I couldn't have produced the unanimous report for the Canada-wide universal health recommendations in 1964. If the scheme had not been successful in Saskatchewan, it wouldn't have become nation-wide. Generations to come will be your debtors (Emmett Hall on Tommy Clement Douglas, qtd. In Stewart 211).*

Tommy Douglas was arguably the greatest public figure in Canadian history. Indeed, the ideas and policy development concerning *health care services programmes* in Saskatchewan have become entrenched in the Canadian psyche and institutionalized through the establishment and maintenance of Medicare across Canada starting in the mid 60's and persisting to the present time. The influence and importance of Tommy Douglas as a key rhetorical figure is summed up effectively in the following accolade:

> Tommy Douglas was the most influential politician never to be elected Prime Minister. He pursued his radical ideas relentlessly until they became so mainstream rival politicians claimed them as their own. Called a communist and threatened by in-party fighting, Douglas battled hard to bring the New Democratic Party to legitimacy in its first ten years. He was often criticized for his singular idealism but through it all Douglas was undeterred, convinced that he was helping to create a better, more humane society. In 2004, Douglas was voted number one in CBC's The Greatest Canadian contest. (*CBC Digital Archives*, 2014)

Serving initially as a federal Member of Parliament for the *Cooperative Commonwealth Federation* from 1935 to 1944, Douglas then went on to serve as Premier of Saskatchewan for seventeen years from 1944-1961. He then returned to federal politics in 1961 to become the first leader of the 'New Party' which is now known as the *New Democratic Party of Canada*. He served in this capacity until 1971 at which time he was replaced by Ed Broadbent. However, he remained in the House of Commons as an MP until 1979 when he retired from politics. On November 30th, 1984, Douglas was appointed to the *Queen's Privy Council* by Governor General Jeanne Sauvé as directed by then Prime Minister of Canada, Brian Mulroney. He was honored by being awarded the *Order of Canada* in 1981 and the Saskatchewan *Order of Merit* in 1985. So clearly, Douglas was a well-liked and respected politician throughout his lifetime of public service and community engagement. I will be honing in on Douglas' rhetorical savvy through a close textual analysis of some key texts from his political career. His socio-political philosophy and engagement are well known. However, studies that focus on his communication style, strategies, and acumen are less prominent.

Overall, my analysis will show that Douglas was a *pragmatic idealist*. This is important both historically and in the present for enacting social change in Canada since Canadian socio-political culture is relentlessly pragmatic. This allows for both a biased argumentation for stability and the institutionalization of public policy which requires idealistic rhetorical figures in order to alter. However, this analysis will also show that Douglas was far from a naïve optimist. He understood the need to ground his ideals firmly in the messy realm of the human. His ability to navigate successfully between

idealism and pragmatism are what makes Douglas such an interesting persona from a rhetorical standpoint. As Douglas himself once mused, "I've no patience with people who want to sit back and talk about a blueprint for society and do nothing about it." This is important since, though he established the first socialist government in North America, the evidence from his political career and from his rhetoric will show that in the end, he was quite moderate.

As this thesis progresses, I will be assessing key texts that evaluate existing health care services programs of which Douglas had a key role in instituting. Then I will examine how these contributions have helped or hindered the needed argumentation process in order to encourage appropriate adaptation to successive audiences that have benefited from this system as well as accounting for and adjusting to, historical contingencies.

More specifically, I shall argue that a close scrutiny of some key speeches from Douglas has revealed the following characteristics or features. First, his rhetoric has a tendency to be emotional or even confrontational in nature. He does not hesitate to bring things to light that calls into question the sincerity or general motivation of his political and ideological opponents. Along these same lines, Douglas could have a tendency to be egocentric as he communicated his ideas and vision for Saskatchewan and Canada. However, he would also frequently temper this passion with humor. Second, Douglas demonstrated sensitivity to the rhetorical evolution of history. While he clearly was a staunch advocate for social change, he felt that the framework for enacting socio-political reform was through legislative bodies such as the provincial

legislative assembly and the federal House of Commons. He was a firm believer in working to establish consensus even within the polarizing and adversarial system of parliamentary democracy. Third, his rhetoric invited his audience to experience a form of 'transcendence' through his message of the inherent value associated with the 'brotherhood of man.'

My analysis of Douglas' rhetoric will start with a brief biography, including a timeline for the establishment of Medicare in Saskatchewan and its eventual adoption nation-wide. Then I will summarize some key dimensions of his socio-political philosophy. Finally, some key speeches will be subjected to rhetorical analysis using ideas and concepts originating from some key terms in our literature such as the 'ego function of protest rhetoric,' 'the rhetoric of confrontation,' and 'comedy as a cure for tragedy.' Recall that a central assertion throughout this thesis has been that initial rhetorical construction and engagement concerning health care in Canada has waned and crystallized into a rather entrenched structure strongly linked to Canadian identity.

Biographical Insights

Social justice is like taking a bath. You have to do it every day or pretty soon you start to stink (Tommy Douglas, speech given at Acadia University).

Thomas Clement Douglas was born in Falkirk, Scotland in 1904. His family immigrated to Canada when he was 14. His early years in Canada were spent in Manitoba. During this time, Douglas witnessed the *Winnipeg General Strike*—a strike on grounds of poor labor conditions and unfair wages—which occurred between May 15 to June 26th 1919. On June 21st, violence erupted in the streets after the Mayor of Winnipeg read the riot act to a crowd of approximately 25,000 strikers and then called in

the then *Royal Northwest Mounted Police*. The police arrived on horseback and charged into the crowd, resulting in the death of two people and injuring many others. Many were also arrested—including strike organizers and supporters along with the editors of the pro labor newspaper. Observing the strike clearly had an influence on Douglas, solidifying the philosophy of non-violence that would characterize his entire political career: "All part of a pattern. Whenever the powers that be can't get what they want, they're always prepared to resort to violence or any kind of hooliganism to break the back of organized opposition" (Qtd in Stewart, 2003, p. 45). It is worth noting that Douglas' stance towards violence did not discriminate between government and protest movements opposing government. Either way he opposed violent means regardless of the ends in mind.

Douglas the rhetorician

While in Manitoba during the late 1910's and early 1920's, Douglas assumed a kind of 'everyman' persona but with a particular interest in communication: "He went to hear J.S. Woodward speak on the steps of the *Norquay Public School*; he went to church; he took elocution lessons and boxing lessons; and he became active in theater" (Stewart, 2003, p. 47). Additionally during this time, he garnered some experience in the media industry "becoming a journeyman printer and member of the Winnipeg branch of the *International Typographical Union* – starting out as a 'printer's devil'" (Stewart, 2003, p. 48). Perhaps partly because of his passion for social justice which was deeply influenced by the *Winnipeg General Strike,* along with his fascination for communication and his engagement with the church, Douglas became a preacher at the

age of 18. In short, Douglas became convinced that "if I had any useful contributions to make at all it was probably in the Christian church" (Stewart, 2003, p. 52). Soon after this, Douglas elected to pursue post-secondary education at Baptist affiliated *Brandon College* in Brandon, Manitoba from 1924-1930. During his time at Brandon, he deepened his interests in social justice and the Christian Church's role in this process. He embraced "the duty of the church to be involved in issues of political and social reform, and if that led to criticism, even banishment from the pulpit so be it" (Stewart, 2003, p. 56). Douglas developed a 'liberal' perspective for Christianity that went beyond personal salvation to social and political engagement to advance the Kingdom of God on earth. His general perspective was that the ideals and theology of Christianity should be applied directly into society in a practical way and that Scripture can and should be interpreted in a way that was relevant to particular local and historical contingencies. In outlining his theology and the role of the Christian church in Canadian culture, Douglas commented as follows:

> Oh, you always start with a text. But the Bible is like a bull fiddle, you can play almost any tune you want on it. My background, being interested in social and economic questions, naturally inclined me to preaching the idea that religion in essence was entering into a new relationship with God and into a new relationship with the universe. And into a new relationship with your fellow man. And that if Christianity meant anything at all, it meant building the brotherhood of man. If you really believed in the fatherhood of God, if you believed what Jesus said, that we live in a friendly universe, then the brotherhood

> of man was a corollary to it. And that meant a helpful relationship between man and man, building a society and building institutions that would uplift mankind, and particularly those who were the least fortunate, and this was pretty well the message I was trying to get across. (Qtd in Stewart, 2003, p. 62)

It is also important to note that while Douglas was developing his theory of Christ and culture that he continued to increase his communicative skill sets through both his academic training and extracurricular activities. Tommy was wide ranging, "with a strong reputation as an orator and debater. In his first year of the B.A. program, he and a partner emerged victors in a debate against the University of Manitoba, arguing the negative of a high-minded argument, 'Resolved: Western Civilization is Degenerating'" (Stewart, 2003, p. 61). In light of the fact that this perspective came out of a generation that had experienced the Great War and the decadence of the roaring 20's, the foregoing emphasizes Douglas' boundless optimism.

After his time at Brandon College was complete, Douglas entered into full time ministry as a Baptist pastor for Calvary Baptist Church in Weyburn Saskatchewan. During his time there, Douglas developed an appreciation for the suffering of the poor and specifically how their financial circumstances exacerbated their plight through an inability to be able to seek and receive treatment for illness and disease. His experiences officiating at funerals positioned human suffering and death as a concrete and ugly reality as opposed to an abstract and/or philosophical problem:

> I remember burying a girl fourteen years of age who had died with a ruptured appendix and peritonitis. There isn't any doubt in my mind that it was just an

> inability to get her to a hospital. I buried a young man at Griffin, and another one at Pangman, both young men in their thirties, who died because there was no doctor readily available, and they hadn't the money to get proper care. They were buried in coffins made by the local people out of ordinary board. This boy at Griffin was buried on a hot day in August. The smell permeated the church. This was a difficult thing. (Douglas, qtd. in Stewart, 2003, p. 72)

Baptist Preacher to Politician

Douglas' concern with the tragedy of wasted human potential, which inevitably emerges from a society's inability or unwillingness to address its citizens' practical needs, was solidified during his tenure as a graduate student in Sociology at the University of Chicago. Douglas had little patience for abstract socialism or versions of Marxism that devalued tangible social planning and policy development. It would appear that these sentiments intensified with his experiences in Chicago. As part of his graduate training, "he interviewed men who had been bankers, clerks, medical students, budding lawyers, and came away convinced that a system that wasted its potential in this way could not last" (Stewart, 2003, p. 75). He seemed to blame the social landscape that he experienced in the U.S. on the American academy's undue focus on the theoretical ideals of socialism, rather than on its practical applications in light of our common connections with the human experience: "They were waiting for a revolution, not passing out clothing and he was not impressed" (Stewart, 2003, p. 75).

Douglas never finished his graduate work at the University of Chicago but instead went on to earn an M.A. in Sociology from McMaster University in Hamilton,

Ontario. He soon came to the conclusion that he was most passionate about social change and policy development, so made the switch from preacher to politician – becoming the leader of the CCF in Saskatchewan, Premier of the Province, and leader of the first socialist government in North America on July 10, 1944. To demonstrate his commitment for social reform, particularly relating to medical care, Douglas simultaneously served as Saskatchewan's First Minister and also it's Minister of Health. He moved quickly in his mandate as Premier and in his portfolio as Health Minister. By the end of 1944, cancer victims, the mentally ill, and those suffering from venereal disease were receiving both medical care and hospitalization at the expense of the state. Early in 1945, the same benefits were extended to old age pensioners, blind pensioners, mother's allowance recipients, and wards of the state (Stewart, 2003, p. 217).; By the end of 1947, 93 per cent of the provincial population was covered by hospital insurance (Stewart, 2003, p. 220).

The Establishment of Medicare in Canada

Ten years later, after some wrangling between the provinces and the federal government, the *Hospital Insurance and Diagnostic Services Act* was passed in April 1957 under the tenure of then Prime Minister Louis St. Laurent. The bill established a 50-50 cost sharing program between the provinces and the federal government. The Act was quickly ratified with Quebec being the last province to opt in on January 1, 1961 (Stewart, 2003, p. 222).

After hospital insurance had been secured across Canada, the battle to persuade doctors to support a similar program for outpatient care (eventually labeled Medicare)

began. Once again, Saskatchewan was the pioneer, enacting its Medicare plan on November 17, 1961 and fully implementing it by the end of 1962. By that time, Douglas had moved back to the federal level as the leader of the *New Party* and started to pressure John Diefenbaker's minority conservative government to implement Medicare nationwide. Diefenbaker attempted to stall the progression of Medicare by referring it to a committee chaired by an old friend and fellow conservative, Supreme Court Justice Emmett Hall. Initially ambivalent about the idea of universal health care, as Hall gathered more evidence he became convinced that a pre-paid single payer system was the optimal approach to meeting Canadians' healthcare needs.

The Socio-Political Philosophy of Douglas

Tommy Douglas' background and some of his experiences as a graduate student and minister predisposed him to attempt to find practical applications for his fresh ideas of social change. However, there is no question that Tommy Douglas was also an idealist. Whether delivering his campaign style diatribes or ruffling a few feathers within the context of the ministry, Douglas pressed hard against the existing status quo with the objective being to enact positive social change. Approximately 10 years into his tenure as Premier of Saskatchewan, Douglas delivered a radio address in celebration of province's 50th Anniversary. An excerpt from this statement illustrates his vision for ideas to move the province forward but at the same time presents shades of pragmatism that operate to actualize these visions: "We shall so conduct ourselves that with divine guidance we may make this province to grow and prosper in a diversity of enterprises and opportunities that we may in the morrow write the finest pages of Saskatchewan's

history." His focus on the future, of course, highlights his idealism; but his reference to a 'diversity of enterprises' speaks to how his province will achieve these goals. Overall, the excerpt reflects Douglas' optimism and his ability to employ elegant language to create hope and excitement for the future. Later, in relation to policy development concerning health care services in Saskatchewan, Douglas again highlighted his visionary persona by underscoring the predicted significance of this social change: "Tommy expected, and announced that he expected, the Saskatchewan program to become the model for Canada… ["]If we can do this – and I feel sure we can – then I would like to hazard the prophecy that before 1970 almost every other province in Canada will have followed the lead of Saskatchewan ["]" (Stewart, 2003, p. 224). Of course history has now proved this statement to be right.

At the same time, Tommy Douglas did not hesitate to attack the dominant system of capitalism on the grounds that it encouraged and perpetuated greed: "The profit system has defiled whatever it has touched. And the profit system has touched everything. It has corrupted, debauched politicians, degraded morals, devitalized religion and demoralized human nature" (Qtd in Stewart, 2003, p. 106). This quote also emphasized the importance Douglas placed on morality and ethics for human beings in general. However he seemed to hold politicians and government at a higher standard as potential moral agents for good in the world.

So while it is clear that Douglas was not afraid to pursue his radical ideals relentlessly or to aggressively attack the status quo, the evidence also shows that he tempered his passion with pragmatism and the realism of careful policy development. A

couple of historical examples that attest to the tendency of Douglas to balance his passionate and sometime extreme viewpoints with pragmatics involved his perspective on deviance within the family structure in Canada as well as his stance toward Japanese Canadians during World War II. In regards to the former, Douglas wrote an M.A. Thesis while at McMaster University that advocated for state enforced sterilization of women with known disabilities including mental health conditions. Though these views are now viewed as controversial to say the least, Douglas did not legislate his views into public policy when he entered into politics. Instead he infused pragmatism into his idealistic stances through advocating for an "approach that emphasized vocational training for the mentally handicapped and therapy for the mentally ill" (Stewart, 2003, p. 81*)*. As for the Japanese question, he sympathized with the position of limiting immigrants to Canada from Japan while at the same time believing that second generation immigrants who had a level of competence in English should be allowed to remain in country:

> We may blame previous governments for bringing the Japanese here, but, now that they are here, I do not see how we can do otherwise than try to make good citizens of them. Sending back to Japan those who speak the Japanese language is one thing, and sending back Canadian Japanese who do not speak the language will be another thing entirely. It certainly is a very complicated problem, and I only hope our people will try to deal with it from a humane point of view. (Stewart, 2003, p. 174)

The above illustrates Douglas' preference for a measured response to local and historical contingencies that is grounded in a general compassion for human beings. Even when he was pursuing health care reform after being elected Premier of Saskatchewan in 1944, he recognized that as urgent and important as the changes were, and *incremental* approach to their implementation was still required: "From the beginning, Tommy believed the way had to be prepared carefully, first by offering coverage to the most needy in the province as soon as possible, then by extending hospital insurance as a universal benefit, and finally by bringing doctors into the scheme with Medicare" (Stewart, 2003, p. 216). Such implementation might also suggest that Premier Douglas was attempting to manage perceptions by seeking to cover those most in need or 'deserving' first and thus mitigating allegations that a prepaid universal health care system might demotivate people to take ownership in their own health and wellbeing.

In addition to moderating his advocacy for the initiation of needed social change with its pragmatic, realistic, and careful implementation, Douglas also demonstrated a complexity of a political ideology that biased socialism. While often branded as a communist due to his support for labor, a more accurate interpretation of the evidence reveals that Tommy Douglas was most concerned with helping people who couldn't help themselves. In short, Douglas was a *moderate socialist*. Though he believed in the positive and at times indispensable role of government in the state of human affairs, he also valued human rights and individual freedoms such as civil liberties. Further, he embraced human responsibility to make a positive contribution to the societies they were part of. The foregoing is borne out in his political biography and is also evidenced in

some of his speeches. For example, in regards to social policies such as welfare and unemployment insurance, Douglas supported 'workfare' which stipulated that "anyone who couldn't find a job elsewhere would be put to work clearing roads, fencing pastures, installing phone lines, or working in community pastures" (Stewart, 2003, p. 170) – something that is today "roundly condemned by every respectable [Canadian] left-winger" (Stewart, 2003, p. 170).

In regards to health care services, Douglas was in support of user premiums above and beyond taxation. He justified this practice with the following statement: "I think people appreciate something if they've paid for it. If you give people a card from Santa Clause entitling them to free hospital services, it is not good psychology. But the amount should be sufficiently small that it doesn't impose financial burdens on anybody" (Qtd in Stewart, 2003, p. 220). And while the Saskatchewan government largely took care of the funding for health care, they did so in a fiscally prudent way that belied the oft used label which characterized more liberal political parties as 'tax and spend.' For example, in order to pay for their new system of Medicare once the doctors finally opted in after a 23 day strike in the summer of 1962, "Saskatchewan increased the sales tax from three to five per cent, raised corporate and personal income taxes by 22 per cent, and charged an annual premium of $12 for individuals or $24 for a family. This sum represented an increase in expenditures and therefore of taxes, of one-fifth" (Stewart, 2003, p. 229). Finally, to counteract attacks primarily made within the media that socialized medicine would mean that the state would interfere with the doctor-patient relationship and the general freedom of medical professionals, Douglas was

careful to take measures to build consensus before policy changes were finalized. As one of the guiding principles for establishing prepaid medical services in Saskatchewan, it was determined that the corresponding legislation "would have to be acceptable to both the public and the medical profession before it came into effect" (Stewart, 2003, p. 224). In short, the government role in providing medical services would be one of funding and *not* administration. In other words, financing for the program would be centralized but the administration of the program would remain decentralized.

Historical Contextual Considerations

The key period of time that I will be looking at to establish context for Douglas' rhetoric is between 1944-1961 when Douglas served as Premier of Saskatchewan. Since significant social and political reform – specifically medical reform - occurred during this time frame with the advent of a unique brand of socialism in Saskatchewan, it is crucial to take a closer look at this time frame.

On June 15, 1944, Tommy Douglas was elected Premier of Saskatchewan after a landslide victory in the provincial election. The *Co-operative Commonwealth Federation* [CCF] won 47 of 52 seats in the provincial legislature. A newspaper commentary published shortly after the election raises a number of issues and problems that the CCF responded adequately to in the campaign. The 1944 provincial election was held approximately 10 days after D-Day and the larger context was the prosecution of World War II. The winding down of the war marked a turbulent and uncertain period in history that started with the crash of the stock markets in late October of 1929, followed by over a decade of economic chaos that was marked by an extremely high rate

of unemployment. While World War II had the effect of stimulating jobs and industry, the event was still traumatic and was marked by tremendous loss of life and significant geopolitical uncertainty. The people of Saskatchewan feared that the depression could easily resurface unless prudent steps were taken by government. The general sentiment that Douglas was faced with, particularly from rural audiences, was described as follows:

> The farmer voted CCF because the great depression was the most profound political fact of our era. It taught Canadians and all other peoples something that they did not fully know in the last Saskatchewan election—a fundamental fear of the future. It convinced them that depression could occur on a scale never imagined before, and it made them fear that it may return. The farmer voted in Saskatchewan—apart from all local issues and the great age of the existing government—for larger measures to prevent the return of depression after the war. He did not accept socialism as the only means of avoiding such a disaster, but he did listen to the CCF which told him that something drastic must be done to avoid it, and that nobody was taking the necessary precautions.

In short, Douglas faced an electorate that was wary of the addictive cycles of the market and were not convinced that the temporary stimulus of the economy precipitated by World War II, would last. Their overall state of mind can be represented by the adage 'once-bitten-twice-shy.' While farmers in Saskatchewan were doing better by the time of the 1944 election, they were not content to rest in this reality. Instead, Douglas' constituency sought stability from the uncertainties of the post-war future:

> The psychology of the CCF support in Saskatchewan could be seen in the attitude of the farmer who went into Regina, just before the election, drew money out of the bank to buy a new car (although he had a good car already) and then walked down the street to contribute $50 to the CCF campaign fund. He was looking, in fact, not for more prosperity now, for he had plenty, but for an insurance policy against hard times later on.

Finally, while farmers in Saskatchewan were capitalists themselves, they were discontented because they believed that they were not getting a fair share of the wealth that they helped to generate. The farmers produced key goods, but it was those in the city that seemed to benefit the most from the market that they played a role in. Their own experiences from the deprivation of the 30's and the devastation of the agricultural industry, created a vigorous suspicion of the capitalist system and had convinced them of the need for economic reform. CCF policy proved to be the scheme that was most solvent in the mind of the agrarian producer. An article in *Canadian Forum*, published in 1946, reflected on the developing appetite for more cooperative economic policy implementation that was marked by prudence and efficiency:

> The need for constitutional change and the reallocation of taxation powers had barely been faced and certainly not settled. Farmers were threatened in the not distant future with a return to the insecurity of the thirties. The world situation had been radically altered by the advent of a Labor Government in Britain, but the bankruptcy of capitalism had only been postponed by the stimulus of a world war. A return to the old instability, the old alteration of boom and depression,

> the old paradox of poverty in the midst of plenty, the old social unrest and glaring inequalities of wealth and opportunity, was just around the corner, if not back again already.

Specifically relating to health care policymaking, industrialization had brought staggering medical advances in the form of equipment, health care facilities, and physicians with specialized knowledge. However, with these advancements came increasingly higher prices for health care which provided a substantial barrier in accessibility for these services. Once again, the market based system of capitalism gives but also takes away. Approximately midway through Tommy Douglas' mandate as premier of Saskatchewan, a feature article was published in *Maclean's* magazine that highlighted some of the hardships associated with the financial barriers that were becoming more prominent in the delivery of health care. For four months in 1952, *Maclean's* reporter Sidney Katz investigated the state of health care services in Canada. In the process, he travelled the country and interviewed medical practitioners and patients from a variety of socio-economic backgrounds. For his report of these experiences he notes that "everywhere I found a growing concern about the high cost of being sick. As a Halifax shipyard worker remarked, 'The average guy can't afford to slip on the street nowadays. It's liable to put him in the poorhouse for the rest of his life" (Katz, 1952). He sums up his findings as follows: "Millions of Canadians are troubled by the most intimate paradox of our times: Medical care has improved beyond measure but its costs have soared so high that an illness, or an accident, can bankrupt almost any family" (Katz, 1952). So in short, Tommy Douglas faced a rhetorical

situation that highlighted a distrust for Capitalism even with its potential to create great wealth and amazing innovation in medical equipment, facilities, and cutting edge training for physicians. While there appeared to be little desire to eliminate market forces and principles from the economy, Douglas did seem to have a mandate to rein these forces in and to administer the economic system so it was more accountable to the people as a whole.

A key audience for Douglas during his initial campaign for election and his consequent governing of Saskatchewan over a period of fifteen years, was the farmer, the working person, and the service providers in general. In a nutshell, Douglas created the perception that he and his government would always act in the best interests of those people. A series of articles were written in 1946 as a means to reflect on the new Premier, relatively early into his political tenure. In a brief exposition of the overall philosophy of the CCF in Saskatchewan, Morris C. Shumiatcher made the point that "in health as in industry, the object has been to co-operate with all who recognize the interests of the people, and who are themselves willing to co-operate." It is presumed that if the government is acting in the best interests of the people, than the people should in turn cooperate with government. However, Douglas acknowledged that universal assent can rarely if ever be achieved and recognized the need and role for government to incorporate ways to monitor and enforce implementation of new policy for the minority that may inevitably disagree with certain measures. Douglas seemed to see the state's role as providing mechanisms to control for or mitigate future uncertainties. This proactive orientation was grounded in a deep concern for people: "We have so high a

regard for human life that even before people are maimed or crippled, we each contribute to their maintenance and support" (Douglas, qtd in Shumiatcher, 1944, p. 55). In sum, it was the people that had the power to elect Douglas. Due to the very specific rhetorical situation that Douglas faced, appeals directed towards the 'little guy' or those whom were most vulnerable or felt vulnerable were rhetorically potent. The proper role for government in a capitalistic system could involve limited ownership or purview of some key industries where goods and services were provided to the people to use rather than to make a profit. Government intervention was justified on the grounds that some people faced this or that situation that disadvantaged them. The government role in these cases was to help people who could not help themselves. According to Brewin in a sort of 'short term assessment' of the CCF government in Saskatchewan: "In two short years the government of Saskatchewan had in every respect demonstrated its ability to govern in the interests of the people who elected it" (1946, p. 129).

Specifically in relation to health care reform and policymaking, once again Douglas faced a very unique audience in Saskatchewan:

> The people of Saskatchewan have always been health-conscious, and have been willing to pioneer in methods of providing medical care. The program on which they have now embarked, is the program of the people and will be carried out with the full participation of the people. While mistakes will undoubtedly be made, this participation and enthusiasm carry with them a guarantee that in the end, the goal will be reached—the goal of making available to every man,

> woman, and child in the province the full benefits of the scientific discoveries in the field of health. (Sheps, 1946, p. 82)

In the final analysis, Douglas faced a rhetorical audience in Saskatchewan that was primed to respond to a new brand of socialism or cooperative government. His audience was not prepared to completely overturn market approaches to the economy. However, within an overall capitalist framework, the people of Saskatchewan were prepared to listen to a politician that was prepared to offer some limited government intervention to provide a measure of stability and assuage a leeriness in the unpredictable and turbulent cycles of the market that had been observed in the 20's and 30's.

Finally, Douglas engaged the rhetorical situation with his careful and deliberate policymaking and also through his style. He basically presented himself as a moderate reformer who connected with his audiences through his Scottish charm, his humor, and his 'down home' persona. A synopsis of his campaign of 1944 summed up the appeal to ethos that he was able to generate: "With moderation in his policy, vaudeville humor in his speeches, a bantam cockiness in his face, a faint trace of Scottish accent in his voice and a homespun friendliness all over him, Mr. Douglas proceeded to sweep Saskatchewan clean. By election night he was a leading national figure to be watched by the whole nation." Moreover, he advanced a form of cooperative socialism that was fresh and somewhat counterintuitive through appealing to the value of efficiency and the provision of high quality government services to the people of Saskatchewan. In addition to the foregoing style for communication, Douglas also exhibited features of exhortative rhetoric in some of his speeches. He was well known for his 'harangues'

which were lecture oriented and quite possibly reflective of his experience as a preacher. One early example of this exhortative style of rhetoric occurred during his first campaign for Premier of Saskatchewan in 1944. In part, he said:

> We have just finished a war fought, we were told, for the preservation of democratic institutions. It would appear that the war is not finished. We have simply moved the battlefields from the banks of the Rhine to the prairies of Saskatchewan. If corporations can have these laws disallowed then there are no laws passed by a free legislature which they cannot have set aside. Where then is our boasted freedom? Why elect governments if Bay Street and St. James Street are to have the power to decide what laws shall stand and what laws shall fall. (Douglas, qtd. in Stewart, 2003, p. 165)

This tendency to rail against opponents even to the point of being inflammatory or employing language and analogies that could be construed as bordering on the insulting or offensive, was also a style he employed when advocating for or defending his beloved Medicare. For health care, Douglas sought to alleviate the distress of disease and illness by providing the people of Saskatchewan with access, on an equal basis, to the ever emerging fruits of health sciences:

> In striving toward this goal the two main aspects of the problem are being kept in mind—the necessity for removing the economic burden of illness from the individual while at the same time raising the standards of care available by an improved organization of the health services and facilities. The government does not wish to subsidize an inefficient program of a low standard on the one hand,

> nor to see model services built up which will be out of the reach of the people. (Sheps, 1946, p. 83)

At the end of the day, Douglas created the perception that he was a visionary persona through his character and through a language of innovation. A 1946 article in the *Regina Leader Post* summarized the deliberative rhetoric that Douglas employed as he initiated health care reform in his province: "'Blazing the trail' for the continent, Saskatchewan had reached the 'first milestone' on the road to complete socialized health services as he moved second reading of the *Saskatchewan Hospitalization Act*" (November 16, 1946, p. 8). This rhetoric ultimately induced cooperation from reluctant provincial governments and slow to act federal governments along with a stubborn and recalcitrant medical profession to implement and accept a national medical scheme for Canada.

It is also important to understand that throughout his political career, but particularly during the 'red scare' in the 40's and 50's, Douglas faced significant opposition from the press. During the campaign of 1944 when he was running for Premier of Saskatchewan, he was faced with convincing "the electorate that most of what they were being told by the province's newspapers and radio stations was simply untrue." Some sample headlines from the time catch the flavor of the problem: "'Socialism Leads to Dictatorship,' 'All Opposition Banned if CCF Wins Power,' 'CCF Government Would Take Away Farms,' 'CCF Government Would Destroy the Credit of the Government'" (Stewart, 2003, p. 159). The variety of scare tactics brought on by inflammatory language was, in fact, astounding.

In response, Douglas was a known agent of mediated communication as was evidenced by his frequent radio addresses and open air style campaign stops. The radio addresses served as a much needed antidote to the negative coverage he was receiving in the provincial newspapers. Douglas recalled these sorts of rhetorical engagements as follows: "I wrote a lot of broadcasts at night until two or three o'clock in the morning in the hotels after a meeting was over. Then I would rush in and do a broadcast, and get on the road again. Many times I'd ride half the night, get a few hours' sleep, write a broadcast, record it, and then get on the road" (Qtd in Stewart, 2003, p. 160). While many of his open air campaign speeches would often employ humor and other pathos, the broadcasts were serious, straightforward expositions of the reforms the party would make from protection for farmers, and encouragement for the co-operative movement, to better laws and hospital insurance (Stewart, 2003, p. 160).

The remainder of this chapter will subject some key speeches and other texts from Tommy Douglas to rhetorical analysis. As the data I will be using for rhetorical criticism was coded, I was able to identify a number of key features to his rhetoric that occurred frequently and/or intensely. As I characterized his rhetoric, I also encountered some literature in our field that provided concepts that helped me to develop an explanatory schema to illuminate the unique power in which Tommy Douglas communicated.

Emotional Rhetoric and Rhetorical History

Burke's comic frame

Operating in the comedic frame involves making a conscious choice to tailor one's rhetoric in a way that is counter to the dominant tragic paradigm for speech in western culture. As Burke notes in his *Attitudes Toward History*, "in the face of anguish, injustice, disease, and death, humans make attitudinal choices that commit them to particular actions, including ways of speaking" (Qtd. in Christianson & Hanson , 1996, p.159). The comedic frame differs in its depiction of the human role in affecting social outcomes from the tragic lens orientation:

> Thus, one may speak or act in the comic frame and yet not be funny per se. Hugh Duncan (1962) writes that 'the burst of glory in comedy… is our sudden reassurance that while some aspect of authority is threatened, the principles of authority are not' and that 'comedy exposes transgressions of rights, but does not question the rights themselves'" (Qtd in Christianson et al., 1996, p. 159).

At the end of the day, he maintains that "mankind's only hope is a cult of comedy (Qtd in Christianson et al., 1996, p. 159). In short, "comedy deals with man in society, tragedy with the cosmic man" (Burke, 1984, p. 42). A comic orientation lights the way for ongoing debate, discussion, and reform, in the realm of socio-political policymaking. Public policymaking should not end with legislation, but instead should continue on through an ongoing critical and reflective thinking process. The comic frame for rhetorical engagement with history "considers human life as a project in 'composition,' where the poet works with the materials of social relationships. Composition,

translation, also 'revision' offers maximum opportunity for the resources of criticism" (Burke, 1984, p. 173). To summarize, the comedic frame for speech communication can be described as non-violent, moderate, humane, rational, and moral: "For Burke, rhetoric in the comic frame is both humane and rational because the rhetor who speaks from the comic frame assumes that humans eventually will recognize their shared social identification and will respond in a moral manner. Such a rhetor has greater faith in the bonds of human connection and reconciliation than in the victimmage and mystification that tragedy requires" (Christianson et al., 1996, p. 160).

Burke goes on to conceptualize the foregoing critical, yet 'humorous' style of discourse as *burlesque*. A reform oriented speaker or leader could employ this style to point out inconsistencies in how authorities govern and legislate without *quite* resorting to character assassination or ad-hominen attacks. This could be accomplished by simply laying out a behavior of an opponent and then allowing for the audience to draw certain inevitable conclusions from this behavior. In so doing, the rhetor "makes no attempt to get inside the psyche of his victim. Instead, he is content to select the externals of behavior driving them to a 'logical conclusion' that becomes their 'reduction to absurdity'" (Burke, 1984, p. 54).

During his political tenure, Douglas primarily dealt with economic inequality and injustices that manifested in the inability of many Canadians to retain access to needed medical care. More generally, he identified with oppressed and frustrated Canadian citizens who lacked the means to live a fulfilling life in a country with ample resources. In fighting for the little person Douglas chose to reflect the urgency of his scene by

using rhetorical strategies that were consistent with Burke's notion of the comedic frame for speech: "Rather than reducing social tensions through mystification, scapegoating, or banishment, rhetoric in the comic frame humorously points out failings in the status quo and urges society to correct them through thoughtful action rather than tragic victimmage" (Christianson et al., 1996, p. 161).

In short, while a speaker may warn that tragedy is imminent if inactivity and neglect persist, the overall thrust of the message will suggest for the capacity of an audience to avoid or avert the potential calamity through human agency:

> One can speak of impending catastrophe and yet remain within the assumptions of the comic frame, so long as the catastrophe is depicted as avoidable through human choice, or simply as an episode that, however unfortunate, represents no rupture in the fabric of history. The comic version of the jeremiad might, therefore, exhibit some structural similarities to the tragic jeremiad that appears in apocalyptic argument; it may offer a list of present ills and predict catastrophe if humanity refused to turn back to the path of righteousness. In the event that the warning is not heeded, the comic jeremiad will seek to interpret the resulting catastrophe in episodic terms, not as a final close but as a moral lesson from which future generations may draw instruction. (O'Leary, 1993, p. 409)

In applying some of this thinking to health care policymaking or policymaking in general, legislation that is enacted should never be considered complete. Rather, it should be construed as one piece of a building block in a never ending quest of reform and social improvement. Even in the best of circumstances, legislation that prompts

social change should be considered a step in the right direction instead of an endpoint where honest discussion and debate cease to occur. The overall attitude toward history within the comic frame is one of optimism. O'Leary's application of Burke's comic frame to apocalyptic discourse asserts that a social change agent can level stern warnings to his or her audience while still retaining a measure of hope and purpose for the future. The resulting rhetoric is hard hitting and ominous but emanates out of a heart of optimism and a heart for change:

> The fully comic interpretation of the Apocalypse, however, would not merely postpone the End. Rather, it would make the End contingent upon human choice, would assign to humanity the task of ushering in the millennium. To be consistently comic, this interpretation would address the topos of Evil by defining it in terms of ignorance and foolishness (which can be overcome by exposure, education, and progress) rather than exclusively in terms of sin and guilt that require blood expiation. (O'Leary, 1993, p. 409)

As shall be seen in an analysis of Douglas' rhetoric, his 'in your face' style was often tempered by his firm belief in the brotherhood of man and his orientation toward the human.

An underlying presupposition in Douglas' rhetoric was the need to employ humor in order to take a step back from more serious and tragic depictions of reality so as to facilitate seeing 'actual reality' more clearly. Comedy and humor is needed from time-to-time to create distance for an audience from the key issues that encompass an historical context so as to rhetorically induce fresh insights to deal with these issues. For

the comedian, "the customary method of self-protection is the attitude of 'happy stupidity' whereby the gravity of life simply fails to register; its importance is lost to them" (Burke, 1984, p. 43). It is clear that a key feature of the rhetoric of Tommy Douglas is its tendency to operate in a manner consistent with a *comic frame*.

While it is granted that Douglas operated within the political establishment, in many ways he was an outsider as the leader of a party that never governed at the federal level. With its frequent 'third party status,' the CCF & NDP offered contrarian policy positions to the more mainstream Liberals and Conservatives. In fact, Douglas presented his party as a type of 'internal protest movement' in his famous *Mouseland* speech. The allegory depicts Canadians as 'mice' who regularly vote in governments of 'cats.' The only change or protest that occurs is among color of cats as the Conservatives and Liberals were different in degree and not kind. Through this story, Douglas suggests that if Canadians want any real change, they will need to vote for the NDP as the only party that will govern in the interests of the 'mice' aka the Canadian people. In so doing, he positions his party as an organization that protests on behalf of the Canadian people. In light of the foregoing thoughts and perspectives, I will be applying two key units of analysis to excerpts from a number of important speeches that Douglas delivered throughout his political career. Specifically, I will be looking to make connections between some of these texts to Burke's comic frame for rhetoric, along with evidence of ego functions for protest rhetoric as a point of departure for my final analysis.

Rhetorical Assessment of Some Key Speeches

It is important to realize that though Tommy Douglas was a prolific rhetorician, many of his speeches were delivered in informal setting such as barnyards, churches, schools and other rural locations. Moreover, much of his campaign style rhetoric was produced during a time frame where camera coverage or audio capture were unlikely, let alone the common tendency today of public performances being posted on social media such as *Facebook* and *YouTube*. This being said, I will be analyzing aspects of three major speeches for the purposes of illuminating the nature of Douglas' rhetoric and argumentation strategies. The speeches in chronological order are 1) *The Cream Separator* speech, 2) His Medicare Speech, again delivered in the *House of Commons*, in 1979 in response to the Liberal Governments proposal to amend the *Health Resources Fund Act*, and finally, 3) A speech delivered in 1983 on the occasion of the 50th Anniversary of the CCF/NDP which is widely touted as one of his most profound messages. Of course I will be filtering my analysis through my rhetorical framework discussed above.

Ego involvement and protest rhetoric

Richard B. Gregg identifies a unique function of rhetoric in relation to social change and protest movements. He observes that "we are witnessing on the public stage a rhetorical function which has been largely ignored in rhetorical study. Specifically, I refer to a particular *ego-function* of rhetoric" (Gregg, 1971, p. 71). In defining what exactly an ego function is in rhetoric, Gregg explores and articulates the types of people that are, based on this ego function, most likely to protest and/or advocate for social

change. He elaborates on how such rhetoric serves an ego function in the following excerpt:

> I shall argue that the primary appeal of the rhetoric of protest is to the protestors themselves, who feel the need for psychological refurbishing and affirmation. Spokesmen for protest movements also become surrogates for others who share their intimate feelings of inadequacy. The rhetoric is basically self-directed, not other-directed in the usual sense of that term, and thus it can be said to be fulfilling an ego-function. (Gregg, 1971, p. 74)

He then identifies how rhetorical appeals are directed at an audience that feels on the fringe of society, and how such people might respond to a different vision for the country that includes them more directly: "There appears to be a strong need to recognize and proclaim that one's ego is somehow ignored, or damaged, or disenfranchised. A second posture, following logically from the first, proclaims, extols, and describes in exaggerated fashion the strengths and virtues of the ego sought after" (Gregg, 1971, p. 76).

The focus that Gregg places on the psychology of the rhetor and audience for social change is instructive since it hints at a potential way forward for a reinvigorated debate on Medicare in the political and societal realm in Canada and the needed health care reform that such increased rhetorical engagement might provide. Perhaps, for example, Canada needs to produce rhetors with egos as one piece in the puzzle in enacting significant social and political change. This 'ego function' for protest rhetoric may be particularly crucial in a country that holds rhetoric in such suspicion. In other

words, it might be more likely that a rhetorical figure in Canada might argue aggressively for the sake of ego engagement than for the sake of simply producing excellent argumentation.

Finally, Gregg identifies some potential strategies that ego engaged rhetoricians might employ in order to persuade for political and social change. It is implied that an attack style rhetoric might serve an ego function:

> This rhetorical identification of personalized enemies enhances establishment of self-hood in several ways. By identifying against another, one may delineate his own position – locate himself by contrast. By painting the enemy in dark hued imagery of vice, corruption, evil, and weakness, one may more easily convince himself of his own superior virtue and thereby gain a symbolic victory of ego-enhancement. The rhetoric of attack becomes at the same time a rhetoric of ego-building, and the very act of assuming such a rhetorical stance becomes self-persuasive and confirmatory. (Gregg, 1971, p. 82)

Capitalism as Insidious

The Cream Separator was a speech Douglas used throughout his career but particularly during the early stages - specifically when he was Premier of Saskatchewan. The speech was geared toward a primarily rural audience and ultimately served as an analysis of the capitalistic economic system in Canada. His *Medicare Speech* was noteworthy because it provided a thorough and historically grounded summary of the fight to institute Medicare in Canada. Further, it highlighted many of the values upon which the system was established along with his vision for the future of the country

concerning health care services that culminated with a broad theory on the role of government. His 50th Anniversary of the CCF/NDP speech that he delivered in 1983 is noteworthy not just for his assessment of the state of Medicare at that time, but also for a wider exposition of his suasory savvy in general.

The Cream Separator speech portrayed a simple piece of farm equipment as symbolic of the ways in which 1930s capitalism was responsible for disempowering the farmer and producer of goods. Douglas started the speech by telling a humorous story about himself as a naïve 'city boy' coming to a farm and not knowing what he was doing. Therefore, he is given the easiest task that the farmers could think of – turning the handle of the cream separator. The story picks up from there:

> Any of you ever turned the handle on the cream separator? Well it's quite an experience. I got to be quite good at it. I got to the place where I could tell you how many verses of 'Onward Christian Soldiers' it takes to put a pan of milk through this thing. And as I was turning the handle and they were pouring in the milk, and I could see the cream come out the one spout and the skim milk coming out of the other spout, one day it finally penetrated my thick Scotch head that this cream separator is exactly like our economic system.

This cream separator as well as the economic system that it represents, is of course something that his audience would not have been in control of. So who is responsible for this disempowering state? It is not the owner or the producer of the instrument. No, it is the instrument itself that diminishes a sense of control and empowerment:

> The farmers and the fisherman have produced so much we don't know what to do with it. We've got surpluses of foodstuffs. And the workers, they've produced so well that today nearly a million of them are unemployed. The fault is not with the worker. It is not with the primary producer. The fault is with this machine. This machine was built to give skim milk to the worker and the primary producer, and to give cream to the corporate elite. (Douglas)

By blaming the cream separator for the farmer's malaise and then connecting this instrument to the wider economic system, Douglas was addressing/rehabilitating the egos of these workers rhetorically. As a symbol of monotonous drudgery, placing blame on this instrument would have been a rhetorically potent way to connect with the audience's less-than-favorite experiences and shed light on why this was so. All of this could conceivably function to increase knowledge as well as rhetorically induce an overall sense of control.

Another strategy for ego mending and building involves an attack on capitalism. If Gregg is right in claiming that feeling disempowered is bad for the ego, than it can be implied that appeals that attack bureaucracy or 'the system' as impersonal, degrading, or lacking in human dignity might go a way toward healing this fracture both for the rhetor and the audience. At the end of *The Cream Separator*, Douglas lays out an ego building vision for the little person by once again characterizing the Canadian people – not government and certainly not the business elite - as predominant: "Now what the, what the democratic socialist party has been saying to Canadians for a long time is that the time has come in this land of ours for the worker and the primary producer to get their

hands on the regulator of the machine so that it begins to produce homogenized milk in which everybody'll get a little cream." By attacking the entrenched system of capitalism and 'diffusing' these power structures by providing many more people with the wherewithal to attain goods and services of quality, Douglas' audience was able to catch a glimmer of a reality outside of the social riddle in which they were ensnared.

Finally, ego repair can be instituted by a rhetor for their audience through painting the perceived enemy in the dark hued imagery of vice, corruption, evil, and weakness. In *The Cream Separator*, the owner of the instrument was portrayed as the clear villain. The owner is depicted as greedy, lazy, unappealing and self-centered. Connecting such a despicable figure to the previously identified instrument that is the nemesis of the rank and file worker would have likely added even more potency to the argument that illuminated their plight:

> And then I thought, but there's another fellow here somewhere. There's a fellow who owns this cream separator. And he's sitting on a stool with the cream spout in his mouth… And every once in a while this little fellow sitting on the stool with the cream spout in his mouth gets indigestion. And he says, 'Boys, stop this machine. We got a recession!' He says to the worker, 'You're laid off, you can go on unemployment insurance and after that on welfare.' And he says to the farmers and the fisherman, 'You know, we don't need your stuff. Take it back home.' And then he sits for a while, indigestion gets better, burps a couple of times, says, 'Alright, boys, start the machine. Happy days are here again. Cream for me and skim milk for both of you.' (Douglas)

The depiction portrayed above is ego building through providing the audience with an evil personification of the instrument of their slavery. The 'fat little fella' who is the owner is not only presented in negative terms but is turned into a bizarre joker like character who holds no merit to the fruits of the system of capitalism. With the foregoing characterization, it would be ridiculous to continue to take this so called authority figure seriously or to be victimized by him. Such a person is actually inferior to the farmer even though he likely serves in some kind of artificial supervisory role over them. It is relatively easy to see the ego building function of such advocacy. It is also important to re-emphasize that part of Douglas' derived rhetorical ethos was egoistic in nature. Hence it is clear that the ego function of his rhetoric was self-directed as well as other oriented. As Stewart notes in his biography of Douglas, "he had a very strong ego but it was tempered by a pretty good dose of humility – from time to time – and he had an unfailing sense of humor" (84). He was also described as feisty and idealistic and known for his preachy harangue. In short, Douglas had a personality that was made for the public spotlight, not just social policy development. His public advocacy also functioned as an ego building and sustaining enterprise for *him*.

Speech in response to Liberal plans to amend the Health Resource Fund

In 1979, M.P. Tommy Douglas, no longer leader of the NDP, rose in the *House of Commons* to lambast the governing Liberals for their plan to amend the *Health Resources Act*. This Act was an agreement between the provinces and the federal government and the fund was part of a cost sharing plan in which the burden for financing Medicare was spread out between provincial legislatures and Ottawa.

Douglas became the voice for NDP opposition of this amendment and was outraged that such an amendment was being considered. He launched into a moral tirade as a clear strategy to gain the full attention of the Prime Minister and the government. Very early in this speech he initiates his moralistic discourse: "I venture to participate in this debate not only because of the impact of the legislation itself, but because of the 'attitude of mind' which it reveals. Because of the emphasis which it gives, to certain aspects of our national life and because of the disjointed scale of values – social values – which I think are displayed in this legislation." The foregoing is an example of a rhetorician moralizing an issue and refusing to separate seemingly pragmatic legislation instituted for bureaucratic convenience, with individual morality. Douglas continued on with his moralistic diatribe by employing more shocking language to point out that while the Liberals were considering freezing the *Health Resources Fund* they were at the same time planning to designate increased funding to the 'for profit' pulp and paper industry: "But, I want to point out, how almost *obscene* it is for a government to talk about giving 235 million dollars to an industry that is making more profit now than it ever did in its history. And at the same time, coming to this house and saying, 'we want to take 80 million dollars back from the provinces which we promised in 1966 we would pay for them if they came into Medicare" (Douglas, 1979) [Emphasis mine]. He then concludes the speech with the most explicit moral argument yet. In so doing, he again provides Canadians with an alternative vision of the role of government and its relationship with society:

> My third criticism of this legislation Mr. Speaker is that it indicates a deplorable standard of priorities… Surely if ever there were an indication of a government having a distorted sense of values, this is it. This is it. Because after all, Mr. Speaker, the measure of a government's worth is not just in the Gross National Product. Not just in the balance of international payments. It's not just in the amount of our gold reserves. Surely the worth of a government in the main, is what it does for its people! That's what makes a nation great! (Douglas, 1979).

Clearly, the foregoing indicates a level of exasperation that Douglas had towards the governing Liberals at that time. But he does not stop with general accusations. On a number of occasions, Tommy Douglas was known to attack political opponents directly. The text reveals that former Prime Minister Pierre Elliot Trudeau was a frequent target of Douglas' rants. References to inconsistencies in positions, and even going so far as to suggest that Trudeau was lacking in integrity approached the level of ad-hominem argumentation. However, once again, Douglas was able to temper and legitimate this blistering style of rhetoric with the infusion of humor. Through employing burlesque in his attacks, Douglas retreats slightly from the level of ad-hominem fallacy. He does this by hinting at a willingness to give elites such as Trudeau the benefit of the doubt while at the same time communicating the fact that he remains suspicious. Before launching into an historical explication of how universal health care in Canada became a reality and defending the role of the federal/provincial cost sharing agreement as supported through the Health Resources Fund, Douglas embarks on some character assassination of the Prime Minister tinged with sarcasm. Consider the following lengthy criticism:

We should understand that this legislation comes before the House, largely as a result of the announcement that was made by the Right Honorable Prime Minister on national television on August the 1st. The Prime Minister had attended an economic conference and sailed on the Baltic with Chancellor Schmidt of West Germany. Had a holiday in Morocco than returned to Canada to do a complete reversal of the Government's fiscal policies. Up until that time, he, and particularly his minister of finance, had been telling the Canadian people that what we needed was an increase in the effective economic demand. And therefore the Canadian people should save less and spend more. But on August 1st, the Prime Minister announced to the Canadian people that the government was going to embark upon a program of restraint. And that they would cut – at first statement – of what was a billion dollars and later this was raised to two billion dollars from the estimates that would be passed it was hoped by the parliament of Canada. It's significant, Mr. Speaker, the cabinet was called together 10 days later to hear what these cuts and their estimates were going to be. Which makes me wonder what has happened to the principle of cabinet responsibility and cabinet solidarity. One of the long standing traditions of the parliamentary system has been that the Prime Minister is 'Primus inter Pares' – first among equals. But that the decisions which are made are not the decisions of the Prime Minister but of the cabinet. And the cabinet must collectively accept responsibility for those decisions after due process of consultation and discussion. But not so in the matter of restraint. The Prime Minister made the

> announcement like the President of a country with a Presidential system and then called together his cabinet ministers merely to hear what decisions had been reached by the Prime Minister himself. I think that's a very serious indictment of the regard which the government has shown for the parliamentary system. There has been growing concern in this country that we are moving step-by-step to some type of presidential system. And if ever it was demonstrated, it was shown on August the 1st when the Prime Minister reversed the fiscal policy without even his minister of finance or his other ministers having been consulted or aware of the decision which had been reached by the Prime Minister himself. (Douglas, 1979)

Notice that in the above criticism, Douglas focuses on the actions and behaviors of the Prime Minister that reflect poorly on his character and credibility as a leader. Trudeau is depicted as being inconsistent, arrogant, authoritative, and disrespecting of the parliamentary system. In essence, he follows his own counsel and is prone to making unilateral decisions – foregoing the deliberative processes that are so germane to a democracy. However, he is able to get away with such harshness through framing the accusations within the context of a seemingly excessive and lavish vacation. And instead of directly accusing Trudeau of being anti-democratic, he 'speculates' that this might be so and ponders how his actions may be related to wider concerns that Canada was morphing dangerously close to an American style of governance. These types of more personal attacks on political opponents that were perceived to be threatening

policy and values that were important to the CCF/NDP became a consistent feature of Douglas' rhetoric.

In addition to such moralistic discourse, Douglas' defense of the *Health Resources Fund* involved a firm anti-establishment position. He chose not to give credit to the Prime Minister or the government or even politicians for the development of Medicare and advances in the system. He did so by providing a brief historical summary of the development of health care programs in Canada and praising non-government officials for doing the heavy lifting for Medicare's administration:

> Now, I enumerate this Mr. Speaker on account of those of us who were interested in this field and those who pioneered this field. I'm not talking about politicians so much, I'm talking about doctors and hospital administrators and sociologists and people who were interested in the wide scope of the health program all reminded the public from time to time that comprehensive health care would come in two phases. (Douglas, 1979)

Perhaps what is most intriguing about this harangue was his attempt to change expectations concerning the potential of health care in Canada and his stubborn refusal to embrace the status quo at that time. Despite everything that had been accomplished, Douglas insisted that Canada must continue to press on. He starts off his relentless and audacious attack on the status quo by arguing that the proposed legislation to cut funding to the provinces for health care "assumes that the purposes and objectives of the health care programs have been attained. And of course Mr. Speaker, they haven't" (Douglas, 1979). Then after outlining a long laundry list of medical services and preventative

approaches that Canadians still did not have access to, he acknowledged that, while much had been done for improving health care, he was anything but satisfied:

> So while we have done a great deal in this country – and I want to say, Mr. Speaker, that I think Canada can be proud of what it's done, in both health insurance and Medicare. It's true we're not as advanced as some of the countries in Europe who have been pioneering this field for several decades. But when you compare our situation with the United States, where they haven't got a plan at all, with all their wealth and with all their power, the Canadian people can be congratulated. And the governments of this country – some of whom were very slow and reluctant – but they can be congratulated that we've gone as far as we have. But it is dangerous to assume, as this legislation does, that the job is finished. When as a matter of fact we have just made a very good beginning and that's all. (Douglas, 1979)

In the foregoing, Douglas continues, through his praise of Canada, to imply that he gives most of the credit to the Canadian people. He then identifies with his audience by making an appeal to Canadian nationalism and ends with kind of a pastoral like 'chastisement.' Instead of celebrating, Canada and its leaders should have a more measured perspective that social progress in not an end all onto itself but merely one stage in what should be an ongoing incremental progression. In a similar fashion to his policy development, Douglas again highlights his pragmatic idealism by connecting his vision for a better and healthier Canada to realistic and gradual logistical steps. It is important to note that Douglas' continued attack on the status quo, which was delivered

with a tone of mild exasperation and even desperation, occurred within a context in which he had already gotten what he wanted. At the time of the address, medical and hospital services had been a reality for 10 years.

Speech to the 50th anniversary convention of the CCF/NDP

In many ways, the address that Tommy Douglas made at the 50th anniversary convention of the CCF/NDP was distressing. Douglas was approximately three years from death, and Medicare was being threatened by extra billing and persistent opposition from medical doctors. Additionally, the occasion served as a bit of a lament due to marginal political success that the party had experienced at both the provincial and federal levels. After Tommy Douglas' resounding victory in Saskatchewan in 1944, the federal CCF under the leadership of M.J. Coldwell never got more than 15% of the vote and at one point sinking as low as 9% in the polls. Then under Mr. Douglas' federal leadership of the NDP starting in 1962, the party did no better than 18% and was consistently perceived as the 'third party.' According to one lifelong CCF/NDP'er, the federal party soon realized its true role not as the government in waiting but as the conscious of the country and as a countervailing influence on government.

In the midst of this backdrop, eighty year old Tommy Douglas delivered a rousing and inspirational speech to the delegates. As Burke indicates, humor is a sophisticated, nuanced and highly abstract form of communication. It looks at things indirectly and in the process, provides illuminating insights into reality. Douglas recognized this and immediately addressed the spirit of lament in the audience through some disarming banter and wit. He did this through the conveying of two stories that

were prefaced by some remarks on the value and importance of comic orientations. At the start of the speech after making some brief acknowledgements, he tells a story harkening back to his days as an MP for the riding of Nanaimo-Cowichan in BC: "I always think of an old story because I think you've been serious in here tonight and you might like to have a laugh for a change…" (Douglas, 1983). He then recounts how one of his then associates, a BC judge and CCF supporter, noticed a young widow wondering through his neighborhood wearing an official party jacket. Suspecting that she might be mentally disturbed on account of her erratic behavior, when the lady knocked on his door, he reminded her that at that time there were three classes of people who were not allowed to vote – judges, convicts, and the mentally ill. To this the lady responded "and which are you sir?" (Douglas, 1983). A little later on, Douglas reasserts the indispensability of humor in the highly technical and 'straight-laced' political scene in Ottawa:

> One of the things I tried to do when I was in politics and particularly in the House of Commons where it can get pretty dull for long weeks and months on end, was to try to retain my sense of humor and every once in a while I'd find somebody who helped in that regard and strange to say two of the men I remember most in that connection were senators. One was Senator Chester Clarke and he was a homely sort of chap who didn't try to sound like a corporation lawyer or a great statesman, he used ordinary phrases and one day he was addressing the Senate and he said, fellow senators, this country is like an old milk cow stretching from the Atlantic to the Pacific. It's fed in western Canada,

> it gets milk in Ontario and Quebec and I leave it to your imagination what it's doing in the Maritimes!

In starting off his speech with two humorous stories in succession, Douglas was insinuating that the path to electoral success for the NDP was not going to be through intense self-reflection or through playing the political chess game that had become so characteristic of Ottawa. Instead, the NDP should focus on developing a message that was fresh and contrary to rhetoric steeped in ideological partisanship. Douglas, as a moderate socialist, saw the danger inherent in the relentless pursuit of ideals over people even though he was an idealist himself. Socialists, implied Douglas, needed to put their pride aside and work together for the sake of the community. Once again, he employs humor to provide this message. Even though the CCF/NDP movement consisted of some unlikely bedfellows that included any Canadian who used either 'hand or brain' to provide services for their communities, it was critical that these competing constituents take time to get to know each other, accept each other, and become comfortable with each other. While the more tragic historical interpretation of his party pointed towards acrimony, Douglas used humor to indirectly suggest that divisive inclinations were short-sighted folly:

> And so we launched the party. We had some disappointments, like when Agnes MacPhail and the members from the UFO went back to Ontario. The United Farmers of Ontario decided that it was bad enough to be associating with some of those people from Saskatchewan and Manitoba but to have the socialist party

> of British Columbia in the same room, it was liable to give you a disease from which you'd never recover. (Douglas, 1983)

Interestingly, though, Douglas still makes reference to an ideological think tank, known as the *League for Social Reconstruction* (LSR) as the intellectual glue that joined together the disparate interests that comprised the socialist movement in Canada. However, Douglas' rhetoric implied that the intellectual component of his movement should serve the function of unifying the citizens of Canada who could benefit for what the party had to offer, rather than operating as some kind of elite and countercultural force. So while holding out an olive branch to the ideological segment of his party, his central rhetorical message was one of moderation and inclusion as versus elitism and exclusion. In short, Douglas insisted that "we can't work together as a socialist movement unless we learn first of all to be tolerant with each other, and second, to trust each other" (1983).

Building upon his application of comedic perspectives to his general socio-political philosophy along with his historical interpretation of the ebbs and flows of the CCF/NDP party, Douglas continued to exhibit aspects of Burke's comic frame as he focused specifically on health care. In short, Douglas depicts health care in Canada as being slowly eroded through a combination of greed, complacency and inflexible administration. His rhetoric infers that discussion and debate surrounding the provision of health services had devolved into neglect, timidity, and sterility. Even worse, there is an underlying spirit of greed that if left unchecked, could sabotage healthcare and other social welfare systems that serve the function of keeping the country humane. He

speaks of the need to "save Medicare from subtle strangulation." Further, he makes the case to the delegates that, not only is universal health care the right thing to do but it is also efficient and economically sound policy. Despite the successes of Medicare, Douglas provides a stern warning that human nature will run its course if it is not checked by continued and ongoing government intervention. He positions the status quo as the enemy and the thought of health care wasting away on account of apathy is something that clearly angers him. Underlying these admonitions is a spirit of optimism that holds out hope that these negative things will not occur if human agents embrace their duty to each other and engage in sustained action:

> I want to warn you as one who started out even before I was in politics, dedicated to the idea of comprehensive health insurance and fought for it all through my political life. I want to say to you that Medicare and hospital insurance are already marked for destruction unless you stop the per capita taxes and the extra billing which most of the governments of Canada are now permitting… We must fight as we have never fought before to throw the per capita tax for healthcare out the window… If you want a two-tiered health program, then just continue the way we're going and I remind you that in this movement we pledged ourselves 50 years ago that we could provide healthcare for every man, woman and child, irrespective of their color, their race or their financial status and by God we're gonna do it! (Douglas, 1983)

The foregoing is vintage Douglas. He presents a noble vision for the future that is grounded in the notion that all humans are our brothers and sisters and are therefore

worthy to be treated with dignity, respect, and compassion quite apart and separate from their financial resources. Even though the rhetorical situation that Douglas spoke into was not dire in the sense that Medicare was alive and well, he painted an ominous picture for the delegates. Medicare was not an established 'medical program' but a reality that facilitates for the service and protection of human beings. The foregoing system was not instituted through bureaucracy but through the 'rhetorical mode of reality' which thrives off of clash. Human agents are required to defend humane systems and attack the all too common destructive elements of human nature. Douglas' rhetoric points to a suspicion that Canadian culture left unchecked is marked by a dehumanizing tendency and is susceptible to greed and a lack of compassion. When addressing the issue of health care, Douglas had a tendency to exhibit a rhetorical style that is confrontational, exhortative, emotional, humorous and egocentric. Moreover his exaggerated doomsday scenarios are tempered by a comic orientation grounded in optimism and a belief that when push comes to shove, human beings will do the right thing. Otherwise put, health care discussion and debate in Canada must at times be focused or 'corrected' through a methodology that is similar to Burke's description of comedy as a corrective force in human society. For his final appeal, he invoked American myth and the poetry of James Russell Lowell as a means to get to the point or the 'heart' of his rhetoric:

> Let me close by saying that tonight we look back 50 years. We look back with gratitude for the men and women who had the courage and determination to launch a movement based on the principal of humanity first. We're gathered

> here 50 years later, first of all, to express our appreciation for them and our admiration for them. But much more importantly, we are here to pledge ourselves to continue the work which they so courageously began and to say to them and their memories and to the people of this country what our forefathers began we will continue. We will continue not with the old ideas because times change and people change, we need new ideas to meet new situations. But the principal of organizing our society for all the people and not for a privileged few, that is still here and that is the principal to which we adhere. My friends, we face another 50 years. I close with these words. I hope you'll try to remember some of them. New occasions teach new duties**;** Time makes ancient good uncouth; They must upward still, and onward, who would keep abreast of Truth; Lo, before us gleam her campfires? We ourselves must Pilgrims be, launch our Mayflower, and steer boldly through the desperate winter sea, nor attempt the future's portal with the past's blood-rusted key.

At the end of the day, Tommy Douglas took a markedly critical approach to Canadian society. However, he refused to allow his perception of social ills and injustices to victimize. Nor was he willing to victimize others through coercive rhetoric or action. Instead he rhetorically induced his audience to come to terms with the folly of their ways and to experience a sense of urgency for future threats and dangers to health care and other services before it became too late.

The supremacy of protest rhetoric

Among other things, what should be clear from the foregoing analysis is that Tommy Douglas was not a big proponent of the status quo. He was an anti-establishment reformer and a social change advocate. Obviously, his rhetoric reflected this fact. The 50th Anniversary Address was no exception. In later chapters, I will address how health care policymaking and the debate surrounding it has been stalled for a number of reasons. An implied preference for administrative and bureaucratic instruments that largely replace rhetoric is one explanation. As well, Medicare has over time become entrenched in Canadian identity making it very difficult for politicians, particularly at the federal level to subject health care system programs to genuine scrutiny. A common feature of health care advocacy is the general statement, made in the various texts, that resting on what has already been accomplished is not a desirable approach to take. Tommy Douglas was clearly an oral precursor to these later texts as he took on the persona of a protest reformer. The rhetorical style that he employed as a social change agent was inherently comic. He rhetorically induced clarity in reflection by inviting audiences to take themselves and their politics less seriously through adopting a playful orientation to authority and the status quo. Moreover, he provided admonitions and warnings to his constituents on the potential consequences of inactivity and apathy. But he refused to consider that tragic doomsday scenarios would have any permanence because he had an optimism that human agents would always 're-engage' important issues always before society reached a point of no return. His reform oriented approach to health care was informed by his general philosophy of activism. At the end

of his address to the delegates at the 50th Anniversary of the CCF/NDP, he confirmed that, in his eyes, the real enemy of universal health care and other humane policies instituted by a benevolent government was complacency.

Implications

So what can be learned from Tommy Douglas? How can the study of Douglas' rhetoric be of benefit to our field? What does his career of social, political, and spiritual advocacy mean for individuals and for society today? First, it is clear that Douglas deftly used rhetoric and rhetorical processes as a clear alternative to violence which of course is an oft stated mantra in our discipline. When applying his more talk and less violence approach to the Medicare situation, the risk for violence may be of a different sort. For instance our recent history has indicated that when governments fail to act and people are reluctant to resort to physical violence or even peaceful assembly and feel disengaged from deliberative bodies such as parliament, the courts or other administrative agencies step in. Once the courts get involved a legislative process morphs into a rigid, legal process where the only change that is likely to occur is from the ruling authority of some kind of intermediary body. I would suggest that these types of circumstances, if they can be avoided through the consistent use of rhetoric, would ameliorate these types of pitfalls. The goal of re-engaging in an argumentation process concerning Medicare and other social safety net programs would serve the purpose of enabling Canada as a nation to deal with these issues rhetorically before things get to the point where the law becomes required.

Last, the ego function for rhetoric as outlined by Gregg could provide prospective politicians and current policy-makers a way forward for stimulating the rhetorical engagement required for health care reform and other social change. It may take a type of egocentric figure to bring fresh ideas and significant change into the political realm. Justin Trudeau has recently come out in support of decriminalizing marijuana and admitted to usage himself. Why did he do this? If we are to follow Gregg's logic, it is because such statements and publicity fulfill some kind of an ego function for him. It would be interesting to perform some kind of psychological analysis on Trudeau to gain a better understanding of what makes him tick. But re-engaging rhetorically to fulfill an ego function could act as compensatory in a society that is suspicious of rhetoric and is less likely to employ it for its own sake. Taking a psychological approach to rhetorical analysis when looking at figures like Justin Trudeau and Tommy Douglas might provide information as to the types of insecurities and motives a social change agent may need to have if Canada is to turn to rhetoric. If anything is clear from the foregoing analysis, the system is relentless in Canada. If meaningful change and health care reform are to occur, leaders need to make a concerted effort to avoid being "divided from their compassion by the institutional system that inherits us all" (Gregg, 1971, p. 82).

CHAPTER IV

THE APPROPRIATION OF CANADIAN IDENTITY

> The collective mind does not penetrate below the surface, but it sees all the surface, which profound thinkers, even by reason of their profundity, often fail to do: their intenser view of a thing in some of its aspects diverting their attention from others (Mill, qtd in Whedbee 180)

There seems to be little question that a crucial dimension of what it means to be Canadian is wrapped up in our health care system. At the endoxic level – a level that would include what Aristotle would refer to as 'untrained thinkers' – our health care system enjoys almost universal assent. A recent online survey, for example, commissioned by the Montreal-based *Association for Canadian Studies* indicated that a whopping 94% of the approximately 2200 respondents considered health care services programmes as a key source for collective pride. Award winning journalist Andrew Cohen, in his work *The Unfinished Canadian* also argues for a strong connection between Canadian Identity and health care: "Today Medicare, like peacekeeping, has become a part of the Canadian iconography, a secular religion. We talk about it endlessly. It has all kinds of benefits to us, including making us different from the Americans and allowing us to feel superior" (2007, p. 82). Later on in his work, Cohen spends some time elucidating a not uncommon argument that Canadian values and policy are in marked divergence from what is seen and experienced with our neighbors to the South: "Gay rights, Kyoto, universal health care, and peacekeeping were our emblems of distinction. They were what made us different; they were supposed to

reflect our progressiveness and accentuate differences with the United States" (2007, p. 127).[1]

The foregoing rosy picture of health care as a strong and steady indicator of Canadian nationalism has not been borne out at the public policy level. Throughout the 1990's, transfer payments from the federal government to the provinces, earmarked for health care as mandated by the *Canada Health Act*, have been reduced significantly. Furthermore, the perception of unacceptable wait times for important services has resulted in attacks on our system at least in part based off of Charter grounds. These attacks culminated in the *Canadian Supreme Court* declaring Quebec's prohibition on the purchase of private insurance coverage for services already covered by the public plan as unconstitutional. And though Cohen acknowledges the conflation of universal health care with Canadian identity, he argues that there are signs that this conflation is eroding and is being replaced imperceptibly by a vision of Canadian nationalism that is closer to recent manifestations of the 'American dream': "The notion Canadians as a people are hanging up their snowshoes, wiping away their coy, deferential smiles, and forsaking both publicly funded medicine and weird, six-character postal codes, to pledge allegiance instead to the dark trinity of gods that increasingly seems to rule America – the triple-headed hydra of money, materialism and the military" (2007, p. 97). Canadian identity is relevant to my overall analysis for health care policymaking in Canada

[1] These identity signatures have shifted under Stephen Harper's Conservatives who were elected in 2006. The Government of Canada withdrew from the Kyoto environmental agreement in 2011. Peacekeeping has also been deemphasized of late with Canada's military being recast in the post 9/11 era as 'peacemakers.'

because Medicare is entrenched in Canadian identity concerns. The routine entrenchment of Canadian identity with health care serves to stifle debate and make needed changes or reforms to the system difficult.

In this section I hope to argue that the tensions between convergence and divergence concerning our relationship with U.S. values are, in the final analysis, less than helpful. Casting Medicare as being 'not American' exacerbates and perpetuates the conflation of health care services with Canadian identity and does not encourage us to take ownership in our system. Further, alternating between widespread assent and either neglect for or challenges directed toward Medicare from elites is unproductive. I will try to show that though the public sentiment of near complete satisfaction with Canadian Medicare is perhaps a distortion of the quality and sustainability of our program, we can actually learn a great deal from the public concerning the nature of Canadian culture in general. Some public sentiment concerning what it means to be Canadian can actually be instructive in providing scholars and public policy makers with fresh insight on the way to move forward with needed health care reform. Our health care system needs to be a Canadian system first and foremost rather than a reactionary system that maintains its appeal at least in part from being distinct from 'American style' medicine. Additionally, Health Care Services needs to be assessed on its own merits and could stand to benefit from being subjected to an ongoing rhetorical process like a majority of our systems, structures, and laws. By being both challenged and defended, alternative visions can be presented and tested in an 'open' public policy process. It is through the

rhetorical path as versus the path of entrenched bureaucracy that Canada will sustain and revitalize an already functional system.

More specifically, I plan to illustrate that healthcare in Canada is unconsciously and indirectly connected to Canadian identity. 'Medicare,' rather than being an active and identifiable system, is instead a passive funding or delivery system. And when an illness occurs, patients do not go to Medicare offices in Fredericton or any provincial capital for service but rather go to a local hospital or clinic or physician or group of physicians and identify health care services with these elements. A relative lack of active identification can lead to a failure to reduce mystery and instead produces greater mystery that perpetuates hierarchy. And briefly going back to the widespread assent that Canadian Medicare enjoys on a popular level, no division or a lack of division in regards to socio-political policy means that compensation is not required. Because as Burke notes, identification is compensatory to division. Therefore, without significant dissent, identification becomes less and less relevant.

As the foregoing argument proceeds, first I will conduct a brief survey of the conception of identity and identification as a rhetorical process as outlined by George Cheney. Second, I will develop a brief survey of the current state of Canadian identity. Third, I will be looking at Canadian health care in terms of being 'not American' and the implications of this perception. Connected to this discussion, I will present Canada as anti-rhetorical in its public policymaking processes and suggest a way forward that could incorporate in a responsible way, more rhetoric into Canadian consciousness and politics.

Rhetorical Identification

The concepts of identity and identification have been applied in depth to symbolic action and rhetorical advocacy. In what follows, I provide a brief overview of this discussion and draw some connections with the relationship between conceptions of Canadian nationalism and our health care systems programmes. Cheney and Tompkins parse out some key terms in their essay on organizational identification and then explore the relationships or interactions among these concepts and draw some conclusions on the implications of these interactions for communication. Identity presents as a relatively stable and passive construct: "Let us define identity to be what is commonly taken as representative of a person or group, either by the person/group in question or by observers" (Cheney & Tompkins, 1987, p. 5). Identification, on the other hand involves more agency in terms of an extension of identity from either a group or an individual to particular targets. Hence identification is more of an active and intentional process than an internal state:

> Identification will be broadly conceived by us as the appropriation of identity, either (1) by the individual or collective in question or (2) by others. (The term 'appropriation' is appropriate here because it subsumes both 'something acquired' and 'something invested.') Identification includes the development and maintenance of symbolic linkages salient for the individual/group, as well as less significant attachments which may be promoted by any rhetor (even the individual/group in question)" (Cheney & Tompkins, 1987, p. 5)

Rhetorical processes that involve identity and identification are geared toward increasing a target's commitment to a particular cause or organization: "High commitment implies an involvement with identity, the evocation of selfhood" (Cheney & Tomkins, 1987, p. 7). In fact, when an individual encounters a collective that interacts strongly with their identity, "pledges of various sorts come rather naturally for the member who defines him/herself rather completely in terms of a particular group. To fail to make a pledge, or a decision, or a commitment is to, in a very real sense, negate the self" (Cheney & Tomkins, 1987, p. 8). In short, 'identity' is presented as more than a static or psychological concept. Instead it is a dynamic construct that is representative of an ongoing working out of human agency and accompanying rhetorical processes. In a sense then, identity can be managed with communication:

> A coherent style, sense of integrity and continuity, do not depend on the abolition of our different identities… What is required is that identities be coordinated as the words of a language are coordinated in the expression of a particular message. We may then infer the usefulness of speaking about a logic, a grammar, an aesthetic, and a rhetoric of identity/identities (Cheney & Tomkins, 1987, p. 4).

Because of the link between identity and identification and commitment, rhetors can harness all of these concepts strategically to induce assent to a particular proposition, cause, or collective. The notion of identification as a rhetorical process has been outlined by Burke and applied by other communication scholars. Human beings, says

Burke, have the capacity to use identification as a rhetorical strategy in a number of ways:

> The first is quite dull. It flowers in such usages as that of a politician who, though rich, tells humble constituents of his humble origins. The second kind of identification involves the workings of antithesis, as when allies who would otherwise dispute among themselves join forces against a common enemy. This application also can serve to deflect criticism, as a politician can call any criticism of his policies 'unpatriotic,' on the grounds that it reinforces the claims of the nation's enemies. But the major power of identification derives from situations in which it goes unnoticed. My prime example is the word 'we,' as when the statement that 'we' are at war includes under the same head soldiers who are getting killed and speculators who hope to make a killing in war stocks (Burke, qtd in Cheney, 1983, p. 148).

The rhetorical situation that prompts attempts to identify with others is characterized by a state of division. Because in nature all human beings have separate physical bodies, this 'gap' needs to be remedied through communication. From a practical standpoint therefore, identification becomes essential. Identification also serves the function of reducing uncertainty and decreasing mystery (Cheney, 1983, p. 145). A rhetor can attempt to compensate for division through inducing a perception of common ground on the part of a receiver: "Seen in this context, identification is the way in which a rhetor states explicitly to an individual (possibly trying to convince himself or herself), 'I am

like you' or 'I have the same interests as you'" (Cheney, 1983, p. 149). Making appeals based on the premise that a particular audience and persuader are 'consubstantial' or of the same substance can be initiated through the identification of a common enemy. For example, Cheney insists that it is not uncommon for corporate documents to "contain passages that emphasize threats from 'outsiders'" (1983, p.148). Finally, rhetors can identify by formulating appeals that are more indirect or subtle in nature through employing what Cheney would refer to as the 'assumed we.' Using this simple term is very effective since it "indicates the mingling processes of association and dissociation, when very dissimilar interests are joined under the transcendent 'we'" (Cheney, 1983, p. 148).

Since identification is receiver oriented and often indirect and unconscious, an organization, institution, or system that employs such tactics does not necessarily have to rely on aggressive advocacy or reasoned argumentation. Instead, the emphasis is placed "on the individual act of identifying, with or without the help of a rhetor" (Cheney, 1983, p. 146). Furthermore, the subtle and indirect process of identification can also be manifested in 'appeals' being made initially to more up front entities that individuals identify more strongly with. If an individual than cognitively connects a certain symbol or collectivity to another target entity that is being appealed to *through* these collectivities, new commitments or investments in identity can then occur. In sum, a rhetor can appeal to individuals to either accept desired targets directly or to make more salient identifications with already valued targets prior to the desired identification occurring (Cheney, 1983, p. 147). This is important because, as has previously been

indicated, it is not always natural or easy to identify with a bureaucratic delivery system. To draw an obvious example, it is much easier to identify and support military personnel in the field than it is carry affection for congress or parliament as the funding source of the mission. Moving forward therefore, it may be helpful for advocates of a universal pre-paid health care system to make identification appeals to 'higher visibility' targets that are a source of patriotism for Canadians. The hope could then be that these types of identifications function as a pathway to more informed and rational orientations towards the merits of health care in Canada and more direct commitments.

Connecting Federal Values to Provincial Systems

At this point, it is helpful to explain the core values that underlie Canadian Medicare. Doing so establishes a framework that will facilitate more accurate, intentional, conscious, and rational identification on the part of the receiver and more effective identification strategies on the part of the rhetor. Furthermore, it might be useful to speculate on the extent that core values underlying Medicare resonate with Canadian identity in general. The first core value that undergirds Medicare is the principal of *universality*. Interestingly, the *Canada Health Act* lays out some of these principles in the form of conditions that each province is required to meet in order to be eligible for federal transfer payments rather than as an 'inherent value': In order to satisfy the criterion respecting universality, the health care insurance plan of a province must entitle one hundred per cent of the insured persons of the province to the insured health services provided for by the plan on uniform terms and conditions (*CHA* 1984, c. 6, s. 10.). Regardless, the value of universality connected to health care is widely

presented as a 'god term' in Canada and thus a value that seems to enjoy widespread assent. Second, there seems to be widespread agreement that healthcare should be 'need based.' Canadians should have access to high quality health care should they need it. And this access should be independent of their ability to pay. Third, health care should be provided to Canadians on a *not-for-profit basis*: "The health care insurance plan of a province must be administered and operated on a non-profit basis by a public authority appointed or designated by the government of the province" (*CHA* 1984, c. 6, s. 8.). The notion of 'for profit medicine' is frequently referred to pejoratively in the media and in political debates and is widely attributed as a characteristic of health care in the United States. Fourth, Canadians should have 'equal access' to high quality to health care: "The health care insurance plan of a province (*a*) must provide for insured health services on uniform terms and conditions and on a basis that does not impede or preclude, either directly or indirectly whether by charges made to insured persons or otherwise, reasonable access to those services by insured persons" (CHA, 1984, c. 6, s. 12.). The value of equality is also a prevalent concern for a range of other socio-political concerns in Canada and appears to enjoy widespread – even unquestioned acceptance among Canadians. Last, health care is widely viewed by Canadians as a *human right*. This term and value is also applied in other areas of Canadian society. For instance 'human rights' is often used as a buzz term in government statements made pertaining to foreign affairs. And the value of human rights as predominant in Canada is evidenced explicitly in our *Charter of Rights and Freedoms*. Once again, this is a value

that seems to permeate through to many aspects of Canadian society with the overwhelming support of the Canadian populace.

So what are some implications associated with the foregoing discussion of identity, identification, commitment, and the values that undergird our health care system? First, it would appear that the relationship between Canadian identity and our commitment to health care is evolving. Tompkins and Cheney make a great case at the theoretical level and this can be applied to what can reasonably argued to be occurring in Canada:

> Consider the substance and form of an individual-organizational relationship not as immutable essence and unchanging structure but as dimensions of a dramatic narrative in which the story is continually being acted, told and written. An interpretive causality rules so that specific identifications point us toward specific commitments and specific commitments, in turn, modify our identifications. Identification and commitment may thus be understood in the dialectical synthesis of lived narratives (1987, p. 10).

It will of course be the position taken in this thesis that the relationship between Canadians with their health care system is in flux despite appearances of near universal support and assent. This is not to suggest that the erosion of our health care system is inevitable. I do feel it is reasonable to argue that ongoing and default appeals to the status quo will be inadequate to sustain it. A 'snapshot' understanding of Canadian identity during the 21st century will help public advocates make explicit in the minds of

Canadians what they are committing to when they say they support Medicare and also provide some clues as to the way forward with health care in terms of change and reform. What is important in general to Canadians should be more aggressively connected and applied to enduring structures such as healthcare that have been recalcitrant to change due to a perception by politicians that any such change would be completely inconsistent with what Canadians value. This is not necessarily the case. Second, it may not be in Canadians best interest to continue to 'blindly' identify with their health care system when the basis for such identifications may be inconsistent to what is actually valued in our individual lives. Again, as Cheney and Tompkins aptly point out:

> Overidentification and overcommittment can stunt the growth of individuals; they can lead individuals into 'committing' collective crimes they would not consider perpetuating on their own. Contrariwise, the individual may see the possibilities of moving in any one of many directions at sea, thereby being unable to move anywhere at all, feeling alienated and dispossessed. In closing we underscore the necessary, often beneficial, but potentially dangerous functions of identification and commitment (1987, p. 12).

Not to suggest that Canadians are committing a crime in their approval of and satisfaction with Medicare. However, unconscious and uncritical support of any system or collective is unhelpful because such support could amount to a case of 'mistaken identities.' Furthermore, since in a democracy it can be problematic to subject a

treasured socio-political philosophy to critical analysis, those advocates who could engage in active identification do not. This is partly because identification is compensatory to division and currently there appears to be a marked lack of division for this issue at this point in our history. Therefore, Medicare appears to survive because Canadians see it as anchored to their national identity. Politicians therefore make little effort to engage in identification in regards to this issue for the purpose of subjecting to rational assessment what Canadians would see as the optimal way in which the management of health could be accomplished. This is unfortunate as a rational inquiry on the nature of what it means to be Canadian could yield valuable insights on innovative ways to keep our health care system strong and to move forward with appropriate change and innovations if necessary. Therefore, the next section will take a closer look at Canadian identity in general and draw some inferences on the type of social policy that might match up with what we currently value.

Canadian Identity in Its Current Context

Canada as not American

In referring to Canada's traditional 'anti-American' sentiments, historian J.L. Granatstein characterizes this tendency as "plain and simple, woven so deeply into the Canadian soul that we barely notice any more. He calls this enduring, unwavering, soft-spoken suspicion, distrust, and hostility toward Americans the founding myth of Canada and remains the state religion, accepted, tolerated and even encouraged" (Cohen, 2007, p. 129). The foregoing quote encapsulates two key elements that make up Canadian identity or contribute to Canadian nationalism – that we are 'not American' and that we

are inherently secular in both our socio-political approach and in our psyche. Both of these things I will argue are strongly related to the initiation, implementation and sustainment of our health care system. Canada has, of course, had a long and complicated relationship toward our neighbors to the south. There have been many times throughout the 20th and 21st Century that Canada and the U.S. have indeed fought 'shoulder-to-shoulder' in various wars. However, we have had our share of more negative incidents that are also instructive as they have played their part in contributing to the less-than-helpful though rhetorically potent self-understanding that we are 'not American.'

All of this discussion is relevant to one of the central assertions of this thesis that health care systems programmes is untouchable in Canada. The mere mention of health care reform or the incorporation of market based approaches to funding and delivery of such services is often branded as insensitive to the notion that health care is a supposed human right and should not be contingent on an individual's ability to pay. Richard Weaver's rhetorical theory is again instructive here as a true, meaningful and honest assessment of our current health care system rarely reaches beyond a superficial level as critical analysis is frequently responded to by the anti-American lobby as well as appeals that engage the Canadian psyche at an unconscious level. By conflating political critique of health care with a key tenet of Canadian identity – namely that we are not American, it becomes difficult to consider and evaluate meaningful policy based issues that relate to Medicare's sustainability.

Before launching in to his discussion on the nature of ultimate terms in contemporary rhetoric, Richard Weaver maintains that "rhetorical force must be conceived as a power transmitted through the links of a chain that extends upward toward some ultimate sources" (1985, p. 211). These 'links of the chain' involve what he characterizes as ultimate terms which he defines generally as "those expressions to which the populace, in its actual usage and response, appears to attribute the greatest sanction" (Weaver, 1985, p. 212). He further parses these ultimate terms down to include 'god terms,' 'devil terms,' and 'charismatic terms.' A 'god term' is classified as a 'good' term in Weaver's schema and is conceptualized as "that expression which all other expressions are ranked as subordinate and serving dominations and powers" (Weaver, 1985, p. 212). Weaver than proceeds to elaborate further on the nature of god term by insisting that the "capacity to demand sacrifice is probably the surest indicator of this 'preferred term,' for when a term is so sacrosanct that the material goods of this life must be mysteriously rendered up for it, then we feel justified in saying that it is in some sense ultimate" (1985, p. 214). As a case in point, Weaver puts forward the word 'progress' as a prime example of a term that has gained essentially universal assent particularly since the 16th century: "By transposition of terms, 'progress' becomes the salvation man is placed on earth to work out; and just as there can be no achievement more important than salvation, so there can be no activity more justified in enlisting our sympathy and support" (1985, p. 213). In contrast a 'devil term' is decidedly negative. However, Weaver asserts that "some terms of repulsion are also ultimate in the sense of standing at the end of the series, and no survey of the vocabulary can ignore these prime

repellants" (1985, p. 223). While 'devil terms' are conceived as the counterpart of a 'god term,' Weaver argues that a 'devil term' is unique or peculiar in comparison on the grounds that they are "without rational perception" (1985, p. 223). He further elaborates by stating that "a singular truth about these terms is that, unlike several which were examined in our favorable list, they defy any real analysis. That is to say, one cannot explain how they generate their peculiar force of repudiation" (Weaver, 1985, p. 223). Finally, another 'good term' that Weaver examines involves language that is granted a wide degree of deference, even though reality does not necessarily line up with the pure meaning of this language. Even though our practical experiences and allegiances may clash with certain terms such as 'freedom' and 'democracy,' we accept, embrace, and sacrifice for the ideas behind such terms nonetheless:

> But in charismatic terms we are confronted with a different creation: these terms seem to have broken loose somehow and to operate independently of referential connections… Their meaning seems inexplicable unless we accept the hypothesis that their content proceeds out of a popular will that they shall mean something. In effect, they are rhetorical by common consent, or by 'charisma' (Weaver, 1985, p. 227)

For example, in the case of freedom, many embrace the idea behind the term even though they increasingly encounter a society that impinges on this freedom often for the sake of freedom.

It is easy to see how the foregoing discussion applies to how public debate concerning Medicare in Canada often proceeds and how such debate contributes to the

perception that a significant part of what it means to be Canadian is caught up in the extent we are seen to be different or other than American.

When conceptualizing Canadian health care as 'American style' it is natural to apply this perception to Weaver's notion of devil terms. These terms, when uttered by politicians and other public figures, illicit quick revulsion from many in the public and a simultaneous (re) affirmation of the Canadian system and the Canadian way. One such term – or series of terms that encourage these reactions is 'two tier health care' which conjures up images of parallel public and private systems with the latter option providing better coverage for those who can afford it. The phrase is used frequently when public discussion or debate about health care is prominent. It has been used in a particularly adept way by those who are against a leadership position that might advocate change or reform to our system. In so doing, it diverts meaningful discussion to the distaste many sense when reflecting on the characteristics of health care in the U.S. In fact, this phrase has become so ingrained in the Canadian psyche that even leadership that may hold to an ideological spectrum that could justify criticism toward or change of Medicare may actually employ the statement in order to either pre-empt attacks or to defend policies as being consistent with Canadian identity. A prominent example of this devil term being employed occurred in the *2000 Canadian Federal Election Campaign*. At that time, Jean Chretien's Liberal Party had released a series of ads accusing the more socially conservative Canadian Alliance Leader, Stockwell Day of supporting two-tier health care. Knowing how devastating such an attack could be, Day came prepared to address the issue at the leadership debate by bringing a hand

written sign inscribed with the words 'no 2-tier healthcare.' He proceeded to challenged then Prime Minister Chretien to "do one of two things. Either right now, sir, would you call me a liar please or would you pull those ads that were wrong?" To this, Chretien immediately responded that "the people of Canada… They don't want to have a two tier system – one for the rich and one for the rest of us." Day's final retort reflects that the Canadian perspective as 'not American' runs deep. In response to an accusation of support for a health care system with distinctly American characteristics, Day counters that Chretien is also behaving and conducting himself in a way that is consistent with American values: "Call me a liar, or pull those U.S. negative style ads. One of the two, which one will it be?"

So what is it, exactly about the term 'two-tier' that elicits such revulsion from the Canadian people? Why is the employment of this term so rhetorically potent? It is because when Canadians conceive of two-tier health care they conceive a system that is unequal, unfair and even cruel. In short, it is not Canadian. Interestingly, in an op-ed written for *CBC News* over ten years after the debate, Day has appeared to shift his position but at the same time assert how persuasive and constraining 'two-tier' is as a devil term. In referring to the reluctance of political leadership to subject our health care system to rational assessment, Day opines as follows: "A warning to those seeking office: even breathe about needing to change the system and you'll get scorched. Well, another scorching is taking place. It is the burning up of an ever-growing portion of every province's budget by health care costs." He then goes on to support the idea of finding alternative ways to fund our system but concludes with the following warning of

the inherent danger of employing terms of revulsion as a way to side-step meaningful engagement of the public policy issues that are strongly connected with Canadian identity: "If we continue to demonize every MLA or MP who wants to at least look at the options and possibilities then we condemn ourselves to higher costs, higher deficits, higher taxes and lower levels of care."

The second devil term that is frequently infused into public debate and discussion about health care is 'for profit.' Often the word 'private' is employed as a kind of parallel devil term to 'for profit.' The use and conflation of these two additional terms of revulsion were used frequently by former NDP Leader Jack Layton. For instance, in a segment of his 2004 Federal Election Platform for the NDP, it is clearly acknowledged that health care has become far more complex and expensive since the early days of Medicare in the 1960's. The platform statement further acknowledges that cost sharing between the federal and provincial governments have become increasingly skewed with a current federal contribution of just 16%. Despite these very real challenges, Layton and the NDP outline some potential solutions for health care and at the same time make it very clear on options that they would *not* support: "Jack Layton and Canada's NDP, challenge the belief that privatizing health care and ushering in a for-profit or P3 model is inevitable or desirable. Simply because Liberals have refused to respond to technological and demographic trends does not mean Canadians should abandon public health care." The foregoing not only conflates a relatively neutral term 'private' with 'for profit' but also combines these devil terms with the more desirable god term of 'public.' A few years later in the *2006 Federal Election*, this same devil

term was invoked by Shirley Douglas in a *Vancouver Sun* Op-ed in support of Layton's position in regards to healthcare. At the same time, she used the opportunity to respond to advocacy from Dr. Brian Day who was at that time arguing for market based solutions to Medicare and eventually became the president of the *Canadian Medical Association*:

> There is a lot of money to be made in breaking Medicare. I believe this is the reason Dr. Brian Day is promoting private, for-profit clinics. He is bringing the U.S. model of investor-owned health care to Canada, and convincing people that this is the only way to remedy waiting times or other problems in our health care system… Jack Layton and the NDP say 'no' to private, for profit health care. And they have backed that position up with action. In the House of Commons, New Democrats have been the most outspoken and effective defenders of Canada's universal health care.

Here, not only is the devil term 'for profit' employed repeatedly, but an explicit connection is made between the terminology and American approaches to health care systems.

An interesting manipulation of ultimate terms as applied to the debate and discussion about Canadian health care is the tendency to employ god terms in defense of current health policy – only in a negative way. Consistent with the direction that such debate often takes, a 'good' or 'positive' term is instead expressed in respect to its negative manifestation. One such god term that has been transformed into a negative expression is the word 'fact.' As Weaver notes: "Today when the average citizen says

'it is a fact' or says that he 'knows the facts in the case,' he means that he has the kind of knowledge to which all other knowledge must defer" (1985, p. 215). This deference to 'facts' is a reflection of the secularization of the western world. It also has a distinctly rational bias.

As Weaver explains, "quite simply, 'fact' came to be the touchstone after the truth of speculative inquiry had been replaced by the truth of empirical investigation" (1985, p. 215). When the Canadian intelligentsia engage in 'system apologetics' vis-à-vis Medicare, two key facts are frequently appealed to. Interestingly enough though, these facts have nothing to do with the Canadian scene and everything to do with American social reality. Recently a young female, Canadian physician testified in front of a congressional hearing in Washington in regards to differing approaches to the delivery of health care. In the process of defending the Canadian approach and responding to challenges to her position, she defaulted to a negative expression of certain facts. In the midst of the 'give and take' of this committee hearing, Dr. Danielle Martin from Toronto was asked the following question by Senator Richard Burr of North Carolina: "On the average how many Canadian patients die on a waiting list each year?" In response, Martin referred to the oft cited and well known reality that many Americans die on account of the 'fact' that they have no insurance at all: "I don't sir, but I know that there are 45,000 in America who die waiting because they don't have insurance at all." The foregoing statistic is a variation of another fact that Canadians have historically been familiar with. That is that 45 million Americans have been uninsured for health care. While this fact will undoubtedly be shifting as more

Americans become insured under the *Affordable Care Act* initiated by President Obama the lack of universality inherent in the American system will undoubtedly still be referred to. But again, note that the fact that there are 45 thousand Americans who die because they don't have health insurance or that 45 million Americans do not have health insurance period is reflective of a *negative statistic*. It is a fact of *absence*. Since Dr. Martin testified in March, she has been wooed to run for political office and has received a good deal of media exposure in Canada.

Yet another negative fact that is frequently appealed to in defense of Medicare is that medical bills in the U.S. are the number one cause of personal bankruptcy. All of these arguments are distinct in that they are ingrained in the Canadian psyche, enjoy a wide degree of assent and refer directly to *American socio-political realities*. In so doing the implication is of course that Canadians do not share these realities. Our health care system, quite aside from whatever it actually 'is' *is not American.*

Another ultimate term that is appealed to as a means to defend and support the values inherent in Canadian Medicare is 'democracy.' Only in this case, Weaver would not conceptualize the foregoing concept as either a god or a devil term. Instead he would label such a concept as 'charismatic.' In his explanation of the distinctive features of a charismatic term, Weaver writes as follows:

> But in charismatic terms we are confronted with a different creation: these terms seem to have broken loose somehow and to operate independently of referential connections… Their meaning seems inexplicable unless we accept the hypothesis that their content proceeds

> out of a popular will that they shall mean something. In effect, they are rhetorical by common consent, or by 'charisma' (Weaver, 1985, p. 227).

In relations to democracy, Weaver argues that the meaning of the term is ambiguous in a similar way that the god term freedom is unclear and vague: "The variety of things it is used to symbolize is too weird and too contradictory for one to find even a core meaning in present-day usages" (1985, p. 228). I would also argue that closely related to democracy are the terms 'secularism' and 'equality.' All of these terms have become prominent in public discourse that defends Canadian Medicare. Health care in Canada is focused on providing a means by which *all* Canadians can have access to high quality treatment for disease and illness. And of course two of the previously referenced hallmarks of the *Canada Health Act* are that a health care system that is consistent with Canadian values should be publically administered and universal. Emmett Hall, for instance made the argument that the 'fruits of health sciences' should not be rationed. Instead, the benefits originating from the elite scientific establishment should permeate throughout society. In a sense, services and treatments made available from health sciences should be 'democratized.'

When it comes to the delivery of health care in Canada, there is also a lot of reference made to what is fair and what is unfair. Medical practitioners should receive fair or 'reasonable' compensation for their services. It is unfair to deny citizens health care on the grounds that they are not a contributor or 'producer' in society or that they cannot afford such services. I would maintain that many of the angles of health care debate and discussion are consistent with principles of secular humanism. Noted

Canadian philosopher Charles Taylor holds that the dominant paradigm in Canada is secularism. In his writings he grapples with the implications of such a philosophical perspective as well its limitations. Anytime a service is universalized or made accessible to a maximum number of people such a service then assumes a kind of 'corporate' character. It is unreasonable to expect that all citizens can have at their disposal the 'best possible health care.' This is why Hall frequently references in both the 1964 and the 1980 *Royal Commission on Health Services*, that Canadians should instead have access to a 'high quality' health care. While Taylor certainly acknowledges the strengths inherent in secular humanism, he also draws out in his thinking some weaknesses and limitations:

> Instead of a search for intrinsic worth and value, we settle for 'procedural ethics…' In other words, we establish a neutral set of rights and liberties designed to allow maximal choice about what constitutes a good life or a proper end. Those rights do not reflect what is good – for that is individually determined – but rather, what is fair (Taylor, qtd. in Bowers, 2002, p. 43).

So in short, when 'democracy' as a charismatic term is appealed to in support of Canadian health care and as a means to discourage subjecting the system to critical scrutiny, such an appeal is rhetorically potent. Canadians widely view it is unfair and undemocratic to deny some Canadians the ability to seek and receive quality health care should the need arise. Furthermore and as has previously been discussed, providing one standard of care for some Canadians and another standard of care for other Canadians is a potential reality that is widely rejected. Even if a level of inequality could be justified

in terms of trying to find creative ways to deliver health care to Canadians more efficiently, such discussion rarely 'gets off the ground' due to the regular employment by policymakers and other intellectuals and the media of ultimate terms in an attempt to 'frame' and limit real debate.

Innovation as Counteractive Ultimate Term

As I have persistently argued in this thesis, in order to move our health care system forward and in order for it to be capable of adapting to changing times, circumstances, and historical contingencies, there needs to be ongoing rhetorical engagement. At a minimum, from time to time health care services could benefit from being subjected to a process of argumentation that allows for competing claims to be presented. As has been shown, the insertion of ultimate terms into public discussion as a way to maintain the status quo can serve to limit and/or frame the debate in a manner that is inconsistent with change or flexibility for *any* public policy or system. So the question that naturally arises is, what can be done from an argumentation standpoint in response to the employment of ultimate terms? The way forward is neither clear nor easy primarily because these ultimate terms have the capability of engaging the 'public mind' in such a compelling way. Recognizing the capacity of ultimate terms to create a wide degree of assent and even to demand personal sacrifice is helpful for the speaker or leader who would speak out against them or on the other hand to "parry some blow aimed at him through the potency of the word" (Weaver, 1985, p. 214). In short, a speaker/leader would need to "realize what a momentum he is opposing" (Weaver, 1985, p. 214).

That said, I would like to suggest one example of an alternative ultimate term that could potentially clash with the ones that have been employed when health care is discussed in a public manner. The purpose of utilizing this alternate term would be to 'equalize' the nature of argumentation currently seen in debate about health care policies in Canada. The term that I would suggest could be used to reenergize the debate and present a competing perspective to the current status quo is 'innovation.' This term could be a helpful term to insert into public discussion of health care – particularly when one or several of the ultimate terms previously referred to are utilized to defend or maintain the status quo. Employing the term 'innovation' could also serve the dual purpose of rhetorically circumventing the conflation of universal health care with Canadian identity. In so doing a maneuver away from the conceptualization of Medicare as 'not American' could be accomplished. Innovation can otherwise be expressed as 'progress' – only without the American baggage that progress evokes. In justifying progress as a god term, Weaver explores the historical roots of the word and how it has, over time, become linked to salvation: "By a transposition of terms, 'progress' becomes the salvation man is placed on earth to work out; and just as there can be no achievement more important than salvation, so there can be no activity more justifiable in enlisting our sympathy and support than 'progress'" (1985, p. 213). In utilizing the term 'innovation' and linking the term and its referents to Canadian identity, a savvy politician or leader could increase receptivity to health care reform and bypass or mitigate some of the revulsion to the phrase 'American style.'

Prime Minister Harper has been well known to make use of the term innovation in his public discourse. For example, at a speech delivered at the *World Economic Forum* in Davos, Switzerland in January of 2012, Harper complained about the misapplication of huge sums of federal investment in research and development and advocated more innovation through greater engagement with researchers at universities. In some analysis of the speech in the *Globe & Mail*, Harper's commitment to innovation was recognized: "It's now clear that innovation – or more precisely, the dearth of it – has rocketed to the top of the Harper government's agenda. The Prime Minister is not happy about the return the country is getting on the roughly $7-billion a year Ottawa pours into research and development." An article in *MacLean's*, elaborates on the focus Harper put on a lack of innovation in the speech and also outlines his plans to address this:

> Harper rather dryly voiced his dissatisfaction with the way heavy federal spending on research has not translated into private sector innovation. "We believe," he said, "that Canada's less-than-optimal results for those investments is a significant problem for our country. His solution is to move on some of the proposals from a report delivered last fall by a task force, headed by software executive Tom Jenkins, on the innovation deficit. Jeremy Leonard, research director at the Montreal-based *Institute for Research on Public Policy*, says Ottawa's priority should be to set up easier ways for companies seeking a competitive edge to connect with university researchers (Geddes, 2012).

Innovation was also employed as a campaign strategy by Harper in the *2011 Canadian Federal Election.* On page 14 of a 67 page policy document, the argument is made that Stephen Harper supports creativity and invention: "Stephen Harper's Government has provided strong support for research and development. Our goal is to promote innovation – and ultimately to help; create good new jobs and foster long-term economic growth." Note the explicit reference to innovation and its direct connection to both R&D and economic development. Canadians tend to be ambivalent toward the notion of economic development and recoil at the juxtaposition of economic related jargon to health care services. However, when couching economic concerns with the god term innovation, the rhetorical repellant associated with market oriented growth devolving in to 'dog-eat-dog' capitalism is softened.

Later on, the Conservatives campaign platform lays out evidence relating to a variety of 'scientific development' initiatives that the party had supported. These initiatives include establishing "the Canada Excellence Research Chairs Program to attract and retain the world's top researchers," and supporting "leading-edge Canadian scientific endeavours through organizations such as the Canadian Space Agency, the Rick Hansen Foundation, and the institute for Quantum Computing." Note that the *Rick Hansen Foundation* is a health care oriented not-for-profit organization that has launched programs advocating for cures, treatments, and quality of life programs for people with spinal cord injuries and related disabilities. Through conflating the god term 'innovation' with an organization such as the *Rick Hansen Foundation*, it plants the idea that market oriented creativity is not mutually exclusive to not for profit health care

initiatives. Finally, the campaign platform statement lists still more developmental initiatives that would be supported should Harper's Conservative be re-elected. These include, supporting the "outstanding work of the *Institut National D'optique* in the fields of optics and photonics" and leveraging "funding to support *Brain Canada's* efforts to develop new diagnostics, treatments and cures for brain disorders, including Alzheimer's disease. In the case of *Institut National D'optique*, based in Quebec City, the organization specializes in, as referenced, optics and photonics, which have broad applications in a variety of industries that include health care relating to vision and laser surgery. *Brain Canada* is Montreal based and seeks to coordinate public, private, and volunteer oriented resources to "understand the brain, in health and illness, to improve lives and achieve societal impact," and to increase "the scale and scope of funding to accelerate the pace of Canadian brain research." The organization seeks to accomplish this vision through the incorporation of the following values. First, the organization seeks to develop "diverse perspectives and approaches" through "fostering original insights and outcomes." Second, it seeks to do so in an environment that focuses on outcomes that deliver value and benefits with efficiency and effectiveness." This is particularly important to the discussion at hand because it connects non-profit based health care initiatives not only to innovation but also to efficiency – a value that secures a lot of mileage in a pragmatic country like Canada.

In short, the *Conservative Party* platform seems to promote innovation, creativity and funding, at least in part, through both private investments and donations, and with the efficient delivery of cutting edge research driven health care. All of these elements

are positioned within the framework of nonprofit organizations. The juxtaposition of innovation and progress with nonprofit health care services rhetorically circumvents the negative link Canadians and Canadian leaders frequently make between market oriented approaches and 'for profit/American style' medicine. When efficiency is added to the mix of innovation and not-for-profit health care services, the foregoing rhetorical circumvention becomes even more potent. As Weaver notes, "if a thing is efficient, it is a good adaptation of means to ends, with small loss through friction" (1985, p. 217). When health care is reformed or 'tweaked' through increased efficiency, any changes are seen as less severe and threatening to the core value of universality with respect to Medicare. When the term is applied to medical initiatives operating outside of the auspices of Medicare, a new perception of health care innovation and delivery within a context that is consistent with Canadian values is infused into the public mind.

Implications

As our analysis of 'Canadian identity' and its relationship to health care draws to a close, a number of conclusions can be drawn. In suggesting a way forward in the debate, it would be helpful if greater attempts were made to make more accurate and direct connections between identity and health. As was referenced earlier, the evidence is clear that Canadians identify with Medicare but what exactly does this mean? It is hard to really identify with a bunch of bureaucrats in the respective capital cities of each of our provinces that are responsible for paying the bills that doctor's charge for insured services. One way to address the inaccuracies and misperceptions associated with identification with our health care system, would be to develop stronger links between

the actual delivery of health care services and the values upon which they were founded. One possible way that this could occur might be through the Government of Canada popularizing health care services through formulating *Heritage Ads* that explore how certain key health services and inventions were made possible through a pre-paid, publically administered, and universal delivery infrastructure. Along these same lines, patients could be more directly engaged by their respective provincial governments through being drawn into policy discussion concerning the maintenance and reform of health care services. By taking greater ownership in our health care system, more direct and accurate identification could be developed.

Second, it is critical for political figures and other elites to have a greater understanding on how public advocacy surrounding health care can have a tendency to get bogged down in unwanted repetitive patterns for argumentation. One area of dysfunction was suggested in this chapter and evolved around the use and misuse of ultimate terms. A more nuanced and principled use of these terms in such a way as to encourage the free exchange of ideas would likely result in value being added to our future health care services and infuse some much needed integrity into our political and rhetorical processes. As Weaver rightly observes:

> An ethics of rhetoric requires that ultimate terms be ultimate in some rational sense. The only way to achieve that objective is through an ordering of our minds and our own passions. Every one of psychological sophistication knows that there is a pleasure in willed perversity, and the setting up of perverse shibboleths is a fairly common source of that pleasure (Weaver, 1985, p. 232).

Third, it is important for scholars seeking to study health care policy in Canada as well as those involved in the public inquiries, debates, and discussions to have a clearer understanding of the complexity of the tension between individual and collective values. While our health care system is clearly founded on communitarian values there have been trends toward individualism surfacing over the past 20 years. There seems little question that Medicare has earned a great deal of presumption with the struggles involved in the initiation of this socio-political policy. However, Canadian identity seems to be in a constant state of flux and to continue framing any discussion of health care in terms of an identity position, nearly identical to what it was back in the 1960's, is tenuous at best. Taking a more critical look at Canadian identity and health care through the lens of community versus the individual can also reveal fresh insights on the nature of Medicare's greatest constituency the patient.

Last, recognition of 'convergence trends' in our relationship with the U.S. will shift discussion and potential future reforms for health care systems from whatever characteristics are 'not American' to a proactive debate on the type of system that is most consistent with Canadian values and the Canadian dream. It is important to avoid the conceptualization of Canadian Medicare in terms of what it is not. At the same time, however, we don't want to create a 'mirror U.S. health care system in Canada.' Engaging a bit more with our American friends and taking the gold nuggets we find in the process can steer us away (at least rhetorically) from old and tired anti-U.S. positions in respect to health care services. Audience perceptions and debate surrounding this issue need to be more balanced.

CHAPTER V

RHETORICAL INVERSIONS OF REALITY

> At the precisely calculated center of the dialogue [Plato's *Phaedrus*] – the reader can count the lines – the question of logography is raised. ['Logography' is the 'writing down' of 'speech,' giving up one's own 'speech' to be 'spoken/read' by someone else.] Phaedrus reminds Socrates that the citizens of greatest influence and dignity, the men who are the most free, feel ashamed at 'speechwriting'… They fear the judgment of posterity, which might consider them 'sophists.' The logographer, in the strict sense, is a ghost writer who composes speeches for use by litigants, speeches which he himself does not pronounce, which he does not attend, so to speak, in person, and which produce their effects in his absence. In writing what he does not speak, what he would never say and, in truth, would probably never think, the author of the written speech is already entrenched in the posture of the sophist: the man of non-presence and of non-truth. Writing is thus already on the scene. The incompatibility between the written and the true is clearly announced (Jacques Derrida).

The foregoing quote raises some important issues in relation to the focus of analysis for this chapter. Key texts that have had a significant historical imprint on the development of Canadian Medicare and the debate surrounding that development such as commission reports, senate committee reports, and court decisions clearly possess peculiar characteristics and limitations that are worthy of initial mention. First, the authors of these key texts often do not speak on their own authority but are granted substantial influence, for a period of time, concerning issues of critical social, economic, and political importance to Canada. Second, the issues raised and conclusions drawn from the authors of these texts are frequently used later by a range of 'arbiters' and are placed under scrutiny from academics that have a stake in or are simply interested about the topic. Third, and as already alluded to, these texts serve an indispensable role of making their imprint on the evolutionary history of the primary artifact that is under discussion and analysis for this thesis. Fourth, the authors of these texts do not

necessarily have unique experience or specialized knowledge on what they have been tasked to inquire about or to report on. And finally, the effect on public policy from these types of texts are often times difficult to assess and measure.

Any analysis that attempts to draw important conclusions concerning the rhetorical significance of the development, maintenance, and reform of Canadian Medicare would clearly be incomplete without providing a close scrutiny of these texts. What is made uniformly apparent in all of these texts is a drive toward reform and a general recognition that the status quo is inadequate. Each of the texts present key arguments for the installation and particularly need for reform for the system. Each of the texts also present key issues concerning health care in general, the nature of the system, and its link to Canadian identity. Perhaps most importantly, the commissions in particular have played a key role in Canadian society. Justice Emmett Hall, the chair of the *Royal Commission on Health Services* in 1964, has widely been touted as one of the fathers of Canadian Medicare alongside Tommy Douglas. And obviously, shortly after the release of the aforementioned commission, the status quo was ruptured as Canada elected to move from a multi-payer system similar to what is still seen in the U.S., to a universal and public 'pre-paid' system of health care.

The Nature of Commissions in Canada

As Conrad & Cudahy note, one of the distinctive features of health care policymaking in Canada is the key role that Royal Commissions have played in such deliberations:

> Canadian policymakers long have relied on Royal Commissions to gather data on controversial issues and offer policy advice to Parliament and provincial legislatures. The structural arrangement is tightly linked to a degree of pride in data-based decision making, in contrast to the more ideological policymaking of the United States. As a result, relying on comparative data, both across provinces and in contrast to the experiences of other nations, is a normal, natural, legitimate part of public policymaking. (2010, p. 552)

In short, Commissions in Canada and in other constitutional monarchies wield substantial power and are commonly convened to address issues and socio-political questions of the highest magnitude. As such, they lay claim to considerable rhetorical import.

I will be taking a thematic approach in my analysis of some of the key textual indicators of the rhetorical 'constitution' of a health care system that Canadians loosely conceive of but strongly identify with as 'Medicare.' While I will be performing a close textual analysis of some of these key rhetorical artifacts, I will not simply be analyzing each document as a self-contained unit. Rather, I will be attempting to weave a big picture assessment together out of these documents so as to facilitate making some generalized observations on the rhetorical complexity of 'health care' as constituted in its provincial, federal, and historical manifestations. One of the reasons why society's attempts to manage disease and illness through developing health care systems is such an emotional topic is that the central problem that is trying to be addressed cannot really be solved by socio-political advocacy. We are primed, however, to focus on the

practical problems that can be solved and hope that such solvency will mitigate the central human dilemmas that health care seeks to address. Furthermore, we are prepared to designate vast economic, technological, and human resources in order to do so. Hence there is always a tension in closely examining discourse that searches for practical solutions to universal problems. As a result, while such discourse does lend well to traditional rhetorical analysis such assessment needs to be connected to the more fundamental issues of health care that touches on the human condition that operate independent of "local and historical contingencies" (Perelman & Olbrechts-Tyteca, 1991). Rushing, for example, has drawn attention to such tensions and their implications for the type of methodological approaches that a rhetorical critic chooses to use:

> In Lloyd F. Bitzer's concept of the rhetorical situation, 'exigence' is an immediate pragmatic problem, a disturbance of equilibrium to be remedied by practical discourse. John Angus Campbell notes, however, that there are 'ultimate' rhetorical exigencies which are enduring and thus do not precisely fit Bitzer's model. Death is such an exigence: 'Beyond the pragmatic world of manageable, mundane exigencies and manageable responses,' claims Campbell, 'looms mortality itself as the omnipotent exigence energizing the trail of symbols which is human history as narratives, as lived experience.' (Rushing, 1985, p. 189)

The goal of this chapter will be to explore such tensions by assessing key texts within the health care debate in Canada that seek to address a range of manageable problems as

one of many steps to facilitate a high standard for the health and well-being of its citizens. As Rushing aptly notes: "Discourse which addresses cosmological matters performs it rhetorical function in relation to history… Contemporary statements addressing the need for transcendence respond to an exigence which is both enduring and developing over time" (1985, p. 189).

In the spirit of the foregoing discussion, I will be taking a chronological approach with my analysis starting with the commission that set off a chain of events leading to the inauguration of universal health care in Canada. The *Royal Commission on Health Services* was established in 1961 and released in 1964. The Chair of this Commission was Justice Emmett Hall. Approximately a decade after universal health care was instituted, Hall was again tasked to address some of the issues and challenges that had surfaced. This second report was released in 1980. My general thesis will be that the rhetoric initiated by Emmett Hall and his commissioners was administrative in nature and geared more toward convincing elites than in inspiring the masses. Nonetheless, the rhetoric of Hall was cleverly crafted in such a way as to sidestep key arguments that he anticipated would be made in opposition to his claims. He did this by providing a range of novel arguments that served the purpose of reframing the terms of the debate concerning health care policy. What resulted was a conflation of a universal and single payer health care system with a highly complex and decentralized approach to medicine from a service perspective.

Rhetorical Criticism and Close Textual Analysis

While rhetorical criticism has traditionally involved the application of classical theory to the assessment of pure orations of the highest order, increasingly rhetoricians have extended their analytical efforts to appreciate the complexity & diversity of communicative processes in the 20th and 21st centuries. Policymaking often involves behind the scenes negotiations and administrative mechanisms, such as commissions, exist to create a forum for discussion and idea generation which is eventually solidified into written form. Therefore, a tension has developed within rhetorical scholarship in terms of the prevalence of analysis of written versus oral text. As this tension has been explored by rhetoricians, a range of methodological considerations have been raised. First, while policy oriented text is frequently presented in written form, it is quite different from literature. As McGee notes, the former is conducive with 'critical rhetoric' while the latter is germane to 'rhetorical criticism:' "The term 'rhetorical criticism' invites us to Black's emphasis on critical practice. The term 'critical rhetoric' invites emphasis on rhetorical practice, 'rhetoric is what rhetoricians do.' With Black's accent, rhetoric is too easily submerged in philosophical and/or literary thinking" (McGee, 1990, p. 275). In short, "criticism is a vehicle for doing rhetoric" (McGee, 1990, p. 276). Second, policy oriented written text is more performance based than esoteric literature: "Our focus is more on the performance of discourse than on the archaeology of discourse… We must understand what it means to treat discourse from the first principle that it is a performance; and we must understand how this first principle affects the way we decide the features of the discourse" (McGee, 1990, p.

279). Third, due to the performative nature of written critical rhetoric the 'final' text is not self-contained or standalone and the context that influences and re-influences such text is ever changing. McGee again sums up the impetus:

> With rhetoric as a master term, we begin by noticing that rhetors make discourses from scraps and pieces of evidence. Critical rhetoric does not begin with a finished text in need of interpretation; rather, texts are understood to be larger than the apparently finished discourse that presents itself as transparent. The apparently finished discourse is in fact a dense reconstruction of all the bits of other discourses from which it was made. It is fashioned from what we can call 'fragments.' Further, whether we conceive it in an Aristotelian sense as the art of persuasion, or in a Burkean sense as the social process of identification, rhetoric is influential. (1990, p. 279)

In short, policy oriented texts such as the commissions as well as legal texts furnished by high court justices can be characterized as being a sort of 'hybridized' rhetoric. While such documents tend to be heavy on performance and demonstrate a clear and plain style of writing, the commissions in particular are also noted for a (re) articulation of the core values and principles that underlie the policy issues that they are grappling with. Whenever discourse becomes value laden it assumes some of the features of literature. Hence, adopting an 'either-or' methodology concerning the rhetorical assessment of text/orality is limiting:

> Rhetorical critics who valorize discourse that is 'only' communicative are thus in a double bind: If they emphasize what distinguishes them from literary critics,

> their mastery of rhetoric, they are incompetent readers of literature, because they cannot account for transcendence ('divinity') very well. If they emphasize what they have in common with literary critics, their mastery of critical theory and practice, they dilute their ability to deal with materiality (the everydayness of practical discourse), for they are in the position of using techniques for interpreting 'divinity' on discourse distinguished by its lack of 'divinity' (by the absence, or the presence in lesser degree, of 'literary value'). (McGee, 1990, p. 277)

Further, while it is true that social policy oriented texts such as the commissions are indeed presented as complete or final in terms of the conclusions it reaches and how these conclusions are communicated to the government, the reality of the processes involved are much more fluid. While it is possible to subject such documents to traditional contextual analysis that conforms to the pragmatics of Bitzer's articulation of the rhetorical situation, it would seem more helpful in this case to assess these texts as one of a succession of rhetorical moments operating out of the eternal present. Hence, some of McGee's ideas and his suggested rhetorical framework that seeks to address some of the previously discussed tensions are instructive.

In his explication on the nature of close textual analysis, McGee outlines three key considerations that the critic should take into his or her assessment of discourse. First, in the process of rhetorical analysis, the critic should take into consideration the relationship between their own argument and the substance, evidence or content of the original document. The criticism of a rhetorical artifact involves articulating the 'point'

or the fragment of that artifact. Of course this point does not encompass the totality of a complete work of rhetorical criticism. The rhetor will be employing other evidence beyond the text to make the point of the document they are critiquing clear. One of the primary challenges when engaging in rhetorical criticism is to make an 'argument for meaning' that is at least consistent with the context of the work that is being assessed. Each of these considerations can be construed as the *relationship between the written discourse that is being analyzed and its sources*. The overarching goal of the critic of discourse is to capture the nuances of the whole text. Using Henry Kissinger as an example, McGee explains the critical process that is involved for close textual analysis:

> The relationship between the fragment and Kissinger's whole essay is nominalistic or semiotic: the fragment is a sign that consists of a signifier (the whole discourse it represents) and a signified (the meaning we are urged to see in the whole discourse). The relationship between the fragment and its new location – in the rhetor's discourse – is more forensic or approbative: The truncation we call 'Kissinger's opinion' is clustered with other similar fragments in relation to a claim we are asked to approve. (McGee, 1990, p. 280)

The second principle that McGee underscores as being important for the rhetorical critic to consider in order to capture the fullest meaning possible of a written text, is *the relationship between discourse and culture*. While culture can of course be a nebulous term, rhetoricians have conceptualized the notion in terms of (en) doxa. 'Culture' – or commonly held conventions can operate both silently and explicitly in a rhetorical text. Conventional wisdom can be intentionally employed by a rhetor as grounds for

authorizing a redress of human grievance. On the other hand, if a rhetor chooses not to make explicit the underlying presuppositions of a text, commonly held opinion can serve to uphold or perpetuate the status quo. If the status quo is problematic and at the same time grounded in endoxa, it becomes the job of the critic to illuminate the unstated conventions in order to reveal the harm inherent in them. In so doing, a rhetorical critic can attack the status quo. In drawing to light missing premises, a rhetorical scholar adds to the fragmented relationship between text and culture already established in the original work. In summarizing the function of doxa within a written text, McGee acknowledges that "doxa is silent, and it should be kept silent unless it becomes itself the source of grievance. When doxa is the source of grievance, rhetoricians in both the Platonic and Isocratean schools envision a king of 'social surgery' where new cultural imperatives are substituted for old taken-for-granted conventions" (McGee, 1990, p. 280). Either way, doxa is a rhetorical concept that is important to consider in any effort by a critic to capture the fullest meaning of a written text.

Third, it is crucial for the critic to consider the *relationship between a written policy statement and its influence.* Of course the question of influence captures the symbiotic relationship between a critic and a text. Without the text having some kind of influence, there would be no need for a critical response. And a key presupposition made by rhetorical critics examining a particular text is that such text possesses sufficient cultural sway to justify the development of a critical perspective on a rhetorical act that has occurred in the past. When examining the relationship between the critic and a text, the question of *salience* arises. If rhetoric fails to move us or is not

deemed to be important or relevant, the critic, reader, or audience is not likely to engage with the discourse. If the discourse is memorable, it can have a range of influence on us. Three ways in which salience can be assessed is to the extent that it has an influence on the receiver's attitudes, beliefs, or actions. Perhaps most relevant to the assessment of the key texts in this chapter is the variable of action. When a critic 'acts' in some way in response to a culturally significant artifact, McGee maintains that "at the very least, we decide to engage in a speech act when we verbalize our motive-ridden beliefs in response to a discourse judged to be salient. At the most, we intervene in the world, physically interposing ourselves upon a problematic condition in an attempt to make the world conform to our will" (1990, p. 282). One interesting 'measure' of the rhetorical influence of the commissions concerning Medicare will be the extent that these documents resulted in something getting done or the general effect they had on the status quo.

In summary, the foregoing discussion has offered a justification for written public policy as providing a basis for rhetorical analysis. At the same time, distinctions were made between literary and rhetorical criticism through pointing out differences between the nature of literature and the more performance based and practical written policy text inherent in commissions. As well, the relationship between context and text is problematized and I suggest that written texts are neither self-contained nor complete. Rather, these written texts that all 'speak' about Canadian Medicare in some way, shape, or form serve to fulfill their function in evolutionary history. Because such texts are interrelated it can be expected that they will interact with each other. Further, the above

discussion has emphasized the complexity of written policy statements and provides a useful framework for capturing the wholeness of the text. In the following analysis, I will be applying many of these perspectives as I assess some of the critical texts that have been connected with the initiation, maintenance, and proposed reform of health care in Canada.

The 1964 Hall Commission Report

> In 1964 the Royal Commission that had been set up by the Right Honorable Member from Prince Albert [John Diefenbaker] headed by Mr. Justice Emmett Hall made its report. I want to say that in my opinion that report was the finest report on comprehensive health insurance that has ever been printed in the English language (Tommy Douglas 1979).

The *Royal Commission on Health Services* was established by Order in Council on June 20, 1961. The purpose of the Commission was to "inquire into and report upon the existing facilities and the future need for health services for the people of Canada and the resources to provide such services, and to recommend such measures, consistent with the constitutional division of legislative powers in Canada, as the Commissioners believe will ensure that the best possible health care is available to all Canadians ..." (RCHS, 1965, p. 1). The Commission was chaired by Mr. Justice Emmett M. Hall. Emmett Hall was a career lawyer born and raised in Saskatchewan. In 1957, he became Chief Justice of the Court of Queen's Bench for Saskatchewan. In 1961, he was appointed as Chief Justice of the Supreme Court of Saskatchewan. In 1962, Hall joined the Canadian Supreme Court and served on the high court until he retired in 1973. Ultimately, the commission recommended that a national health policy and a comprehensive health care program be instituted and provided detailed research and

evidence that supported this conclusion. The findings of the *Hall Commission* were released on December 7, 1964.

Any scrutiny of the political and rhetorical processes involved in the initiation of Canada's system of universal health care would be insufficient without a detailed analysis of the Hall Commission Report. This report is both important to look at and unique in its rhetoric for a number of reasons. First, it is arguably one of the most unbiased examples of policy oriented advocacy on the issue of health care yet produced in Canada. In argumentation theory, one of the ways that an advocate or critic can test the quality of evidence produced in support of a position is through assessing *source willingness*. For this particular test of evidence, Ziegelmueller and Kay insist that two key questions should be considered: 1) Is the source of the evidence willing to report or interpret the situation fairly? and 2) Does the *self-interest* of the source or the source's sponsor prejudice the evidence (1996, p. 90)? Parties that present arguments that are opposed to political affiliations they are part of are, in general, perceived as highly credible. In other word, they can be construed as *reluctant sources*.

Traditionally in Canada Conservative politicians tend to be more fiscally conservative than members of more leftist parties such as the *Liberal Party* and the *New Democratic Party*. Further, Conservatives are more leery of big government or even the notion that the government is best equipped to solve people's most pressing problems. The notion that the government could or should step into the domain of health care and interfere with the freedom of physicians to apply the knowledge and expertise they have gained in the way they see fit would generally be received with a great deal of

skepticism in Conservative circles. Emmett Hall was a Progressive Conservative out of Saskatchewan and libertarian in his economic outlook. In short, he would not be an obvious candidate to recommend a publically administered and universal 'pre-paid/single-payer' system of health care. Yet he did recommend such a system and therefore from an argumentation standpoint is highly credible and worthy of close scholarly scrutiny. Hall's rhetorical ethos has grown considerably since 1964 and he is commonly seen as one of the 'fathers of Medicare' alongside Tommy Douglas and Lester B. Pearson. Second, the ideas that Hall and the commissioners presented resulted in the greatest implementation of change in Canada of any of the other reports and court decisions yet to be produced. Both the *Romanow Commission* and the *Chaoulli* decision which concerned health care in Quebec have been criticized for having very little effect on the current status quo for health care system programmes in Canada. This criticism is obviously not valid for the *Hall Commission* as its ideas and conclusion resulted in nothing short of a complete rupture of the status quo. Approximately five years after the report was released, Canadian Medicare had become a reality. A final reason why the Hall Commission lays claim to significant rhetorical import is due to its conflation of legal jurisprudence with public policy or 'deliberative' discourse.

Analysis

One of the key features of the *Hall Commission* was its focus on in depth and high quality research in general for the formulations of its perspectives on the future of health care in Canada. In the introductory comments for volume 2 the authors imply that in order to meet the mandate that has been given to them from the government and

from the crown, hard work will be required and extensive research demanded: "In accordance with its Terms of Reference the Commission was directed to make recommendations to ensure 'that the best possible health care is available to all Canadians'" (RCHS, 1965, p.1). They then go on to elaborate on 'best possible' as to mean 'of the highest possible quality' (RCHS, 1965, p. 1). The foregoing indicates lofty goals and incredibly high expectations being leveled at the Commission during a time frame when the current health care system largely resembled the current U.S. system. The reader is not even required to dig particularly deeply into the report to sense its complexity and depth. As alluded to earlier, the *Hall Commission* was convened in 1961 and did not wrap up until 1965. That is a lot of time to spend researching a single critical issue in Canadian society! Additionally, the report was quite lengthy. In his analysis of the Commission published in the *Canadian Journal of Economics and Political Science* the year after the report's conclusions were reached, Courtney argues as follows: "The Hall Commission Report is a monumental document, both in size and in resolve. Its two volumes, totaling close to 1300 pages, provide the most thorough and intensive examination yet undertaken on the condition, nature, provision, and future of health services in Canada" (1965, pp. 594-596). In summarizing the magnitude of the process involved in reaching its recommendations, the *Health Canada* website provides the following synopsis: "The Commission held 67 days of public hearings in all provinces and in Yukon, visited and studied health care systems in several other countries, received submissions, heard individuals and delegates from 406 organizations, and commissioned 26 research studies" ("Health Canada," 2004). In short, the report

was vast in length and comprehensive in its research to the point that it is perhaps the defining textual feature of this socio-political document.

Specifically, a close scrutiny of the text reveals that the sources used by the commission illustrated the future of health care in Canada being assessed in markedly economic terms. Further, the type of research that was undertaken by the Commission and the nature of research suggested for future inquiry concerning the issue was empirically and statistically oriented. For instance, one of the concerns in which the Commission responded to was the risk that the establishment of universal health care would result in the system being abused by both physicians and patients. In addressing this objection, the Commission quoted from *News & Views on the Economics of Medicine*:

> We see every-day examples of the possibly insecure physician who in his enthusiasm, or for other reasons, over services the majority of his patients… We also know that there has been a certain segment of the population which has always demanded a great deal of medical care and which will continue to make unreasonable demands if not brought under control by the medical profession. (RCHS, 1965, p. 5)

Taking an economic or market focused approach in the advocacy for the installation of a universal system of health care was a persistent theme throughout the *Hall Commission*. In so doing, the commission was able to recommend a system oft branded as 'socialized medicine' on primarily pragmatic grounds that were consistent with a country that had at that time and continues to have to this day a market oriented and capitalistic economy.

However, it is important to state that though the overall thrust of the report was pragmatic, the argumentation was not devoid of value statements. Hall was also known to use emotion and to justify the removal of financial barriers for needed health care by appealing directly to the human condition:

> Economic growth is not the sole aim of our society and, given the growing wealth of Canada, economic considerations should not solely be used to deny individuals the health services needed to alleviate illness and disability and to extend life expectancy. Although we recognize that resources are limited, and individuals cannot expect to receive unlimited amounts of health care, the value of a human life must be decided without regard to whether the person is a producer or not. Health services must not be denied to certain individuals simply because the latter make no contribution to the economic development of Canada or because he cannot pay for such services. Important as economics is we must also take into account the human and spiritual aspects involved. (Emmett Hall, qtd. in Stewart, 2003, p. 232)

The foregoing encapsulated the hallmark of Hall's argumentation strategy. While acknowledging the reality of scarce resources that are ever present within a system of capitalism, he insists that there is something about the nature of health care that necessarily should go beyond primarily economic considerations. The nature and inherent dignity of the human being, says Hall, transcends economic production.

Concerning the Commission's focus on empirical research through the collection of data from survey research and the assessment of this data through the principles of

statistical analysis, the following comments can be made. First, the commissioners argue that current empirical evidence relating to health care services is lacking: "There is evidence that the analysis of health statistics, from the point of view of assessing the needs of the community and the success with which health services and programmes meet these needs, has lagged substantially behind the collection of data" (RCHS, 1965, p. 134). Furthermore, the commissioners go on to praise the United States [in particular] as an exemplar for the collection and analysis of data relating to health care. Comparisons between the US, in addition to fulfilling national identity functions, have waxed and waned over the years in terms of assessing differences in quality between the two systems. Often times, of course, when differences are noted, they tend to be favorable to Canadian approaches as a way of defending the status quo through making direct appeals to national identity as being 'not American.' The *1964 Hall Commission* appears to take a much more balanced approach to such comparisons:

> Another area in which data are limited and where new work could usefully be initiated is at the individual and family level in order to determine not only unmet health needs but the extent to which individuals and families receive various services. The latter can only be measured adequately at the point where such services are actually received. Here, household interview surveys can provide such data as well as the social, demographic and economic characteristics of the individual involved. In the United States this type of survey is carried out on a continuing basis but nothing has been done in Canada since the Sickness Survey of 1951. (RCHS, 1965, p. 138)

As a way to remedy stated deficiencies for the analysis of data, the commission appeals to two sources – one from the U.S., and the other one from Canada. The U.S. is again is set apart as an example of a nation that organizes and centralizes its data effectively:

> In the planning and design of health statistics as a system, account should be taken of the experience gained elsewhere, notably in the United States where the establishment of the *National Center for Health Statistics* permits the integration of statistics from a variety of organizations whose activities it is intended 'to supplement but not supplant.' (RCHS, 1965, p. 143)

The Canadian organization that is pointed to again and again as a conduit for which data processing can occur is the *Health Science Research Council*, which eventually morphed into its current manifestation – the *Canadian Institute of Health Research*.

Second, and on a more philosophical level, the value of empirical evidence for the provision of health services and the maintenance of health care programs are justified by the commission on both epistemological and pragmatic grounds:

> Because of the importance of statistical information in the field of health research, as well as in the administration of the health services, we have examined this subject in depth in this volume… Thorough and continuing planning is needed to accomplish these objectives and to ensure that health statistics provide the answers to the questions arising in the sciences and to facilitate the planning, formulation, operation, and evaluation of health services. If this is done, the possibility of achieving the best possible health care for Canadians will be much enhanced. (RCHS, 1965, pp. 149-150)

Not only are statistics used to compare and assess quality in health care services, but they also provide the basis upon which our most pressing needs and dilemmas, relating to the management of disease and illness can be resolved. In short, a key dimension to the rhetoric of the *Hall Commission* is the conveying of an empirical bias as instrumental in achieving excellence in the development of health care. Referring directly to the assessed historical context of 1964, the commissioners argue the following:

> It is evident that the business and government organizations that exist in Canada today are profoundly different from those of a generation ago. They are learning to live in a world of rapid change, where some degree of co-ordination and planning is necessary, where mathematical theories of decision-making and data-processing equipment are used to achieve both the goals of the organization itself as well as those of society as a whole. (RCHS, 1965, p. 204)

So what does the above discussion suggest for the relationship between the *Hall Commission's* seemingly complete document for health care services and the sources that the commissioners used to make the 'final' arguments? First, it can be said that the focus on surveys, statistics and the general collection of data was a reflection of the times that existed during the period that the commission was active and the report was released. This was, after all, before the postmodern revolution that gained significant wind in the 1980's. However, the notion of using statistical analysis as a means for evaluating health care services and as a way to compare these services between regions is a principle that has continued to evolve in Canada. For example, the magazine *U.S.*

News & World Report produces a yearly issue that ranks hospitals in categories of commonly agreed upon medical specialties. Until very recently, Canada has produced no comparable assessment of its own hospitals for mass consumption. Now *Maclean's* magazine evaluates Canadian hospitals in small, medium, and larger demographical areas. It does so based upon a range of criteria that are applied uniformly across all health institutions that are assessed. And of course as was referenced in the previous chapter in the analysis of a select number of health institutions that reflect Canadian identity in some way, the trend does appear to be to evaluate cutting edge health care services by American standards.

Relationship between discourse and culture

Clearly, the *Hall Commission Report* engaged Canadian culture in a substantial way. As has already been referenced, the *1964 Commission* was unique because of its ability to significantly alter the status quo within approximately five years after its release. It did so primarily through attacking the status quo through systematically addressing potential objections to the establishment of universal health care in Canada by questioning the underlying assumptions of commonly held positions at that time. Of course, many of these commonly held positions would be skeptical toward, if not completely against, a move away from the market based system that was then the norm.

The first way that the *Hall Commission* illuminated commonly held presuppositions concerning health care, only to then refute them, was by presenting *freedom as a counterintuitive god term*. I say 'counterintuitive' because it was supposed that a publically funded and universal system of health would limit freedom and not

encourage it. The connection between freedom and universality was anything but 'common.' Such a connection was, rather, novel argumentation. 'Freedom' in the *Hall Commission* is presented largely through a working out of tensions between society and the individual. Recall that in an earlier discussion on potential constitutional precursors to universal health care, I argued that Canada is predisposed to favoring society over the individual. This of course has been true in some respects and not true in others historically in Canada. It is clear that Hall, as a fiscally conservative libertarian with Progressive Conservative affiliation, was attempting to grapple with this tension as he and the other commissioners considered the feasibility of a health system in which the value of universality would become the cornerstone. As Hall and the commissioners looked into the future and considered the feasibility of their proposed tectonic changes to health care and to the Canadian economy, it became readily apparent that the Commission was not prepared to sacrifice freedom on the altar of equality and universality. In fact, it would be unlikely that the commission could meet its terms of reference for providing the "best possible health care to all Canadians" if freedom was not an integral part of any future pre-paid system: "Inseparably linked to quality are the freedoms of the health professions and the freedom of the public as potential patients. These freedoms must be spelled out in the basic legislation, safeguarded through appropriate organizational arrangements, and mutually respected" (RCHS, 1965, p. 1).

With the foregoing general commitment to freedom made, the Commission proceeded to spell out these freedoms more specifically as well as grapple with the inevitable tensions that would arise between competing values in a system where the

defining principle would be achieving universal coverage for all Canadians through a single payer/publically administered health care system. In relation to the doctor/state relationship, the Commission engages in lengthy advocacy that not only firmly establishes the right of physicians to practice freely but also refuting the notion that government sponsored remuneration would limit this freedom:

> [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, nor 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, 1965, p. 11)

The foregoing is sophisticated argumentation. The commission in essence 'bypasses' the often levelled critique of a universal health care system as being strongly connected with the baggage of socialism. It does so by insisting that universal health care has nothing to do; with socialism or any other socio-political philosophy for that matter. Instead, a government sponsored prepaid health care system merely provides a mechanism of compensation for a doctor's professional services that are practiced *freely*. And to pre-empt a retort that if a physician is held 'beholden' to government he or she

will necessarily be under some kind of bureaucratic control or constraint, the Commission makes the point that any such relationship would be *voluntarily established*. By providing at least the theoretical ability of a doctor to opt out of such an arrangement, the perspective that physicians operating within a universal system would inevitably be controlled by government is mitigated. Finally, the Commission establishes the advantages that the removal of financial barriers for service would likely have on the doctor/patient relationship. The one and only constraint placed on a doctor's freedom to practice by the Commission concerns the right of a physician to set their own fees should they choose to take part in a publically administered prepaid system:

> The emphasis on the freedom of practice should not obscure the fact that the physician is not only a professional person but also a citizen. He has moral and social obligations, as well as self-interest to do well in his profession. 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, 1965, p. 11)

While it is certainly acknowledged that Justice Hall goes to great care to maintain freedom for physicians within the parameters of a universalized system, it must be noted that the proposed removal of a professional's right to set their own fees for services provided is awfully aggressive argumentation within the context of a market oriented and capitalistic economy. This said, the aggressive nature of the contention is tempered

by the overall emphasis that is placed on freedom in general. It is clear that Justice Hall is a very skilled rhetorician.

After having dealt thoroughly with the doctor/state relationship, the Commission then establishes both patient freedoms and responsibilities. One again, Justice Hall addresses head on the common perception that universal health care substantially limits a patient's ability to choose their own doctor or hospital. And of course his repeated use of the world 'quality' refutes the perception that socialize medicine diminishes excellence in care doxastically. First, in regard to patient responsibility the following arguments are advanced:

> The Commission believes that the individual's responsibility for his person 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, the 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, 1965, p. 11)

Here again, we see sophisticated argumentation that explores a number of tensions and embraces the complexity of modern day management of disease and illness. As has previously been established, Hall clearly places a high degree of importance on pragmatic and economic concerns when it comes to health care. Similarly, he embraces the ability of empirically based knowledge to mitigate for poor health substantially. However, once a higher standard of health care has been achieved through the application of the benefits inherent in the health sciences, the nature of the human being must be attended to. Human behavioral and lifestyle choices maintain their indispensability. Modern health care and statistics can certainly be an aide to human health and well-being but do not represent the 'end of the matter.' The state of the human condition must also be considered. In short, with the great freedoms of having access to the fruits of the health sciences irrespective of ability to pay, comes great responsibility to take advantage of these freedoms and to supplement them with classical notions of temperate living.

The last tension that the *Hall Commission* addresses is between the potential for bureaucracy in a health care system funded by government and the need for diversity of involvement in the overall delivery of services: "Our recommendations concerning the provision of health services, rather than envisaging a centralized monolithic bureaucratic organization, are characterized by a desire for diversity, for the participation of all kinds of institutions, private, voluntary, professional and public, in meeting the health needs of Canadians" (RCHS, 1965, p. 10). Here again, we can see some complexity of argumentation which has facilitated the development of a pretty complex health care

system. Hospitals are regionally organized under regional health authorities. The boards of these authorities consist of a diverse group of individuals. Individual hospitals have a 'clinical' website and a corresponding 'foundation' website. The former is concerned with patient services and information; the latter with funding for equipment and various capital gains projects. Currently there are private medical services provided for medical procedures that are not insured through Canadian Medicare. The list can go on. At the end of the day, however, after all of these tensions and complexities are attended to in the report, Justice Hall goes back to the fundamental counterintuitive god term of freedom as the proposed linchpin within the new normal precipitated through a health care system anchored in the values of universality and equality:

> The pattern of organization will not represent a single, unified, monolithic government-controlled system… It is not government controlled because of the emphasis on the cooperative aspect of planning, implementing and organizing health care programmes in Canada in which all sectors of society and government participate on a continuing basis and also because it leaves the practice of medicine and of dentistry wholly in the hands of physicians and dentists on whose integrity and competence will depend a high standard of professional performance *based on free professions in a free society*. (RCHS, 1965, p. 235) [Emphasis mine]

In short, the *Hall Commission* undertook to apply commonly accepted propositions to an idea that had experienced significant resistance from government, insurance companies and perhaps most importantly physicians. Of course when I reference 'physicians' I also

include the associations, colleges, and societies that support them such as the *Canadian Medical Association* as a key example.

Closely related to the Commission's foregoing rhetorical strategy was the *counterintuitive focus that was placed on decentralization*. Yet another commonly held presupposition relating to universality and health care is the perspective that individual creativity will be eroded. Additionally, it has been presumed that the ability of medical practitioners and their patients to manage the complexity associated with disease and illness will be stifled. This is primarily because the words 'single-payer' and 'public administration' infer a sort of centralized control over medical care. Once again the members of the *Hall Commission* directly addressed these underlying presuppositions and refuted them through conflating universal health care with decentralization in a novel way. They first do this through making a direct appeal to the constitution concerning provincial responsibility for health care and elaborate on the benefits of the scheme developed by the founding fathers:

> 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 health services that will best meet the needs of the community (RCHS, 1965, 212).

In developing their argument for decentralization, they connect the proposed new system with experimentation. To experiment, invent, and create is often viewed from a capitalist perspective as being driven by the market and private industry. The *Hall Commission* directly refutes this and seeks to create an alternative endoxic perspective that universality and human creativity can coexist. The commissioners continue to develop their in depth argumentation for decentralization through appealing to what they see as the 'special nature of health care.' As referenced earlier, the provision of health care is a complex process that is heavily dependent on the individual creativity of a medical practitioner applying his/her specialized knowledge into *very specific* circumstances. The *Hall Commission* argues that it is for this very reason that a successful remodeling will involve a hybrid between public and private, collective efficiency and individual initiative:

> It is not possible to produce an all-inclusive blueprint for the future provision of health services that would meet all contingencies. We cannot and do not wish to specify who should provide each and every health service. What we foresee is not a vast centralized bureaucratic organization solely responsible for the provision of all services with little opportunity for individual initiative and responsibility. Even though efficiency and responsibility are characteristics of large private and public corporations as well as government departments, the special nature of health services in Canada has led us to support a decentralized system in the provision of health services which is in keeping with the federal

> nature of this country and the historical development of this area of service. (RCHS, 1965, p. 214)

The commissioners end their major appeals for decentralization by directly referring to the human factor for health care. They successfully steer away from the common connection that is made between the *type* of organization or institution and the *degree of human initiative* and creativity. Rather, they separate 'system considerations' from 'individual considerations' and argue that irrespective of the type of system set up to provide a particular good or service, the human spirit of invention must be maintained as an indispensable and separate part of structure:

> 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. (RCHS, 1965, p. 234)

In sum, by providing sophisticated advocacy in support of two key counterintuitive positions vis-à-vis endoxa, the Commission was able to alter the terms of discussion and provide a game changer in the debate for health care reform at that time.

Relationship between written policy statement and its influence

In concluding the close textual assessment of the bombshell report that engaged the issue of health care in Canada during the 1960's, I will be seeking to provide some answers to the question, 'Why and how was this document persuasive?' Specifically, I will be looking at the report's ability to create 'salience' for the issue. In so doing, I'll be examining the nature of the audiences that the Commission seemed to address and will develop my own critical response to the report's message. I will be arguing that the Commission developed a central message directed at one key group of stakeholders. These stakeholders were medical doctors in their various organizational manifestations. Specific audiences engaged were the *Canadian Medical Association*, the *College of Physicians and Surgeons*, and a range of provincial Medical Societies. These audiences can be inferred by the central message developed in the report that centered on *the authority of the medical practitioner*. In addition for providing for the independence of the physician from the state in terms of clinical practice, the Commission also bolsters the notion that doctors are *exceptional professionals* that the state will rely on for expert medical judgment and diagnosis:

> Both health professions and health institutions along with governments have recognized that individuals and families generally do not determine the quantity of health services they receive – other than first visits – and that they are unable to evaluate the services they do receive in a significant way. As a consequence, both government and the professions have developed techniques to perform for the individual what he cannot perform himself. By law the practice of medicine,

> dentistry, nursing, pharmacy and other health occupations is restricted to those who are professionally qualified, hospitals must be approved and in general, Canadian governments acting on behalf of their citizens ensure that institutions and personnel are qualified to perform their duties. Professional bodies require a high standard of achievement before granting a license to practice a profession or permitting a professionally trained person to classify himself as a specialist in some health field (RCHS, 1965, p. 206).

Here the physician is placed as the final arbiter for both *which* medical services are provided and *when* those services are provided. The patient is disempowered by being presented as incompetent or otherwise unable to engage with the medical establishment in any meaningful way. Additionally, the elite nature of the medical profession is established through the rigor of standards they have to meet in order to be qualified to manage patient care. And of course it is the government that is instrumental in setting and enforcing these standards. In an even more explicit statement on the scope and power of the physician to make sound medical decisions on behalf of their patients, the commissioners appeal to the rhetoric of safety as a prime basis for the key role they should potentially play within a new single payer health system:

> While the consumption of legal or educational services is unlikely to do harm to the individual, this is not the case for many health services. Thus, 'unnecessary' surgery, excessive radiological services or too many prescription drugs can have serious consequences for the user. It follows then that for the majority of health services, the amount, the type and the location of health services must be decided

> by the practitioner on the grounds of medical or health needs. The judgment of the profession determines quality of care; the consumer generally does little more than accept the decision of the practitioner. (RCHS, 1965, p. 205)

In response to one of the central messages of the Commission concerning the authority of a medical practitioner, a number of points can be raised. First, it is possible to infer the target audience to whom the message is geared toward through a close assessment of the text. As Edwin Black noted in his description of the *Second Persona*:

> It seems a useful methodological assumption to hold that rhetorical discourses, either singly or cumulatively in a persuasive movement, will imply an auditor, and that in most cases the implication will be sufficiently suggestive as to enable the critic to link this implied auditor to an ideology. (Black, 1970, p.334)

It does not appear that the intended influence of the *Hall Commission* was to the masses. It is not particularly elegant rhetoric, nor is the language employed lofty. Further, when you put the message of the commission together with its focus on freedom, decentralization, and the authority of a physician, a clear strategy is seen whereby the rhetors are primarily raising common objections of elites and then answering them. Through an analysis of the many objections that can be inferred from the foregoing claims made by the Commission, it is easy to see that the physician is the source behind all of the objections. Other auditors could include additional elites such as the media, conservative legislators, and big business.

In response to the reinforcement of the physician's authority, it seems appropriate to raise the following issue. What are the nature of arguments that make

direct appeals to authority? Ironically, the special status that the Commission appears to ascribe to medical practitioners has in certain cases over the years served to *limit* their authority. One area in which the patient-doctor relationship has been eroded by the rhetoric of expertise is in the domain of confidentiality. As the commissioners clearly argued: "The state does not interfere in any way with his professional management of the patient's condition, nor with the confidential nature of the physician-patient relationship" (RCHS, 1965, p. 11). However, many provinces now have mandatory reporting laws for 'unfit' drivers. An unfit driver could include old age citizens, individuals with a range of physical issues such as seizure disorders, suffering from a stroke and other neurological issues including mental health considerations. Since physicians are now required by the state to report drivers that could even potentially be unfit to drive, this creates a conundrum whereby law and medicine are mixed. It also, of course, violates confidentiality and can therefore damage the doctor-patient relationship. Finally, since the state 'relies' on the expertise of the doctor in these cases, once reported as unsafe to drive, a patient is left with little recourse for appeals or reviews of such actions. And going back to some of the introductory comments in this thesis, hierarchy increases mystery and mystery perpetuates hierarchy. The foregoing Burkean rhetorical cycle can have the effect of disempowering patients through the instigation of a narcotizing dysfunction. The establishment of the physician as the supreme authority by the state for medical care can provide the patient with little impetus to take ownership of their own treatment when the medical system is engaged.

Implications

The foregoing perspective and analysis suggest several implications concerning the nature of this 'administrative style' rhetoric that is seen in the *Hall Commission*. First, with its focus on decentralization, it seems reasonable to assess if there might be any risks or limitations to this position for health care in Canada. As was referenced in the chapter examining Canadian identity, the current health care system is a complex mix of private and public sources for funding and provision of care. Then there are also provincial/federal cost sharing formulas that add to this complexity when considering health care delivery. Even when just the provincial plans are considered there are still a range of dichotomies as each province divides up their health care system into different regional authorities and the relationship between the respective legislatures that hold the purse strings and the medical establishments that are funded by these legislatures is loose. And of course, Hall's prediction of constitutionally prescribed diversity within our health care system has in fact transpired as Canada currently has 13 different approaches to the management of disease and illness. All of this can mean that it can be difficult to assess the nature of health care in Canada. It can also be difficult to track funding and establish uniform benchmarks for quality of care. All of this decentralization, while good in theory for fostering creativity and encouraging individual initiative and diversity can also foster a lack of clarity or transparency for the Canadian people on how Medicare can be assessed.

Second, and related to the aforementioned, the lack of clarity concerning the money trail, federal/provincial transfer ratios or even a basic general understanding on

how Medicare is funded not only violates another core principle that Justice Hall espoused but also has left our universal system open to attack by right wings organizations such as the *Fraser Institute*. A core critique by the institute claims that Canadians are simply unaware of how expensive Medicare is for taxpayers as individuals and families. This reality, to the extent it is true, would certainly not have been endorsed by Hall:

> In view of the need to improve the quality of health care that Canadians receive and to ensure that scarce health resources are used most effectively, some organization must take responsibility for evaluating the quality of health services and, what is essentially another dimension of quality, the manner in which scarce resources are utilized. (RCHS, 1965, p. 200)

Third, with the *Hall Commission's* heavy emphasis on maintaining freedom within a universal system for both patients and doctors, it is interesting to speculate the extent in which this portrayal of the 'language of patient/physician rights' may have been a precursor to court rulings such as the Chaoulli decision. While it is unclear What Justice Hall's perspective on this court decision might have been, it does raise the question that freedom within health care system programmes has been eroded over the years.

Finally, and on a more positive note—at least from an argumentation perspective—the *Hall Commission's* focus on transparency through establishing measurable benchmarks, the efficient management of scarce resources, and the effective 'triage' of patients and services by medical professionals seems to be a useful point of

departure for health care debate today. As referenced in the last chapter, Canadians still seem to be receptive to proposed changes to Medicare based on the grounds of future *sustainability*. Perhaps when these discussions arise or public debate is at a standstill, policymakers and academic thinkers would do well to revisit the central arguments in this fine report.

In short, the Hall Commission was all about the working out of tensions between values and pragmatics as well as economic versus humanistic considerations for the provision of health care. What is most impressive about this document was its ability within a very short period of time to encourage a near complete overhaul in the status quo for health care services in Canada. The report appeared to succeed rhetorically by effectively arguing to elite bodies that could enact such reform. It was effective by illuminating endoxic objections to universal health care within that time frame. Through a series of nuanced and sophisticated arguments, Justice Hall and his commissioners insisted that there did not have to necessarily be a conflict between universality and capitalism, freedom and equality, the individual and the collective. Instead, he rhetorically situated health care expenditures as "primarily an investment in human capital and not welfare expenditures" (RCHS, 1965, p. 222). At the end of the day, there is no necessary relationship between health care delivery and health care services.

The 1980 Hall Commission Report

As has been alluded to, the *Hall Commission of 1964* was unique in terms of its ability to significantly alter the status quo in very short order after its release. One of the critiques of the commissions concerning health care has been the lack of influence or

change seen after their release. This general trend of a relative lack of change is primarily due to the failure of governments to enact many of the commission's recommendations. As we consider briefly the timeline for the institution of Medicare in Canada, it is helpful to review several historical moments that led to this end. Recall that it was Prime Minister John Diefenbaker's Conservative government that established the terms of reference for the 1st *Hall Commission* in 1961. Diefenbaker, however, was ousted from office by the Liberal's led by Lester B. Pearson who then became Prime Minister from 1963-1968. So it was Pearson's government that received the completed report for the 1st *Hall Commission* in 1964. Two short years later, the Liberal's introduced the *Medical Care Act*. The Act was fully implemented in 1968 bringing universal coverage into Canada for the first time.

So essentially, the second *Hall Commission's* task was necessarily very different as its job was no longer to assess the future of health care services in Canada but instead to evaluate the first decade of a brand new system! In 1979, Lester B. Pearson's successor, Pierre Elliot Trudeau was defeated by Joe Clark and the Conservatives ending 16 years of rule by the *Liberal Party of Canada*. Shortly thereafter, the new *Minister of National Health and Welfare*, David Crombie, moved quickly to appoint Mr. Justice Emmett Hall to conduct a commission to determine how Medicare had evolved since its introduction and what problems needed fixing. Specifically, the Commission was tasked to 1) examine the extent to which principles of portability, reasonable access, universal coverage, comprehensive coverage, public administration, and uniform terms and conditions were being achieved 2) consider whether there should be other basic

principles for health insurance delivery and 3) consider the nature and extent of necessary revisions to *Hospital Insurance and Diagnostic Services Act* and *Medical Care Act* and related legislation. In short, The Health Services Review was established under terms of reference, or guidelines, that were set out by the federal and provincial ministers of Health on September 17, 1979. It met under a much more limited budget and timeline than in 1964 but nonetheless released its conclusions and recommendations to the new Liberal government that had defeated the short lived Conservatives, on August 29th, 1980. This report, among other things, became the impetus and basis for the *Canada Health Act* that achieved Royal Assent in 1984.

Analysis

The primary matter that was dealt with in the *Hall Commission Report of 1980* was the 'extra-billing' issue that had cropped up during the first ten years of Canadian Medicare. Extra billing was a practice initiated by some physicians that involved charging patients more than the state was willing to cover. The resulting public discussion and debate centered on the role and rights of the state in the delivery of health care versus the right of the physician to set their own fees in the provision of health care. Extra billing was a practice that was unpopular with patients and was also criticized as have a negative influence on accessibility -- one of the core values outlined in the *Medical Care Act*. Of course the state argued that when a certain group of individuals are granted a monopoly to provide for an essential service, it should have the wherewithal to set and enforce a fee structure in the absence of physician agreement. Essentially, Hall argued that neither the state nor physicians were right. The state, said

Hall, did not have the right to 'conscript' doctors. At the same time, doctors did not have an inalienable right to set their own fees. The solution, the commissioners argued, was to strive for and enforce – based off of previously agreed upon terms – a negotiated settlement. In short, both parties were to have a voice in the matter.

The 'terms of reference' for the *1980 Hall Commission* were much more limited than was the case for the 1964 report. While the depth of research of the 64 report was not matched by the 1980 version, the diversity of outside sources engaged was impressive. The 1980 report also had a tendency to deal with current issues by raising old arguments proffered in 1964. Overall, the Commission engaged an eclectic mix of sources and evidence ranging from peer reviewed journals to medical periodicals to government officials to studies instituted by the 1980 report itself. In short, the breadth of evidence employed in the 1980 report was substantial. A key document that was referred to in support of one of the Commission's central argument concerning the importance of preventative medicine and community health was titled *A New Perspective on the Health of Canadians.*

Relationship between discourse and culture

In respect to our orientation toward the truth, Aristotle claims that "Humans have a natural disposition for the true and to a large extent hit on the truth; thus an ability to aim at commonly held opinions [endoxa] is a characteristic of one who also has a similar ability to regard to the truth"(1991, p.33). In the *1980 Commission Report*, Emmett Hall seeks to de-emphasize commonly held yet artificial opinions that the primary ways by which health problems are solved are through doctors, hospitals and general medical

treatment. Instead, the commissioners push for a preventative approach to healthcare where patients assume ultimate responsibility for their own well-being. At one point he even links this argumentation to the value of equality through making reference to the historical role that women have played in more holistic approaches to healing. Quoting from the *American Academy of Arts and Science*, Hall exhorts patients to develop a realistic perspective on the role of health sciences for the maintenance of human health:

> According to the Great Equation, Medical Care equals Health. But the Great Equation is wrong. More available medical care does not equal better health. The best estimates are that the medical system (doctors, drugs, hospitals) affects about 10 per cent of the usual indexes for measuring health: whether you live at all (infant mortality), how well you live (days lost due to sickness), how long you live (adult mortality). The remaining 90 per cent are determined by factors over which doctors have little or no control, from individual life-style (smoking, exercise, worry), to social conditions (income, eating habits, physiological inheritance), to the physical environment (air and water quality). Most of the bad things that happen to people are at present beyond the reach of medicine. Nobody says doctors don't help. They mend broken bones, stop infections with drugs, operate successfully on swollen appendixes. Inoculations, internal infections, and external repairs are other good reasons for keeping doctors, drugs and hospitals around. More of the same however, is counterproductive. Nobody needs unnecessary operations, and excessive drugs can create dependence or allergic reactions or merely enrich the nation's urine. (Wildavsky, 1979, p. 284)

This quote is key because it makes explicit the extent that the western world has come to rely on science and medicine to cure them even though common 'harms' to human beings such as disease, illness, and injury are in reality outside of the purview of the medical practitioner. And in fact, too much interaction with the realm of the health sciences can actually exacerbate existing harms or even create new ones. The adage 'prevention is worth a pound of cure' has appeared to be co-opted by the supposed capacity of scientific technique to heal, cure, and through logical extension, resolve some of our most profound dilemmas. The Commission employs rhetoric to draw attention to some of these culturally derived misconceptions.

As the commissioners continued their rhetorical efforts to reclaim common sense, they point out that now that communicable diseases have been substantially repressed, even more responsibility is then placed on the patient to take advantage of this stability and to live a temperate life in response. If anything our responsibility for our own health has increased with additional structural irritants such as the Internet, a significant increase in prescriptions for narcotic medications, etc. In the face of the reality of increased opportunity to live the good life by preventing illness through responsible living, the 'Canadian way' remains focused on seeking medical treatment for symptoms arising from self-destructive lifestyles:

> I heard many submissions that this should be the era of Preventive Medicine but few, if any, concrete workable steps to allay the onset of illnesses arising from our present day 'lifestyle.' I see no change in sight in the present Canadian way of life. We are in the era described by Dr. Waldavsky where some 90 per cent of

> our illnesses, disabilities or complaints are determined by factors over which doctors have little or no control, -- but we go to them and expect them to restore us and keep us well while we pursue the same course… In this climate, curative health services are the last resort and loom large and almost usurp the fiscal capacity of the nation. Some hopes for easing the financial and human cost which may flow from an enlightened citizenship and post curative procedures (RCHS, 1980, p. 66).

The foregoing quote raises the important issue of how individuals and society are to respond to self-destructive inclinations that do inevitably result in a compromise of health. This response is particularly important in light of the expenses involved in the treatment of conditions precipitated by behavioral choices. In light of the foregoing, the commissioners seem to argue that seeking treatment for symptoms arising out of poor lifestyle choices should be considered as a last resort – though sometimes needed – option for the patient. This is primarily due to the fact that the costs and consequences associated with poor personal judgment could potentially get even higher if professional help is not sought:

> Lung cancer, cardiac illness, alcoholism, and highway and other accidents, all appear to be, in part, the consequence of individual behavior. In a sense, more responsible behavior would eliminate the need for many health expenditures. But having incurred an illness it would still pay an individual to regain his productive position and avoid disability or premature demise. We may regret unwise human behavior but we have to accept it as a reality of life. We feel that

> even where the net gain to society is negative; i.e., when output to be expected is less than the costs of health services required, it still is desirable to assist people to regain their health. (RCHS, 1980, p. 64)

In short, the commission sought to influence the attitudes of Canadians and their perceptions of the role of medical care for health maintenance by 'inverting' the priority of two commonly held presuppositions. Rather than living dangerously and then utilizing medical services as a sort of safety valve, Canadians should strive to live a temperate life – focusing on the underlying causes of a majority of ill health that afflicts humans today. By removing the cause, the need for engaging health care services will be mitigated. However, as a last resort, it does make sense to seek treatment for the acute situations that can result from chronic poor choices and behaviors.

Relationship between written policy statement and its influence

A key way to write with influence, says McGee (1990), is to convey a message to a target audience or audiences that has *salience*. According to Richard Vatz, it is the trained rhetorician that is best equipped to translate a 'situation' in such a way that it generates meaning for his or her receiver. If a situation is infused with meaning for an audience, it suddenly matters to them. If it matters to them, the message often warrants a response which sets in motion the process of rational deliberation. And of course policy development and reform is often a product of rational deliberation:

> Communicating situations is the translation of the chosen information into meaning. This is an act of creativity. It is an interpretative act. It is a rhetorical act of transcendence… In a world of inexhaustible and ambiguous events, facts,

> images, and symbols, the rhetorician can best account for choices of situations, the evocative symbols, and the forms and media which transmit these translations of meaning. (Vatz, 1973, pp. 228-229)

As a high ethos rhetor, Emmett Hall and his Commission molded the situation vis-à-vis health care services in 1979 & 1980 in such a way as to create salience to select target audiences. The rhetoric of the report seems to indicate that Hall's primary target audiences were physicians and the Canadian people. Briefly revisiting the tension between cure and prevention discussed above, it is clear that the Commission did not let physicians off the hook for addressing, on demand, problems that it was not equipped to solve. Doctors and institutions that train doctors are responsible for constituting a professional worldview that privileges curing acute conditions. In the face of a reality where chronic conditions are predominant, the Commission notes that patients that present with such conditions are often treated with a lack of care and patience:

> It is, therefore, both surprising and, at times, appalling that a problem of this magnitude should be treated by the health professions with what can only be described as a lack of interest. The emphasis is still permanently and primarily placed on acute and short-term illnesses where the efforts are more or less ensured of dramatic results and success. As this dramatic aspect decreases, so does their interest in the patient's illness. The great deficiency, therefore, lies in the health workers of modern medicine who fail to realize the evident priorities in today's health panorama (RCHS, 1980, p. 67).

Of course the clear implication of the 1980 report's focus on preventative medicine is that the philosophy of medicine it was addressing was wrongheaded. The medical establishment should be participating and contributing to fostering the lifestyle changes that are required to prevent and manage many chronic conditions. By momentarily drawing attention to physician neglect for this issue, the Commission creates salience with respect to the medical system and medical practitioners. While patients clearly need to take more responsibility for their health and wellbeing and adjust the expectations they have of the medical community, doctors need to refrain from an undue focus on curative approaches to medicine.

It is clear that, as referenced, the primary issue that the 1980 version of the *Hall Commission* addressed was the extra billing issue. In order to deal with this issue adequately, the Commission had to address physician concerns with rhetoric and at the same time buttress their position by making direct appeals to the Canadian people. They did so adeptly. Using the key word 'adequate,' the Commission developed enthymematic arguments that encouraged physicians to rethink their position in respect to fee structures and strike actions and to solidify public opinion firmly behind sustaining Medicare. In his work On Rhetoric, Aristotle conceptualizes an enthymeme as an adapted form of a rhetorical syllogism. Since audiences tend to derive a certain amount of pleasure in drawing inferences from a speaker or writer's rhetoric, leaving out a major premise in an argumentation syllogism can be a strong identification strategy*:* *"*For if one of these is known, it does not have to be stated, since the hearer supplies it" (Aristotle, 1991, p. 42). The Commission leaves out a key major premise in the

arguments presented concerning what constitutes 'fair' remuneration for physicians by the state. They essentially do so by bypassing the argument advanced by physicians on the right to set their own fees and failing this resort to withholding services to patients when the state remains unwilling to compensate them accordingly. After arguing at length concerning the responsibilities of the state and obligations of physicians within the existing framework of universal health care, they eventually get to their main point:

> Consideration and discussion of the question of outlawing extra-billing however resorted to must always be accompanied by a recognition of the physician's right to adequate compensation and vice-versa. A solution to the problem concerning the right to adequate compensation must be accompanied by a recognition that extra-billing within the system is not permissible… These two elements must always co-exist; there cannot be recognition of one without recognition of the other. Separation for any reason will distort and render invalid any argument or publicity relating to what I am now proposing… The real and fundamental question that has to be faced and resolved is how can these two basic principles or ideas be twinned and harnessed so as to achieve survival of the health services program. It is a pure question of survival. Repetitive conflicts year after year that may result in strikes by physicians in one or more provinces must be prevented. This can be achieved through the creation of a mechanism that will avoid strikes and at the same time assure physicians of adequate remuneration… This Gordian knot has to be broken by some means short of effecting a conscription of the providers or the withdrawal of services by them. *If*

physicians are adequately paid, there will be no need for extra-billing nor for strike action. (RCHS, 1980, p. 28)

The final sentence in the foregoing lengthy argument rhetorically induces the Canadian people to consider the following. If doctors are paid adequately by the state but continue to persist in sticking with their preconceived notions in terms of a suitable fee structure and continue to threaten to strike or actually withhold services in response to their demands not being met, what does this mean? What then becomes the issue? Why would doctors continue to hold fast to their position and threaten Medicare through withholding services if they are being adequately remunerated by the state? The Commission sets up their argument concerning the extra-billing issue in such a way as to encourage the Canadian people to provide their own answers to these questions. In so doing, the Commission implicitly questions the purity of the motives of doctors in respect to the remuneration and extra-billing issues. Could it be that physicians are greedy? Through completing arguments not stated explicitly by the Commission, this would seem to be a plausible conclusion that the Canadian people could draw.

Finally, the Commission turns to addressing objections and concerns raised by doctors concerning the right to set their own fee schedule as a basis for ameliorating a perception that they are being underpaid by the state. Why might doctors conclude that they are *not* being adequately compensated for their services? One reason might be the acknowledgement of a less than flattering comparison for generated income with other professions. As Hall notes: "I am fully aware of the stress physicians appear to be enduring as they purport to see their status and position in relation to other professionals

and wage-earners eroded in recent years… Some physicians sense a loss of status or prestige as other occupations catch up to them in the economic race" (RCHS, 1980, p. 27). But this acknowledgment begs the question. Why the concern with status and prestige? What constitutes status and prestige? Why are medical practitioners granted a great deal of deference and respect in society? Once again, the argumentation invites the Canadian people to provide their own answers to these questions. A possible answer to these questions is provided in the report through utilizing – perhaps ironically – medical associations as a mouthpiece:

> The idea of doctors striking or withdrawing their services was said to me by the Medical Associations to be totally repugnant to the whole concept of service to humanity which has developed over the centuries, resulting in the status of the medical doctor and the esteem in which the profession has been and is held by all citizens… That status and that esteem did not flow from the fact that the doctor was a high earner but rather from the recognition and appreciation of the service rendered by those in the profession. (RCHS, 1980, p. 32)

So what conclusions does this extended argumentation invite the Canadian people to come to? What is the enthymeme? One possible observation might be that the Canadian people may think that if it is true that a doctor's status is derived through service to humanity, and the predominant way that extra-billing is justified by medical practitioners is through an appeal to maintaining this status, then the warrant for extra billing would appear to be quite weak. If physician's status is achieved through service to humanity then it does not make sense that getting paid more through extra billing

would have any effect at all on the same. In fact, making such an argument could harm the prestige of a doctor if they are already being paid adequately by the state. If they are being paid adequately and status is not derived from money, then what could be the real motives behind the physician's grievance? The chance that the Canadian people would provide an answer to this question that would reflect well on medical practitioners would seem to be slim.

Implications

As this chapter draws to a close, it is appropriate to draw some comparisons between the 1964 and 1980 reports. In both versions, Hall et al. engage in sophisticated rhetoric through anticipating potential objections to arguments and addressing them ahead of time. A unique textual feature of the 1980 report was the engaging in enthymematic argumentation which encouraged direct engagement on behalf of the audience that Hall perceived to be his strongest ally – the Canadian people. Both reports relied on rational inquiry to make their points and demonstrated high quality research and careful reasoning to advance their position. In both reports, the commissioners would try to 'recast' arguments surrounding a particular issue in another light as a means to strengthen their rhetoric. In the 1964 report, commonly held positions on the nature of a universal and single payer health care system were recast as simply a pragmatic shift in health care delivery as versus an ideological shift of a tectonic nature that would drastically reduce quality and limit freedom. In the 1980 report, the extra billing issue was reduced to ensuring that physicians were reimbursed adequately for their services. In so doing, the Commission sidestepped arguments concerning the right of doctors to

set their own fees as well as the notion that medical practitioners merited high salaries in order to maintain their prestige and reputation as highly educated and highly trained professionals. In both reports, the key target audience appeared to be physicians but as referenced, appeals were extended to engage the Canadian people in the 1980 document. It is also noteworthy to mention that a close textual analysis of the 1980 report appears to validate McGee's argument that a written text is never 'complete' or 'final.' This is seen as Emmett Hall repeatedly cites himself in 1980. He relies heavily on reproducing key arguments presented in 1964 in such a way that they apply to a very unique issue that had cropped up since then – namely the extra-billing issue. Despite this, the 1980 report still maintains its own unique 'rhetorical flavor.'

In terms of the specific rhetorical messages of both reports, the following observations should be helpful. First, across the board Emmett Hall argued that universal health care is justified on the grounds that it is good, solid, economic policy and makes good practical sense. The provision of universal health care is nothing short of an investment in human capital. In both reports, nuanced and well researched arguments were presented in support of a particular position by a career lawyer who eventually became a provincial and ultimately federal Supreme Court Justice. Further, Hall was a particularly high ethos source as his arguments for nationwide universal health care could be perceived as objective as it would not be assumed that a devoutly religious lawyer with a libertarian philosophy of economics and with *Conservative Party* affiliations, would have advanced the recommendations concerning the future of health care services that he did. Canada is in sore need for additional high ethos rhetors and

objective sources to (re) engage the issue of health care reform and get the discussion moving again. Utilizing rhetors with leftist biases to argue for either more of the same or at most minor repairs to the status quo is not what is needed to create a rhetorically robust climate that will contribute to Medicare being sustainable into the future. Finally, if the rhetoric of the *Hall Commission* does anything, it provides us with a clue on how Canadians might truly take ownership in their health care system without resorting to Burke's notion of the power of the 'negative' as the primary defense of the status quo.

CHAPTER VI

DE-EMPHASIZING RHETORIC

> The rhetorician is not confined to a single movement. After he captures the appropriate and places it temporally, he moves toward the suggestion of the possible. The starting point for the articulation of the possible is the ontological assumption that the main driving forces in the man's life are his desires, especially the desire to be other and to be elsewhere. Another relevant assumption is that the sphere of actuality always entails a lack, the absence of that which exists only in the future; more particularly, that actuality frustrates man when he dreams of being other and binds him to where he already is when he wants to be elsewhere (Poulakos, *Toward a Sophistic Definition of Rhetoric* 42&43).

The *Canada Health Act* (CHA) was an important document in respect to health care policy. After the landmark *Hall Commission Report of 1964*, Canada had initiated a universal and prepaid health care system by the end of that decade. This new system was based upon principles of the *Medical Care Act* that came into effect on July 1st 1968. As with any novel system that evokes economic, social, and organizational changes at a tectonic level, there is a period of adjustment where assessment needs to occur and necessary changes made. For example, a major issue that arose between 1968 and 1980 was the 'extra-billing' issue of patients by providers who deemed the government payment schedule inadequate. When the recommendations of the 1980 version of the *Hall Commission* were presented to the newly minted Liberal Government, *Minister of National Health and Welfare*, Monique Begin, saw an opening to enact some changes into the existing system and to 'formalize' Canadian Medicare into the framework that it is known today. The result of this process -- the CHA -- was written and achieved royal assent on April 1, 1984.

Because the CHA has demonstrated significant stability since its enactment in 1984, it makes sense to employ it in this thesis as a sort of 'fulcrum' in my analysis of the rhetorical/textual history of Medicare. Approximately 16 years later, the principles outlined in the CHA were used as a starting point for another commission report on health care that was chaired by then Premier of Saskatchewan, Roy Romanow and an alternative 2002 report generally labeled the *Kirby Report*. Furthermore, the CHA exemplifies the relationship between the federal and provincial government for the provision of health care. As a federal document, the CHA identifies the values or principles that the provinces are advised to follow as they exercise their constitutional prerogatives and concentrate on the *delivery* of health care services. Because of the CHA's focus on values or standards upon which Canadian Medicare should be based, it lays claim to significant rhetorical import. Therefore, this chapter will start off with an analysis of the CHA and how it set the stage for latter discussion of the maintenance, sustainment, and proposed reforms for health care services in Canada. Then the discussion will shift to a rhetorical assessment of the reports released in 2002. My general thesis will be that during this era the rhetorical skill that was necessary to establish universal healthcare in Canada was missing during the debates at the turn of the new century. The application of rhetorical principles can provide a key way forward.

Analysis of Canada Health Act

The likely the primary rhetor for the Canada Health Act was Monique Begin who was the *Minister of Health and Welfare* during the early 1980's. Begin had also served in the same cabinet position from 1977-79 under Pierre Trudeau before his party's defeat

at the hands of Joe Clark's *Progressive Conservatives*. After a very brief stint out of power, Begin's cabinet posting was reinstated again after the 1980 election and she stayed in the post until the *Liberals* were again defeated in 1984. Begin had a wealth of experience in the health portfolio and the wherewithal to be an instrumental rhetor in the CHA's development. She also had the educational credentials to craft together such a key document. She earned an M.A. in Sociology from the *Universite de Montreal* and a Ph.D. from the *Sorbonne* in Paris.

The values for Medicare established in the CHA are largely a continuation of the earlier *Medical Care Act*. The values that the CHA sets out for health care mandates that any provincial system should be *publically administered, comprehensive, universal, portable, and accessible* (1984, c. 6, s. 7 a-e). The CHA then provides very brief descriptions on what these terms mean when applied to health care. Concerning public administration, "the health care insurance plan of a province must be administered and operated on a non-profit basis by a public authority appointed or designated by the government of the province" (1984, c. 6, s. 8). In respect to comprehensiveness, "the health insurance plan of a province must insure all insured health services provided by hospitals, medical practitioners or dentists, and where the law of the province permits, similar or additional services rendered by other health care practitioners" (1984, c. 6, s. 9). In order to adhere to universality, "the health care insurance plan of a province must entitle one hundred per cent of the insured persons of the province to the insured health services provided for by the plan on uniform terms and conditions" (1984, c. 6, s. 10). In order to be portable, provincial health care plans "must provide for and be

administered and operated so as to provide for the payment of amounts for the cost of insured health services provided to insured persons while temporarily absent from the province" (1984, c. 6, s. 11). Concerning accessibility, provincial health plans "must provide for insured health services on uniform terms and conditions and on a basis that does not impede or preclude, either directly or indirectly whether by charges made to insured persons or otherwise, reasonable access to those services by insured persons" (1984, c. 6, s. 12). Additionally, the plans must "provide for the payment of amounts to hospitals, including hospitals owned or operated by Canada, in respect of the cost of insured health services" (1984, c. 6, s. 12).

A striking thematic feature of the CHA was the continuity it established from the *Hall Commission Report of 1980* – specifically in regards to the extra-billing issue. Essentially, the CHA stated that any province that was caught reimbursing a physician that extra-billed his or her patients would be subject to a reduction of transfer funds from the federal government: "In order that a province may qualify for a full cash contribution referred to in section 5 for a fiscal year, no payments may be permitted by the province for that fiscal year under the health care insurance plan of the province in respect of insured health services that have been subject to extra-billing by medical practitioners or dentists" (1984, c. 6, s. 18). Additionally, the CHA adopted Emmett Hall's recommendations concerning the rate a physician should be remunerated by the state when extra-billing is no longer permitted. A medical professional is compensated reasonably when the following conditions apply:

> If the province has chosen to enter into, and has entered into, an agreement with the medical practitioners and dentists of the province that provides a) for negotiations relating to compensation for insured health services between the province and provincial organizations that represent practicing medical practitioners or dentists in the province and b) for the settlement of disputes relating to compensation through, at the option of the appropriate provincial organizations referred to in paragraph (a), conciliation or binding arbitration by a panel that is equally representative of the provincial organizations and the province and that has an independent chairman. (CHA, 1984, c. 6, s. 12)

In short, the CHA solidifies the perspectives advanced by Emmett Hall in 1980 in terms of managing the tension between the power of the state and the professional freedoms of the physician. While the physician does not have the absolute right to set their own fees, neither can fees be arbitrarily and unilaterally set by the state. Fee schedules must be mutually agreed upon by both parties and disputes resolved in an objective and impartial manner.

One of the persistent themes I have encountered in the literature and text surrounding health care in Canada is a general misunderstanding of rhetoric. This misunderstanding can be seen in many aspects of Canadian society. A close scrutiny of the text of the CHA is no exception. Aristotle defines rhetoric as the 'counterpart of dialectic' and proceeds to flesh out the distinctions between the two. Rhetoric is all about a speaker or writer using whatever devices are at their disposal to move an audience *in a particular situation* in some way. Furthermore, rhetoric tends to be

adversarial in nature and derives its benefits from clashes between competing positions. In short, Dialectic tests and maintains an argument; rhetoric defends and attacks (Aristotle, 1991, p. 48). Aristotle elaborates on this theme and justifies the value of rhetorical clash on the grounds that better decisions are reached as a result of this process.

The foregoing can provide a useful framework by which the textual features of the CHA are unpacked. First, clearly the CHA is a *value driven document*. This is seen as the CHA sets an ideological and value framework by which health care services should be delivered in the provinces. Second, the CHA is a federal document and as such operates within a federal framework. The CHA seeks to provide leadership for the provinces and to establish the ethos of this leadership through offering or withholding funds. Whether funds are provided or withheld is dependent on the extent that the provinces follow the leadership set up in the CHA for the administration of health care services.

Unfortunately, the representation of the national values in the CHA comes across more as a 'listing of principles' than an inspirational articulation and defense of Canadian values. In order for this document to be more consistent with rhetorical principles, it would need to provide a much more detailed explanation on what the values that are expressed mean, and why they are important. Probably the most noteworthy defense of a CHA value occurs in the explanation of accessibility when the writers maintain that medical care in Canada should be provided *independent of ability to pay*. The accessibility defense is more compelling because it explains the value the

term represents in more detail. Health care should be provided *without financial or other barriers* and in a way that does not *impede or preclude access*. In short, the nature of an accessible health care system is laid out in some detail and in several different ways. As a result of this more aggressive defense, politicians repeatedly use some of the above phrases in campaigns and in debates as buzz terms to the point that the phrases could be elevated to the level of a series of god terms as outlined in Weaver's rhetorical scheme.

Moreover, the federal government has lost a lot of credibility in terms of the practical defense of the values of the CHA – basically since the mid 1980's. If values are not backed up in some way, they lose their rhetorical power. And since health care is constitutionally prescribed as a provincial responsibility, the only way in which national values of Medicare can be defended at the federal level is through the provision or withholding of transfer payments to the provinces based on the extent to which the respective provincial plans operate in a way that is consistent with these values. In short, it is the role of the federal government to provide leadership concerning values for health care and to enforce this leadership through utilizing the power of the purse. This power, while evident in the document is used sparingly. In essence the rhetoric of CHA reveals a 'soft ball' enforcement of or ritualized national values. Through a lenient enforcement of national values, the authors imply that they are reluctant to aggressively defend Medicare through avoiding clash or confrontation. For instance, in the CHA's discussion of 'conditions for cash contribution' the authors state that if one or more criteria are not honored by a provincial plan that the federal government should "send by

registered mail to the minister responsible for health care in the province a notice of concern with respect to any problem foreseen" (1984, c. 6, s. 14). However, before funding is reduced or withdrawn, the federal government is required to engage in collaboration and discussion with their provincial counterparts in order to either receive a satisfactory explanation for the inconsistency, or try and resolve the problem so action does not need to be taken. In short the federal minister of health is mandated to:

> Seek any additional information available from the province with respect to the problem through bilateral discussions, and make a report to the province within ninety days after sending the notice of concern; and if requested by the province, meet within a reasonable period to time to discuss the report. The Minister may act without consultation under subsection (1) if the Minister is of the opinion that a sufficient time has expired after reasonable efforts to achieve consultation and that consultation will not be achieved. (CHA, 1984, c. 6, s. 14)

Even in the worst of cases, funds are withdrawn in proportion to the offense that is perceived to have been committed in relation to the Act. And funds are only reduced on a 'per-offense' basis. Once a solution is found or the offenses are discontinued, reduction or elimination of funding is ceased and in some cases the provinces are even reimbursed for funds that were withheld due to the incident involved. For example, in respect to the extra-billing issue: "Where, in any of the three fiscal years referred to in subsection (4), extra-billing or user charges have, in the opinion of the Minister, been eliminated in a province, the total amount deducted in respect of extra-billing or user charges, as the case may be, shall be paid to the province" (CHA, 1984, c. 6, s. 20). It

must also be added that extra-billing is not so much outlawed in Canada, but discouraged through the power of the purse. Finally, it must also be stated that when the enforcement of key national values in a treasured national system are already weak, if this is coupled with a significant reduction in transfer payments to the provinces over many years, the potential for these values being eroded is enhanced. Traditionally, it has been the federal government that has set and enforced values for Canadian Medicare. It is the job of the provinces to administer the health care programs. If one level of government 'defaults' on their role, there is less of a guarantee that the respective administration of provincial health care systems will reflect national values that have engaged Canadian identity in recent history. An aggressive defense of values requires rhetoric and in order for rhetoric to function, the primary persuaders need to be high ethos in nature. In sum, the CHA hardly comes across as an ideological document let alone a manifesto.

Second, the CHA is a *legal document.* In a sense, this type of rhetoric has become common in Canada to the point that the *rule of law* has been elevated into another sort of god term in political discourse. Legal rhetoric can be limiting when it is interpreted by the target audience as an inducement to adhere to the 'letter of the law' instead of the 'spirit of the law.' This tendency is exacerbated by the nature of legal language, which invites its audience to engage in close scrutiny of the text – even to the point of distinguishing between single words. Legal language also encourages audiences to adopt a minimalist orientation toward textual interpretation, focusing on what is absolutely required. In looking at the *Canada Health Act*, one key word that has

appeared to make a world of difference in the outcome of health care in Canada is the word 'or.' The key way that this short word has had an influence on the type of health care Canadians currently receive is in the 'accessibility' criteria that is laid out in the CHA: "In order to satisfy the criterion respecting accessibility, the health care insurance plan of a province must provide for reasonable compensation for all insured health services rendered by medical practitioners or dentists" (1984, c. 6, s. 12). A cursory read of this clause might cause one to think that dental coverage is included in Medicare. The inclusion of dental services within Medicare would certainly not be inconsistent with the *spirit* of the law. However it could be construed as being inconsistent with the *letter* of the law. The 'or' in this clause provides a way out for dentists not to push or agree to opt in to Medicare for dental services and also for provincial governments not to fund such services. This is precisely what has happened in Canada. According to Quinonez, writing in a working paper sponsored by the *Network for Canadian Oral Health Research*, the inclusion of dental care into a national plan encountered significant opposition from dental professionals. This opposition is reflected in the following short vignettes, presumably from dental professionals:

> "Before a packed audience, he condemned governmental interference in such intimate relationships as those existing between patients and practitioners."

> "The moment any able-bodied individual holds out the hand and accepts something for nothing, that moment there begins a moral disintegration. The thing most needed in society is individual responsibility" [18: 64-68]. ()

> "If we are to have a national health program we should emphasize dental care for the child rather than for the adult; we should urge that it be done under the system of private practice" [19: 56]. (Qtd. In Quiñonez, 2013, p. 2-3)

From a rhetorical perspective, it seems reasonable to argue that the key term 'or' provided dentists with a way out of participating in a national program by way of enabling them to follow the letter of the law while de-emphasizing the spirit of the law. It is also noteworthy to mention that the current reality concerning the lack of public coverage for dental services contravenes the recommendations of Emmett Hall, specifically in the *1980 Commission Report*. His central argument that all children up to the age of 18 should be entitled to comprehensive dental care from the provinces was punctuated with the following statement:

> We also believe this programme to be so important that it cannot await Federal Government and Provincial Government decisions on the comprehensive health program as a whole and of which this benefit might be considered a part. ***This program must have one of the highest priorities among all our proposals***. (*RCHS*, 1980, p. 47) [Emphasis in the original text]

The benefit of legal rhetoric is that it can provide a mechanism by which a position is *defended*. Conversely, a legal document can provide a framework within which parties that operate against the position can be *attacked*. Unfortunately, the text of the CHA does not reveal that the authors took advantage of the genre of rhetoric to either defend the values of Medicare or attack those who are against such values.

Implications

In light of the foregoing discussion, it makes sense to elaborate on Aristotle's perspective for legal rhetoric and the insights that his position could provide for the rhetorical significance of the *Canada Health Act*. The most applicable discussion for legal rhetoric that Aristotle offers for the subject at hand is the contention that such advocacy is concerned with matters of justice and injustice. The writers *Canada Health Act* sought to lay out value based parameters on what a 'just' of 'fair' national health care system should look like. The core principles outlined in the act that were discussed above provided a precise benchmark that the provinces are encouraged to follow to deliver health care to their citizens in a just manner. However, even with this precision it has been argued that enough ambiguity still resided in the text that allowed the provinces to 'opt out' of providing services that though suggested in the Act were not absolutely required. Aristotle recognized the tensions inherent in deciding matters of justice and injustice and ultimately recommended a careful definition of terms on the part of the rhetor and a flexible interpretation of the legal message on the part of the audience:

> Since people often admit having done an action and yet do not admit to the specific terms of an indictment or the crime with which it deals—for example, they confess to have 'taken' something but not to have 'stolen' it or to have struck the first blow but not to have committed 'violent assault' or to have had sexual relations but not to have committed 'adultery' or to have stolen something but not to have committed 'sacrilege' (claiming what they took from a temple did

> not belong to the god) or to have trespassed but not to have committed 'treason' – for this reason, [in speaking we] should give definitions of these things: what is theft? What is violent assault? What is adultery? In so doing, if we wish to show that some legal term applies or does not, we will be able to make clear what is a just verdict (Aristotle, 1991, p. 104).

One of the challenges of definition and interpretation in the *Canada Health Act* concerns the inclusion of dentistry within Medicare. Although dental services were specifically referenced in the Act, provincial governments have, for the most part, failed to fund these services and the profession has generally been opposed to taking part in the Medicare programs. The failure of dentistry to be included as an 'insured service' in most provinces is in marked contrast to the recommendations made by Emmett Hall in his 1980 Report. Interestingly, Aristotle would seem to suggest that the error involved may have been one of interpretation as versus an error in rhetorical craftsmanship. He maintains that it is fair for the receivers of judicial rhetoric "to look not to the law but to the legislator and not to the word but to the intent of the legislator, and not to the action but to the deliberate purpose and not to the part but to the whole" (Aristotle, 1991, p. 106). So what can be learned from this brief discussion of Aristotle's taken on legal rhetoric? Aristotle's perspective would seem to put at least an equal onus on the consumers of this genre of persuasion to encourage an optimal or 'liberal' interpretation for the message. In applying this line of thinking to the interpretation of the *Canada Health Act*, it might be helpful if dental societies, deans and professors of dental schools etc., would instill philanthropic and humanist values into the profession's understanding

of the valuable role that they play in society. The humanistic import of dentistry is clear in the *Hall Commission* and is referenced 'in spirit' within the *Canada Health Act* but something was missing in the interpretation of the message that precluded governments and the dental profession from providing these services on a more holistic and comprehensive basis. Aristotle would seem to argue that this was a misinterpretation of legal rhetoric as "what contravenes the unwritten codes of justice [is a greater wrong]; for it is characteristic of a better person to be just without being required to do so; thus, what is written is a matter of necessity, what is unwritten not" (Aristotle, 1991, p. 108).

In summary, in contrast to dialectic, Aristotle maintains that rhetoric attacks and defends (Aristotle, 1991, p. 48). The benefit of rhetorical processes being engaged for policy development is that the 'truth of the matter' is more likely to be illuminated when a legislative position requires defense. Policies that are truer, better, preferable are likely to surface out of an adversarial process where competing perspectives are subject to clash (Aristotle, 1991, p. 34-35). It seems clear that the primary purpose of the *CHA* was to *solidify* and *maintain* value principles. So a misunderstanding of, or reluctance to, employ rhetoric as is illustrated here, places health care services in a bit of a bind. One of the most dangerous considerations would be the consequences associated with a lack of active identification by the Canadian people for the values that underlie our system of universal health care. Fortunately, there seems to be a number of steps that could be taken by the federal government to remedy these dilemmas.

First, the principles that are outlined in the CHA need to be more aggressively enforced. For example, a particular clause in the conditions for cash contributions

section would seem to be very useful for addressing some of the identification concerns that I referenced in the last chapter. In section 13.b. the document reads as follows: "In order that a province may qualify for a full cash contribution referred to in section 5, the government of the province "shall give recognition to the *Canada Health Transfer* in any public documents, or in any advertising or promotional material, relating to insured health services and extended health care services in the province" (1984). If the federal government strictly enforced this condition and the provinces overtly complied, such advertising would expose the Canadian people to the national leadership and values that 'connect the dots' between the differing provincial health plans. Granted, a token nod toward federal values would likely not make a significant rhetorical difference. This is why national leadership should encourage provinces to adhere, not only to the letter of the CHA, but also the spirit behind the document.

Second, based on Canadians suspicion of 'American style rhetoric,' a compromise position might be to engage in cooperative argumentation surrounding health care issues. Here, Poulakos can provide some guidelines: "In distinction to episteme, rhetoric does not strive for cognitive certitude, the affirmation of logic, or the articulation of universals. Conditioned by people who create it, rhetoric moves beyond the domain of logic and, satisfied with probability, lends itself to the flexibility of the contingent" (1983, p. 26). While the purpose of the CHA appears to be to solidify the values underlying health care, this should not be the end of the matter. A recognition that the values articulated at that time were 'probably' the best course of action would leave the door open for policymakers to remain sensitive to emerging situations that may

justify a re-opening of debate. Paradoxically, subjecting health care services to ongoing rhetorical processes could serve to protect Medicare. Potential threats to the system could be recognized and addressed early. Moreover, policymakers would not be expected to be satisfied with what has been attained as admirable as that may be. This type of orientation would require an ontological shift from, and on behalf of, the Canadian people. As Poulakos aptly notes, people participate "at once in two worlds each of which opposes the other. For Georges Poulet, man finds himself in 'two realities which simultaneously exist at a distance and which reciprocally deny each other: the reality in which one lives and that in which one does not live, the place in which one has situated one's dream and the place where with horror one sees oneself surrendered to chance and ill luck" (Poulakos, 1983, p. 30). 'Situating one's dream' for Medicare would involve creating a space for additional flexibility and creativity for the document rather than persisting on considering the CHA as a finished document. Seeing the CHA as 'closed' leaves it more vulnerable to the inevitable contingencies of history. Clearly, after much debate and wrangling, the dream of universal health care was established in Canada. But we cannot afford to stop with this. In order to move forward from the realm of the actual to the realm of the potential, a greater balance needs to be achieved between ideology and pragmatics; between dialectic and rhetoric. The federal government can play a key role in establishing this balance and some of these roles are discussed by Roy Romanow in the next major document in the ongoing rhetorical/textual evolution of health care in Canada.

The Romanow Report

The *Commission on the Future of Health Care in Canada*, chaired by Roy Romanow, was released in November of 2002. Otherwise known as the *Romanow Commission*, the inquiry was authorized by Governor General Adrienne Clarkson on the advice of then Prime Minister Jean Chretien. Romanow, the primary rhetor of this report was a career lawyer who had substantial political experience. Perhaps most notably, he was heavily involved in the deliberations that resulted in the repatriation of our constitution in 1982 and the concurrent release of the *Charter of Rights and Freedoms*. He was friends with former Prime Minister Pierre Elliot Trudeau and has been lifelong friends with Jean Chretien. Although likely not the high ethos rhetor that Emmett Hall was, Romanow did have a lot of credibility as a prominent political figure coming out of Saskatchewan – the province that instituted the first universal health care system in Canada. He was Premier of Saskatchewan from 1991-2001 for the provincial *New Democratic Party*. While it is acknowledged that the NDP are left of centre on the political spectrum, Romanow, like Douglas, was a more conservative NDP leader than most, demonstrating fiscal conservatism and practicing 'third way' politics. This brand of political leadership had also been practiced by US President Bill Clinton and British Prime Minister Tony Blair. Additionally, the NDP have traditionally been the political party in Canada that most consistently employs rhetoric in defense of Medicare – even when such defense goes against the political grain. And since policy defense and rhetoric are inextricably linked, it is important to analyze the suasory value and import of this document. Unlike the *Hall Commission Reports* which were engaged in the

rhetoric involved in initiating a new system, or the *Canada Health Act,* which concerned itself with solidifying and solemnizing the values upon which Medicare should be based, the *Romanow Commission* focused on creating a framework that would keep health care services sustainable in to the future.

A major theme of the *Romanow Commission* was that a 'wait and see' attitude concerning Medicare would not suffice. The status quo was not acceptable and in order to keep Medicare viable in to the future, decisive action needed to be taken at the pragmatic level. At the same time, the Commission insisted that the core values upon which our system is based needed to be protected, cherished, and maintained. As a means to accomplish sustainability for health care in Canada, Romanow argued for greater federal leadership and funding. In response to the final report, some limited action was taken by the federal government out of the many recommendations that were proffered. The most noteworthy recommendations that were adopted was the simplification of the transfer mechanism for health care from the federal to the provincial governments and a 10 year joint federal/provincial agreement that committed a substantial increase in funding to address some of the deficiencies that Romanow pointed out.

The Rhetoric of The Romanow Commission

The key rhetorical audience appealed to in the *Romanow Commission* was the Canadian people. These appeals represented a shift in argumentation to convincing elite stakeholders of the validity and economic viability of a universal health care system, to implying that the Canadian people – as the crucial recipients of broadened services

constituted a new and distinct stakeholder for medical care. The nature of the stakeholders in this relatively new yet stable system shifted from those who could afford to pay for medical services at prices that were dictated by the market to 'every citizen' contributing what they could in the form of taxes. Unfortunately, the commissioners argued, government and medical practitioners had failed to adjust to this new rhetorical reality. Ironically, it was the patients as the new key stakeholder that were becoming increasingly separate and disengaged from the system they contributed to on a collective basis. This patient/service dichotomy was occurring for several reasons. First, because patients no longer paid for medical care directly at the time of service and the government was not transparent enough with the people on the ways in which it funded the new system on their behalf, a sort of artificial distance had developed between those presenting themselves for needed care and providers. From a rhetorical standpoint, this phenomenon could be said to induce greater mystery between caregivers and those that are cared for. A sense of mystery can increase curiosity or even facilitate a sort of 'wonder' for health care. In Burkean terms these patient perceptions can precipitate a sort of 'cat and mouse' game where medical services are sought after in a naïve way. Second, this Burkean cycle can serve to be demotivating for medical practitioners who are being pursued by patients for services with less of a return for providing such services. Either way, the result can be an increased distantness between patient and provider. The *Romanow Commission* suggests solutions to these dilemmas through making patients more aware of how medical services are delivered and providing medical practitioners with incentives for efficiency and excellence of care. The

Romanow Commission further maintained an orientation towards federalism in respect to health care that was in marked contrast Hall. As a major solution to the rhetorical exigencies identified, the commissioners advocated for greater federal involvement for both the delivery and reinforcement of values of health care. Finally, the *Romanow Commission* depicted rhetoric about Medicare in negative and skeptical ways. While both of the *Hall Commission Reports* of 1964 and 1980 argued for the value of a careful analysis of evidence that was factual or empirical in nature, they did not include any explicit attacks on the validity of dialogue, vigorous argumentation or rhetoric themselves. In fact, Emmett Hall was a very skilled rhetorician and responded directly and at length to arguments made by opponents to national health insurance. In contrast, the *Romanow Commission* portrayed debate and emotional argumentation as destructive, inaccurate and destabilizing for Medicare. At the same time however, the commissioners did not hesitate to employ some of the same techniques of persuasion they castigated in defense of their efforts to sustain Medicare.

This shift in views of rhetoric and debate may have reflected changing cultural realities in Canada that had seemed to de-emphasize and discourage rhetorical advocacy that is deliberative in nature. Instead, Canadian culture was placing a much greater focus on administrative rhetoric that sought to establish a relatively neutral set of individual rights and judicial review in protection of these rights. I will be illuminating these endoxic principles in my analysis, and attempt to make clear the potential limitations of these conventions and the ways in which a de-emphasis and malignant of rhetoric could be problematic for future health care policymaking. At the end of the day,

I will encourage a shift away from the perception that health care is a right, to a greater sense of active ownership in a health care system that is distinctly Canadian and rhetorically (re) constituted on an ongoing basis.

Relationship between a written policy statement and its influence

While there were many themes that played out in *The Commission on the Future of Health Care in Canada*, a core message of the report seemed to focus on transparency and accountability. In fact, these principles were recommended to be added to the *Canada Health Act* in addition to the core values it already espouses. Though on a policy level, the foregoing key recommendation was not carried out by the federal government and the CHA was not altered, it still poses significant rhetorical import since the ideas were geared toward strongly engaging the Canadian people. The Canadian people, the commission maintained, were enthusiastic supporters of the underlying values behind a universal and single-payer system of health care. However, their experiences in accessing the system were not as positive. In particular, the commission referenced wait times – specifically for diagnostic services as a source of frustration for patients:

> There is clear evidence that Canada has under-invested in diagnostic technologies in comparison with other OECD countries and the result is long waiting times for essential diagnostic tests. The new Diagnostic Services Fund should be used not only to purchase equipment but also to train the necessary staff and technicians. Targeting this area as a first priority, provinces and

> territories could free up additional resources to address wait times for other essential services. (*Romanow Commission*, 2002, p. xxix)

But on an even more fundamental level the commission insisted that a major source of frustration for Canadians was the complexity of health care services:

> Indeed, despite our common use of the term 'our health care system,' the relevance of this term is increasingly doubtful. A system where citizens in one part of the country pay out-of-pocket for 'medically necessary' health services 'free' in others, or where the rules of the game as to who can provide care and under what circumstances vary by jurisdiction, can scarcely be called a 'system.' There are many examples of the 'disconnect.' Elderly people who are discharged from hospital and cannot find or afford the home or community services they need. Women – one in five – who are providing care to someone in the home an average of 28 hours per week, half of whom are working, many of whom have children, and almost all of whom are experiencing tremendous strain. Health professionals, who are increasingly stressed, while performing tasks ill-suited to their abilities and training. *Patients, who are forced to navigate a system that is a complex and unfriendly mystery, in order to find the right specialist, the nearest facility, and the best treatment.* (*Romanow Commission,* 2002, p. xix) [Emphasis mine]

A system that is complex can bring on mystery. And as has been referenced before, mystery perpetuates hierarchy which sets in motion the Burkean notion of pure persuasion where the objects of influence are loyal to the 'rhetor' even as access to them

is limited. In addition to the need of Canadians to navigate a sometimes nebulous health care system, when they are injured or ill, there is also a marked lack of knowledge on how health services function – particularly in relation to funding. While there is a general sense that health care is paid for through general tax dollars, even this can be muted because payment is rarely required at the time that services are sought after:

> Accountability must also be improved. Health care in this country is now a $100 billion enterprise, one of our society's largest expenditures. Yet no level of government has done a very good job accounting for how effectively that money is spent. Canadians still do not know who to believe in the debate over which level of government is paying what share for health services. (*Romanow Commission*, 2002, p. xix)

Ultimately, the commissioners present a central argument that resonates directly to Canadians, by reminding them that they are the trustees of the system. Without the Canadian people, not only would the system be unable to be funded, but it would have no reason to exist. Therefore, governments should be held accountable to the Canadian public in the delivery and communication of health services. A major way in which this accountability can be achieved is through greater transparency and clarity in respect to the nature and features of the health care system:

> Canadians are the shareholders of the public health care system. They own it and are the sole reason the health care system exists. Yet despite this, Canadians are often left out in the cold, expected to blindly accept assertion as fact and told to simply trust governments and providers to do the job. They deserve access to the

> facts. Canadians no longer accept being told things are or will get better; they want to see the proof. They have a right to know what is happening with wait lists; what is happening with health care budgets, hospital beds, doctors, and nurses, and whether the gaps in home and community care services are being closed; whether the number of diagnostic machines and tests is adequate; and whether outcomes are improving. (*Romanow Commission,* 2002, p. xix)

These types of appeals, directly to the Canadian people, were a key theme throughout this document.

After establishing the general nature of the problem concerning accountability and transparency, the commissioners advocated for a very focused and practical solution that did not involve an alteration in the CHA. Simply by creating a mechanism by which the 'money flow' could be tracked could serve to increase the transparency on the delivery of health care to Canadians. The tweak that was suggested to accomplish this was a modification of the federal transfer fund that provided provincial governments with added revenue to fund their health care programs. In the months and years leading up to the release of the *Romanow Commission*, the transfer fund that was designated for this assistance incorporated not only health care but other social programs as a source for the cash influx. The overgeneralization of the recipients of federal transfer payments, created over time inefficiencies and an inability to account for or contain the costs of health care. In a mini-literature review of the history of federal assistance to the provinces for health care, the *Romanow Commission* draws attention to an added problem concerning the evolution of these cost sharing formulas. Essentially, since the

early 1980's, federal contributions to health care services have been gutted. These substantial reductions have resulted in the provinces having to apportion a higher and higher percentage of their budget for health care. The transfer scheme that was employed at the time that the *Romanow Commission* was released, not only reflected the earlier cost cutting trends but also lacked clarity since the federal funds could be designated toward a multiplicity of social programs. As the commissioners noted:

> In 1995, the third federal transfer regime was introduced in the form of the Canada Health and Social Transfer (CHST). The CHST has been a contentious program since it was introduced. In addition to health care and post-secondary education that were part of the EPF (established programs financing), social assistance and social services were added to the new omnibus CHST transfer. Like EPF before it, only a portion of the CHST is intended for health care and involves a mix of cash and the tax points. The combination of funding three major social programs through a single block transfer, in addition to the complexities of the cash and tax portions of the arrangements, make estimating the value of the federal contribution to health care extremely obscure to even the most informed. (*Romanow Commission*, 2002, p. 38)

As a result, the commission recommended that one fund for health care be designated by the federal government to the provinces. The foregoing recommendation was one of the few that were acted on by the governing Liberals and a new fund, known as the *Canada Health Transfer (CHT)* was put together.

Another key way that the *Romanow Commission* appealed directly to Canadians was through the recommendation that a *Health Care Covenant* be established between the various level of government and the people. Essentially, the proposed health covenant would be expected to assume a level of importance similar to the *Charter of Rights and Freedoms*. It was suggested that such a document should be signed by all provincial leaders (premiers) and affirmed by the federal government. The commission recommended that the premiers and federal officials meet as soon as possible to develop the agreement. As for the content of such a document, the commission affirmed that it should be acknowledged that a new age had dawned concerning government and service accountability to patients: "People are no longer prepared to simply sit on the sidelines and entrust the health system to governments and providers. They want to be involved, engaged and acknowledged, and well informed as owners, funders, and essential participants in the health care system" (*Romanow Commission*, 2002, p. 49). More specifically this 'patient bill of rights' spelled out a variety of things that Canadians were *entitled* to concerning health care services. Chief among these entitlements was the ability to "make informed decisions regarding their personal care, and to receive all information and medical documentation related to them, while respecting the judgement and expertise of health providers" (*Romanow Commission*, 2002, p. 51). The report also recommended that along with these entitlements for patients that governments should shoulder a significant portion of the responsibility for creating a clear, efficient, and assessable health care system. Governments, the commissioners insisted, "have a responsibility to regularly review the performance and operation of the health care

system and report to the public so that Canadians can make informed decisions and contribute to the system in an informed way" (*Romanow Commission*, 2002, p. 51). Although the federal government did not directly address issues of accountability through regimenting that value into the CHA, it did indirectly address the issue by creating a pragmatic mechanism to facilitate stakeholders being able to 'follow the money trail.'

In short, this document was persuasive because it geared its rhetoric toward the Canadian people as a primary target audience. Essentially, the rhetoric of the commission implied that the Canadian people constituted the missing piece in the puzzle concerning policy deliberations for health care. Overall, our system is commendable, but in the process rank and file citizens have been overlooked by elites. These statements brought to light a cultural reality that has persisted in Canada – specifically in the way that health care services are delivered to Canadians.

Relationship between discourse and culture

The primary way in which the rhetoric of the *Romanow Commission* interacts with culture is through the series of statements, made by the authors that reveal a significant misunderstanding and mischaracterization of rhetoric. Although this misunderstanding and distrust of rhetoric can be inferred through the mechanical listing of principles in the *Canada Health Act*, the *Romanow Commission* makes this anti-rhetoric position explicit. In a nutshell, the report is riddled with statements that reveal this misunderstanding, paranoia and distrust of rhetorical processes. Since it is the job of the rhetorical critic to illuminate underlying presuppositions within a text that a wider

audience may not be aware of or might accept uncritically, the rhetorical phobia that permeates this document is particularly important to note.

In the preamble for the entire document – the section the commission labels 'a message to Canadians' -- numerous statements are made that appear to draw on commonly held perspectives in Canada that rhetoric is a very bad thing. The perspective the commission takes for its view on the relation of rhetoric to health care policy could be construed as a microcosm to wider and deeply ingrained cultural tendencies. This perspective is referenced early and often and is then deepened as the authors of the report elaborate for Canadians their investigative findings. In a general defense of the status quo, the commissioners offer the summary that "*the often overheated rhetoric* about Medicare's costs, effectiveness and viability does not stand up to scrutiny" (*Romanow Commission,* 2002, p. xvi) [Emphasis mine]. A little later on, the commissioners reference the dysfunctional relationship between the provinces and the federal government for health care and argue as follows:

> Sometimes by design, sometimes by financial necessity, and more often by default, provinces are increasingly willing to go it alone insofar as their respective health care 'systems' are concerned. Today, we sit on the cusp. Left unchecked, this situation will inevitably produce 13 clearly separate health care systems, each with differing methods of payment, delivery and outcomes, coupled by an ever increasing *volatile and debilitating debate* surrounding our nation, its values and principles. (*Romanow Commission*, 2002, p. xviii) [Emphasis mine]

Nearing the conclusion of the commission's message to Canadians, it is acknowledged that the prevention doctrine for health care as espoused by Justice Hall in his 1964 and 1980 report is correct but that such a perspective needs to be backed up by money and action:

> Keeping people well, rather than treating them when they are sick, is common sense. And so it is equally common sense for our health care system to place a greater emphasis on preventing disease and promoting healthy lifestyles. This is the best way to sustain our health care system over the longer term… *But we need more than rhetoric; we need action.* I am therefore recommending a greater emphasis on prevention and wellness as part of an overall strategy to improve the delivery of primary care in Canada, the allocation of new moneys for research into the determinants of health, and that governments take the next steps for making Canadians the world's healthiest people. (*Romanow Commission*, 2002, p. xx) [Emphasis mine]

As can be seen in the initial statements of the report, the commissioners portray rhetoric and debate as damaging, destabilizing and destructive. Rhetoric in particular is portrayed as being emotionally laden and volatile. And this is just the beginning. As the report progresses, the commissioners essentially deliver the same message grounded in endoxa over and again using a variety of negative adjectives and other pejorative phrases.

One of the key problems identified in the commission was a combination of a lack of federal leadership and a lack of stable federal funding concerning health care.

Emanating out of these issues was the inevitable conflict and squabbling between the provinces and Ottawa. Rather than seeing this clash between the different levels of government as an opportunity to resolve evolving matters in health policy, the commissioners portrayed the conflict situation as not only worsening problems but literally as *the* fundamental problem that could damage the system in a significant way: "In the last decade or more, defining that balance in terms of funding has been the subject of considerable acrimony and debate. Provinces accuse the federal government of no longer shouldering its traditional share of the rising costs of health care while the federal government counters by saying provinces have chosen to finance tax cuts over health care" (*Romanow Commission*, 2002, p. 36). What seems to be missing from this argumentation is the possibility that such conflict could provide an important impetus to engage in needed debate and discussion and that through this process, significant good could arise. Instead, the commission characterizes these types of conflict situations as 'nation damaging' as versus a normal function of democratic policy making and reform. Of course it is easy for the commissioners to take such a position since a suspicion and distrust of rhetoric is a discreet cultural phenomenon in Canada. The commissioners then go on to justify and defend a pragmatic and bureaucratic solution for health care reform by arguing for a semi fixed commitment for a federal cash influx that takes into account GDP growth and corresponding increases in spending for health services. Why? Because making firm structural changes will pre-empt and avoid functional rhetorical processes from unfolding:

> Under the CHST, there is no mechanism for providing for natural increases in health care spending in the calculation of federal transfers. Increases in CHST transfers are at the discretion of the federal government. Since its inception there have been two increases, one in 1999 and another in September 2000. The absence of an escalator formula for increases in federal contributions to provincial and territorial health expenditures means that there is no link between the growth in either health expenditures or the growth in the economy. *This results in provinces making regular demands for increases in the transfer and has contributed to the highly politicized and acrimonious nature of debate over health care funding in recent years.* (*Romanow Commission*, 2002, p. 39) [Emphasis mine]

Granted, it did turn out that the recommendation that a new and more focused transfer fund be established was adopted. In fact, it was one of the few recommendations that was acted upon. However, both the argumentation from the Commission and the decision to implement this particular recommendation from the government, reveals a preference for formulating mechanisms and structure that limit debate. I would suggest that these types of mechanisms, while pragmatic and efficient, produce public policy implementation that is rigid, inflexible, and bland.

In addition to depicting rhetorical processes as destructive and as getting in the way of tangible action being taken to address emerging problems in the health care system, the commission even goes so far as to suggest that rhetoric 'obscures the truth of the matter' for this issue. The following lengthy summary on provincial/federal

relations concerning health care services reveals a lot on the Commission's perspective on rhetoric:

> In their recent sparring over health transfers, Ottawa and the provinces have tried to put the best possible spins on their respective versions of this history. For its part, Ottawa has downplayed the fact that its contribution to provincial health expenditures has been declining as a share of those costs for the past two decades. Just as importantly, the federal government has successfully moved the risk of growing health expenditures to the provinces through its occasional reductions in the cash portion of the transfer and the elimination of an escalator when the CHST was introduced as described in Chapter 1. For their part, the provinces have conveniently eliminated the tax transfer from their calculations or the federal contribution despite the fact that they welcomed the original tax points transfer in 1977, assuming as they did at the time that its value would eventually grow faster than the cash contribution. In addition, they have continued the rhetoric that the original 50:50 cost-share bargain was for all provincial health expenditures even though it was only intended to cover the narrower band of Medicare services. *All of these arguments divert us from focusing on the most elemental aspects of the Canadian system. They obscure the critical role that the federal government has played in the past through health transfers in getting Medicare off the ground on a national basis and in protecting it when the system was threatened by user fees and extra-billing. They prevent us from seeing the central and innovative role the provinces have*

> *always played in the administration and delivery of health services, including establishing the first workable Medicare model.* (*Romanow Commission,* 2002, pp. 66-67) [Emphasis mine]

The foregoing makes distinctions between 'rhetorical history' and 'actual history.' Rhetorical history is the 'spin' from both sides of a debate that the Commission maintains has been prominent for health care. Actual history is a careful referral to fact or 'the record.' Actual facts are different than a rhetorical spin on facts. Rhetoric, implies the commissioners, is all about technical strategy. Rhetoric involves arguments being presented by both sides for the purpose of holding a position even if this means that information is conveyed inaccurately and things are taken out of context. In short, rhetoric obscures the truth of the matter in respect to the history of health care policymaking in Canada. In so doing, it draws attention away from facts or a view of history that, if built upon, would move the country forward by protecting and strengthening Medicare. Unfortunately, the commission's perspective fails to acknowledge that many other arguments or 'rhetoric' could be advanced by both the provinces and the federal government that might be efficacious for health care reform. This failure is a result of a misunderstanding and mischaracterization of rhetoric.

In light of the foregoing analysis it makes sense to briefly examine, from a scholarly perspective, what is the relationship between rhetoric and policymaking. Further, what is the relationship between rhetoric and truth or 'fact?' What is missing from the Commission's characterization of rhetoric and rhetorical processes? How might good health care policymaking be eroded or diminished from an absence of

rhetoric? First, a de-emphasis on rhetoric limits the abilities of the multiple stakeholders to present competing positions with *conviction*. As Scult notes, sound rhetorical processes have the ability to lead humans closer to the truth even in cases where complex situations and matters are being deliberated and multiple courses of action are possible: "The rhetor must be able to aim at truth, knowing he will never reach it. At the same time, the rhetor must be able to invest his discourse with conviction, or rhetoric becomes reduced to sophistry" (Scult, 1976, p. 177). Second, a de-emphasis on rhetoric ironically has deleterious epistemological considerations. As Scott argues, rhetoric can actually serve the function of knowledge building. This perspective obviously clashes with the position implied in the *Romanow Commission* that an accurate portrayal of a policy situation is diminished by rhetoric. Instead in Scott's scheme 'truth' and 'rhetoric' work hand and hand is such a way as to help humans to function in the face of contingency:

> At best (or least) truth must be seen as dual: the demands of the precepts one adheres to and the demands of the circumstances in which one must act… Man must consider truth not as something fixed and final but as something to be created moment by moment in the circumstances in which he finds himself and with which he must cope… In human affairs, then, rhetoric, perceived in the frame herein discussed, is a way of knowing; it is epistemic. (Scott, 1998, p. 138)

It is not enough simply to accurately convey information that has a bearing on a particular situation. It is also important to 'weigh' this information against one's convictions and principles or some kind of external standard. Through engaging a set of

circumstances with one's best arguments that are grounded in some semblance of truth, fresh knowledge of that situation is created and deepened. Third, and as has been referenced, a key solution that the commission devised for the rhetorical situation of health care at that time was simply to create a mechanism by which the 'money trail' could be followed. The Canadian people did not need 'rhetoric' but a system of funding that was more transparent and predictable than had been the case up to that point. In other words, the Canadian people deserved real and tangible action to be taken. It can hardly be argued that the infusion of money into the system does not constitute real and tangible action. However, it must also be insisted that money is not the only mode in which decisive action could occur. As Bitzer insists, rhetoric can also provide a mechanism in which real and decisive action or change can be enacted:

> A work of rhetoric is pragmatic; it comes into existence for the sake of something beyond itself; it functions ultimately to produce action or change in the world; it performs some task. In short, rhetoric is a mode of altering reality, not by the direct application of energy to objects, but by the creation of discourse which changes reality through the mediation of thought and action. The rhetor alters reality by bringing into existence a discourse of such a character that the audience, in thought and action, is so engaged that it becomes mediator of change. In this sense rhetoric is always persuasive. (1968, pp. 3-4)

As has previously been alluded to, the commission portrayed rhetoric as obfuscating or obscuring the 'truth of the matter' in relation to cost sharing formulas for health care between the federal government and the provinces. Rhetoric, the commissioners

maintained, has also acted to obscure the 'essence' of the situation in terms of the unique contributions both the provinces and the federal government have made to the Canadian health care system. Donald Bryant depicts a different orientation toward rhetoric. In contrast, he conceptualizes rhetoric as energizing truth: "That is, rhetoric could be the art of prose when prose was predominately concerned with the intentional, directional energizing of truth, of finding in any given situation all the available means of persuasion, and of using as many of them as good sense dictated" (Bryant, 1953, p. 403). In fact, in a lengthy exposition a little further in to the essay, Bryant goes so far as to say that rhetorical processes play an indispensable role in the resolution of complex problems and that in the face of the uncertainty and limitations of understanding that can arise when human beings confront such issues, these processes provide the best hope that we have for providing a measure of light to guide our ways. This conceptualization of rhetoric would seem to be so useful in the social policymaking for the complexities of health care services that it is worth quoting at length here:

> Rhetoric exists because a world of certainty is not the world of human affairs. It exists because the world of human affairs is a world where there must be an alternative to certain knowledge on the one hand and pure chance or whimsy on the other. *The alternative is informed opinion, the nearest approach to knowledge which the circumstances of decision in any given case will permit. The art, or science, or method whose realm this is, is rhetoric. Rhetoric, therefore, is the method, the strategy, the organon of the principles for deciding best the undecidable questions, for arriving at solutions of the unsolvable*

> *problems, for instituting method in those vital phases of human activity where no method is inherent in the total subject-matter of decision*. The resolving of such problems is the province of the 'Good man skilled in speaking.' It always has been, and it is still. Of that there can be little question. And the comprehensive rationale of the functioning of that good man so far as he is skilled in speaking, so far as he is a wielder of public opinion, is rhetoric. (Bryant, 1953, p. 407) [Emphasis mine]

In contrast to the perspective presented in the *Romanow Report*, rhetoric is here portrayed as a tool that illuminates rather than obscures. In short, the foregoing position implies that it would be foolhardy not to infuse rhetoric into the complexities and omnipotent exigencies that emanate from maintaining a government scheme for the management of disease and illness.

Finally, in several placed in the report, debate and argumentation surrounding health care was depicted as acrimonious, polarizing and destructive. Argumentation between the provinces and the federal government was portrayed as 'squabbling' with the result being destabilizing for Medicare and for the nation. In contrast, and again turning to Bryant, rhetorical processes are presented as but useful and constructive for human industry and action: "Rhetoric aims at what is *worth* doing, what is *worth* trying. It is concerned with *values*, and values are established with the aid of imaginative realization, not through rational determination alone; and they gain their force through emotional animation" (1953, p. 415) [Emphasis in original text]. The foregoing is somewhat ironic in light of the Commission's focus on reform and the role of federal

leadership for (re) establishing the values that should underlie Medicare in moving forward. In short, the *Romanow Commission* presented rhetoric in classic 'Plato v. Sophists' terms. Inferred in the characterization of the role that rhetoric was seen to be played for health care policymaking was the idea that anything that threatened Medicare was sophistic. However, as has been referred to earlier, the commissioners did not hesitate to present 'rhetoric' of their own in support of Medicare and overall Canadian values. As Bryant notes, these types of paradoxes are not uncommon in light of the difficulties involved in defining rhetoric's function and scope. As Bryant noted, the common use of rhetoric has come to mean "empty language, or language used to deceive, without honest intention behind it. Without question this use is in harmony with the current climate of meaning where what our opponents say is rhetoric, and what we say is something else" (1953, p. 403).

Obviously, the aforementioned clearly contests both the implication and direct statements made throughout the *Romanow Commission* that rhetoric is a destructive form of 'non-action' that obscures truth and gets in the way of practical problem solving. Rhetoric has the capacity to lead to pragmatic action through its ability to engage an audience. The audience, through being moved by the presentation of ideas or the 'message' then acts directly in a situation which in turn results in reality being altered or changed. Yes, the Canadian people deserve action. But this action does not have to be in a rigid and bureaucratic form. In the concluding chapter, I will be suggesting a framework that could be used in Canada to encourage rhetorical processes in a way that is consistent with Canadian identity and values. After all, as Conrad and Cudahy note,

"making well-reasoned, data-based policy decisions even during highly charged historical and political moments is 'the Canadian way'" (2012, p. 561).

Implications

In summary, the Commission repeatedly held that clash, conflict, and rhetoric are negative elements that should be avoided for health care policymaking. Ironically, however, the Commission did not hesitate to employ the same or similar brand of 'rhetoric' in efforts to connect with Canadian identity. It seems that the Commission employed a double standard with their reasoning – discouraging anything perceived to threaten the status quo by labelling it as 'bad' rhetoric while at the same time employing commonly heard and understood 'platitudes' as a way of reinforcing Canadian superiority. For instance, in his initial message to Canadians, Romanow argues as follows:

> Canada's journey to nationhood has been a gradual, evolutionary process, a triumph of compassion, collaboration and accommodation, and the result of many steps, both simple and bold. This year we celebrate the 40th anniversary of Medicare in Saskatchewan, a courageous initiative by visionary men and women that changed us as a nation and cemented our role as *one of the world's compassionate societies.* (*Romanow Commission*, 2002, p. xxi) [Emphasis Mine]

A little later on in the report, in an overall assessment of health care services at that time, the commissioners state that, "based on the *United Nations Human Development Index* of income per capita, literacy, and life expectancy, Canada scores very high. For a number of years, Canada was ranked number one in the world and, although it is

currently in third position behind Norway and Sweden, the system is clearly doing well" (*Romanow Commission,* 2002, p. 10). Later on, the Commission actually sets up an admonition against acrimonious debate that is perceived to be threatening to the system, while at the same time encouraging a vision for the future that affirms our supremacy for health:

> The time has come for governments to focus on a collective vision for the future, rather than the jurisdictional or funding issues that have been the focus of intergovernmental debate for much of the past decade. This collective vision must focus on achieving effective reform and modernizing the system. It must reflect the priorities of Canadians. *Ultimately, the collective objective of current and future Canadian governments should be to establish and maintain Canada as the country with the healthiest population in the world.* (*Romanow Commission*, 2002, p. 53) [Emphasis mine]

It is not that such argumentation is improper but that a more consistent perspective on the nature and function of rhetoric be attained which tolerates arguments being presented on both sides of important issues.

Reducing human nature, behavior and health and well-being to a numbers game can result in systems that are somewhat drab and solutions that are somewhat boring. As has been mentioned over and again, Canadians need to understand clearly why the values that underlie health care services are compelling. Canadians need to take ownership in their system that goes beyond distinguishing it as 'not American. As Hall notes, the issues surrounding health care are humanistic and spiritual in nature and as

such these issues are conducive for rhetorical engagement. Canadians could benefit from knowing that the federal government is doing more to enhance the health care system than altering transfer formulas and increasing the money flow.

The *Romanow Commission* has become known for presenting a range of recommendations for health care reform to the federal government. Very few of these recommendations were acted upon. The continued inaction combined with substantial cuts of funding and a reluctance of the federal government to enforce the CHA eventually created a situation in Canada where Medicare became more open to individual attacks from stakeholders most affected by this inaction. In most democratic societies, when people strongly disagree with legislative action or inaction and governments fail to redress such grievances, the only recourse left open to such individuals is a court challenge.

The Health of Canadians – The Federal Role

The Kirby Report was generated by a committee chaired by Liberal Senator Michael Kirby and co-chaired by Conservative Senator Marjory LeBreton. Like the *Romanow Commission,* it was conducted over a period of approximately two years and released in the fall of 2002. In general, the *Kirby Report* was seen as a competitive alternative to the *Romanow Commission* because it considered increasing the privatization of healthcare delivery, with the possible result of creating a 'two-tier' health care system in which wealthy citizens received different levels of care than poorer ones. Some critics attributed this difference to the fact that Kirby had served on the boards of some organizations that either advocated or provided private health care in

Canada. In this sense, it served as a precursor to the issues that would be considered three years later in the Canadian Supreme Court's Chaoulli decision which will be assessed in the next chapter.

The report dealt with several common perceptions held by Canadians in respect to health care. First, because insured services covered under the *Canada Health Act* are funded through tax dollars, patients are not required to 'pay' for the services of a doctor or hospital *at the time of service.* As has been suggested earlier, this can induce peace of mind that health care services will be there when a citizen needs them. Further, it can create a sort of artificial distance between physician and patient both in respect to services rendered and also in the economic aspects involved with the delivery of these services. In short, health care is perceived to be free in Canada: "The Committee is aware that no system providing services that are perceived to be 'free' can ever fully meet the demands placed on it, and that at present we are unable to discriminate between the demand and the genuine need for timely access to health services of all kinds" (*The Kirby Report*, 2002, p. 9). Second, the Committee addressed the question as to whether health care is a right under the Charter. To this question, the authors insist that even though Canadians, again, perceive health care to be a right that this perception if not constitutionally or legally sound:

> In Volume Four, the Committee noted the existence of public opinion polls that reveal that Canadians, encouraged by politicians and the media, believe they have a constitutional right to receive health care even though no such right is explicitly contained in the Charter. Nor does any other Canadian law specifically

> confer that right, although government programs exist to provide publicly funded health services. (*The Kirby Report*, 2002, p. 100)

Finally, and most importantly to the major issue that is dealt with in this report, the authors establish that whether or not Canadian life and health is being threatened by waiting for health services, Canadians perceive that accessibility is a problem:

> Repeated public opinion polls increasingly have shown that the greatest concern Canadians have about the existing publicly funded health care system is the perceived length of waiting times for diagnostic services, hospital care and access to specialists. This concern is evidence that timely access to health care – as that is defined by patients – is often not available. (*The Kirby Report*, 2002, p. 99)

Since this is true, the committee asserts, there are important implications that this reality has for the future of health care in Canada. Specifically, the authors explore whether this perceived lack of timely health care, coupled with existing legislation that is geared toward protecting the public system, might indirectly trigger the charter rights of Canadians. In fact, they even question the fairness of a governmental system that fails to provide timely care and at the same time does not provide for alternatives for Canadians to receive the care that they think they need from other providers. As alluded to, neither the *Charter of Rights and Freedoms* nor the *Canada Health Act* conceptualized health care as a right. However, the Charter can still be triggered when scenarios surface that impinge upon Canadians' ability to access health care due to government actions such as rationing public services and prohibiting citizens' capacity to look for the missing care

elsewhere. In a nutshell, the Charter is admonitory in the sense that it seeks to protect Canadians *in advance* from governmental encroachment on freedom and security:

> In 1994, the Canadian Bar Association Task Force on Health Care expressed the opinion that there is no right to health care under the Charter. This conclusion was based on the view that the Charter is often interpreted as a negative rather than a positive instrument – one that generally does not compel governments to act in a particular manner, but rather protects Canadians against coercive government action. (*The Kirby Report*, 2002, p. 103)

Of course the foregoing alludes to the crux of my argument in chapter 2 where I conceptualize the *Canadian Constitution Acts* as predominately admonitory in nature. I go on to suggest that this Burkean derived criteria could facilitate for a later cultural bias that privileges citizens seeking judicial review of laws that are seen to be a violation of their rights while avoiding more direct and flexible legislative activism.

The Kirby report and informal argumentation

The committee goes on to provide in depth analysis on what they see as an indirect relationship between individual rights as outlined in the Charter and the softer right of health care that seems to have developed over time out of popular convention. To do this, they use principles of informal argumentation to establish a series of warranted claims.

The first argument states that the Charter provides for the right of all Canadian to health care. However, as has previously been indicated, simply making this argument as it is articulated above would not be sufficient. In fact it would likely fall on the basis

that the Charter doesn't indicate that Canadians have an explicit legal or constitutional right to care. However, this right can be inferred from the Charter if certain conditions apply. What the authors of the *Kirby Report* argued is that the Charter does point to a right for health care *assuming that there are laws in place that impede Canadians ability to pay for more timely services that the public system is failing to provide.* The foregoing argument implies that inaccessibility to needed health care will threaten Charter rights. But what about those citizens that can't afford to pay for other alternatives to health care? Obviously, any law prohibiting citizens from seeking care outside of the public system would not apply to the poor. But yet they would still have access to health care within Medicare. So it would seem that for the poor, Charter rights would not be triggered because they are not being restricted by government and have some level of access to health care. So if the argument would not work for the poor, then to be fair, the argument should not work for those who can afford to pay for private medical services. In other words, the claim can be refuted on the grounds that a prohibition against purchasing private care could be construed as being in the interests of fundamental justice. Hence, the condition of 'fundamental justice' could also be included as a rebuttal for the link between the Charter and health care.

The second informal argument that can be extrapolated from the *Kirby Report* is the idea that the state assumes obligations to provide for adequate and timely health care when government imposes a monopoly system on its citizens through restricting alternative modes of services. If the state did not impose a sort of monopoly on Canadians, then the obligation to provide more adequate and/or timely care would be

less pronounced. However the mere existence of a single tier system is not enough to make the above argument clear. To clarify the argument, it could be useful to state that citizens living in a country that has a universal and single payer system of health care will suffer and die if services within that system are not timely and of quality. But even when the foregoing situation exists, there is a common sense understanding that health services must be funded. In other words, there must be enough money within any single payer and universal system to furnish health care that is timely and of high quality to its citizens. The authors of the *Kirby Report* presented the rhetorical situation as one in which the government really only had two options. The first option would involve heavier taxation to fund health care services that Canadians may or may not agree to. Failing increased revenue from taxation, the government would then be obligated to allow for alternative ways in which Canadians could receive health care on a timelier basis. In short, the commissioners imply that 'yes' government assumes a level of responsibility to Canadians if it sets up a scheme for health care, fails to provide timely access and restricts the purchase of private services *unless the state does not have the resources to improve upon accessibility.*

The authors of the *Kirby Report* make clear their preference that additional funds be infused into Canada's single payer system in order to address perceived wait time issues. This in turn would minimize the risk of legal challenges to Medicare that might 'force' governments to allow for a parallel private system to improve upon accessibility. This being said, the report distinguishes itself from the *Romanow Commission* through 1) establishing the uniqueness of the Canadian system in comparison to most other

OECD countries and 2) exploring other creative approaches employed by a range of European countries and make clear how these differing schemes influence issues such as accessibility and the freedom of both patients and medical professionals.

As should be clear at this point, the *Kirby Report* focused on the principle of accessibility that is outline in the *Canada Health Act*. The authors argue that there does appear to be a problem with wait times in the public system and that governments have basically responded to this exigence through a combination of inaction and a defense of the status quo. This defense of the system approach has even gone as far as failing to provide timely care for life and death situations and then refusing to ameliorate the situation through furnishing patients with creative alternatives. The Committee members provide one such example of this through recounting the circumstances faced by a patient in Quebec who had been diagnosed with a terminal condition:

> Although not argued on Charter grounds, another Quebec case (Stein v. Quebec) took a different approach by holding the provincial government responsible for reimbursing a patient's medical expenses incurred in the United States for treatment for a life-threatening condition when timely access to the required care was not available in Quebec. In the Stein case, the patient was advised to seek surgery for life-threatening cancer no later than four to eight weeks after the diagnosis. After waiting longer than the suggested period for the required treatment, Stein sought medical care in New York. Subsequently, Stein contested the Quebec health care insurance board's refusal to reimburse his medical expenses. The court sided with Stein, noting that in his circumstances,

> where the danger to his life was increasing daily, it was unreasonable for him to have to wait for surgery in Montreal. In this case, it is worth noting the emphasis the court placed on timely access to care. (*The Kirby Report*, 2002, p. 107)

While in this case, the Province of Quebec was forced by the courts to pay for timely care outside of the country, this phenomenon is not unheard of in other provinces. For instance, residents of Ontario can currently apply for Out of Country Service (OOC) if a patient has the support of their specialist to receive an accepted or comparable service in the United States. The application process is outlined in the *Ministry of Health and Long Term Care* for Ontario and allows OOC for certain procedures not available in Canada but medically acceptable and necessary and also in cases where delay of care could result in death or medically significant irreversible tissue damage (www.health.gov.on.ca/english/providers/program/ohip/outofcountry). Generally in these cases, provincial health plans have agreements with 'preferred providers' in the US that Canadian patients are authorized to go to for care *should they receive prior approval from the government.* Still, this appears to represent an improvement over the situation in Quebec that was previously discussed.

Piggy-backing off of this perspective that provincial governments in Canada generally legislate in such a way as to protect Medicare, the authors of the *Kirby Report* provide a significant amount of detail as to how these protections can affect both the freedom of patients and physicians. The below table summarizes the range of restrictions that were placed on patients and doctors at the time of the report.

Table 1 Summary of protective measures for Medicare in Canada

Province	***Restrictions/privileges Placed on Patients***	***Restrictions Placed on Doctors***
All Provinces	People who purchase private health insurance do so out of after-tax income and must continue to pay the same rate of general income tax	
Alberta, BC, Manitoba, Ontario, and PEI	Prohibit insuring services covered under public health care plans	Can only provide private care for services not covered under the public plan (e.g. elective plastic surgery)
New Brunswick, Newfoundland, Nova Scotia, Saskatchewan	Private health insurance for services covered in the public plan is permitted, but few purchase because of the limitations placed on doctors in these provinces.	Physicians prohibited from practicing both in the publicly funded system and privately.
Additional Issues Unique to Nova Scotia		Opted out doctors cannot bill privately in excess of the fee specified on the public insurance fee schedule.
Additional Issues Unique to Newfoundland	Patients of opted-out doctors are entitled to public coverage up to the amount set by the fee schedule to defray private costs. But few doctors elect to opt out in Newfoundland	
Additional Issues for New Brunswick and Saskatchewan	Patients of opted out doctors cannot be subsidized by the public plan as they would be in Newfoundland.	

What the above information indicates is that there are a significant amount of restrictions that governments place on both patients and medical practitioners for the sake of protecting the current health care system. The authors of the *Kirby Report* draw a number of conclusions from this data – the first being that Canada is really a 'lone wolf' for the extent that measures are put in to place to discourage parallel private engagement with the public system. The orientation that provincial governments have taken toward privatization of health care has meant that "it is simply not economically feasible for patients, physicians or health care institutions to participate in a private parallel system" (*The Kirby Report*, 2002, p. 102). Therefore, it is not so much that the Canadian health care system is 'not American.' In reality, it is distinct from both U.S. *and* European health care systems: "Canada is the only major industrialized country which does not have some element of a parallel private hospital and doctor system" (*The Kirby Report*, 2002, p. 302).

Moreover, the authors of the report cast some doubt on the commonly understood perception that Canada has an exclusively 'single tier' system. And linked to this observation, the situation the authors of the report depicted at that time, seems to call in to question the extent in which doctors motives are as altruistic as Canadians might expect. The authors point out that for health care, as is the case for many other things, 'rank hath its privilege.' Those who have connections and power do at times have preferential access to high quality health care: "There is also strong anecdotal evidence to suggest that the situation in Canada is similar to that in Australia, where, in the words of one of the Australian witnesses who testified before the Committee; 'access

to public (health) services is usually more easily obtained by wealthier and more powerful individuals who understand how the system works and have appropriate contacts in hospital service delivery and administration" (*The Kirby Report*, 2002, p. 302). This even more so when increased mystery is infused into the system because of the separation placed between patients and the system due to the reality that payment is not made at the point of service.

As mentioned, physicians were referenced in addition to government as being a needed instrument in the overall effort to improve wait times and to increase accessibility. As well, there are ways in which physicians can and 'top up' on their income despite the built in discouragements for this which are inherent in most provincial systems. The authors of the Committee Report refer to *Worker's Compensation Boards* as one example but there are others:

> Provincial Worker's Compensation Boards in most provinces receive preferred access to treatment for their clients on the argument that they need to ensure the client goes back to work quickly (which, of course, saves the Worker's Compensation Board money). In some provinces, the Boards have contracts with hospitals for a specified number of beds and diagnostic procedures, ensuring quick access to services for WCB patients. *They also make direct payments to physicians for services performed and these payments do not count toward any cap on a physician's income which may exist in the province.* (*The Kirby Report*, 2002, p. 302) [Emphasis Mine]

Other examples of the ways in which doctors can enhance their income or 'double dip' would include work for or within either the prison systems or the Canadian Armed Forces due to the fact that payment would be received from the federal government and is outside of the boundaries of Medicare. Some doctors are also hired by wealthy citizens in Canada to provide personalized care whereby they are remunerated with cash.

Implications

The foregoing perspective and analysis suggest several implications concerning the importance and legal ramifications of accessibility for Medicare and also the feasibility for allowing for more privatization for health care in Canada. The *Kirby Report* was distinct from the *Romanow Commission* in that it provided a fairly comprehensive accounting for approaches to privatization among European countries. After outlining the complexity that can be associated with allowing for parallel private medical services within publically administered and universal plans, the authors of the report conclude that none of the examples of a public/private mix among European countries should be incorporated into the Canadian system: "On the basis of the evidence available from other countries, the Committee has concluded that no country in which a parallel private health insurance and delivery system coexists with a public health care insurance scheme can serve as a model that should be adopted, without change, by Canada" (*The Kirby Report*, 2002, pp. 301-302). Despite this, the Committee was firm in declaring that in order for Medicare to be sustainable in the future, the Canadian people and government need to make a choice between two options, a significant infusion of federal dollars from revenue generated from higher

taxes, or exploring options in which the accessibility issue could be addressed in the private sphere. The authors were also firm in their perspective that the status quo is not an option and that continued inaction by governments will lead to increasing legal challenges made by private citizens against Medicare. In other words, it may be true that the either/or dichotomy set up by the *Kirby Report* for health care reform was a false one.

Second, it must be emphasized that it was the clear position of the committee that Canada is truly a lone wolf in terms of the nature of the health care system that it has developed. I see this as very positive in the sense that Medicare does not have to be conceptualized and defined as primarily 'not American.' If Canadians could be made more aware of the nuances and uniqueness of Medicare through more aggressive rhetoric, then we could take more ownership for a 'made in Canada' health care system. Either way, this report was valuable because it explored in depth the relationship between the *Charter of Rights and Freedoms* and health care in respect to one important principle of the *CHA* – accessibility. Accordingly, the authors sketched out the parameters of this relationship through utilizing principles of informal argumentation. In so doing they addressed the perceptual view of many Canadians that health care is a right. The *Canadian Supreme Court* went into much more in depth analysis of the legal issues associated with waiting for care from both a health standpoint and from the perspective of individual rights. Perhaps most importantly, the Supreme Court ironed out some details associated with the jurisdiction that courts should have in complex social policy issues and legislation emanating out of the provision of a government

scheme for health care services. Some of these additional issues and arguments will be explored in depth in the next chapter.

CHAPTER VII

JUDICIAL RHETORIC AND SOCIAL CHANGE

If the long-term impact of the court's rulings last week remains unclear, the effect on the quality of the public discourse should be instantaneous. The judges took hold of a debate that has been mired in stale sloganeering and yanked it into the real world (Geddes 18).

In June of 2005, the *Canadian Supreme Court* handed down a complex decision that declared the province of Quebec's prohibition of the purchase of private health insurance to be unconstitutional. The Court heard arguments in June of 2004 so took an unusually long time to deliberate among themselves before reaching their decision. In a 4/3 vote, the Court ruled that Quebec's ban on the purchase of private health insurance violated the provincial *Charter of Rights and Freedoms*. The court deadlocked on whether this ban also violated the *Canadian Charter of Rights and Freedoms* with a 3/3 vote with one justice abstaining.[2] Therefore three separate opinions were written that reflected the two perspectives on the Charter and of course the dissenting opinion. In response, the Attorney General of Quebec requested an 18 month stay on the decision. The Court granted 12 months.

Throughout the Court's reasoning the extent that the judiciary should 'defer' to elected politicians was grappled with. Hence, many jurisdictional concerns and arguments were presented. The initial petition to the Court was spearheaded by a Quebec doctor, Jacques Chaoulli and his patient, George Zeliolitis. Zeliolitis had waited

[2] For appeals brought before the Canadian Supreme Court, not all 9 appointed Justices are required to be present. A minimum of 5 Justices must be on hand but most often for these types of cases and decisions 7 to 9 justices are available. When oral arguments were given on June 8, 2004 before the Court, only 7 of the 9 justices are listed as present.

a year for hip replacement surgery in 1997. As a result of this, he became a patient advocate for timely medical services to be delivered in Quebec hospitals. Chaoulli is an 'outside the box' physician who was known for making house calls in the province and applied for a medical license to practice at a privately run hospital. His application was rejected due to the provincial legislation ban on private health insurance. The key issue in the case was the wait time issue. The majority determined that when the State formulates a 'scheme' that creates a *monopoly* on a crucial service, it is then obligated to provide these services to its citizens within a 'reasonable' time frame. The Court asserted that wait times were actually implicit 'rationing' of medical services by the State. Ultimately the Court argued that when timely medical services are not provided and patients are not able to look outside of the State imposed scheme for these services, both provincial charter and federal charter rights are then 'triggered.' The federal rights in question were *life* and *security of the person*. The Quebec rights were slightly different including *life* and *personal inviolability*. The distinction between the federal and provincial rights became important in the decision because one of the four Justices that comprised the majority position of the Court found that *only* the provincial charter rights had been violated by Quebec's legislation that prohibited the purchase of private health coverage for services already insured through the public system. The other three Justices of the majority held that *both* Canadian charter rights and provincial charter rights had been violated. As a result, the majority decision only effected the Province of Quebec and not the rest of Canada. The *Attorney General of Quebec* argued that the Charter violations were justified *in the interests of fundamental justice* – another Charter

right. The majority of the Court essentially ruled that individual rights trumped the rights of the collective in this case due to the fact that waiting for medical services had the capacity to exact both physical and psychological suffering on these patients.

In the aftermath of this decision there was much media speculation concerning the potential for the ruling to result in the dismantling of Quebec's Medicare system. Not surprisingly, the *Canadian Medical Association* supported both the Majority decision and the perspectives developed in that opinion. In short, the Court blamed the government for neglect and inaction for the wait time issue. In so doing, they strongly implied that 'staying the same' was not an option, a central argument in the *Romanow and Kirby Reports*. Though the ruling generated much media attention it has had little tangible effect on Canada's single-payer, universal, prepaid system of healthcare. Nonetheless, the ruling lays claim to significant rhetorical importance since judicial rulings concerning socio-political issues are becoming increasingly common in Canada. When the legislatures shun rhetoric and replace it with administrative bureaucracy, a window for judicial review is created. And since both culturally and politically, Canada tends to privilege the rule of law over public advocacy this window for judicial style rhetoric will likely not close any time soon. The greatest effect of this ruling was that it has created an added space for argumentation concerning this issue in Canada. As Geddes argued in his *MacLean's* Op-Ed, shortly after the ruling was released, "by refusing to view the issue the way it is so often cast—as a stark choice between Canada's public, love-thy-neighbour philosophy and the U.S.'s private, dog-eat-dog

alternative – the judges made a bid to fundamentally alter the terms of the debate" (2005, p. 20).

Relationship between discourse and culture

As has been referenced, the prime rhetorical exigence that the Court grappled with in their decision was the issue of wait times. The Justices spent some time painting a picture of the severity of the problem and how the problem has a deleterious effect on medical care. In short, they portrayed the problem of wait times as significant and commonly understood. As one of the Justices frankly noted, "some patients die as a result of long waits for treatment in the public system when they could have gained prompt access to care in the private sector" (*Chaoulli v. Quebec*, 2005, p. 818).[3] They then go on to spell out in some detail the nature of the effect that waiting for services has on medical care. First, in regards to cardiovascular conditions, a heart surgeon is quoted as saying how serious waiting for a needed a procedure can be in terms of survivability:

> Delays in the public system are widespread, and have serious, sometimes grave, consequences. There was no dispute that there is a waiting list for cardiovascular surgery for life-threatening problems. Dr. Daniel Doyle, a cardiovascular surgeon who teaches and practices in Quebec City, testified that a person with coronary disease is 'sitting on a bomb' and can die at any moment. He confirmed, without challenge that patients die while on waiting lists. Inevitably,

[3] The dissenting position argued that there was no empirical evidence to substantiate the majority's claim and that it could not be inferred that patients who die while on a wait list died *because* they were on a wait list.

> where patients have life-threatening conditions, some will die because of undue delay in awaiting surgery (*Chaoulli v. Quebec*, 2005, p. 846).

Although there are a range of examples of patients waiting for elective surgical procedures where their life is not in jeopardy in the face of such delays, the justices made the point that being wait listed is still significant since it can cause suffering and hamper the results of surgery. In the case of orthopedic surgery, the justices quote from Dr. Lenczner who argued as follows:

> The one-year delay commonly incurred by patients requiring ligament reconstruction surgery increases the risk that their injuries will become irreparable… 95 percent of patients in Canada wait well over a year, and many two years, for knee replacements. While a knee replacement may seem trivial compared to the risk of death for wait-listed coronary patients, which increases by 0.5 percent per month, the harm suffered by patients awaiting replacement knees and hips is, significant. Even though death may not be an issue for them, these patients 'are in pain,' 'would not go a day without discomfort' and are 'limited in their ability to get around,' some being confined to wheelchairs or house bound (*Chaoulli v. Quebec*, 2005, p. 847).

Finally, the justices establish that pain and suffering is not limited to physical concerns but also enters into the psychological realm as patients face the uncertainty and lack of closure that is commonly involved when waiting for medically necessary treatments and procedures:

> Studies confirm that patients with serious illnesses often experience significant anxiety and depression while on waiting lists. A 2001 study concluded that roughly 18 percent of the estimated five million people who visited specialists for a new illness or condition reported that waiting for care adversely affected their lives. The majority suffered worry, anxiety or stress as a result. This adverse psychological impact can have serious and profound effect on a person's psychological integrity, and is a violation of security of the person (*Chaoulli v. Quebec*. 2005, pp. 847-848).

In identifying and elaborating on a commonly understood problem within the Canadian Health Care System, the justices appealed directly to the Canadian people. They acknowledged that being required to wait for medical services with no alternatives to fall back on constituted a serious harm. As such, the justices positioned themselves as protectors and advocates for the people of Canada from legislators that refused to take action for important issues surrounding the provision of health care that directly affect their representatives. The main basis for the Court's reasoning concerning the constitutional harm of wait times, can be seen in two sections – one from the *Quebec Charter of Rights and Freedoms* and the other from the *Canadian Charter of Rights and Freedoms*. Since the justices argued that waiting for needed medical care 'triggered' sections in both charters, it is helpful to reference both of the sections in full. The relevant section in the *Quebec Charter* reads as follows: "Every human being has a right to life, and to personal security, inviolability and freedom" (1975, Section 1). The relevant section in the *Canadian Charter* state that "everyone has the right to life, liberty

and security of the person and the right not to be deprived thereof except in accordance with the principles of fundamental justice" (1982, Section 7). To make their case, the Court provided a variety of compelling arguments and as such established themselves as accomplished rhetoricians.

The key argument that the justices seemed to rely on was that a restriction or a prohibition had been established by the provincial government of Quebec. This restriction prevented Quebecers from purchasing private insurance to provide for medical services that were insured under the public plan. Essentially the justices argued that the legislative branch could not have it both ways. If the government chose to impose a scheme on Quebecers to allow for medical services and then not provide those services within a 'reasonable time frame,' they could not then say to Quebecers that they could not search for alternatives to this dilemma. The judges are succinct in their assessment of the situation: "Quebecers are denied a solution that would permit them to avoid waiting lists, which are used as a tool to manage the public plan" (*Chaoulli v. Quebec*, 2005, p. 821). In fact, the justices went so far as to suggest that wait lists amounted to implied rationing of services within the system. Further, they assert that this rationing is intentional. In responding directly to a trial judge in an earlier ruling, the *Supreme Court of Canada* insisted that the burden of proof in this case was on the *Government of Quebec*, not the appellants: "The burden of proof does not rest on the appellants. Under s. 9.1 of the Quebec Charter, the onus was on the Attorney General of Quebec to prove that the prohibition is justified. He had to show that the measure met the minimal impairment test. In other words, if a Charter right is violated in some way

by government legislation, the violation should be as little as is reasonably possible. The trial judge did not consider the evidence on the basis that there was a burden on the Attorney General of Quebec" (*Chaoulli v. Quebec*, 2005, p. 827). The foregoing is novel argumentation as in the past, the default position by governments and courts was to defend the status quo by placing the burden of proof on those critical of the system to show how their ideas and perspectives would solve for harms they identified within Medicare. As Judge Deshamps noted, the trial judge appeared "to have placed the onus on the appellants to prove that private insurance would provide a solution to the problem of waiting lists" (*Chaoulli v. Quebec*, 2005, p. 827). In the conclusion of the Majority Decision, Judge Deschamps summarizes her perspective on which party had the burden of proof for this matter:

> The relief sought by the appellants does not necessarily provide a complete response to the complex problem of waiting lists. However, it was not up to the appellants to find a way to remedy a problem that has persisted for a number of years and for which the solution must come from the state itself. Their only burden was to prove that their right to life and to personal inviolability had been infringed. They have succeeded in proving this. The Attorney General of Quebec, on the other hand, has not proved that the impugned measure, the prohibition of private insurance, was justified under s. 9.1 of the Quebec Charter (*Chaoulli v. Quebec*, 2005, pp. 841-842).

What is seen in the Court's analysis is a nuanced characterization of the philosophy behind the concept of burden of proof. In general, the status quo enjoys presumption

and those that seek to change or alter it assume the burden of proof. In other words, they need to prove their case for change. However, the burden of proof changes in this case because a *restriction* or limitation is involved. For this matter, restrictive legislation has been imposed by the provincial government ostensibly to protect the public health care system. However, the restriction of people's rights and freedoms as outlined in the constitution trumps any benefit such restriction might have on the status quo for health care services programs. In order for a restriction of freedoms to stand, it needs to be justified by the government proving that the legislative restriction minimally impairs these rights. Hence, whether or not the purchase of private health care coverage would be good or bad for the existing status quo becomes irrelevant. In short a restriction of rights trumps the normal presumption of the status quo. Richard Whately would seem to argue in his theory that the justices reasoning for this matter is rhetorically sound:

> *Restriction* is in itself an evil; and therefore there is a Presumption in favor of its removal, unless it can be shown necessary for prevention of some greater evil: I am not bound to allege any specific inconvenience; if the restriction is unnecessary, that is reason enough for its abolition (Whately, 1828, p. 1023).

While the judges were not advocating for a precipitous obliteration of the existing status quo, they reasoned that just because Quebec's public system for health care had built up a degree of presumption, this did not imply that it warranted a defense at all costs. In so doing they engaged public opinion by bringing to light the peril involved at defending a status quo that was impinging on fundamental rights and freedoms. In fact, they went so far as to outline steps that the *government* must take in order to justify the legislation

they imposed on the Quebec people through restricting their ability to secure private alternatives for health care. The prohibition, they argued, must not be 'arbitrary.' Moreover, the objectives behind such a restriction must be pressing and substantial (*Chaoulli v. Quebec*, 2005, p. 823).

Second, the Court argued at some length that they need not defer to the legislative branch in this matter and that they were justified in subjecting social policy and law to critical assessment using the Quebec Charter as a 'lens' to do so. The central argument of the majority opinion involved accusing the legislature as failing to act on an issue that has finally triggered the constitutional rights of its citizens. The government has set up a scheme to facilitate the delivery of health services. The scheme has become problematic since it has created wait times for needed medical treatments and procedures. These problems have not been addressed. Finally, the government has introduced legislation that pre-empts the ability of citizens from addressing the situation by taking matters into their own hands. Such a set of circumstances, says the Court, puts the people of Quebec in a double bind whereby their only recourse to address the problem is through the judicial branch. As such 'due deference' does not apply in this case: "The issue of the validity of the prohibition is serious. Chaoulli is a physician and Zeliotis is a patient who has suffered as a result of waiting lists. They have a genuine interest in the legal proceedings. Finally there is no effective way to challenge the validity of the provisions other than a recourse to the courts" (*Chaoulli v. Quebec*, 2005, p. 818).

As mentioned, the primary value of this Supreme Court decision from an argumentative and rhetorical standpoint was an infusion of reason into an emotionally laden issue and debate. The defense of Medicare, implied the Court, has been based off of irrational appeals to fear and paranoia. Due to the nature of this argumentation, key issues surrounding the delivery of health care have been obscured. As Judge Deschamps notes:

> Health care services in Canada must be administered publicly, it must be comprehensive and universal, it must provide for portability from one province to another and it must be accessible to everyone. These broad principles have become the hallmarks of Canadian identity. Any measure that might be perceived as compromising them has a polarizing effect on public opinion. The debate about the effectiveness of public health care has become an emotional one (*Chaoulli v. Quebec*, 2005, p. 811).

It is well known that health care is an emotional issue for Canadians. What is not as well-known are the potential pit falls and limitations to emotional argumentation. As well, Canadians may not be aware or have carefully considered how this type of argumentation may stand up to rational inquiry. Such considerations can draw new issues and insights to light and provide for different ways at looking at things. A key feature of the Court's rhetoric was to draw to light some of the weaknesses of emotionally based appeals and draw attention to new perspectives attained through rational investigation. Rather than seeing the issue in front of them as a situation that may force them to rule *against* health care system programs, the court chose to define

things much more narrowly. In referring to the dissenting opinion from the court the majority argues as follows: "The tone adopted by my colleagues Binnie and LeBel JJ. is indicative of this type of emotional reaction. It leads them to characterize the debate as pitting rich against poor when the case is really about determining whether a specific measure is justified under either the Quebec Charter or the Canadian Charter" (*Chaoulli v. Quebec*, 2005, p. 811). Justice Deschamps then goes on to contest the validity of the fear, paranoia, and revulsion that often is connected to the idea of private medicine:

> In reality, a large proportion of health care is delivered by the private sector. There are also many services that are not delivered by the state, such as home care or care provided by professionals other than physicians. In 2001, private sector services not paid for by the state accounted for nearly 30 percent of total health care spending… In the case of private sector services that are not covered by the public plan, Quebecers may take out private insurance without the specter of the two-tier system being evoked (*Chaoulli v. Quebec*, 2005, p. 811).

In a similar fashion to the rhetoric exemplified by Justice Hall in the *Hall Commission Reports*, the 2005 version of the *Supreme Court of Canada* drew to light emotionally based arguments and subjected them to critical analysis. Just as Emmett Hall correctly pointed out that one mode of delivery for health care cannot be deemed sacrosanct, the Supreme Court Justices in this case question the emotional contention that 'private' and 'health care' should not be mixed in Canada.

With respect to the rather narrow question which grappled with the reasonableness of the *Government of Quebec* placing a restriction or prohibition on the

ability of Quebecers to purchase private insurance for services already insured under the public plan, the Majority basically made the point that the impetus of the ban was based on fear. They further argued that adequate protection for the dominant public health care system exists. The justices quoted from an earlier trial ruling that examined the impetus or motive behind the legislation in question: "These provisions are based on the *fear* that the establishment of a private health care system would rob the public sector of a significant portion of the available health care resources" (Qtd in *Chaoulli v. Quebec*, 2005, p. 831). Another concern broached by the defenders of the law prohibiting the purchase of private insurance was that these "insurers would reject the most acute patients, leaving the most serious cases to be covered by the public plan" (*Chaoulli v. Quebec*, 2005, p. 830). In response to these objections and concerns, the majority offers up several rational arguments:

> Participation in the public plan is mandatory and there is no risk that the Quebec public will abandon the public plan. The state's role is not being called into question. As well, the HEIA contains a clear provision authorizing the Minister of Health to ensure that the public plan is not jeopardized by having too many physicians opt for the private system… Furthermore, because the public plan already handles all the serious cases, I do not see how the situation could be exacerbated if that plan were relieved of the clientele with less serious health problems (*Chaoulli v. Quebec*, 2005, pp. 829-830).

In summary, what the Court accomplished with this rhetoric was to emphasize a reality concerning health care debate that Canadians are already well aware of. However, they

extended their argumentation to identify for Canadians ways in which fear based perspectives could be problematic or even oppressive. In a nutshell, the justices elaborated on commonly held positions concerning health care that Canadians were neither familiar with nor aware. In so doing they underscored the value of subjecting this issue to rational assessment. Of course the foregoing discussion also raises other questions such as ways that fear based appeals or perspectives can be responded to and how rhetors can operate effectively in an emotionally charged environment. Moreover, it encourages speculation on the ethics and role of pathos for rhetorical appeals in general. Aristotle certainly acknowledges the role of fear within rhetoric as a speaker can take advantage of the emotion particularly if they are aware of the state of mind of an audience that may be moved by such appeals:

> Whenever it is better for a speaker's case that the audience experience fear, he should make them realize that they are liable to suffering; for he can say that others even greater than they have suffered, and he should show that there are others like them suffering now and at the hands of those from whom they did not expect it and suffering things they did not expect and at a time when they were not thinking of the possibility (Aristotle, 1991, p. 141)

It is interesting that in this case both the majority opinion and dissenting opinion utilize fear based appeals as a means of communicating directly with the Canadian people. The majority opinion underscores how well-worn rhetoric has served to perpetuate a status quo that has and will continue to cause them suffering as they wait for key medical treatments and procedures. The dissenting opinion warns the people that the cure is

worse than the ill and the measures to address wait lists advocated by the appellants has the potential to degrade and erode a system and a philosophy for health care that they overwhelmingly support:

> Indeed, this is the view taken by our colleagues the Chief Justice and Major J. who quote the appellants'' arguments that 'disallowing private insurance precludes the vast majority of Canadians (middle income and low-income earners) from accessing' private health care. This way of putting the argument suggests that the Court has a mandate to save middle-income and low-income Quebecers from themselves, because both the Romanow Report and the Kirby Report found that the vast majority of 'ordinary' Canadians want a publically financed single-tier (more or less) health plan to which access is governed by need rather than wealth and where the availability of coverage is not contingent on personal insurability (*Chaoulli v. Quebec*, 2005, p. 868).

Health Care Debate and Informal Argumentation

The last key feature of the Chaoulli decision involves the tendency of the Court to apply principals of informal argumentation to central issues that were brought up in the case. For instance, one of the key reasons that the Court provided in their ruling pertaining to the prohibition of private health insurance was that the legislation that mandated the restriction was *arbitrary* in nature. The court declared that a "law is arbitrary where 'it bears no relation to, or is inconsistent with, the objective that lies behind it" (*Chaoulli v Quebec*, 2005, p. 852). The critical tension that was grappled with in this case was between competing charter values. Recall that in section 7 of the

Canadian Charter it is mandated that "everyone has the right to life, liberty and security of the person and the right not to be deprived thereof except in accordance with the principles of fundamental justice" (1982). The Attorney General of Quebec argued that the infringement on life, liberty and security of the person brought on by the prohibition of private health insurance was justified on the grounds of fundamental justice. The majority of the Court disagreed with this reasoning and used principles of informal argument to question the link between the prohibition (which were seen to infringe on Charter rights) and sustainment of the public system (which was deemed to be in the interests of fundamental justice). In short the Court argued that the government needed to prove or show that the infringement of charter rights would be in the interests of democratic or collective values. If they could not, then the law could be construed as being arbitrary:

> The government must show that the restrictive law is neither irrational nor arbitrary and that the means chosen are proportionate to the end served… The government has the onus of demonstrating on a balance of probabilities that the impugned means are proportional to the object sought. He also spoke of the necessity that the government show the absence of an irrational or arbitrary character in the limit imposed by law and that there is a rational link between the means and the end pursued (*Chaoulli v. Quebec*, 2005, p. 822)

Based on the above logic, the justices then rationally assessed the strength of the link between the 'object sought' and the 'impugned means.' They ended up 'parsing' the notion of impugned means with the concept of a *monopoly* for a needed service. Would

the government's imposition of a monopoly for the provision of health care protect the integrity of the public system and its mandate for delivering high quality health care to its citizens? Ultimately, the majority of the Court answered 'no' to this question. They did so by questioning the link between a monopoly or exclusive government scheme for health care and high quality services:

> There is no real connection in fact between prohibition of health insurance and the goal of quality public health system. The evidence adduced at trial establishes that many western democracies that do not impose a monopoly on the delivery of health care have successfully delivered to their citizen's medical services that are presently available in Canada. This demonstrates that monopoly is not necessary or even related to the provision of quality health care (*Chaoulli v. Quebec*, 2005, p. 854).

In short, the justices employed principles of informal argumentation to insist that there is no warrant to suggest that the law in question (prohibition of private health insurance) facilitated the prime objective claimed by the state for this law – namely the protection of the dominant public health care system. In fact their arguments could even infer that it might be possible to see health care services improve in quality should the law cease to exist and greater private involvement in health care was seen. More importantly, the Court concluded that 'conventional wisdom' or doxastic arguments did not stand up to the cool winds or reason in this case. In summary of the Government of Quebec's legal position, the court stated that "their conclusions were based on the 'common sense' proposition that the improvement of health services depends on exclusivity… They

simply assumed, as a matter of apparent logic, that insurance would make private health services more accessible and that this in turn would undermine the quality of services provided by the public health care system" (*Chaoulli v. Quebec*, 2005, p. 853).

The Dissenting Perspective

Justice Louis LeBel and Justice Ian Binnie – both originating from Quebec - offered a nuanced dissenting position to the majority in the Chaoulli decision. Essentially, they based many of their arguments around the specter of a 'two-tier' system arising out of the allowance of greater opportunities for the purchase of private health care. Since this term is frequently employed in both the deliberative and judicial realm when rhetorical agents grapple with health care policy, it is helpful to parse out its meaning. In the Kirby Report – a 2002 committee document for health care produced by Michael Kirby and Marjory LeBreton of the Canadian Senate – the following explanation of the nature of a two-tier system is offered:

> In the broad sense, a two-tier system refers to two coexisting health care systems: a publicly funded system and a privately funded system. *This definition implies that there is a differential access to health services based on one's ability to pay, rather than according to need.* In other words, those who can afford it may either obtain access to better quality care or to quicker care in the privately funded system, while the rest of the population continues to access health care only through the publicly funded system (*Kirby Report*, 2002, 8.6) [Emphasis mine]

I highlighted the phrase 'ability to pay, rather than need,' because it is frequently injected into public discussion relating to health policy as a way of extoling the virtues of universal health care in Canada. Similarly, the argument that health care should be provided to all Canadian citizens 'independent of their ability to pay' is often employed by politicians who support the current universal system as a way to directly counteract or refute the reviled alternative of a parallel private and 'for-profit' system operating simultaneously with the public system. This phrase is also frequently employed by the dissenting justices in the decision as a mode of health care that Canadians have 'chosen' through successive elections where health policy issues have presumably been discussed. Along these same lines, Binnie and LeBel make the point repeatedly that the Court is a less than ideal jurisdictional setting to address the primary exigence presented by the appellants – namely potential remedies for wait times for needed medical services. Essentially, the dissenters see these issues as social and moral issues rather than a legal or constitutional matter:

> The issue here, as it is so often in social policy debates is where to draw the line. One can rarely say in such matters that one side of a line is 'right' and the other side of a line is 'wrong.' Still less can we say that the boundaries of the Quebec health plan are dictated by the constitution. Drawing the line around social programs properly falls within the legitimate exercise of the democratic mandates of people elected for such purposes (*Chaoulli v. Quebec*, 2005, p. 866)

The foregoing perspective supports one of the central arguments of this thesis that Medicare, like any other social policy should be regularly subjected to healthy debate

and argumentation in order to test the premises upon which the system is based and measure them against up-to-date local and historical contingencies. And as was referenced in the analysis of the majority opinion, the change and reform wrought from judicial ruling is extremely narrow. Further to the point, the dissenters question the nature of the rights that are supposedly being impinged upon by Quebec's prohibition of the purchase of private health care for insured services already covered under the Provincial plan. Recall that the legal basis for the appellants challenge to the Court were a series of rights outlined in both the *Canadian Charter of Rights and Freedoms* and the *Quebec Charter*. Again, section 7 of the Canadian Charter states: "Everyone has the right to life, liberty, and security of the person, and the right not to be deprived thereof except in accordance with the principles of fundamental justice" (1982). Section 1 of the Quebec Charter reads: "Every human being has a right to life, and to personal security, inviolability and freedom" (1975). But is a person's fundamental rights of life, liberty, security of the person, inviolability and freedom threatened by an inability to purchase private insurance for medical services already offered in the public plan? The dissenters raise some doubts as to whether this prohibition constitutes a violation of fundamental rights as versus simply a denial of a privilege. The appellants seemed to imply that if they were financially able to purchase added medical coverage then they should have the 'freedom' to do so. But nowhere in the charter is there a guarantee of financial freedom. And further, a prohibition of added coverage purchased by cash and based on ability to pay would not deny the appellants or anyone else access to those same services in the public sphere that are there to preserve life. In short, the dissenters

argumentation implied that the privilege associated with purchasing private care may have the capacity to enhance life but cannot be construed as preserving life in any unique way since the public system offers these same services on a per need basis. The flow of the dissenter's argument as summarized above originates from their refutation of the legal analysis from their colleagues that formed the majority opinion:

> Our colleague Deschamps J. states at para. 4: 'In essence, the question is whether Quebecers who are prepared to spend money to get access to health care that is, in practice, not accessible in the public sector because of waiting list may be validly prevented from doing so by the state.' This I so, but of course it must be recognized that the liberty and security of Quebecers who do not have the money to afford private health insurance, who cannot qualify for it, or who are not employed by establishments that provide it, are not put at risk by the absence of 'upper tier' health care. It is Quebecers who have the money to afford private medical insurance and can qualify for it who will be the beneficiaries of the appellants' constitutional challenge (*Chaoulli v. Quebec*, 2005, pp. 862-863).

Yes, a degree of freedom is constrained from those who can afford insurance for private health care by the State. But since those who cannot afford private health care are also being limited in their freedom, I would maintain that it is too simplistic to characterize this situation as the State limiting the freedom of its citizens. In fact, the State's actions in this case could be perceived as a measure in place to ensure that all citizens have an equality of freedom for seeking and receiving services within the domain of health care.

In addition to exploring the tension between competing freedoms and teasing out the difference between a right and a privilege, the dissenters – like the majority justices – employ principles of informal argumentation to cast some doubt on the legitimacy associated with connecting issues and problems of health care with broad constitutional measures. For instance, LeBel and Binnie point out that it is very difficult to measure from a legal standpoint, what exactly constitutes receiving needed health care in a 'reasonable' amount of time? And further, where should the courts draw the line for the appropriateness of rationing public health services in the interests of 'fundamental justice?' The dissenters argue that there are no clear *legal* answers to these questions:

> We cannot find in the constitutional law of Canada a 'principle of fundamental justice' dispositive of the problems of waiting lists in the Quebec health system. In our view, the appellants' case does not rest on constitutional law but on their disagreement with the Quebec government on aspects of its social policy. The proper forum to determine the social policy of Quebec in this matter is the National Assembly (*Chaoulli v. Quebec*, 2005, p. 864).

Therefore, once again, they assert that these very specific and practical problems associated with health care would be better addressed and resolved in the legislative realm.

The dissenting perspective differed from the majority position in respect the principle of 'fundamental justice' in an additional way. The Quebec Government justified their prohibition on the purchase of private health insurance based largely on the reference in the Canadian Charter to the 'interests of fundamental justice.' Freedom

is not to be curtailed by the state unless such constraints are in the interests of fundamental justice. The majority of the court disagreed with the *Attorney General of Quebec* and settled on the individual rights of 'life' 'liberty' and 'security of the person' as trumping interests of fundamental justice in this case. The dissenters had a different interpretation. Instead of relying on the Canadian Charter, they parsed out in more detail what 'in the interests of fundamental justice actually means: "Rights under the *Quebec Charter* are to be exercised with 'proper' regard to 'democratic' values (including those of the electorate) 'public order and the general well-being of the citizens of Quebec' (including those who cannot afford, or may not qualify for, private health insurance coverage)" (*Chaoulli v. Quebec*, 2005, p. 870). In other words, unlike the justices who comprised the majority position, the dissenters did not see the *Quebec Charter* as providing an additional legal basis to overturn the prohibition. If anything, LeBel and Binnie insisted, the *Quebec Charter* provides a more stringent rationale for the state to insert measures to protect the public health care system. If a measure such as a prohibition can be justified by the state as a legitimate constraint on freedom on the grounds that such a limitation would contribute to public order or the public good, the Court should not have a basis to strike such a measure down. Further to the point, if a limiting measure for freedom can be shown to contribute to the health and wellbeing of individual citizens then once again, it should withstand legal scrutiny. As a quick case in point, if a patient is known to have a history of substance abuse and they exercise their freedom to go from doctor to doctor requesting narcotics and other controlled substances and then disperse any prescriptions received to numerous local pharmacies,

the state and/or medical establishment would then be in their rights to request that that patient limit his or her freedom and stick to one doctor and one pharmacy for the prescribing of any controlled substances. Yes it is true that the patient's freedoms would be somewhat curtailed but such curtailment would be actioned for the sake of the patient's health and well-being. There are times when limits placed on freedoms can have positive consequences for both individuals and society.

Finally, the dissenters differed with the majority position on the place that emotions such as fear and paranoia should play when these types of health policy issues are discussed and debated. As mentioned, the majority position was that emotional approaches broadened the parameters of debate in a way that was inappropriate for the legal question at hand. The majority perspective saw the issue as simply providing an answer to the question as to whether and to what extent the prohibition on private health care insurance violated the appellant's rights under the Canadian and/or the Quebec Charter. The dissenters characterized the issue as a battle between single and two-tier health care and argued that the latter effected the poor and minority groups disproportionately. Granted, as the majority position pointed out, there is no necessary connection between the ability to purchase private health care and an erosion of the public system. Additionally, the majority maintained that the prohibition was not even necessarily an effective means to protect the public system. However, the dissenters asserted that these connections did not need to be established by the state in order to establish a warrant for concern: "As stated, Quebec further takes the view that significant growth in the private health care system (which the appellants advocate)

would inevitably damage the public system. Our colleagues the Chief Justice and Major J. disagree with this assessment, but governments are entitled to act on a *reasonable apprehension of risk of such damage*" (*Chaoulli v. Quebec,* 2005, p. 869). [Emphasis mine]

In other words, LeBel and Binnie were stating that though future damage to the system from the removal of the ban on private health insurance was uncertain, a reasonable person could fear that such damage may occur. This is particularly true in light of the fact that the dental profession has been resistant to opting into the *Canada Health Act*. Moreover the 'paramedical services' that are not considered insured services in the CHA have not had a stellar track record of philanthropy or providing services – even at scaled rates – to financially stressed individuals. Private health insurance companies in Canada deny coverage or charge more for applicants with pre-existing medical conditions and frequently review their revenue lines and adjust individual and organizational premiums accordingly.

Implications

In summary, LeBel and Binnie presented sophisticated argumentation in defense of the idea that health care reform and social policymaking in general should fall to the legislative realm to sort out and address. However, their jurisdictional perspective does raise the interesting question as to what individual citizens should do if they disagree with government action or inaction with respect to social issues. They do not seem to provide a clear answer to this question if the Courts are indeed not a suitable forum for governmental social policy to be challenged. The foregoing question is particularly

pertinent in light of the fact that as argued in this thesis, there has seemed to be a tendency to ritualize or 'regiment' health care legislation making it difficult to critique or change. And since, health care services are entrenched in Canadian identity, there is a clear perception in the legislative realm to take a hands off or a kid glove approach to an honest scrutiny of Medicare. This being said, the dissenting perspective showcased some high level advocacy that championed a sort of 'umpire approach' to jurisprudence. It is the role of the *Canadian Supreme Court* to rule on the constitutionality of provincial and federal legislation, not to create new legislation from the bench. The dissenting position did not see the challenge the appellants raised in response to the wait time issue in Quebec's health care system as conducive to umpire like calls. Finally, LeBel and Binnie took a federalist approach to the issue similar to the orientation that Roy Romanow took as the Chair of the Romanow Report. Medicare should be guided by federal leadership and the provinces should honor the federal principles for health care set out in the *Canada Health Act*. Since one of the criteria set out in the CHA was that provincial systems should be publically administered, it is fair and even proper to limit the provision of insured services to the public realm. At the end of the day, prohibition of private insurance for health care already provided by the public system is consistent with provincial efforts to meet the terms of the CHA.

The Chaoulli ruling is one example of a rhetorical message that infuses focused rationality into the ongoing discussion of the current state and future of health care services in Canada. The foregoing perspective and analysis suggest several implications concerning judicial rhetoric operating within health care policymaking in Canada.

First, this case brought to light the effects that can occur when value based social systems are bureaucratized. As has been seen, the *Canadian Supreme Court* took on this case because there was evidence to show that wait times were becoming a significant and persistent problem within the health care system. The Court leveled some blame at the legislative branch for setting up a single and exclusive system and then failing to act appropriately to manage the system on behalf of the patient and the Canadian people. When such a situation exists, concerned citizens need to be given *some* hearing. When the government is unwilling to change or to be responsive to evolving and devolving issues pertaining to a health care system that it manages, the courts become the only recourse available. Unfortunately, however, there are limitations to what the courts can do and there are limitations to judicial rhetoric. This case was characterized with a very narrow and complex ruling relating to a single problem within health care systems programs. It would be much better – as the dissenting perspective implied – for these complex social issues to be argued out within the legislative forum. Legislative rhetoric is more flexible and can provide for more meaningful change and reform than the courts. There needs to be a way for rhetoric to function concerning this issue while at the same time taking into account cultural suspicions and misconceptions of this ancient and noble art. Some potential frameworks will be suggested in the concluding chapter on how this could occur.

Second, the Chaoulli decision introduced some fresh argumentation relating to health care system programs that are worth mentioning. As has been previously referenced, debate concerning health care has become bogged down in tradition,

misconceptions, fear and entrenched identity. One way that this has happened is through the regular employment of charismatic terms by political leaders when health care issues come up in public discussion and political campaigns. In the chapter on Canadian identity I suggested several ways in which this rhetorical stalemate could be addressed through the application of 'counteractive charismatic terms.' A review of the rhetoric of the *Canadian Supreme Court* provides some additional possibilities for this suggested rhetorical strategy. The Court made the point that when the state establishes a scheme for a needed social service and enforces 'exclusivity' to this scheme it then becomes accountable to the people, the constitution, and ultimately the courts to provide the service at a reasonable quality and within a reasonable time frame. If the state fails to do this, it cannot neglect to take action or make needed changes and at the same time restrict its citizen's ability to look for alternatives. The Court also maintained that there is no necessary connection to establishing a monopoly for a service as a means to protect that service. This logic would seem to allow for private and more market based alternatives to the public system. It would seem that public leaders could get some mileage by employing some of these devil terms as a means to stimulate needed public discussion concerning health care. It would not be unreasonable to assume that many Canadians would not take kindly to thinking of the public system as an intentional scheme imposed on them by the government to facilitate health care. Then to conceptualize this scheme as an exclusive monopoly would not improve the public perception. Employing these types of devil terms could be a way to add renewed vigor to health care discussions and debate in Canada.

Third, the way that the Court's reasoning highlighted the value of rational inquiry is instructive for the future of health care policymaking in Canada. As was mentioned, through employing techniques of informal reasoning to several key issues, it encouraged the nature of health care services to be seen in a different and fresh light. It did this by illuminating some of the pitfalls of relying on emotional rhetoric and defaulting to appeals made to fear as a way of perpetuating the status quo. Emotional rhetoric has a way of stalling debate and obscuring the key issues that are involved in sorting through problems in the health care system – particularly if these problems infringe on individual rights that have recently been established in the *Canadian Charter of Rights and Freedoms*. In similar fashion to the venerable Emmett Hall, these justices employed reason to problematize conventional wisdom and opinion. The majority position in this ruling insisted that 'private' did not have to be a dirty word within the context of health care services. The Court drew on evidence from other countries that outperform us in health care with a mixed public/private or 'two-tier' type of system. Therefore they asserted that there does not seem to be a compelling reason why two-tier has taken on such an ominous specter in the Canadian scene. While the Chaoulli ruling did not produce much by the way of policy change for health care, it did make significant contributions to the means in which this issue can be argued and debated. The nature of judicial rhetoric, though limited in ways referred to above, seems to comport well with the way in which Canadians value the rule of law. Therefore, if there are ways that this type of rhetoric could be employed within the legislative realm, it

could provide additional clues on the way to move forward in health care policymaking from a rhetorical standpoint.

Medicare - From Chaoulli to Present

Conservative leader Stephen Harper became Canada's new Prime Minister on February 6, 2006 after 13 years of Liberal rule at the federal level. He has remained Prime Minister until the present time after being re-elected with a stronger minority government in the fall of 2008 and a majority government in May of 2011. During his tenure as Prime Minister, Harper has faced several significant challenges in both the domestic and international fronts, and his government has adopted a number of policies to deal with them. In contrast, no policy initiatives involving health care have been pursued during the Conservative's reign. Three health ministers have been appointed – Tony Clement (2006-2008), Leona Aglukkaq (2008-2013), and Rona Ambrose (2013-present). Despite the relative lack of major movement for this portfolio, several issues have evolved that are important to discuss. The Harper government has absorbed a fair bit of criticism for failing to provide leadership, allowing important health related agreements to expire, for lacking in compassion and overall neglect of this important social program.[4] While there is certainly some basis for this criticism, some of the complaints have been exaggerated

[4] For instance, Harper has been characterized as lacking in interpersonal communication skills and empathy. These characterizations have been reinforced by his 'tough on crime policies' and the discipline that he enforces in his Party's caucus.

The federal money flow

In respect to the federal funding for Medicare through the Canada Health Transfer, Harper has been criticized for failing to renew the Health Accord of 2004 under Prime Minister Paul Martin and also for allowing the Health Council of Canada to dissolve. The Health Accord of 2004 was a provincial/federal agreement that resulted in a commitment by the federal government to stable and predictable increases in funding of healthcare for a period of ten years. In conjunction with this Accord, the Health Council of Canada was formulated to ensure a degree of federal leadership and control through addressing key issues such as controlling wait times and setting benchmarks for efficiency and performance. Because Harper has failed to hold another summit with provincial leaders to hammer out a new agreement and game plan for health care, he has been criticized for reneging on federal leadership responsibilities, distancing himself from Medicare and its core principles, and even moving toward a dismantling of the system through a persistent laissez-faire orientation. An Op-Ed letter published in a 2013 issue of the Toronto Star, Michael McBane – National Coordinator of the Canadian Health Coalition is typical.[5] First, McBane contended that the decision not to renew the 2004 Health Accord and the dissolution of the Health Council of Canada, will lead Medicare to become fragmented and 'unreadable:'

> When the Harper government says it is time to wind down the Health Council of Canada, it is saying in effect, it is time to wind down national medicare… The

[5] The Canadian Health Coalition is a left-leaning lobby group dedicated to preserving Canada's current Medicare system and to promoting the overall goal and policy of universal public health care.

> Health Council of Canada was formed in 2003, following the Romanow Commission on the Future of Health Care in Canada, to provide accountability, oversight, planning and national coordination for our health care system. It achievements to date include lowering wait times and encouraging innovation in the public health care system to ensure access to a continuum of services, in and out of the hospital (McBane, 2013).

Second, McBane insists that Harper is 'abandoning' national Medicare through taking punitive action with little consultation in respect to equalization payment formulas for health care to the provinces. Some examples of punitive action would include dissolving the Health Council of Canada and refusing to meet with provincial governments in traditional provincial/federal planning sessions for health care that previous Prime Ministers have taken part in.

> The Harper government unilaterally announced major cuts to the federal transfer payments for health as well as fundamental changes to equalization payments. The cumulative effect will be to take more than 60 billion out of health transfers and equalization payments in the decade following 2014. The heart of medicare, as designed by the Hall Commission in 1964, called for the federal government to negotiate high national standards and to establish an equalization formula to ensure all regions could meet those service standards (McBane, 2013).

The possible consequences of reducing federal transfer payments to provinces is that the poorer provinces will be required to allocate increasingly higher proportions of their budgets for health care in attempts to cope with rising costs. Eventually, these budgets

could become unsustainable and unacceptably degrade other essential systems and services such as education and public safety.

However, an Op-Ed in the Winnipeg Sun, posted on March 26, 2014 offers a competing perspective. Tom Brodbeck argues that some of the vitriolic attacks on Harper are reflective of a tendency within the health care debate to significantly deemphasize honest deliberation and rational argument. Referring to the attacks made on Harper from the Canadian Health Coalition, Brodbeck comments as follows:

> They probably won't listen to the facts because their goal is to take partisan swipes at the federal Conservatives. But if they did want to have an adult conversation about Canada's medicare system, how it is funded by Ottawa and what the rules of engagement are under the federal Canada Health Act, they would have to admit that the system is as well-funded today – and will be tomorrow and next year – as it has ever been (2014).

He then continues on by arguing that the accomplishments associated with the *Romanow Commission*, the consequent Health Accord and Canadian Health Council have been overstated. In the end, says Brodbeck, all of the foregoing can be reduced to a simple agreement between the provinces and the federal government on the degree of federal funding. Perhaps most significantly, the commentary questions the Canadian Health Coalition and other Harper critic's interpretation of the 'math' for funding: "The CHC also says the Harper government plans on cutting $36 billion in health care funding over the next 10 years. Actually, they're not cutting anything. They're increasing funding annually by 6% and then by a minimum of 3% after 2017. How's that a cut" (Brodbeck,

2014)? He finally supplements his claim through providing a ten year breakdown of transfer payment commitments that have been made by the Conservatives for health care. The below table demonstrates the increase for health care funding that he is referring to.

Table 2 Summary of federal funding under Harper's Conservatives

Year	***Dollar Amount***
2006	20.1 billion
2007	21.7 billion
2008	22.8 billion
2009	24.5 billion
2010	25.7 billion
2011	26.9 billion
2012	28.6 billion
2013	30.3 billion
2014	32.1 billion
2015	34 billion
2016	36 billion

So where does the truth lie with these competing claims and perspectives? I would submit that the truth of the matter would like somewhere in between the contrasting positions discussed above. Did Emmett Hall encourage aggressive federal funding for the provincial health plans? Of course. But he also promoted decentralization for the sake of maximizing creativity and individual initiative through empowering the provinces to take separate and unique stances to the provision of health care. Therefore it is fair to state that the primary role of the federal government for Hall was funding with relatively no strings attached and delegating leadership and administration of the provincial plans to the provinces. By the same token the claim made that health care spending has been increased under the Conservatives is true, but if we compare these commitments for increased funding with the previous agreement brokered by the Liberals in 2004, then the increases do not look as flattering. In short, both perspectives appear to be lacking in some context.

Harper's general style of leadership in respect to health care is presented in a more nuanced fashion in a 2011 *Globe and Mail* Op Ed by Geoff Norquay. Essentially, he argues that Harper has a quieter and more unassuming leadership style than his predecessors. Rather than arranging for high profile meetings with Premier's where agreements are carried out in an adversarial and very public manner, Harper prefers behind the scenes negotiation and interpersonal engagement for communication. In other words, Harper's engagement for the issue is different in kind to prior approaches and therefore cannot fairly be construed as being reduced in degree. As Norquay notes, there have been changes in style:

> Much has been made of the Prime Minister's avoidance of first minister's conferences, those clambakes of inflamed rhetoric in which premiers play to their home parish and lacerate the prime minister of the day for real and imagined slights. Mr. Harper's approach is different: quiet, calm, private conversations conducted one on one by telephone or in person with premiers. The issues are worked out or there is agreement to disagree quietly (2011).

So overall it would seem that Harper's Conservatives have shown good leadership for health care in terms providing for continued and aggressive federal funding to the provinces through the Canada Health Transfer. Where Harper would seem to be lacking is in his rhetorical leadership. Even if it is granted that Norquay is right and Harper prefers more of the behind the scenes approach to policy discussion and negotiation, there are ways in which the genre or style of his communication could be tweaked in order to facilitate a wider distribution of the message. For example, Harper has shown deftness in the back-and-forth/Q&A approach of a news conference. As such, it would not be inconsistent with his persona to communicate to the Canadian people in a more high profile way through this manner. In short, there has got to be a way to fill these types of rhetorical vacuums.

Competing views of federalism

In summary, many of the distinctive features of Harper's orientation toward health care can be explained through different approaches that have been taken towards federalism among key leaders that have made contributions to the debate. Federalism implies some kind of relationship with and separation between federal and provincial

governments. Furthermore, federalist forms of government usually involve, to varying degrees, some kind of devolution of centralized powers, responsibilities, and jurisdictions to an assortment of more regional authorities, systems, and organizations. In applying federalism to the provision of health care, Banting & Corbett conceptualize the relationship as "the role of different levels of government in defining the basic framework of health policy" (9). They then go on to lay out two criteria for measuring the relationship between federalism and the provision of health care and state that this relationship can be summed up through assessing "the comprehensiveness of the central framework and the process of its determination" (Banting & Corbett 9). The type of orientation a political figure has on federalism is particularly relevant to health care policymaking in Canada as the constitution prescribes health care as a *provincial* jurisdiction. Norquay Maintains in his *Globe and Mail* Op-Ed that Harper is seeking to keep health care in the provinces where he believes it belongs based off of his interpretation of the Constitution:

> As a classic federalist, he believes passionately in the sanctity of Sections 91 and 92, which define the respective responsibilities of the two levels of government. As he told Policy Options in March of 2006: 'It's always been my preference to see Ottawa do what the federal government is supposed to do… Ottawa has gotten into everything in recent years, not just provincial jurisdiction but now municipal jurisdiction. And yet at the same time if you look at Ottawa's major responsibilities, national defense, for example, the economic union, foreign

> affairs, beginning obviously with the most important relationship, with the United States, Ottawa hasn't done a very good job of these things' (2011).

So the general approach for health care that would be taken from this orientation towards federalism can be summed up in the phrase 'a commitment to funding but a laissez-faire perspective for administration.' Roy Romanow had a very different view on federalism and interpretation of the proper relationship between the provinces and the federal government for health care. He was not persuaded by the strict provincial/federal bifurcation for health care and saw federal leadership and funding as both critical if Medicare is to be sustained. He justifies federal intervention or involvement for health care based off of two short commentaries on the Constitution:

> As Justice Estey of the Supreme Court of Canada pointed out in *Schneider v. The Queen*: "Health is not a subject specifically dealt with in the *Constitution Act* either in 1867 or by way of subsequent amendment. It is by the Constitution not assigned either to the federal or provincial legislative authority" (quoted in Gibson 1996, 1). In Peter Hogg's (1997, 485) words, "health is an 'amorphous topic' which is distributed to the federal Parliament or the provincial Legislatures depending on the purpose and effect of the particular health measure in issue" (*Romanow Commission*, 2002, iii)

This position on federalism can be seen in the role for the *Health Council of Canada* that he envisioned. One of the few recommendations articulated in the Romanow Report that were carried out by the governing Liberals in the early 2000's was the separation of the *Canada Health and Social Transfer* to the *Canada Health Transfer*. As discussed

previously, the change encouraged more focused and stable federal funding for what was at that time a cash strapped program. In conjunction with this change, then Prime Minister Paul Martin chaired a first minister's conference in which the details of the cash influx were ironed out. Part of these details included the establishment of the *Health Council* which acted as sort of a federal watchdog to monitor whether the money was being spent by the provinces appropriately and that key issues such wait times were being addressed. So in a word, the federal influx rhetorically induced by the *Romanow Report* can fairly be described as 'strings attached funding.' All of this was justified by Romanow's belief in the necessity of federal leadership for the issue and his general view on federalism. So it should not be a surprise that Harper ordered that the Health Council should be dissolved once the *2004 Health Accord Agreement* between the provinces and the federal government expired. Instead, the approach that has been taken by Harper and Minister Flaherty has been to continue with the stable increase of federal dollars but to let the provinces decide how they will use this money to administer their respective health care plans without interference from the Government of Canada. Interestingly, the position that has been taken by Harper has support from both Emmett Hall and the *Supreme Court of Canada*. Hall saw aggressive decentralization of health care system programs as essential to promote innovation which is a concept that Harper has embraced on a variety of levels. Similar to Harper, for Hall, the only thing to be changed with the implementation of universal health care was the method of payment for medical services. Governments were to take a 'hands off' approach in respect to administration:

> 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 health services that will best meet the needs of the community (*RCHS,* 1965, p. 212)

In the Chaoulli decision of 2005, the justices made the case for the clear jurisdiction for health care to the provinces as they grappled with whether or not they should intervene or overturn Quebec's ban on the purchase of private insurance coverage for health care:

> The basis for provincial jurisdiction over health care is clear. The Constitution Act, 1867 provides that the provinces have jurisdiction over matters of a local or private nature (s. 92(16)), property and civil rights (s. 92(13)), and the establishment of hospitals, asylums, charities and eleemosynary institutions (s. 92(7))… On this point, and based on the division of powers analysis in the preceding section, it is indisputable that the provincial government has jurisdiction over health care and can put mechanisms in place to ensure that all Quebecers have access to health care (*Chaoulli v. Quebec*, 2005, p. 812&813).

So based on the foregoing evidence, it would seem that Mr. Harper may have some support on federalist grounds for his decision to dissolve the *Health Council* in 2014.

Summary

In short, Mr. Harper has conflated his tough on crime and law and order orientation, at least to a degree, into the domain of health care. While the style of this advocacy may be lacking on compassion, it essentially conveys the message that if you are addicted to drugs and alcohol, we will treat you but if you use or deal drugs illegally, we will punish you. Additionally, the rhetoric of the Harper Government has appeared to take a step back from harm reduction approaches to addiction. An inference can be drawn from the argumentation surrounding the desirability of safe injection sites that the preference should be placed in treating the underlying addiction itself with abstinence – rather than stable use – rhetorically positioned as the ultimate goal. Moreover, Mr. Harper has taken a highly decentralized approach to health care through shying away from high profile conferences with provincial leaders in order to broker big deals. While the evidence does not seem to bear out the allegations that Harper is either dismantling Medicare or starving out the system with substantially reduced funding, the tendency of the Conservative Government to lean toward acceding to the individual ultimate responsibility for their own health care is somewhat troubling. For there are many cases where people for a variety of reasons may not be able to help themselves without outside intervention or controls.

CHAPTER VIII

SUMMARY OF HEALTH CARE POLICY IN CANADA

As this thesis has attempted to show, the institution of a universal and pre-paid system of health care in Canada has arguably been one of the greatest policy accomplishments in the nation's history. Instrumental in achieving this policy direction was the rhetoric employed by Tommy Douglas and Emmett Hall. Unfortunately, the rhetorical vigor that was so instrumental in ushering in health system programs in the late 60's and early 70's eroded. The effect of this erosion has been felt most deeply by patients, health care facilities and health care practitioners. This is unfortunate as Romanow has noted that it is Canadians who are owners and trustees of our health care system. Nonetheless, a strong majority of Canadians still support Medicare and report that they are pleased with the quality of care that they receive out of the system when they need it. I share this perspective. Like most Canadians, I am a supporter of our health care system. However, I also want to see it thrive and flourish well into the future. But if the status quo continues to be defended at all costs, and if public leaders continue to feel 'chilled' from speaking out about problems and deficiencies within ;Medicare and the topic continues to be taken off the table of public discussion then the future of health care services is less hopeful.

Rather than continue to subject health care system programs to rational inquiry and the clash of argumentation, it seems that we have preferred to solidify and bureaucratize Medicare into a stable and inflexible entity. And due to the strong connection between Medicare and Canadian identity, it could even be stated that the

system has been 'solemnized.' For instance, Romanow referenced that the *Canada Health Act* has assumed a level for health care policymaking that has made it nearly untouchable and beyond scrutiny and revision. The repeated formations of Commissions to address emerging issues in health care also appears to privilege a 'stability biased' medium. The Chaoulli decision also pointed to a preference from the Government of Quebec to defend the status quo and to generally resist change by removing the option for patients to look for alternatives for care outside of the established public system. And of course, one of the key reasons that the Canadian Supreme Court took the case was due to a perception of inaction from government to address the pressing issue of wait times within the system. Moreover, it was also referenced in the Romanow Report that the major federal influence concerning health care derives from the 'power of the purse.' In other words, the federal government can decide to reduce or eliminate transfer funds to the provinces if the provinces are deemed to be in violation of the principles laid out in the *Canada Health Act*. But as Romanow noted, the federal government has been very reluctant to do so in practice. Even if they chose to employ the power of the purse more often, the sway that this would hold is questionable since the quantity of transfer funds to the provinces have been substantially reduced over the years.

All of this serves to distance patients and practitioners from being able to engage the values of the system – either in a positive way or by way of critique and suggested reform. Meaningful reform requires the flexibility that is inherent in rhetoric and in the legislative arena. If government prefer to bureaucratize rather than to debate the ideas

and ideals surrounding health care, then change tends to occur in a markedly narrow way often in the judicial realm.

Exacerbating the financial neglect and hands off approach taken by successive federal governments in respect to health care is the emotional way that it is often represented. The limitations of relying on emotions is that important issues can be overlooked and problems neglected – thus again, stunting the potential for change or reform. Oftentimes emotional reactions are evoked by political leader's invocation of a range of devil terms and phrases that were discussed in chapter 4. Again, as Weaver notes, such devil terms tend to create a feeling of 'repulsion' that designates whatever is perceived as the enemy or greatest evil in culture. Due to this emotional reaction that the application of these terms create, once again productive and rational debate and discussion can be pre-empted or stifled. And of course many of the devil terms that have been employed concerning health care services are strongly connected to Canadian identity. I suggested ways in which debate and discussion could be (re) stimulated through the application of counteractive ultimate terms that enjoy a significant degree of support in Canada such as 'sustainability' and 'innovation' as two examples. As this thesis has progressed, other potential examples of counteractive devil terms have surfaced such as the Supreme Court's reference to our health care system as being initiated through a created government 'scheme' and the perceived need of government to create a 'monopoly' for service for the sake of protecting the public system.

Another major finding in this thesis was a repeated cultural misunderstanding or mischaracterization of rhetoric. These mischaracterizations were particularly evident in

the *Romanow Report*. Filling in that argumentation deficiency would not only help facilitate debates surrounding health care, but potentially improve the current system and act as a catalyst for idea generation and knowledge building. I hinted at a way around this problem in the section on the *Romanow Report*. Part of the distrust surrounding rhetoric is the perception that 'that is what Americans do.' Canadians are more objective and fact based; or so the saying goes. However, not wishing our discourse to assume certain traits that are seen in American discourse is unrelated to the validity and value of employing rhetorical principles for engaging issues and problems that are pertinent to health care. It may be helpful if some rhetoric was infused into discussions about health care in such a way that it is consistent with Canadian values. One possibility could be to employ Poulakos' sophistic model for rhetoric. This way, rather than clashing aggressively and in an adversarial fashion with the goal being to 'win' the debate, the aim would be cooperative argumentation. Otherwise put, both sides in a debate surrounding the current state and future of health care would not hesitate to be assertive in communicating their perspectives. However, in addition to making a firm argument both parties would agree to listen carefully to the other's arguments and be willing to suspend their beliefs. In other words, both sides would make a commitment to learn from the other and be willing to change their minds if the discussion warranted such a change. The downside to this approach would be the potential for debate concerning health care to become wishy-washy and lapse into soft relativism. I don't think Canadians need to be afraid of aggressive argumentation that is at the same time consistent with cultural tendencies and preferences. Therefore, I wish to advance a

model of rhetoric that may avoid some of the pitfalls of sophistic approaches but at the same time is sensitive to ethics and values. To do so we will once again turn to the ideas of Richard Weaver. The overall goal for this mini-case study will be to answer the question, 'How can rhetorical theory and criticism contribute to the health care debate and discussion in Canada?'

Richard Weaver and Argument from Definition

In his search for an 'ethics of rhetoric,' Richard Weaver lays out a range of principles and criteria for rhetoric that could be helpful if applied to health care policymaking in Canada. Through using examples from the rhetoric of former President Lincoln, Weaver is able to articulate a number of observations that have a bearing on the nature, scope, function and domain of rhetoric. An ethical rhetor, says Weaver, will strive to base his or her appeals on 'first principles' or 'first causes.' In order to do so, they will attempt to reduce the matter under consideration to general ideas and concepts that are grounded in succinct definitions. Quoting from a law partner and later biographer of Mr. Lincoln, Weaver starts to unpack some of the characteristics for an ethics of rhetoric:

> Not only were nature, man, and principle suggestive to Mr. Lincoln; not only had he accurate and exact perceptions, but he was causative; his mind apparently with an automatic movement, ran back behind facts, principles, and all things to their origin and first cause – to the point where forces act at once as effect and cause. (Weaver, 1985, pp. 85-86)

In short, an ethical rhetor strives to determine in so far as possible, the nature of the issue that is under discussion or debate. In other words, he or she 'gets to the point' or works to define the issue that is in question. Additionally, Weaver establishes through Lincoln the import of the rhetor demonstrating an astute understanding of human nature and to gear appeals accordingly. Otherwise put, Weaver implies, 'know your audience.' One of the fundamental observations that Lincoln made about human nature was the tendency of people to pursue their own self interests. Since we are driven by ambition and this drive – as an aspect of human nature – is permanent, duty can sometimes be sacrificed at the altar of this motive. Therefore a strong appeal could constitute a rhetor 'molding' or creating a situation in which duty and ambition coincided. In essence, people are more likely to do the right thing if it is both their duty and in their self-interests to do so.

Interestingly, Weaver's scheme also provides some guidelines concerning ways in which political leaders can rhetorically manage *institutions*. These perspectives are particularly germane to institutions that seem to be 'fixed' into a nation and demonstrate a sort of stubbornness for reform or change. Rather than to speculate and argue the rightness or wrongness of this recalcitrance, Weaver again advances a 'first principle' for institutions as per Lincoln's example. Any institution will only sustain itself to the extent that the principles of the institution are handled with a degree of flexibility. If in contrast, political leadership holds fast to the existing foundations, definitions, and guidelines of an institution for the purposes of limiting its ability to grow or change, the sacrosanct nature of some systems can in effect be bypassed. In referencing Lincoln's

argumentation tendencies, Weaver sums up the foregoing impetus: "There is quite possibly concealed here another argument from definition, expressible in the proposition 'that which cannot grow must perish.' To fix limits for an institution with the understanding that it shall never exceed these is in effect to pass sentence of death" (Weaver, 1985, p. 96).

Another useful feature of Weaver's explication of an ethics of rhetoric is the variety of 'rhetorical topoi' such explication provides. One such topoi that is suggested from Weaver's analysis is an 'argument from the nature of the sovereignty of the people.' Once again, this argument can be related to the longevity of institutions and factors that have a bearing on their ability to endure. This time around, institutional change is explored in terms of the role that people and leaders play in this process cooperatively. The people, maintains Weaver, have the right to request and even demand change. However, absent a clear mandate it should be the responsibility of the political leader to sustain institutional structure. Again referencing Lincoln, Weaver unpacks the extent that status quo should enjoy protection from change:

> Lincoln conceded the right of the whole people to change its government by constitutional reform or by revolutionary action. But he saw this right vested in the people as a whole, and he insisted that any change be carried out by the modes prescribed. The institutions of the country were finally the creations of the sovereign will of the people. But until a will on this issue was properly expressed, the government had a commission to endure as before. (Weaver, 1985, p. 99)

At first glance, there may seem to be an inconsistency in position concerning the appropriate justification and mode for institutional change. However, since the change Lincoln was grappling with involved slavery, it can be reasonably inferred that a leader should only 'starve out' an institution as a last resort if it is highly problematic and demonstrates a significant recalcitrance for any kind of significant alteration.

Further to the point for the need of a rhetor to be aware of and sensitive towards their audience, an ethical orator must also rely heavily on rationality and rational appeals. Even though the focus is on the rational, Weaver explores through Lincoln the relationship between logos and pathos for an ethics of rhetoric. After a hard fought election Lincoln made clear that emotion, though it served a purpose should ultimately be limited to particular 'seasons' of politics: "Passion has helped us but can do no more… Reason, cold, calculating, unimpassioned reason—must furnish all the materials for our future support and defense" (Qtd. in Weaver, 1985, p. 96). This statement could infer that once a transition period in society is over and change has occurred, it is better to deal with existing institutions and socio-political policy with reason.

In order to fashion rational appeals to an audience, Weaver makes the point that this will present some very clear demands for the rhetor. It requires self-discipline, a strong sense of duty to a larger cause and a sense of tolerance to persuade ethically in difficult situations or for complex and emotional issues. Continuing on with the foregoing example, Weaver suggests that when times get difficult and a leader is faced with important, complex, and contentious issues, an ethical rhetor should act as a gentle and stabilizing force in the process: "The fact that Lincoln's thought became

increasingly logical under the pressure of events is proof of great depths in the man" (Weaver, 1985, p. 107) So here we see the need and value for a combination of logos and ethos as modes for managing highly charged and controversial issues. Such a focus and disposition from political leadership would serve both a counteractive and calming role in the face of emotion and irrationality.

Weaver spends a great deal of time in developing his theory to ways that rhetoric can function while avoiding relativism and pursuing the 'good' or the 'right.' In so doing however, a leader should avoid ulterior motives or hidden agendas and should keep the public good in mind. All of these rhetorical characteristics are particularly critical for issues that are polarizing and controversial. In other words, avoiding relativism for core or fundamental issues should not be contradictory to respecting dissenting viewpoints and showing tolerance towards those who oppose you. Even though the debating of contentious issues can be emotionally charged, it is the rhetor's responsibility to not act or react based on emotion. Once again, Weaver uses Lincoln as a case in point:

> It goes without further demonstration that Lincoln transcended the passions of the war. How easy it is for a leader whose political and personal prestige are at stake to be carried along with the tide of hatred of a people at war, we have, unhappily, seen many times. No other victor in a civil conflict has conducted himself with more humanity, and this not in some fine gesture after victory was secured—although there was that too—but during the struggle, while the issue was still in doubt and maximum strain was placed upon the feelings. Without

> losing sight of his ultimate goal, he treated everyone with personal kindness, including people who went out of their way in attempts to wound him. (1985, pp. 110-111)

There are some issues such as war that are highly charged emotionally and also polarizing. In these cases, there does not seem to be a middle ground and there doesn't necessarily have to be. For issues of great societal importance and complexity it is important for a rhetor to strive to do what is right and to have an ultimate objective in mind that is other/nation oriented rather than self/party oriented. With socio-political issues that are entrenched in national identity and have a bearing on key rights such as happiness, freedom, equality and personal wellbeing, it can be very difficult to inject rhetoric into such issues when historical context invites such engagement. However, important and contentious issues must be engaged from time-to-time even if such engagement is risky and carries low political payback. For appropriate engagement to occur in these cases, a sensitive and skilled orator is required.

Oftentimes important socio-political issues such as war, weighing national security with civil rights, moral issues, religion and policy relating to health and well-being assume a certain character that can make it difficult for a rhetor to induce assent. Weaver's scheme provides some useful direction concerning the type of orientation a rhetor should have towards such issues. First, Weaver makes the point that there are some questions and issues that are not conducive to compromise positions being taken. In fact, he goes so far as to suggest that some issues of great importance can only have one right answer and that in cases of war, one side must be wrong. Therefore, it

behooves a rhetor in these cases to refrain from taking a neutral stance. In referring to excerpts from two of Lincoln's speeches, Weaver lays a case for a rhetor to be proactive in taking a firm stance for issues that are deemed to have a great deal of import:

> No Man can logically say he don't care whether a wrong is voted up or down. He may say he don't care whether an indifferent thing is voted down, but he must logically have a choice between right and wrong. And… Let us be diverted by none of those sophistical contrivances wherewith we are so industriously plied and belabored – contrivances such as groping for some middle ground between the right and the wrong: vain as the search for a man who should be neither a living man nor a dead man; such a policy of 'don't care' on a question about which all men do care. (1985, pp. 106-107)

In short, Weaver insists through Lincoln that leadership should take important issues seriously, and to be persistent in finding real, tangible solutions and generally to move in the right direction. The rhetorical trait of "pressing toward the ideal goal while respecting, but not being deflected by, circumstances" (Weaver, 1985, p. 102) is key to Weaver's theory of rhetoric.

In summary, Weaver's commentary of arguments made from definition, has the potential to provide some answers to a key question: How can rhetorical theory and criticism contribute, enhance and improve health care policymaking in Canada? While Canadians in general are suspicious of leaders making 'truth claims,' and like to compromise in policymaking, it seems quite clear that for health care, they want leaders to take the issues seriously, strive to find real solutions to problems and expect timely

and decisive action to be taken to ensure that Medicare is viable into the future. Otherwise put, Weaver's typology would seem to fit well with how seriously Canadians take their health care system. Finally, Weaver's notion of arguing from definition, would seem important for establishing a strong argumentative base on the nature of health care system programs in Canada. Once the core principal (s) behind our health care system is ascertained and that rhetorical foundation is set, health care policymaking and reform could become much more focused. In the pages that follow, I will use some of the principles and criteria discussed above and apply them to some key issues for health care debate and discussions that have been covered in this thesis.

Analysis

One of the major problems that has afflicted health care services in Canada for quite some time is a lack of funding. The *Romanow Report* made it clear that federal contributions to health spending dropped substantially from the inception of Medicare in the late 60's and early 70's till the early 2000's. The report parsed federal contributions into two distinct categories – one for hospital and physician expenditures and the other for total health care expenses:

> Federal 'cash only' transfers for hospital and physician expenditures have ranged from a high of close to 47% in 1976/77 to a low of 14.6% in 1998/99… The federal share of total health expenditures have always been well below the 50% line… As for cash, the highest point reached was an almost 38% contribution in 1971/2 which had dropped to slightly less than 10% by 1998/99. (*Romanow Commission*, 2002, lxvi)

Granted, based on the recommendations of the report, the Health Council of Canada was created that acted as a watch dog of sorts for a ten year Health Accord agreement between the federal government and the provinces, established in 2004. As part of the agreement, the federal government agreed to a 'strings attached' influx of 41 billion in transfer payments to the provinces, provided they addressed wait time issues and worked to provide electronic health records for Canadians. As Romanow noted, the advantage to the accord and council was that they provided for "commitment to a level of funding and a degree of reform. We had the council to neutrally assess how we were doing on those reforms" (Romanow, qtd. in Boyle, 2014). However, in March of 2014, the governing Conservatives decided not to extend the ten year agreement and abolished the health council and reduced funding. Romanow was critical of these decisions and offered the following commentary in an article published in the *Toronto Star*: "I am concerned that without leadership from Ottawa and with reduced money, we are going to see a further slowdown of reforms, more regional disparities and a push for more private health care" (Romanow, qtd. in Boyle, 2014).

So basically, all of the foregoing points to a progressive weakening of federal commitment to health care in Canada interspersed with occasional efforts of reform and influxes of cash. Therefore, the original 50/50 cost sharing agreement for Medicare has been substantially eroded over many decades. When the daughter of one of the Fathers of Medicare, Tommy Douglas, was asked to comment on what her Dad would think of the state of health care in Canada if he was alive today, she offered the following comments: "Before my father died, he warned that we were watching the slow

strangulation of health care. He said, 'If you don't get up and fight for it, you are going to lose it. Don't pretend you didn't know'" (Douglas, S., qtd. in Boyle, 2014). The progressive bleeding of federal contributions for health care in Canada has meant that more and more of provincial budgets are being eaten by health care expenses. According to the *Canadian Institute of Health Information*, "spending on healthcare varies across Canada, but on average provinces spend approximately 40% of their total budgets on healthcare" (1994). And as was referenced in the chapter on Canadian identity, in New Brunswick, the foregoing figure is closer to 70%. Of course the erosion of federal transfer payments can potentially have a number of consequences for Medicare such as increasing inequality of services between the 'have' and the 'have not' provinces and of equal importance, raise questions regarding the sustainability of the system into the future.

Applying the money issue to Weaver's discussion on argument from definition, it must be stated that federal neglect and inaction *is* a rhetorical strategy: "That which cannot grow must perish. To fix limits for an institution with the understanding that it shall never exceed these is in effect to pass a sentence of death" (Weaver, 1985, p. 96). A more pertinent consideration would be to assess how ethical such a strategy is for the issue of health care. In response, it must be stated that while such an approach might be effective in managing recalcitrance for change, it is likely would not conform to an ethics of rhetoric. As has been referenced, Medicare is entrenched in Canadian identity. Therefore, seriously looking at health care on its merits and making needed changes and proposing new policy directions is avoided by politicians. Because of the sacrosanct

nature of health care services, subjecting the system to critical assessment can be political suicide. When this reality is recognized, it becomes reasonable to evaluate the progressive cuts in funding as a possible attempt by governments to bypass explicit change that could trigger public sentiment concerning Medicare. Neglect can be cloaked behind a perception of government support for the values and principles of the system even if these values are not being paid for. However, a close scrutiny of the example Weaver provides from Lincoln implies that such approach should only be taken as a last resort. In other words, it is not enough that an institution is recalcitrant towards change. It also must be highly problematic and be faced with substantial opposition. It would be difficult to characterize Medicare in this way as it has been a system that has served Canada well and has decreased the proportion of Canadian that are uninsured for hospital and physician services to almost zero. And as Romanow noted, "Canadians appear to be pleased with the system: Canadians have been clear that they still strongly support the core values on which our health care system is premised – equity, fairness and solidarity. Our health outcomes, with a few exceptions, are among the best in the world, and a strong majority of Canadians who use the system are highly satisfied with the quality and standard of care they receive" (*Romanow Report*, 2002, xvi). Therefore, it must be concluded that the ongoing trend of federal neglect for Medicare is a clear and effective rhetorical strategy. However, it does not appear that that type of strategy fits well with the issue and the situation. In short, it would not appear to comport with Weaver's ethic of rhetoric.

As Weaver also emphasizes, "the argument from definition, in the sense we shall employ here, includes all arguments from the nature of the thing" (1985, p. 86). Argument from definition involves arguing "largely from first principles" (Weaver, 1985, p. 85). So in applying this perspective to debating and discussion of health care in Canada, it is worthwhile to identify the first principles for Medicare. As has been referenced earlier, the core values or principles for Medicare are spelled out in the *Canada Health Act* as publically administered, portable, comprehensive, accessible, and universal. I was critical of the way in which these values were laid out in the *Canada Health Act*. My critique lay in the way the values were mechanically listed rather than elaborated on and defended. It would seem that such an elaboration and defense would have the capacity of inspiring a lot of Canadians to take ownership in the uniqueness of our health care system. If it were possible to extrapolate a core and all-encompassing value from this list of key principles and then to utilize this value as a core foundation for argumentation concerning health care system programs, it could add a lot of focus to deliberations and policy directions. To flesh out this idea a bit more, I would like to propose that the value of 'universality' be employed as the first principle that can best approximate the nature of the thing. If Canadian health care is above all else 'universal' then all other argumentation would start from that foundation. The range of issues that are attached to health care and the health care debate would need to connect or 'engage' in some way with the foregoing core value.

First, it would seem that the value of universality could be justified as the key value that captures the 'essence' of Canadian Medicare since it interacts with other core

values for health care and in Canadian society in general. As was referenced in the chapter on the constitutional precursors for health care, the Charter of Rights and Freedoms places a great deal of import on the value of equality:

> Parliament and the legislatures, together with the government of Canada and the provincial governments, are committed to
>
> (d) Promoting equal opportunities for the well-being of Canadians;
>
> (e) Furthering economic development to reduce disparity in opportunities; and
>
> (f) Providing essential public services of reasonable equality to all Canadians
>
> Parliament and the government of Canada are committed to the principle of making equalization payments to ensure that provincial governments have sufficient revenues to provide reasonably comparable levels of public services at reasonably comparable levels of taxation. (*Constitution Act*, 1982, s. 36 (1); a-c)

Since obviously the term 'universality' strongly implies 'equality,' placing an emphasis for Medicare as inherently providing for universal access to high quality health care would seem to auger well with wider Canadian cultural values. The value of universality also touches on the doctrine of prevention that was covered in depth by Emmett Hall in his 1980 commission report. Universal access to primary health care empowers Canadians to be able to see a physician at the earliest indication that something is amiss which of course facilitates more effective treatment for disease and illness. In short, prevention is much more difficult to achieve on a widespread level without citizens having universal access to health care that is 'need based' rather than

contingent on ability to pay. Even the notion of health care being provided on a basis of need touches on universality as disease and illness is not only unpredictable but ubiquitous to the human condition. Finally, the provision of high quality health care in a universal fashion on the bass of need recognizes that there is something intrinsically valuable in human beings that warrant us having access to the fruits of the health sciences for the sake of our wellbeing as complete people. Hall makes the case convincingly that there is something about the nature of health care services that justify their universal availability independent of economic status or circumstances:

> Economic growth is not the sole aim of our society and, given the growing wealth of Canada, economic considerations should not solely be used to deny to individuals the health services needed to alleviate illness and disability and extend life expectancy. Although we recognize that resources are limited, and individuals cannot expect to receive unlimited amounts of health care, the value of human life must be decided without regard to whether the person is a producer or not. Health services must not be denied to certain individuals simply because the latter make no contribution to the economic development of Canada or because he cannot pay for such services. Important as economics is we must take into account the human and spiritual aspects involved. (RCHS, 1964)

In short, placing a focus on the value of universality as a key term in defining the essence of our health care system, puts an emphasis on the notion that a level of universal health care for all citizens is fair, is right and is good policy.

Further to the above, an important advantage to isolating universality as a unifying term for defining health care would be its ability to add focus to debate and discussions on health care policymaking. Through applying universality as a sort of 'unit of analysis' the assessment and evaluation of the current state of the health care system could become clearer. For example, as was referenced in the section on Canadian identity and healthcare, the notion of 'two-tier' healthcare in Canada tends to be employed frequently by politicians as a term of revulsion for one type of care being provided for the rich and another type or quality for the poor. It would be useful to assess the viability and ethics of a mixed public and private system in terms of how such a mix would impact on universality. Or even more generally, what type of role should the free market play for the Canadian health care system? The answer to the question would be directly related to the core value of universality. It is well known in Canada that a 'two-tier' system exists for health care in its totality as Medicare only covers insured services provided by a physician or for medically necessary care attained at a hospital. Health care related services that are not covered include, optometry, physiotherapy, massage therapy, chiropractic, psychological services, dentistry, paramedics, drugs, acupuncture etc. Therefore it is obvious that universality is connected to another key principle from the *Canada Health Act* – comprehensiveness. How might the absence of all of these elements of health care impact on universality? It would seem a lot. Although Emmett Hall advocated for incorporating prescription drug coverage and dental care for children into Medicare, this has never been fully realized. Provincial health care plans generally will not fund the costs associated with prescription

drugs either. The negative impact of not having access to these 'para-medical' services would seem to be exacerbated based on Hall's assessment of the value of preventative care referenced in the 1980 Commission:

> According to the Great Equation, Medical Care equals Health. But the Great Equation is wrong. More available medical care does not equal better health. The best estimates are that the medical system (doctors, drugs, hospitals) affects about 10 per cent of the usual indexes for measuring health: whether you live at all (infant mortality), how well you live (days lost due to sickness), how long you live (adult mortality). The remaining 90 per cent are determined by factors over which doctors have little or no control, from individual life-style (smoking, exercise, worry), to social conditions (income, eating habits, physiological inheritance), to the physical environment (air and water quality). Most of the bad things that happen to people are at present beyond the reach of medicine. Nobody says doctors don't help. They mend broken bones, stop infections with drugs, operate successfully on swollen appendixes. Inoculations, internal infections, and external repairs are other good reasons for keeping doctors, drugs and hospitals around. More of the same however, is counterproductive. Nobody needs unnecessary operations, and excessive drugs can create dependence or allergic reactions or merely enrich the nation's urine. (Wildavsky, 1979, p. 284)

If there is a disparity of access to those services that help people to help themselves, then it would seem that a large proportion of factors that are likely to have significant

influence on health and well-being remain unavailable to people that cannot afford or do not have insurance for para-health benefits.

Depending on how 'universality' is defined, the above referenced lack could be seen as relatively insignificant or even beneficial to achieving an appropriate level of health and well-being for Canadians. Of course this approach would fit with Weaver's scheme because it would encourage an answer to the question, 'What is the nature of a universal health care system?' If, for instance, 'universal care' was defined as all citizens having access to acute care predominately, this view would seem to be consistent with what doctors and hospitals generally do. If access to unlimited care for chronic conditions is precluded, this would still not have to conflict with the value of universality. Many chronic conditions are treated more aptly by the 'para-medical' realm and through personal lifestyle choices. And by leaving chronic care more up to patients, individual responsibility for health and well-being would be encouraged. This all being said, the para health industry could be encouraged through government and the respective professional organizations and societies to be more sensitive to the poor, community minded, and generally philanthropic. And as additional funds permit, it certainly would be consistent with the principal of universality to provide greater access to prescription medication for all citizens. New Brunswick again provides an interesting case study. Effective April 1st, 2014, New Brunswickers that do not have access to an employer drug plan and have a Medicare card are eligible to join a newly conceived government plan. The plan will involve scaled premiums according to incomes and provide access to most drugs and co-pays will be 30% of the cost of the medication and

are not to exceed $30. Currently 70,000 New Brunswickers do not have any kind of drug plan and the initiative spearheaded by Premier David Alward and the governing Conservatives has attained bi-partisan support. In particular, NDP Leader Dominic Cardy has applauded the plan as 'ground-breaking:' "This is a shining example of government doing what it should be doing for the people — focusing on core services like health, transportation and education" (qtd. In Poitras, 2013). Health Minister Ted Flemming says despite the expense, the program is the *right thing to do*, and will also save money in the health care system:

> When people have access to the prescription drugs they need to manage disease or prevent or treat illness, they're healthier. They take less time off work. They visit emergency rooms less. They're less likely to be hospitalized. *We need to make sure a patient is in a financial position to follow his doctor's orders.* (qtd. In Poitras, 2013).

It is important to note that much of the warrant for the newly unveiled drug plan is based off of the concept of universality and other 'first principles' such as the plan being the right thing to do. It also promotes equality and fairness by defraying some of the barriers of cost to needed medication.

But what about the added question that concerns the level of engagement that the market should have in the funding and delivery of acute care for Canadians? Should there be greater numbers of private hospitals? What effect would there be in health services in Canada if there were more doctors 'opting out?' What would happen if the private sector was more involved in facilitating diagnostic tests for people who could

afford to pay? Would greater provision of private care for elective services help or hinder the public system? There are a range of perspectives that can be offered in response to these questions. A hard line approach to this question could be Lincoln's example of a 'house divided cannot stand' orientation toward secessionism and the slavery issue during the U.S. Civil War: "I believe this government cannot endure permanently half slave and half free. I do not expect the Union to be dissolved – I do not expect the house to fall – but I do expect it will cease to be divided. It will become all one thing or all the other" (qtd. In Weaver, 1985, p. 106). A paraphrase for this logic for Medicare would be 'I believe Medicare cannot endure permanently half public and half private. I do not expect Medicare to be dissolved but I do expect health care will need to cease to be divided. It will become all one thing or all the other.' Granted, this is a pretty absolute perspective but as Canada is still a relatively small nation with limited resources, the capacity of increased privatization to dismantle Medicare should not be discarded. A more moderate perspective was articulated by Romanow in the commission on the future of health care. In essence, he advocated for a system with a strong public foundation but with an allowance of some limited market engagement. For 'direct medical services' publically administration on a not-for-profit basis was seen as the best course to follow. For 'ancillary services' such as food preparation, 'for profit' delivery was seen as an acceptable alternative. Romanow explains the rationale for this perspective in the following summary:

> Unlike ancillary services, direct health care services are very complex and it is difficult to assess their quality without considerable expertise. Indeed, the effects

> of poorly provided service may not be apparent until sometime after the service has been delivered, as in the event of a post-operative complication. This is what most clearly distinguishes direct health care services from ancillary services – a poorly prepared cafeteria meal may be unpleasant, but poor quality surgery is another matter altogether. It is also unlikely that there would be a significant number of competitors able to offer health care services if a given for-profit provider is unsatisfactory. There simply is not a significant surplus of health care administrators or providers waiting in the wings to take over service delivery in a hospital. Thus, if services are of poor quality, it is going to be much harder to find a replacement once public facilities have stopped providing the services – the capacity that existed in the public system will have been lost. (*Romanow Commission*, 2002, p. 7)

And of course the dissenting opinion in the Chaoulli decision by the Canadian Supreme Court castigated the notion of a mixed public/private system on the grounds that such a dichotomy would result in increased inequalities. I would tend to concur with both the dissenting perspective of the Canadian Supreme Court and the position articulated in the *Romanow Report*. However, due to a reduction in federal transfer payments and a general lack of funding available to the public systems, I would suggest that added support and funding for public facilities from private interests should be considered. Again, turning to New Brunswick for a case in point, recent additions to the Moncton Hospital were accomplished through mixed contributions from the provincial government, private sector and donations from individual citizens. The private

involvement was facilitated by the *Friends of the Moncton Hospital Foundation*. These foundation websites can be found in many hospitals across Canada and help to account for the deficiencies in funding received from the differing levels of government. Since these foundations exist exclusively to build upon and strengthen the public system, I cannot see a major harm in their involvement.

All of this discussion of universality also triggers another important issue for discussion of the nature of health services in a modern and industrialized democracy. Is health and well-being a right of citizenship? In response I might suggest that Canadians are entitled to access to high quality health care without having to encounter financial obstacles that would preclude such services. However, as has been referenced a number of times in this thesis, times are changing and increasingly Canadians are recognizing that a significant proportion of health and wellbeing boils down to personal responsibility. This is why, like Emmett Hall, I would advocate for more accessibility to services that empower patients and clients to 'help themselves.' Again, this is where paramedical services would come in to play including greater access to mental health services. The problem, of course, lies in the substantial reductions that have been made over several decades in federal transfer payments made to the provinces. This, combined with some of the issues covered in chapter 6 that point to the federal government taking a relatively 'laissez-faire' stance toward the provinces in enforcing the principles of the *Canada Health Act*. Reduced funding + soft enforcement is not an optimal formula for federal leadership that might facilitate a more national system that 'hangs together.' Nonetheless governments should continue to strive to provide

additional services to Canadians if financially feasible. In times of austerity the burden would have to shift to health professionals and their respective societies to be more sensitive to the poor and community minded. Of course the question of 'sustainability' as addressed in chapter 4 must also be kept in mind. Federal budgets have been crowded out by other priorities that have surfaced since September 11, 2001 in areas of national security, defense, and foreign affairs. And it must also be noted that proportionately, Canada is on the 'low end' for spending in the above mentioned domains. Therefore, it does not seem to be unreasonable to suggest that social programs such as Medicare have been feasible, in part, due to savings reached from a relative lack of spending in these other areas.

Authority, Freedom and Liberal Judgment

In her analysis of the rhetorical theory of Richard Whately, Karen Whedbee explores the tensions between and subtleties inherent in presumption and burden of proof. Moreover, in his *Elements of Rhetoric*, Whately alludes to both terms and the interaction between them: "Presumption in favor of a supposition does not involve a preponderance of probability in its favor, but, implies that it must stand good till some sufficient reason is adduced against it; in short, that the Burden of proof lies on the side of him who would dispute it" (Whately, 1828, p. 1019). In applying these terms to the discussion on the relationship between Canadian identity and health care, 'presumption' could be construed as the conflation of identity with Medicare. This connection between identity and health care services could manifest in values such as equality and communitarianism. This relationship is rhetorically induced through elites either

defaulting to or protecting the status quo through 'buzz terms' such as 'universality,' 'public,' etc. The burden of proof seems to rest on those who would conceptualize Canadian identity in alternative ways that are not necessarily consistent with Medicare's underlying values. Some concepts that might clash with the dominant paradigm of Canadian identity might be 'individuality,' 'freedom,' and rational evaluation of existing systems.

Based off of Whedbee's elaboration of Whately's rhetorical scheme, I will suggest ways to move the health care debate forward through the application of the following theoretical criteria to the discourse of some key Canadian institutions that have achieved excellence in health care. Consistent with the development of my thesis thus far, I will extrapolate the theoretical units employed in Whedbee's commentary to focus on ways of overcoming presumption. First, I will assess the institutions in terms of their tendency to engage Canadian identity and its connection with public Medicare with a sense of *restrained skepticism*. Whedbee discusses the impetus at length in the following statement:

> Skepticism is a healthy response to a society which takes universalist dogma and the 'truths' it yields for granted: To question the self-evidence of a form of experience, knowledge or power, is to free it for our purposes, to open new possibilities for thought and action. By contrast the rhetoric of assent suggests that skepticism is not healthy: Instead of making doubt primary, let us see what happens if we know whatever we can agree together that we have no good reason to doubt, whether or not we can apply other more formal tests of doubt. In this

> project, assent becomes the prior act of knowing: what we believe together with sureness is given 'the benefit of the doubt. (1998, p. 172)

I will attempt to balance the tensions inherent in the foregoing quote through advocating for a restrained skepticism as a plausible way forward as health care delivery and services continue to evolve. After all, "the unrestrained questioning of tradition, initially exciting and liberating, eventually produces anarchy and a terrifying lack of certainty" (Whedbee, 1998, p. 174). Second, I will assess these health care institution's rhetoric in terms of the extent to which they make *reality based observations*. These observations could bring to light certain limitations to our current system and at the same time illuminate or predict evolving trends for health care in Canada: "To overcome presumption, the advocate must pry the ought from the is, rousing the audience to a new critical awareness of alternative possibilities in any situation and of the necessity of choosing between these possibilities" (Whedbee, 1998, p. 177). Again, these alternative possibilities will include inferences that could be made regarding fresh perspectives on Canadian identity gathered from the approaches that institutions, which have achieved excellence in health care, take to its delivery and services. Canadian identity can be a nebulous concept that is based more on intuition and perception than reality. As Whately maintains, "presumptive allegiance has no rationale; habitual presumptions, he says, are 'apt to depend on feelings; - often, on whimsical and unaccountable feelings" (Whately, qtd. in Whedbee, 1998, p. 178). Third, I will assess the extent that the health care institutions examined 'popularize' health care services through creative uses of marketing, advertising and media. The discourse itself could also illuminate ways that

health care could be presented that directly appeals to popular culture and sentiments. The benefit of popularizing the presentation of health care services could lie in attempts to understand the 'public mind' in the development of popular appeals: "The collective mind does not penetrate below the surface, but it sees all the surface, which profound thinkers, even by reason of their profundity, often fail to do: their intenser view of the thing in some of its aspects diverting their attention from others" (Mill, qtd. in Whedbee, 1998, p. 180). Since much of Canadian identity is appropriated in popular media appeals and through popular institutions that are seen to be consistent with features of Canadian culture, it will be interesting to see what inquiry based on the foregoing criteria will reveal.

Implications

As this thesis draws to a close, it is worthwhile to highlight some key themes that have been attended to that would improve debate and consequently health care policymaking in Canada. First, the value of rational appeals being infused into an oftentimes emotional issue cannot be overemphasized. Health care discussions have become increasingly deadlocked and polarized in Canada for a range of reasons. As was referenced in the discussion of health care and Canadian identity, we have come to view universal and pre-paid health services as being part and parcel with the Canadian way. And of course a major part of what it means to be Canadian has been expressed in terms of being 'not American.' As a result, debate can become stifled as politicians fear the consequences associated with subjecting health care services to rational critique. This fear is exacerbated when the issue is politicized by the repeated use of ultimate terms by

some leaders in public debate. Examples of alternative charismatic terms being employed as a means to 'counteract' this emotionally based argumentation were provided in chapter 4. Part of the problem remains that the respective provinces remain hesitant to really take a hard look at health care and to engage in vigorous, honest, and rational debate. This combined with a relative lack of defense of the values that underlie Medicare, has left the system open to attack by various interests employing the language of individual rights and freedoms. The recent rhetorical situation has the left the door open for the courts to step in and rule for or against the status quo on a very narrow basis. It would be much better, as the justices in the dissenting perspective of the Chaoulli ruling asserted, that the complex issues of health care be subjected to clash in the respective legislatures. A clue to filling in the gaps for the argumentation deficiencies referenced might lie in a greater willingness to debate 'big issues' and practice an ethic of civility in the public square. As former Prime Minister Mulroney recently noted in response to a question posed to him on a talk show relating to the issue of mutual respect in the House of Commons and whether the caliber of rhetoric and leadership has changed over the years:

> Well Pierre Trudeau, Joe Clark, Ed Broadbent – these were great debaters and parliamentarians. There was very little of this nonsense that passes for debate in the House of Commons today. They were great orators, and they dealt with great issues. Nothing was perfect. But when I was there my own observation was that it was a privilege to be part of that public debate. And we had big debates. There were big issues being debated apart from the economy. Meech Lake.

> National unity was big. When I did the Canada/US acid rain treaty on the environment. NAFTA. All of these things were big ticket items. The Manitoba language issue which was a huge leadership question in 83/84. Huge because it dealt with leadership. I remember Trudeau speaking in that debate – I spoke in it of course – he was excellent. I mean there was high, high caliber oratory. Joe Clark spoke in it and he was terrific. So those were big days (Mulroney, "George Stroumboulopoulos Tonight," 2009).

As was discussed in chapter 3, it is difficult to replace excellent rhetoric which acts as a catalyst for change in respect to important social and political issues. Of course Tommy Douglas as a Baptist preacher turned politician certainly fit the bill for overcoming the status quo back in the 40's and establishing the first socialist government in North American history. The reforms that he instituted in the province of Saskatchewan eventually led to hospital insurance and eventually Medicare in Saskatchewan. This model, implemented in 1961, became the basis by which Medicare was introduced in other provinces. It also became the basis for federal leadership from former Prime Ministers Diefenbaker, St. Laurent, and Pearson that culminated in the *Medical Care Act* and eventually the *Canada Health Act* that was unveiled in the early 1980's. It is important to emphasize that this high caliber deliberative rhetoric was supplemented by the careful administrative and judicial rhetoric of Emmett Hall.

Future Directions for Research

One of the major finding of this thesis, particularly in the Romanow Report, is that there seems to be a cultural mischaracterization of rhetoric. Debate and discussions

surrounding health care services in Canada have tended to take on an emotional bent and are polarizing in nature. Early on in the Commission on the Future of Health Services in Canada, Romanow exhorts that "we need more than rhetoric; we need action" (2002, xx). Variations of this phrase are frequently seen in political debates as if rhetoric is incommensurate with action. The general theme that rhetoric is emotionally laden and destructive was noted throughout the Romanow report. Fortunately, most of the commission reports have infused some much needed rationality into the way the issue of health care in Canada is conceptualized. This type of rational argumentation was also quite apparent in the legal reasoning of the 2005 Chaoulli decision though more evidence of pathetic argumentation was observed in the dissenting position. It has seemed to be a pattern for health care policymaking that rhetoric has taken a minimal position that was really only explicitly apparent in the battle to initiate universal health care in Canada. Rhetorical figures such as Tommy Douglas and Emmett Hall were instrumental during Medicare's early development. Since then rhetoric has sprung up from time to time to essentially engage in damage control in response to emerging issues and problems in the new system. Examples of this would include the *1980 Hall Commission Report*, the *Canada Health Act of 1984*, the *Romanow Report* of 2002, and the *Chaoulli ruling* of 2005. As a rhetorician I find this bothersome and I concur with the dissenting judges in the Chaoulli ruling that key debates and discussions of such a complex social issue should be more focused in the House of Commons and the respective provincial legislatures. As such, a future direction for research would involve a detailed explication based on the nature, function, and scope of rhetoric. One a

comprehensive theoretical framework is established, going back through the textual and rhetorical history of health care in Canada and seeing how these principles would contribute and improve policymaking could provide a helpful sketch on how some key issues that have spanned the course of time could be addressed differently. Additionally, I think it would be helpful if the values of Medicare were communicated more frequently to Canadians. Currently, the idea of 'Medicare' has become nebulous as Canadians tend to identify more actively and directly with health care practitioners and facilities in their respective provinces as opposed to principles originating from politicians and their documents such as the *Canada Health Act*. The *CHA* itself mandates this more active identification through its suggestion to the provinces to provide for public acknowledgment on how federal funds and contributed and made possible the delivery of health services. In section 13 under 'conditions for cash contributions' the authors state:

> In order that a province may qualify for a full cash contribution referred to in section 5, the government of the province
>
> - (*a*) shall, at the times and in the manner prescribed by the regulations, provide the Minister with such information, of a type prescribed by the regulations, as the Minister may reasonably require for the purposes of this Act; and
>
>   (*b*) shall give recognition to the Canada Health Transfer in any public documents, or in any advertising or promotional material, relating to

> insured health services and extended health care services in the province. (*CHA,* 1985, c. 6, s. 13)

Of course the problem has been and continues to be that the federal government has substantially reduced these cash contributions over many years. Hence, the 'power of the purse' has been eroded and as Romanow noted, the federal government tends to be very reluctant to enforce the principles of the CHA through reducing or eliminating transfers to provinces who are not in full compliance.

An initial case was laid out in this chapter advocating for the use of the key term 'universality' as a kind of organizing principle for health care policymaking. Through defining the 'essence' of Medicare as the provision of high quality medical services that are universally accessible, it could help the federal and provincial governments to 'stay on track' in respect to this issue. Additionally the simplification of the issue for Canadians could be a source of inspiration that would facilitate stronger ownership being taken for Medicare beyond the notion that it is 'not American.' As well, 'universality' triggers many other key cultural elements within Canada such as the value of equality and a sense of fairness. In short, Medicare is a principle steeped in the underlying philosophy of secular humanism. As such, it would be useful to engage in a detailed explication of what secular humanism means and how its principles have been applied into and embraced by Canadian culture. Charles Taylor provides an exhaustive sketch of Canada's relationship with secular humanism and the implications that this has, both positive and negative. A greater understanding of the strengths and limitations of this

ideology may help rhetoricians engage the values of Medicare in a more sophisticated way.

Finally, a more detailed sketch of the effect that 'regionalism' has in Canada could be instructive. Essentially, because the constitution mandates provincial jurisdiction for health care, we currently have 13 different health care systems. And since the Conservatives have allowed the health care accord signed by all premiers in 2004 to expire and the coinciding health council federal watchdog has been abolished, this decentralization is even more pronounced today. Canada has a unique culture with two official languages at the federal level, significant regional disparities between the 'east' and the 'west,' residual ties with Great Britain and the Commonwealth, multiculturalism etc., that can make it very difficult to attain a level of national cohesion. In particular, multiculturalism can be contrasted with the U.S. notion of a cultural melting pot where people from different ethnic backgrounds share the common foundation of being American. Dickinson and Dolmage sum up the distinction:

> In its crudest form, the debate is a contest between, on the one hand, melting down the citizenry into a nation of "Americans" or "Canadians," people who will largely share nationally defining characteristics and attributes, and, on the other hand, balkanizing them into officially structured units within the state, each with their own defining characteristics, attributes, and values. (1996, p. 364)

In his *1964 Commission Report on Health Services*, Emmett Hall positioned decentralization as having a positive effect on his proposed universal and pre-

paid health care system. And as was referenced, the focus on decentralization served to counter criticism that universal health care would wind up being a bureaucratized and monolithic instrument of the government that would stifle individual creativity and innovation:

> 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 health services that will best meet the needs of the community. (RCHS, 1965, p. 212)

Since that time there has been some criticism levelled – particularly by Roy Romanow – that the decentralized nature of Medicare has compromised the value of equity for all Canadians. I also suggested some limitations to decentralization for health care in my analysis of the Hall Commission Report. Either way, it would be useful to examine in more depth the roots and consequences of our regionalism and multiculturalism with the goal being to strike a more appropriate balance between a system founded on the value of universality while at the same time respecting regional distinctiveness.

In summary, this thesis initially argued that the patient has been lost in the fray in the midst of a health care system that was conceived with the best of intentions. Further, this thesis has emphasized that debate and discussion

concerning health care services in Canada has reached a sort of stale mate. Both of these arguments have been supported by the textual evidence. Romanow emphasized repeatedly that the Canadian people had become the 'unknown' or the 'missing' audience as rhetorical processes concerning the issue have unfolded historically. Emmett Hall made a similar claim as he tackled the very specific question of extra-billing in the 1980 Commission Report. A major reason for this patient disempowerment seems to be the repeated setting in motion of the Burkean cycle of mystery and hierarchy. The precursors of this rhetorical cycle can be seen in the *1964 Hall Commission* as the authority of the physician based off of their specialized knowledge and rare talent was emphasized. The mysterious nature of health care services in Canada has been exacerbated by a less than direct connection between Medicare and Canadian identity. Canadians can relate quite easily to their doctor and local medical facilities such as clinics and hospitals but are not as clear on how these facilities and professionals connect to the federal values of Medicare and the provincial mechanisms by which services are delivered. Therefore, it can become a challenge to understand why and how they wait for needed services and what their legitimate voice is within these processes. Additionally, it seems quite apparent that Canadian culture has been shifting over the last 15 to 20 years and a reasonable case can now be made for converging values with the U.S. as opposed to earlier and more traditional arguments for divergence. One obvious example of a cultural shift has been with our armed forces which is no longer

seen as fulfilling a primarily peacekeeping function. Rather, public perception of the military is now more consistent with the role the military has traditionally seen of themselves – to close with and destroy the enemy. A variety of ultimate terms employed by politicians has attempted to ensure that health care remains firmly entrenched in Canadian identity. I proposed some 'counteractive ultimate terms' not as a way to defeat the status quo but to subject the status quo to argumentative 'clash.'

The value of rhetoric for Medicare is established on the grounds that, if nothing else, will serve to counter built up apathy and lethargy. It is not enough to fight hard for a system and then to adopt a laissez-faire attitude. Such an orientation toward Medicare will either drive health care policymaking by default by subjecting it to the contingencies of circumstances and historical context or worse be utilized as a sort of intentional strategy that may allow for the system to die a long and slow death by 'one thousand pin pricks.' Traditionally, a strength to health care in Canada has been that it has been evidence based and 'data-driven.' However, Canadians need to know what all of this data and numbers mean and why they are important. In short we need to be inspired through rhetoric to (re) embrace a system that has given us so much. The responsible use of rhetoric could serve as an important piece in the puzzle in heeding the warning that Tommy Douglas gave near the end of his political career to celebrate what we have accomplished but to avoid complacency and to

remain vigilant in ensuring that health care services programs not only remains viable but flourishes for future generations of Canadians:

> So while we have done a great deal in this country – and I want to say, Mr. Speaker, that I think Canada can be proud of what it's done, in both health insurance and Medicare. It's true we're not as advanced as some of the countries in Europe who have been pioneering this field for several decades. But when you compare our situation with the United Sates, where they haven't got a plan at all, with all their wealth and with all their power, the Canadian people can be congratulated. And the governments of this country – some of whom were very slow and reluctant to act – can be congratulated that we've gone as far as we have. But it is dangerous to assume that the job is finished when as a matter of fact we have just made a very good beginning and that's all. So instead of saying it's all over with, we've done that job, we should be recognizing that there's a tremendous tasks still confronting us – if we are going to give to the people of Canada, the health services which they need and to which they are entitled in a country with the resources that we have with the billions of dollars we spend on much less important matters. (Tommy Douglas, 1979)

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