



CHAPTER 3

Building on Values: Ethics in Health Care in Canada¹

**Janet L. Storch, Rosalie Starzomski,
and Patricia Rodney**

*“Access to health care based on need rather than ability to pay
was the founding principle of the Canadian health-care system.”*

(Martin et al., 2018, p. 1)

THE PROVISION OF HEALTH CARE in any country is influenced by economic, political, social, and cultural forces. While there are clearly many influences on the structures of all social programs, as Canadians, our values determine how we frame problems in health care and the solutions we endorse or reject (Kenny, 2002). Publicly funded health care in Canada has been a source of pride, is held up as a reflection of Canadian values of equity and solidarity, and involves sharing burdens and benefits (Beauchamp & Steinbock, 1999; Pauly & Storch, 2013). As Villeneuve (2017) stated, numerous

studies, debates, and agreements show that Canadians value accessibility to health care without out-of-pocket payment. While the Canadian health care systems that are in place nationwide are not perfect, the ethics of caring for one another continues to be sustained as an espoused social value by a majority of Canadians (Martin et al., 2018; Nixon et al., 2018; Storch & Scaia, 2019).

It is important for advanced practice nurses (APNs), and all nurse leaders, to understand how Canadian health care is delivered, as well as the associated challenges with service delivery, in order to guide those seeking care, assist persons already receiving care, and help those wishing to reform health care systems to know how they can be involved. APNs need a firm understanding of the origins, development, and trajectory of Canadian health care systems in order to wisely debate health care issues, and, where needed, be agents of change in health care structures and processes.

In this chapter, we begin with a focus on the manner in which health care delivery is structured in Canada, with particular attention to federal, territorial, and provincial responsibilities. We provide a brief overview of the history, financing, and delivery of Canadian health care, and explicate underlying values captured in key principles that have provided direction for the development and provision of health care in Canada. Limitations and challenges of publicly funded health care in Canada are also discussed. Some of the current limitations and challenges are linked to the historical development of Canada's health care systems, and include deficiencies in a number of areas, such as long-term care (LTC), care of the mentally ill, and health care for Indigenous people. Other growing and pressing contemporary deficiencies are evidenced by the increasing number of Canadians who lack access to a primary caregiver, and the many Canadians who are unable to obtain timely access to emergency, medical, and surgical services. Throughout the COVID-19 pandemic, there has been a major shortage of health care providers (primarily nurses and physicians), resulting in a further lack of access to primary and acute care, thus further broadening the portrait of an eroding system of care. Over time, privatization of health care services and extra-billing have been promoted by some as a way to address the limitations of the publicly funded health care system. We briefly discuss these approaches as a

way to address access to health care. We conclude the chapter by examining the role of leaders in nursing in addressing health care system challenges, with specific attention to the role of advanced practice nurse leaders.

Division of Federal, Provincial, and Territorial Responsibilities

One way to reflect upon Canadian health care is to examine how it was “built,” and how federal, provincial, and territorial goals were harmonized over time. Speaking about Canada’s health care system as *one* system is inaccurate, since Canada is a federation of 13 provinces and territories, each with a different health care system (Fierlbeck, 2011). Contrary to what the public might assume, provincial and territorial authorities—not the federal government—have managed the development and deployment of most health services, and continue to do so today.

Fierlbeck (2011) defined the Canadian health care system as “a fragmented system *controlled* by the provinces but *coordinated* by the federal government with the provinces’ consent” (p. 18, emphasis in original). Villeneuve (2017) pointed out that “it is important for nurses and other students of public policy to understand from the outset that Canada’s provinces do not report in some hierarchical way to the federal government” (p. 41). As an example of this, there was fragmentation during the COVID-19 pandemic, with officials in each province and territory stipulating the rules in their individual jurisdictions about the wearing of masks, vaccine administration, rapid testing, and other directives related to the global pandemic.

Canada’s founding legislation, the *Constitution Act, 1867* (originally known as the *British North America Act (BNA Act)*), set out the division of federal and provincial responsibilities, with particular attention to health care. Historically, there was considerable debate among federal and provincial governments, eventually culminating in reasonable decisions about the division of responsibilities. Specific duties for all provinces were described in section 92 of the *Constitution Act*. The *Act* gave provinces exclusive powers for “the establishment, maintenance, and management of

hospitals, asylums, charities, and eleemosynary institutions (i.e., supported by or dependent on charity institutions) in and for the province other than marine hospitals” (Aucoin, 1980, p. 244). Each province was also given the right of direct taxation within its boundaries in order to raise revenue for provincial purposes, and they were to attend to all matters of a local and private nature in the province or territory.

The federal government’s powers under the *Constitution Act* were limited to the raising of money through a system of taxation, conducting the census and maintaining statistics, providing for quarantine and the establishment and maintenance of marine hospitals, and overseeing Indigenous lands reserved for Indigenous Peoples (Aucoin, 1980, p. 244). It should be noted here that the lack of inclusion of Indigenous people in Canada-wide planning for hospitals, asylums, and Indigenous lands has had serious ongoing repercussions.

Throughout the development of the health care systems, both levels of government attempted to develop programs that did not violate the powers which had been assigned to them in the *Constitution Act*. Initially, these arrangements seemed workable. However, as Aucoin (1980) noted, “the largest portion of these financial outlays was paid to provincial governments in order that they might finance health care schemes in their provinces,” but in doing so the federal government “exercised considerable leverage in determining the purposes for which these allocated funds could be spent,” including “determining the kind of research which would be supported in the sciences on which modern health care was based” (p. 245). Thus, the federal government gradually began to have a greater say in how the provinces were using health care finances.

Activities of the Federal Government

Underlying values evident in determining Canadian priorities are the fundamental commitments to “peace, order and good government” in our constitutional framework, relative to the fundamentally different US constitution of “life, liberty and the pursuit of happiness” (Villeneuve, 2017, p. 27). In the *Constitution Act*, matters regarding social welfare were described as both local and

private, and thus under the clear jurisdiction of the provinces (Rice & Prince, 2000). However, the Great Depression of the 1930s “left no doubt in the minds of Canadians that social conditions rather than individual behaviors determined the fate of most families” (p. 14). To extend that insight, the federal government commissioned a report called *Social Security for Canada*, commonly known as the *Marsh Report* (1943), in which programs were recommended, then developed, “to help people deal with problems created by modern industrial society” (Rice & Prince, 2000, p. 15).

Unfortunately, the federal government did not include Indigenous people in any determinations regarding social programs, and, as a result, there were tragic consequences for Indigenous communities. For example, the Canadian government developed a policy “to remove children from Aboriginal families and place them in residential schools in an effort to assimilate them into the majority culture of people who settled on Aboriginal lands” (Villeneuve, 2017, p. 9). We now know that “much of the treatment of those children in many residential schools ... was cruel to the point of being inhuman” (p. 9), and numerous unexplained deaths of children occurred. In addition, discrimination against Indigenous women became more visible. In fact, “Canada was admonished by the United Nations in 2015 for its ‘grave violation’ of human rights by failing to take on the disproportionate levels of violence against Aboriginal women” (Villeneuve, 2017, p. 9). Indigenous leaders and federal, provincial, and territorial governments have been engaged in ongoing dialogue, discussion, and investigations about these violations and their outcomes, attempting to find a way forward (Truth and Reconciliation Commission of Canada [TRC], 2015).

As a result of the Great Depression in the 1930s, Canadians began to see social policies as necessary to uphold their lives and their work. Several post-World War I pensions and other programs to aid returning soldiers were offered, leading to the introduction of the *Old Age Pensions Act* in 1927 (Rice & Prince, 2000, p. 45), which became a long-standing program. In Table 3-1 below, we outline the major federal legislation passed between 1867 and 1985 which influenced the evolution of the Canadian health care system.

TABLE 3-1

Timeline of Federal Legislation Affecting Health Care, 1867–1985

Date	Name of Federal Legislation
1867	<i>Constitution Act (formerly British North American Act [BNA Act])</i>
1927	<i>Old Age Pensions Act</i>
1947	National Health Grants
1957	<i>Hospital Insurance and Diagnostic Services Act (HIDS Act)</i>
1966	<i>Medical Care Insurance Act (Medicare)</i>

Provincial and Territorial Government Actions

In 1947, the federal government developed a series of national health grants to be provided to each province and territory. The grants included a health survey grant, followed by a series of other grants for public health, venereal disease control, mental health, tuberculosis control, cancer control, children with disabilities, public health research, hospital construction, and professional training (Taylor, 1987). These grants were intended to assist the provinces and territories in building their health services and infrastructure (Rice & Prince, 2000). The grants were followed by grant packages that included funds for health planning, public health, hospital construction, professional training,^H as well as other basic services. The grants were offered with the understanding that each province or territory was free to decline the offer of any and all grants (Hastings, 1980).

Subsequent developments in several provinces set the stage for the uptake of new approaches. The fundamental value of caring for people in need of health care, without out-of-pocket cost, is credited to Premier Tommy Douglas and officials in the province of Saskatchewan, who were committed to ensuring that everyone should have free access to health care (Taylor, 1987).³ Douglas became aware of the need for all people to have free access to health care when, as a child, he needed privately offered and costly care (Margoshes, 1990). His experience, and the plight of others, caused him to argue, as summarized by Fierlbeck (2011), that “health care

ought to be built on a recognition of human dignity, as well as a framework of economic efficiency” (p. 18).

Saskatchewan, with Douglas as premier, became a leader in the provision of province-wide health services and other notable innovations. For example, the *Act* outlining Saskatchewan’s hospital insurance plan received royal assent on April 4, 1946 and was implemented on January 1, 1947. It served as a model for the development of the federal *Hospital Insurance and Diagnostic Services Act (HIDS Act)* in 1957 (Taylor, 1987). As Taylor noted, “A social idea had been translated into an operating reality: the first universal hospital insurance program in North America had been launched. For Saskatchewan there was no turning back” (p. 103). In 1961, Saskatchewan added a public insurance plan for payment of physician services, which became a model for the federal *Medical Care Insurance Act* (Medicare) in 1966.

After Douglas helped establish the first universal health care programs in Canada, he stepped down from his role as Premier of Saskatchewan to lead the newly formed federal New Democratic Party (NDP), which became a successor to the national CCF (Cooperative Commonwealth Federation). In 1961, Douglas was elected the NDP’s first federal leader, and “in order to signal the primacy his government would allocate to health services, he also assumed the portfolio of health minister” (Taylor, 1987, p. 86).

Launching Medicare legislation (1966) was not without incident. As Douglas laid out plans for universal medical insurance, physicians’ strong opposition to the compulsory nature of the plan (which replaced fee-for-service with government payment to physicians) grew. For three weeks, 90% of physicians withdrew their services in reaction to what they perceived as “socialized medicine” (Villeneuve, 2017, p. 83). The standoff ended when the government agreed that physicians could opt out of Medicare.

As a result of the Medicare legislation, each province had to “buy in” to a program of hospital and diagnostic services insurance, then medical care insurance, to create and become part of Canada’s “universal” health care system. Thus, these two programs covering hospital insurance and medical insurance could only come into existence by agreement with each province, in order to avoid violation of the federal-provincial legislated rights.

Major Federal Legislative Action

Two significant federal programs came about with passage of the *HIDS Act* in 1957, and the *Medical Care Insurance Act* in 1962. Taylor described the *HIDS Act* as “an historic measure.... It was the largest governmental undertaking since the war and would require federal-provincial cooperation on a scale never known” (Taylor, 1987, p. 230). In fact, in the early 1960s Prime Minister John Diefenbaker became anxious about health care costs, calling for a review of the system and appointing the Honorable Justice Emmett Hall to undertake this review (known as the *Hall Commission*) (Villeneuve, 2017).

Most of these legislative innovations were first adopted by the remaining provinces, then adopted at the national level. Notably absent then, and still needed now, was adequate funding and coverage for two major programs: a program for Pharmacare (Fierlbeck, 2011), and funding for long-term care. These programs continue to be under discussion for inclusion as insured services under the *CHA*.

In relation to Pharmacare, Fierlbeck (2011) noted that both federal and provincial governments were concerned about offending pharmaceutical companies, “recognizing that when they are seen as good corporate citizens by governments (providing jobs, taxes and publicity) there is much less willingness to step on their toes by implementing a program that would disadvantage such strategic corporate allies” (p. 159). However, a national Pharmacare program could have been cost-saving for the government and beneficial for the public.

Commencing in 1961, Justice Emmett Hall was appointed by the Diefenbaker government to chair a national commission to inquire into facilities and services that had been developed, and to forecast future needs for health services for Canadians. He was also to recommend what steps should be taken, consistent with the division of legislative powers in Canada, to develop the best possible health services accessible to the Canadian people (Villeneuve, 2017, p. 83).

Villeneuve (2017) noted that nurses were particularly politically active during the 1960s and that the Dean of Nursing at the University of Montreal and past president of the Canadian Nurses

Association (CNA), Alice Girard, was a sitting member of the Hall Commission. The CNA, on behalf of Canadian nurses, presented a brief to the Commission containing twenty-five recommendations to improve nursing services and enhance Canada's health care systems.

The *Medical Care Insurance Act* and the *HIDS Act* eventually led to the development of the *Canada Health Act* (1985). When the two Acts were combined, the four principles that were meant to govern health care were established as part of the *Canada Health Act*. Later, a fifth principle was added. Thus, the *Canada Health Act* eventually included five principles which remain central to Canadian health care: public administration, comprehensiveness, universality, portability, and accessibility (Fierlbeck, 2011; Villeneuve, 2017). We will elaborate further about these principles in the section “The *Canada Health Act*.”

Federal and Provincial Planning and Evaluation of Health Care Delivery

During the period spanning 1964 to 2002, several key provincial processes were underway to study provincial health care provisions and systems. Four significant federal reports were also developed; these provided national guidance in key areas of health care. The reports are listed in Table 3-2 below and will be discussed briefly.

TABLE 3-2

Key Federal and Provincial Reports by Year and Province

Year(s)	Province	Name of Report
1961–1964	Federal	<ul style="list-style-type: none"> • <i>Royal Commission on Health Services: Vol. I.</i> June 19, 1964 • <i>Royal Commission on Health Services: Vol. II.</i> Dec 7, 1964 • <i>Hall Commission</i>
1970	Quebec	<ul style="list-style-type: none"> • <i>Commission of Inquiry on Health and Welfare in Quebec</i> • <i>Castonguay Report</i>
1972	Manitoba	<ul style="list-style-type: none"> • <i>White Paper on Health Policy</i>
1972	Federal	<ul style="list-style-type: none"> • <i>Report of the Community Health Centre Project</i> • <i>Hastings Report</i>
1973	British Columbia	<ul style="list-style-type: none"> • <i>Health Security for British Columbia</i> • <i>Foulkes Report</i>
1974	Ontario	<ul style="list-style-type: none"> • <i>Ontario Health Planning Task Force</i> • <i>Mustard Report</i>
1974	Federal	<ul style="list-style-type: none"> • <i>A New Perspective on Health of Canadians</i> • <i>Lalonde Report</i>
2002	Federal	<ul style="list-style-type: none"> • <i>The Standing Senate Committee on Social Affairs, Science and Technology Study on the State of the Health Care System in Canada</i> • <i>Kirby Report</i>
2002	Alberta	<ul style="list-style-type: none"> • <i>A Framework for Reform: Report of the Premier's Advisory Council on Health</i> • <i>Mazankowski Report</i>

Provincial Reports

Since these reports influenced further developments in health care, a brief synopsis of each report is provided below.

- Provincially, Quebec led the way in completion of the *Commission of Inquiry on Health and Welfare* (1970), also known as the *Castonguay Report*. Developed over a six-year period, it was a broad inquiry into an income, health, and social security system for Quebec. This extensive report was

six years in the making, comprising seven volumes and numerous appendices, and has had lasting significance in Quebec.

- Manitoba published a *White Paper on Health Policy* in July 1972, which was designed for discussion with the public and health care professionals, and used to foster integration of activities within its seven regions. In the report, there was a call for combined community health and social service centres to be set up within districts.
- In 1974, Ontario embarked on a study (called the *Mustard Report*) to develop a comprehensive health plan for the Province of Ontario. The establishment of District Health Councils and Area Boards within the Councils to coordinate institutional management, primary health groups to provide continuous complete care, and secondary care groups to provide specialist services were recommended.
- Within the *Foulkes Report* (1973) in British Columbia, there was a call for the establishment of seven regions with local boards to have independence and autonomy, and for public health nurses to be classified as “physician associates” who would have a major role in coordinating care.
- Within Alberta’s *Mazankowski Report* (2002), there was an emphasis on new public management, which was essentially a clear commitment to move towards more market-oriented reforms. Fierlbeck (2011) noted that in both Alberta and Quebec, where there were proposals to privatize health care, those “proposals ... were quickly shelved since there was public opposition” (p. 66).

Federal Reports

Meanwhile, the writers of two significant federal reports—a *New Perspective on the Health of Canadians*, known as the *Lalonde Report* (1974), and *The Community Health Centre in Canada*, known as the *Hastings Report* (1972)—urged a shift to less expensive community care to facilitate health promotion, disease prevention, and foster community action. Marc Lalonde, the Canadian

Minister of National Health and Welfare in 1974, “recognized that what usually are called health services are really sickness or treatment services” (Gellman, et al., 1980, p. 281). Lalonde (1974) concluded that

Marvelous though health care services are in Canada in comparison with other countries, there is little doubt that future improvements in the level of health of Canadians lie mainly in improving the environment, moderating self-imposed risks and adding to our knowledge of human biology. (p. 18)

The authors of these reports all described the engagement of professionals and the public in debates about their findings. Most of the reports contributed to federal, provincial, and territorial health care priorities and planning.

Two additional federal reports particularly worthy of note are the *Kirby Report* (2002) and the *Romanow Report* (2002). Kirby, in his report, focused on identifying Ottawa’s five key roles in health care: financing, research and evaluation, provision and monitoring health infrastructure, population health, and service delivery to specific groups (for example, the military and Indigenous people). Kirby also noted that the poor “health conditions of Aboriginal people on and off reserves was becoming more prominent” (Fierlbeck, 2011, p. 50).

Against the background of a debate about private for-profit service delivery versus the commitment to the public system in place, Romanow (2002) called for the creation of a Canadian Health Care Covenant. In the report, *Building on Values: The Future of Health Care in Canada*, Romanow suggested that this “new Canadian Health Covenant should be established as a common declaration of Canadians’ and their governments’ commitment to a universally accessible, publicly funded health care system” (p. 83). Romanow also proposed that additional funding should be targeted for home care, which could become the basis of a national home care strategy, and that the *Canada Health Act* should be revised to cover home mental health intervention, case management services, and post-acute home care and palliative home care. The *Romanow Report* set

the stage for the greater use and comprehensive management of electronic health records information and technology.

Following the reports by Kirby and Romanow, subsequent reports and activities were focused on the mental health care of Canadians (for example, *Out of the Shadows*, the 2006 report chaired by Kirby and Keon about mental health) (Fierlbach, 2011). Unfortunately, few of the recommended directions for mental health services have been lasting (Villeneuve, 2017).

These multiple reports across Canada, and their uptake, were an indication that Canadian citizens have had an ongoing historical commitment to enhancing Canadian health care systems. Canadians have been, and continue to be, ready to be engaged in understanding, valuing, reviewing, promoting, and using health care. However, over time, the reality of rising health care costs has required governments to turn their attention to finding strategies to contain the escalation of expenditures.

Federal-Provincial Funding

The federal government raised concerns in 1977 about the rapidly escalating federal health care costs, and began to seek new and different ways to finance health care. Thus, they developed a system that same year “that permitted them to place clear and predictable limits on the amount of funding directed to the provinces” (Fierlbeck, 2011, p. 51). The proposed system included a cost-sharing arrangement between the federal and provincial governments for funding health care. This arrangement included a system of “block funding,” with a formula of 25% direct cash payments, plus tax points (13.5 + 1.0 tax points)⁴ transferred to the provinces (Van Loon, 1980, p. 349). These public funds were all to be offered under the same principles as *HIDS* and Medicare (i.e., public administration, comprehensiveness, universality, portability, and accessibility) (Fierlbeck, 2011 p. 21). This arrangement became known as the *Established Program Financing Act (EPF)* (1977). However, the outcomes of this block funding program still left wide room for deviations in practice in each province. These included deviations from the goal of a national health care system, some loss of control of health care standards, increased pressure for user fees,

and criticisms that the process favoured the richer provinces (Fierlbeck, 2011).

Monique Bégin's appointment as the federal Minister of Health and Welfare in 1977 ensured that the federal government had a champion for its universal health care programs. Bégin, known as the "saviour of [M]edicare," (Bégin, quoted in Hibler, n.d) wrote:

[B]y 1979, I concluded that extra-billing and user-fees were a cause of erosion of the system and that something had to be done. But what and how? The constitutional challenge — controlling provincial institutions and health professional behaviour — was not insignificant and was the most important task to address. It took almost three years to find a way and we succeeded thanks to top constitutional experts outside of government. Convincing Cabinet was also a challenge. (quoted in Fierlbeck, 2011, p. 20)

The Canada Health Act

Seen as the next logical step, the *Canada Health Act (CHA)* of 1985 replaced the *HIDS Act* and the *Medical Care Insurance Act*. Through its introduction, the federal government sought to correct the negative effects of block funding. In the preamble to the *CHA*, emphasis was placed upon the need for cooperative partnerships of governments and health professionals, as well as voluntary agencies. These criteria were stressed as critical to the health and well-being of Canadians. It was at this time that the additional principle of *accessibility* was added to the set of four principles which had been established and confirmed in Medicare. The intent of this addition was to ensure that all residents of a province or territory were entitled to health care based on uniform terms and conditions. The five principles of the *Canada Health Act*, as paraphrased from Ville-neuve (2017, p. 86), are

- **Public Administration:** All provinces and territories must administer Medicare on a not-for-profit, single-payer basis.
- **Comprehensiveness:** The insurance program must cover all medically necessary services.

- **Universality:** Every resident of a province or territory must have access to public health insurance based on uniform terms.
- **Portability:** When a provincial or territorial resident requires access to insured services while temporarily outside their own province or territory, or outside of Canada, equivalent services to what they would receive in their home province must be provided.
- **Accessibility:** Canadian residents must have reasonable access to insured health services, free of charge or other restrictions, and must not be discriminated against because of, for example, age, income, or health.

Both provincial and federal governments have varying degrees of jurisdiction over different aspects of health care. However, it has generally been accepted that the provinces and territories have primary jurisdiction over the organization and delivery of health care (Romanow, 2002). To appreciate Canada's funding approach, it is important to remember that although Canada's fragmented health care system is coordinated by the federal government, the provinces and territories control the system and consent to these arrangements (Fierlbeck, 2011). Fierlbeck stated that it is only public opinion and cash that give a national structure to Canadian health care, and both variables are unpredictable.

Access to Health Care: The Citizen's Health Care Card

To operationalize the provisions of the *CHA*, each Canadian citizen carries a unique provincial health care card, which gives them access to health care, for example, at an emergency department. Physicians' office personnel and laboratories also use the card number to provide services to citizens without out-of-pocket payment. The prohibition placed upon this use is that extra-billing is not allowed. Most Canadians under the age of 60 take this card, and the access to health services it provides, for granted. They do not realize that prior to the mid-1960s, individuals had to pay out of pocket for each service in order to see a health care professional and receive health care, x-rays, and other medical tests. One of the authors of this chapter (Storch) experienced the inability to access

necessary health care when she was in the United States, as she describes in the following personal narrative.

PERSONAL ETHICS NARRATIVE

A Challenge Accessing Urgent Health Care Services

In 1996, I was a Visiting Professor at the Kennedy Institute of Ethics and Georgetown University in Washington, DC. During my final month in Washington, I experienced a very sore throat that lasted several days, which I self-diagnosed to be a strep throat. I eventually had to seek care, and joined in the waiting line at a hospital outpatient department (OPD) nearby. The OPD was crowded with persons in need of care and their friends or relatives. I watched many being sent away from the department because they could not pay the price of examination nor the cost of the procedure and the necessary drug. For example, I watched two women appealing for help for their sick mother. They had no health insurance and were unable to pay, so they left with their mother untreated. When I reached the front of the line, I was told that I did not have any travel health insurance, and therefore, I could not be seen unless I paid several hundred dollars. Since my experience in the US, I have become more aware of the importance of protecting and sustaining a Canadian health care system that does not operate on the ability of the patient to pay for services.

Deficiencies in the Canadian Health Care System

Although significant progress had been made in almost all areas of health care by the time the *CHA* was passed in 1985, at least three areas of care did not experience sufficient progressive developments to meet the needs of Canadian residents. Those three areas were long-term care (LTC), mental health and illness care, and improved services for Indigenous people, all of which continue to be problematic. In what follows, we provide a brief overview of some of the deficiencies in these areas. Please refer to Chapters 15, 10, and 5 for more detailed discussions of long-term care, mental health, and Indigenous health care, respectively.

Deficiencies in Long-Term Care Services

Inadequate funding for long-term care in Canada was clearly recognizable during the COVID-19 pandemic (Estabrooks et al., 2020). Since nursing homes fell outside the *CHA*, the principles applicable to acute care settings did not apply to long-term care. As residents in need of long-term care were among the sickest and most likely to die during the pandemic, this built-in inadequacy was immediately visible. Nurses were among those who witnessed first-hand the poor planning and inadequate provision for this sector of care, and, as a consequence, the many deaths from COVID-19 that occurred in long-term care (Picard, 2021).

Residents in long-term care became the victims of inadequate services resulting from a chronic lack of funding to cover the costs of sufficient nurses and other health care providers, as well as equipment for mobility. In addition to the need for improved long-term care funding, Canadian journalist Picard (2021) described infrastructure deficiencies in long-term care, which he noted have been decades in the making. Picard framed the issue this way:

Canada's provinces need to make judicious use of the wrecking ball. What needs to replace many of our large, decrepit institutions are smaller, more home-like facilities that are built to the needs of residents. For example, elders with dementia need to be able to wander safely, not just be confined to rooms; homes need to be equipped on the assumption that everyone could have mobility issues. (p. 168)

Picard (2021) identified other problems, including LTC sites being unprepared for the rapid spread of COVID-19, and the challenges created by the mix of residents' needs. He also noted concerns about the inadequacy of resources, such as equipment and supplies, including PPE (personal protective equipment). In care homes with older infrastructure, isolation of those with COVID-19 was impossible because the structure of the buildings did not allow for isolation measures. The limitations of the structures also restricted, or seriously limited, family members from visiting loved

ones (even after visiting was permitted), thereby causing more grief and anguish for long-term care residents and their families.

Deficiencies in Care of the Mentally Ill

Fierlbeck (2011) provided a summary of mental health care in Canada, emphasizing that “mental care is not a subset of health care because it is qualitatively different from it” (pp. 196–97). Since mental health is under provincial and territorial jurisdiction, establishing asylums for those who were mentally ill slowed mental health reform for a long time in Canada. The federal government was not permitted to regulate policy in this area. Following the publication of the Romanow (2002) and Kirby (2002) reports, there was a call by some citizens for a return to the mid-sixties asylums, which were seen by some people as the best treatment for the mentally ill. However, in the Senate report *Out of the Shadows at Last*, the committee chaired by Kirby and Keon (Standing Senate Committee on Social Affairs, Science and Technology, 2006) called for a reinvigoration of Canada’s mental health care system. In 2009, a draft framework was developed for a comprehensive national strategy on mental illness and mental health. However, little action followed.

Deficiencies in Health Care for Indigenous Peoples

Deficiencies of health care for Indigenous peoples has not only been discussed in Canada, but was raised by the United Nations Commission on the Rights of Indigenous Peoples. Article 7 of the 46 Articles of the *United Nations Declaration on the Rights of Indigenous Peoples* (United Nations General Assembly, 2007) is focused on Indigenous individuals’ “rights to life, physical and mental integrity, liberty and security of person.” In 2008, Canada established the Truth and Reconciliation Commission of Canada (TRC) as part of the Indian Residential Schools Settlement Agreement (Government of Canada, n.d.). In 2015, the commission published their final report, which included calls to action to address child welfare, education, language and culture, health, justice, and all matters of reconciliation. Responsibilities for health in the *TRC Calls to Action* (2015) are reproduced below:

18. We call upon the federal, provincial, territorial, and Aboriginal governments to acknowledge that the current state of Aboriginal health in Canada is a direct result of previous Canadian government policies, including residential schools, and to recognize and implement the health-care rights of Aboriginal people as identified in international law, constitutional law, and under the Treaties.

19. We call upon the federal government, in consultation with Aboriginal peoples, to establish measurable goals to identify and close the gaps in health outcomes between Aboriginal and non-Aboriginal communities, and to publish annual progress reports and assess long-term trends. Such efforts would focus on indicators such as: infant mortality, maternal health, suicide, mental health, addictions, life expectancy, birth rates, infant and child health issues, chronic diseases, illness and injury incidence, and the availability of appropriate health services. (pp. 2–3)

These commitments are critical to improving Indigenous health care in Canada.

Other Deficiencies in Canada's Health Care System

Other gaps in Canada's health care system that have always existed are the lack of coverage for dental care and prescription drugs. As the Liberal government's federal budget was being prepared for presentation in April 2022, there was speculation that funds for both a dental care program and a Pharmacare program would be established. But on budget day, only one of these programs was introduced: a phasing-in of a dental-care program focusing on children (Department of Finance Canada, 2022a). In the Federal Budget 2022, the government stated that it would establish a Canada-wide Pharmacare bill by the end of 2023. The Canadian Drug Agency would be given the task of developing a list of essential medicines that would support implementation of this bill (Eckler, 2022). In considering the changes that are necessary in the

Canadian health care system, Lee et al. (2021) stated that “[r]eal change that fully embraces the values that Canadians want in their healthcare system will only come when there is broad public support for politicians to make difficult policy choices” (p. 40).

Proposed Solutions to Health Care Access: Privatization and Extra-Billing

With a clear choice by Canadians to value equality of access and maintain a strong publicly funded health care system, ways and means continue to be sought to improve funding of health services. Fierlbeck (2011) stated that “All health care systems are a mix of public and private elements; and many are structured on mechanisms (like social insurance schemes) that are neither fully public nor private” (p. 32). People advocating for private insurance, Fierlbeck noted, think it is more efficient and provides more choice.

Romanow (2002) created a clear distinction between necessary clinical and non-clinical services (for example, cosmetic surgery), proposing that only the latter could be provided on a for-profit basis. Yet, as Pauly (2004) noted, there has been an enduring belief among some that for-profit delivery of health services would be more efficient. Pauly stated that

it is essential that nurse leaders understand the way in which health care is funded and delivered in order to assess the *ethical* consequences of introducing particular health care reform strategies. The choice to support publicly funded health care and to refuse to allow further private for-profit health care in Canada is a value choice Canadians have made and can continue to make. These values are morally sound and consistent with nursing values and current research. (p. 199, emphasis in original)

In examining provincial practices with respect to private health care, Flood and Archibald (2001) reported that a significant private sector had *not* developed in any of the provinces up to 2001, and that measures had been developed to make adoption of the private sector less desirable. These authors attributed “the lack of a flourishing

private sector in Canada” to the rules prohibiting physicians from topping up their incomes by turning to the private sector (p. 830). However, by 2012, Forbes and Tsang suggested that there was a “privatization creep” underway in Canada, and they offered cautions toward preserving the public system. They suggested that the public system ultimately rests “on the will of the Canadian people” and indicated that “it would be a pity to see strong beliefs in equality buried by a lack of public preparation” (p. 4).

Questioning whether increased private health care for Canada would be the right solution, Lee et al. (2021) found that increases in private funding did not reduce health expenditures or improve health outcomes. These authors also recommended that ongoing debates about health care “should not be rooted in the source of funding but in the values Canadians regard as necessary for their health care system” (p. 31). In their study on the quality and sustainability of health care, Quinn and Manns (2021) did not find any evidence that resorting to private financing would impact challenges confronting Canadian health care. They urged that structures be found to “foster sustained physician engagement [which] will be critical in order to successfully improve the quality and sustainability of the healthcare system” (p. 9). Yet, in Canada, there continues to be ongoing and heightened discussion about privatization in health care as a potential way to better manage costs (Lee et al., 2021).

As an example of this ongoing discussion about privatization in health care, in Quebec, physicians warned the government and the public that family physicians were leaving the public sector for the private sector (Sherwin, 2022). Sherwin explained that the intentions of those leaving appeared to be a reaction to the Health Ministry’s attempt to legislate how primary care was delivered. Sherwin, along with other spokespersons, noted that “this was a bad move for the population” (p. 4). In addition, Sherwin indicated that some students in family medicine were seeking opportunities outside Quebec, and that several physicians were opening private clinics. Those monitoring this creep of family physicians leaving public clinics noted that Quebec was already short 1,000 family physicians.

Over 10 years ago, Fierlbeck (2011) stated that those critical of privatization “argue that attempts to push health care into the private

sector, if successful, would favour the wealthy while creating a disadvantage for the poor and ill” (p. 37). Doing so, these critics of privatization argued, would undermine the public system. Others agree that privatization should be resisted and instead, there should be enhancement of the public system to cover some additional private services not currently covered (CMA Duong, 2022; Yeo et al., 2020).

As another way of handling health care costs, there has been a growing tendency of health care providers to extra-bill and/or to impose user-fees on Canadians (Flood & Archibald, 2001). This is being done even though the *CHA* bans extra-billing (sometimes called balanced billing by physicians). Extra-billing is a system whereby a physician charges their patients an additional fee or “extra charge” for services covered by the public plan (Flood & Archibald). This practice means that not only do physicians receive payment from the public plan, but they also receive whatever costs they bill patients. This was a practice Monique Bégin bemoaned in 1979, believing that it constituted an erosion of the health care system.

Extra-billing has been used in some provinces as a way to help cover health care costs. Shortly after the use of extra-billing began, HCPS and extra-billing program administrators were required to provide the federal Minister of Health with estimates of the expected costs incurred from extra-billing (or user fees), as well as the methods used to determine that amount. Although extra billing seemed to be widespread,⁵ locating those physicians who were extra-billing for health services eventually focused on only a few. One of these physicians was Dr. Brian Day of Vancouver, BC. In advertising his long-standing private specialist referral clinic, the Cambie Surgery Centre, Day continued to challenge federal and provincial governments about the right to operate and directly bill those who used the clinic’s services. Day’s claims were focused on long wait times in the public system. He believed this should be addressed by allowing physicians, who worked within Medicare, to also be allowed to sell their services to people willing to pay for faster care. However, as mentioned previously, under the *CHA*, physicians are prohibited from providing for-profit care. In his argument against this prohibition, Day took his challenge to various BC courts where he lost his case a number of times (Baron, 2021; Canadian Doctors for Medicare (n.d.); CBC News, 2020; Fine,

2020; Jackman, 2020). Some consider this a huge win for public health care; however, Day continued his challenge by seeking approval from the Supreme Court of Canada to hear his case (Flood & Thomas, 2021). In April 2023, the Supreme Court dismissed Day's appeal and the case will not be heard by the court (CBC News, 2023). Nonetheless, it is clear that the discussion about privatization of health care in Canada will be part of future debates about health care system reform.

Moving Toward Change in Health Care

There are changes being proposed to improve health care in a variety of areas (Wherry, 2022). For example, in early 2022, a draft of national long-term care services standards was released for public review (CSA Group, 2022). In the draft, the Standards Council of Canada focused on six foundational principles to inform the development of the national standard:

1. Homes in LTC are both workplaces and homes.
2. Homes are focused on the perspectives of LTC residents.
3. Resident-centred care focuses on equity, cultural safety, inclusion, diversity, and attention to systemic racism.
4. Residents in LTC have a right to live at risk.
5. Improving resident-centred care requires continuous data collection.
6. Meeting LTC standards requires mechanisms to enable achievement.

Ethics in Practice 3-1, below, exemplifies the hope that APNs and others have to improve the long-term care system.

ETHICS IN PRACTICE 3-1*A Valiant Agent of Change*

Rhys is a nurse practitioner who works in long-term care. He changed his workplace in the last eight months, transitioning from working in a critical care unit to working in a nursing home. Rhys made this move because he wanted to respond to the difficult situations in nursing homes that came to light during the COVID-19 pandemic. He has become very aware of the shortage of staff in long-term care and is appalled at the conditions under which many of his nurse and care aide colleagues work. Nurses and care aides working alongside Rhys tell him that “he will get used to it; that is just how long-term care is run.” He does not accept that for an answer and he is seeking a way to change this reality. He comes to you, an advanced practice nurse and nurse leader, seeking advice on actions he might take to better understand the situation and to make needed changes.

REFLECTIVE QUESTIONS

1. *What steps would you suggest Rhys take to collaborate with other nurse practitioners active in long-term care to initiate change?*
2. *How could Rhys work with leaders in his organization to initiate progressive change in his long-term care facility?*
3. *How might Rhys include residents and their families in planning for change?*
4. *How might Rhys ensure that all involved are acquainted with the draft national long-term care services standard?*

Moving Forward on Reconciliation with Indigenous People

The federal government continues to work with Indigenous people to improve housing, to support children and education, and to respond to the Truth and Reconciliation Commission’s Calls to Action (Department of Finance, 2022b). Among the successes include the lifting of 131 long-term drinking water advisories by March 21, 2022. Also, since 2016, the government committed nearly \$4 billion toward meeting the needs of First Nations children through a program called Jordan’s Principle.⁶

Although progress has been made, widespread deficiencies in Indigenous communities remain to be addressed, as articulated in

the *Truth and Reconciliation Commission of Canada: Calls to Action* (2015). Advanced practice nurse leaders have a role to play in attending to the calls to action. The following Ethics in Practice scenario focuses on improvements needed in health care in Indigenous communities, as discussed in the *Truth and Reconciliation Calls for Action*.

ETHICS IN PRACTICE 3-2

Developing a Plan for Improved Primary Care

Kelly is an advanced practice nurse who has been appointed to co-lead a new committee designed to plan for changes in primary care in a First Nations community. Kelly was born in the community and identifies as having Coast Salish ancestry. The committee's mandate is to develop a plan that will address the deficiencies in access to primary care in their community. Kelly is employed by the First Nations community and has permission to invite people to join the committee from the community. She may also invite professional advisors and service providers whom she believes could make a significant difference to the community's planning.

REFLECTIVE QUESTIONS

1. *What should Kelly consider in regard to criteria, membership, and process when establishing the committee?*
2. *What kinds of preparation and support are needed to create an effective committee?*
3. *What are some ideas about how communication can be set up to keep the community informed?*
4. *How might Kelly build constructive dialogue and trust among/between diverse stakeholder members on the committee and within the broader community?*

Nursing Leadership: Political Action of the Canadian Nurses Association

Given the challenges within the health care system, and the need for progressive change, sustained and skilled leadership by nurses across Canada is essential. This leadership is being demonstrated by the Canadian Nurses Association, as they have been collaborating

with other national professional bodies in political action to influence policy and practice changes required for health system reform. In a joint paper with the Canadian Medical Association (CMA, 2013), the CNA provided evidence of the Canadian public's strong support for the five principles of the *CHA*. At that time, they also urged that beyond hospital and physician services, prescription drugs, home care, and physiotherapy services should be included in plans for subsidized care.

In March 2020, the CNA prepared a new paper on intraprofessional collaboration, which urged regulated nurses to seek out and value each other and to recognize “the important contributions that each nursing designation makes to patient care and the health system” (CNA, 2020a, p. 1). Included in the paper was a focus on resources required to promote and support optimal intraprofessional collaboration. The CNA next developed a brief on how long-term care could be improved; this was delivered to the Government of Canada in May 2020 (CNA, 2020b). The writers of the brief asked the federal government to appoint a committee of inquiry on aging. Further, they urged the federal government to work with provincial, territorial, and Indigenous governments, as well as public leaders, to conduct an evaluation on Canada's response to COVID-19, and to encourage all levels of government to increase investments in “community, home and residential care to meet the needs of our aging population” (p. 2).

On June 1, 2020, a letter was sent by the CNA and the CMA to the Minister of Health, Health Canada and the Minister of Seniors, urging their attention to the challenging effects COVID-19 has had on the health care system, particularly LTC (CMA, 2020a). In December 2020, the Canadian Nurses Association joined the Canadian Medical Association and the Canadian Society for Long-term Care Medicine in an appeal to the federal government for national long-term care standards (CMA, 2020b).

On February 1, 2022, the federal government reinstated the position of the federal Chief Nursing Officer (CNO) for Canada. This action was preceded by years of lobbying by the Canadian Nurses Association. Due to a health workforce crisis, the re-establishment of the CNO role was welcomed as a significant step for nurses, and particularly for Canada's health care system (CNA, 2022). The intro-

duction of this role has the potential to provide nursing leadership, and a nursing voice, for health system planning at the federal level. This is particularly important since, as the pandemic progressed, the loss of nurses and other health care workers was substantial and was emphasized in a news release from the CNA (2021) titled “Without health workers, there is no health care: Health care leaders call for urgent action at an emergency COVID-19 summit” (CNA, 2021). At the summit, the CNA and the CMA brought together approximately 40 national and provincial health organizations to develop short- and long-term actions for an effective COVID-19 response and to ensure that Canada’s health system remained sustainable.

Improving Canada’s Health Care: The Role of Advanced Practice Nurses

Despite gradual improvements in the areas of deficiency noted in this chapter, two immediate problems for Canadian citizens are increasingly evident: (a) the lack of primary care providers (Xiao, 2022), and (b) the lack of timely access to health care services (Lee et al., 2021). There is an urgent need to address these two shortfalls, and advanced practice nurses (APNs) can play a significant role in meeting the health care needs of people in a variety of settings.

Nurses’ current level of preparation and certification for this role has extended their involvement in all fields of advanced nursing practice. As a result of the shortage of physicians, nurse practitioners (NPs) are considered by many to be able to bridge the gap in primary care. Bramham (2022) emphasized the lack of family physicians and promoted health reform; however, she overlooked the significant roles NPs could fill in health reform.

APNs are nurses who undertake graduate nursing education for advanced practice. They have studied specialized nursing and health care knowledge, gained substantial experience in clinical nursing, and engage in complex decision-making to serve health needs of persons, families, special groups, communities, and populations. It is imperative that APNs fill current and widening gaps in health care and provide more comprehensive care for all. APNs have a role in urban and rural centers and have major roles in meeting the needs of underserved populations.

In the past, nurses have served in the Northwest Territories, the Yukon, Newfoundland and Labrador, as well as in the northern areas of the prairie provinces. Although their preparation varied at that time, almost all grew into the role needed for what was often called “outpost nursing.” Outpost nursing was, and continues to be, an area of practice for registered nurses with experience, skills, and willingness to work in very challenging conditions, often in small, remote communities. Once again, it is time for nurses “who integrate graduate nursing educational preparation with in-depth, specialized clinical nursing knowledge and expertise in complex decision making to meet the health needs of individuals, families, groups, communities, and populations” (CNA, 2019, p. 13). These nurses are required now, more than ever. For example, with the growing shortage of physicians in primary care, it is timely for nurse practitioners to apply their knowledge and skills toward family practice to fill the void in primary health care. NPs who are working within primary health care are essential in filling the gap for those who are seeking a primary care provider (Whittaker, 2022).

Conclusion

In this chapter, we provided a brief history of how Canada’s health care system was built, including a focus on federal, provincial, and territorial responsibilities. We discussed federal legislative decisions and their effects on federal, provincial, and territorial obligations. Further, we described the challenges of the distribution of power in Canadian health care. The five principles of the *Canada Health Act* were discussed, with shortfalls in various health services identified. Current inadequacies in three areas of health care (deficiencies in long-term care, deficiencies in care of the mentally ill, and deficiencies in health care for Indigenous people) were identified. We argued that nursing leadership is essential in health care reform and that advanced practice nurse leaders have a role in addressing the deficiencies in health care, as well as other challenges noted in this chapter. Serious health care concerns, including the impact of the COVID-19 pandemic on the Canadian health care system, are expected to continue to challenge APNs, other HCPS, and the public in general. The knowledge and skills of advanced practice

nurse leaders are required in order to promote and provide quality health care for Canadians.

QUESTIONS FOR REFLECTION

1. *Are Canadian values about health care shifting, and, if so, what is responsible for this shift?*
2. *What are the ethical tensions associated with greater private for-profit health care funding and delivery in Canada for advanced practice nurse leaders?*
3. *What are the ethical responsibilities of advanced practice nurse leaders in response to tensions at the various levels of health care (micro, meso, and macro)?*
4. *What constraints or facilitators might advanced practice nurse leaders experience in taking action consistent with their ethical duties and obligations in the development of health care policy?*
5. *How has the history of the evolution of the Canadian health care system contributed to the current health care challenges we face?*

Endnotes

- 1 In this chapter, we draw on content from: Pauly, B., & Storch, J. L. (2013). Ethics and Canadian health care. In J. L. Storch, P. Rodney, & R. Starzomski (Eds.), *Toward a moral horizon: Nursing ethics for leadership and practice* (2nd ed., pp. 236–253). Pearson.
- 2 It is interesting to note that one of the authors of this book (Storch) was a recipient of one of these grants, which aided her in completing her Bachelor of Science in Nursing degree.
- 3 Douglas's passionate pleas for "free" health care earned him the title of "Father of Medicare" (Canadian Health Coalition, n.d.).
- 4 A tax point is a permanent transfer of income tax room from the federal government to provincial governments. The federal government reduces its basic tax rate by a specific percentage and the provinces increase theirs by an equivalent amount, thereby leaving total federal and provincial tax unaffected.
- 5 Extra-billing is a longstanding concern in Canada. See Flood and Thomas (2020).
- 6 Jordan's Principle represents the government's commitment to eliminate systemic barriers that prevent First Nations children from accessing the services and supports they need. Jordan's Principle is named in memory of Jordan River Anderson, a young boy from Norway House Cree Nation in Manitoba. Jordan was born in 1999 with multiple disabilities, and stayed in hospital from birth since the federal and provincial governments could not agree on who would pay for home-based care. Jordan remained in hospital until he passed away at age five. In his memory, the House of Commons created Jordan's Principle as a commitment to First Nations children to ensure they receive the services and supports they need (Department of Finance Canada, 2022b).

References

- Aucoin, P. (1980). Federal health care policy. In C. A. Meilicke & J. L. Storch (Eds.), *Perspectives on Canadian health and social service policy: History and emerging trends* (pp. 244–268). Health Administration Press.
- Baron, J. (2021, June 14). A bizarre form of social cruelty: Vancouver Cambie surgery's fight for better health care. Canadian Constitution Foundation. <https://theccf.ca/a-bizarre-form-of-social-cruelty/>
- Beauchamp, D. E., & Steinbock, B. (Eds.). (1999). *New ethics for the public's health*. Oxford University Press.
- Bramham, D. (2022, May 13). COVID-19 jump-started health reform. Now it is time to finish it. *Vancouver Sun*. <https://vancouver.sun.com/opinion/daphne-bramham-covid-19-jump-started-health-reform-now-its-time-to-finish-it>
- Canadian Doctors for Medicare. (n.d.). The Cambie case. <https://www.canadiandoctorsformedicare.ca/cambie>
- Canadian Health Coalition. (n.d.). *Tommy Douglas*. <https://archive.healthcoalition.ca/tommy-douglas/>

- Canadian Medical Association. (2020a, June 1). *Improving long-term care for people in Canada* [Parliamentary submission]. <https://policybase.cma.ca/link/policy14246>
- Canadian Medical Association. (2020b, December 8). *National standards for long-term care: The art of the possible?* <https://policybase.cma.ca/link/policy14383>
- Canadian Medical Association & Canadian Nurses Association. (2018, March 3). *Principles to guide health care transformation in Canada* [Position statement]. Canadian Medical Association. <https://policybase.cma.ca/link/policy10218>
- Canadian Nurses Association. (2019). *Advanced practice nursing: A pan-Canadian framework*. <https://www.cna-aiic.ca/en/nursing/advanced-nursing-practice>
- Canadian Nurses Association. (2020a, March). *Intra-professional collaboration* [Position statement]. <https://www.cna-aiic.ca/en/policy-advocacy/policy-support-tools/position-statements>
- Canadian Nurses Association. (2020b, May). *2020 Vision: Improving long-term care for people in Canada*. https://www.casw-acts.ca/files/documents/2020_Vision_-_Improving_Long-term_Care_for_People_in_Canada.pdf
- Canadian Nurses Association. (2021, October 6). “Without health workers, there is no health care”: Health care leaders call for urgent action at emergency COVID-19 summit. CNA News Room. <https://community.cna-aiic.ca/blogs/cn-content/2021/10/06/without-health-workers-there-is-no-health-care-hea>
- Canadian Nurses Association. (2022). *CNA applauds federal government for reinstating chief nursing office for Canada* [News release]. CNA News Room. <https://www.cna-aiic.ca/en/blogs/cn-content/2022/02/01/cna-applauds-federal-government-for-reinstating-ch>
- CBC News. (2020, September 10). Private Vancouver clinic loses constitutional challenge of public health-care rules. <https://cbc.ca/news/canada/british-columbia/cambie-surgeries-case-trial-decision-bc-supreme-court-2020-1.5718589>
- CBC News. (2023, April 6). *Supreme Court dismisses B.C. doctor’s appeal in challenge over access to private health care*. <https://www.cbc.ca/news/canada/british-columbia/private-health-care-dr-brian-day-supreme-court-appeal-dismissed-1.6803463>
- CSA Group. (2022, January). *What we heard: Final report*. Health Canada. https://www.csagroup.org/wp-content/uploads/CSA-WWH-FinalReport-EN_Accessible.pdf
- Department of Finance Canada. (2022a). *Government of Canada releases budget 2022* [News release]. Government of Canada. <https://www.canada.ca/en/department-finance/news/2022/04/government-of-canada-releases-budget-2022.html>
- Department of Finance Canada. (2022b). *Budget 2022, Chapter 7: Moving forward on reconciliation*. Government of Canada. <https://budget.gc.ca/2022/report-rapport/chap7-en.html>

- Duong, D. (2022, October 28). How can Canada reduce surgical backlogs without expanding privatization? *Canadian Medical Association Journal News*. <https://doi.org/10.1503/cmaj.1096025>
- Eckler. (2022, April 14). *2022 Federal budget highlights* [Special notice]. <https://www.eckler.ca/2022-federal-budget-highlights/>
- Estabrooks, C. A., Straus, S. E., Flood, C. M., Keefe, J., Armstrong, P., Donner, G. J., Boscart, V., Ducharme, F., Silvius, J. L., & Wolfson, M. C. (2020). Restoring trust: COVID-19 and the future of long-term care in Canada. *FACETS*, 5(1), 651–691.
- Fierlbeck, K. (2011). *Health care in Canada: A citizen's guide to policy and politics*. University of Toronto Press.
- Fine, S. (2020, September 10). A look at the B.C. Supreme Court ruling and where Brian Day's challenge may go from here. *The Globe and Mail*. <https://www.theglobeandmail.com/canada/article-a-look-at-the-bc-supreme-court-ruling-and-where-brian-days/>
- Flood, C. M., & Archibald, T. (2001). The illegality of private medical care in Canada. *Canadian Medical Association Journal*, 164(6), 825–830.
- Flood, C. M., & Thomas, B. (Eds.). (2020). *Is two-tier health care the future?* University of Ottawa Press.
- Flood, C. M., & Thomas, B. (2021). Round two of Canadian public medicare on trial. *The Hamilton Spectator*. <https://www.thespec.com/opinion/contributors/2021/07/04/round-two-of-canadian-public-medicare-on-trial.html>
- Forbes, C., & Tsang, E. (2012). Healthcare in Canada: Privatization and how to contain it. *The University of British Columbia Medical Journal*, 4(1), 4–5.
- Gellman, D. D., Lachaine, R., & Law, M. M. (1980). The Canadian approach to health policies and programs. In C. A. Meilicke & J. L. Storch (Eds.), *Perspectives on Canadian health and social services policy: History and emerging trends* (pp. 280–292). Health Administration Press.
- Government of Canada. (n.d.). *Indian residential schools settlement agreement*. <https://www.rcaanc-cirnac.gc.ca/eng/1100100015576/1571581687074>
- Hastings, J. E. F. (1980). Federal-provincial insurance for hospital and physicians' care in Canada. In C. A. Meilicke & J. L. Storch (Eds.), *Perspectives on Canadian health and social services policy: History and emerging trends* (pp. 198–219). Health Administration Press.
- Hastings Report. (1972). *Report of the community health centre project to the conference of health ministers*. Canadian Association of Community Health Centres (CACHC). <https://www.cachc.ca/an-idea-ahead-of-its-time-hastings-report-1972/>
- Hibler, M. (n.d.). Monique Bégin: A true teacher and friend. *Tabaret*. uOttawa. <https://www.uottawa.ca/tabaret/en/content/monique-begin-true-teacher-and-friend>

- Jackman, M. (2020). Chaoulli to Cambie: Charter challenges to regulation of private care. In C. Flood & B. Thomas (Eds.), *Is two-tier health care the future?* (pp. 37–68). University of Ottawa Press.
- Kenny, N. P. (2002). *What good is health care? Reflections on the Canadian experience*. CHA Press.
- Lalonde, M. (1974). *A new perspective on the health of Canadians: A working document*. Government of Canada. <https://www.canada.ca/en/health-canada/services/health-care-system/commissions-inquiries/federal-commissions-health-care/new-perspective-health-canadians-lalonde-report.html>
- Lee, S. K., Rowe, B. H., & Mahl, S. K. (2021). Increased private health care for Canada: Is that the right solution? *Healthcare Policy*, 16(3), 30–42. <https://doi.org/10.12927/hcpol.2021.26435>
- Margoshes, D. (1990). *Tommy Douglas: Building the new society*. XYZ Publishing.
- Martin, D., Miller, A. P., Quesnel-Vallee, A., Caron, N. R., Vissandjee, B., & Marchildon, G. M. (2018). Canada's global leadership on health 1 – Canada's universal health-care system: Achieving its potential. *Lancet*, 391, 1718–e1735.
- Nixon, S. A., Lee, K. L., Bhutta, Z. J., Blanchard, S., Haddad, S., Hoffman, S., & Tugwell, P. (2018). Canada's global leadership on health 2 – Canada's global health role: Supporting equity and global citizenship as a middle power. *Lancet*, 391(10131), 1736–1748.
- Pauly, B. (2004). Shifting the balance in the funding and delivery of health care in Canada. In J. L. Storch, P. Rodney, & R. Starzomski (Eds.), *Toward a moral horizon: Nursing ethics for leadership and practice* (1st ed., pp. 181–208). Prentice Hall.
- Pauly, B., & Storch, J. L. (2013). Ethics and Canadian health care. In J. L. Storch, P. Rodney, & R. Starzomski (Eds.), *Toward a moral horizon: Nursing ethics for leadership and practice* (2nd ed., pp. 238–253). Pearson Canada.
- Peter, Elizabeth. (2004). Home health care: Ethics, politics, and policy. In J. L. Storch, P. Rodney, & R. Starzomski (Eds.), *Toward a moral horizon: Nursing ethics for leadership and practice* (1st ed., pp. 181–208). Prentice Hall.
- Picard, A. (2021). *Neglected no more: The urgent need to improve the lives of Canada's elders in the wake of the pandemic*. Penguin Random House.
- Quinn, A. E., & Manns, B. J. (2021). Commentary: Improving the sustainability of healthcare in Canada through physician-engaged delivery system reform. *Health Care Policy*, 16(3), 43–50.
- Rice, J. R., & Prince, M. J. (2000). *Changing politics of Canadian social policy*. University of Toronto Press.
- Romanow, R. (2002, November). *Building on values: The future of health care in Canada: Final report*. Government of Canada. <https://publications.gc.ca/collections/Collection/CP32-85-2002E.pdf>
- Sherwin, C. (2022, March 4). Family doctors warn private medicine is becoming 'trend' in Quebec. *CTV News*. <https://montreal.ctvnews.ca/family-doctors-warn-private-medicine-is-becoming-a-trend-in-quebec-1.5806134>

- Standing Senate Committee on Social Affairs, Science and Technology. (2002, October). *The health of Canadians – The federal role. Volume six: Recommendations for reform*. Government of Canada. <https://publications.gc.ca/site/eng/398166/publication.html>
- Standing Senate Committee on Social Affairs, Science and Technology (2006, May). *Out of the shadows at last: Transforming mental health, mental illness and addiction services in Canada*. Mental Health Commission of Canada. https://mentalhealthcommission.ca/wp-content/uploads/2021/09/out_of_the_shadows_at_last_-_full_o_o.pdf
- Storch, J. L., & Scaia, M. (2019). Canadian healthcare. In C. McDonald & M. McIntyre (Eds.), *Realities of Canadian nursing* (5th ed., pp. 85–104). M. Wolters Kluwer.
- Taylor, M. G. (1987). *Health insurance and Canadian public policy: The seven decisions that created the Canadian health insurance system and their outcomes*. McGill-Queen's University Press.
- Truth and Reconciliation Commission of Canada. (2015). *Truth and Reconciliation Commission of Canada: Calls to action*. https://www2.gov.bc.ca/assets/gov/british-columbians-our-governments/indigenous-people/aboriginal-peoples-documents/calls_to_action_english2.pdf
- United Nations General Assembly. (2007, September 13). *United Nations Declaration on the Rights of Indigenous Peoples*. United Nations. https://www.un.org/development/desa/indigenouspeoples/wp-content/uploads/sites/19/2018/11/UNDRIP_E_web.pdf
- Van Loon, R. J. (1980). From shared cost to block funding and beyond: The politics of health insurance in Canada. In C. A. Meilicke & J. L. Storch (Eds.), *Perspectives on Canadian health and social services policy: History and emerging trends* (pp. 342–366). Health Administration Press.
- Villeneuve, M. J. (2017). *Public policy and Canadian nursing*. Canadian Scholars.
- Wherry, A. (2022, January 9). Ready or not, a new debate about the future of health care has begun. *CBC News*. <https://www.cbc.ca/news/politics/health-care-pandemic-transfers-1.6307798>
- Whittaker, M.-K. (2022, March 15). “Chipping away at barriers”: Nurse practitioners filling primary-care gap. *Healthy Debate*. <https://healthydebate.ca/2022/03/topic/nurse-practitioners-filling-primary-care-gap/>
- Xu, X. (2022, April 29). Nearly 900,000 British Columbians don't have a family doctor, leaving walk-in clinics and ERs swamped. *The Globe and Mail*. <https://www.theglobeandmail.com/canada/british-columbia/article-nearly-900000-british-columbians-dont-have-a-family-doctor-leaving/>
- Yeo, M., Moorhouse, A., Rodney, P., & Kahn, P. (2020). Justice. In M. Yeo, A. Moorhouse, P. Kahn., & P. Rodney (Eds.), *Concepts and cases in nursing ethics* (4th ed., pp. 273–326). Broadview Press.