

CANADIAN VALUES AND THE REGIONALIZATION OF ALBERTA'S
HEALTH CARE SYSTEM - AN ETHICAL ANALYSIS

by

BASHIR JIWANI

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Department of PHILOSOPHY

The University of British Columbia
Vancouver, Canada

Date AUG 29, 1998

Abstract

In Alberta, decision-making in the health system has been devolved to seventeen Regional Health Authorities (RHAs). This thesis undertakes a broad analysis of the values that underlie this regionalization.

Divided into two parts, the first half of the thesis develops a liberal egalitarian theory for the distribution of resources in society that turns on the importance of providing all people with the basic resources required to plan for, develop and achieve their life goals. Four requirements for any health system that seeks to uphold the values inherent in this theory are then articulated. These requirements include the need for the health system to be sensitive to the broader determinants of health, and the need for understanding the concepts of health and disease within the context of the social and cultural communities that the system is meant to serve. Part One concludes with an argument suggesting that expressions of Canadian values cohere with the normative theory developed.

In Part Two the evolution of Alberta's regionalized healthcare system is traced. The values implicit in the regionalization of the health system in this province are then examined for their congruence with the four requirements developed in Part One. Following this, the ethical difficulties faced by RHAs are considered. The thesis culminates with thoughts on the ethical challenges Alberta's regionalized healthcare system must confront, offering recommendations for how some of these challenges may be addressed.

It is concluded in the thesis that while a regionalized health system is not necessary for meeting the requirements elucidated, these standards can be met with a regionalized approach. However, at least in the case of the Alberta experience, a number of important changes would have to take place for this to occur. Among these changes is a paradigm shift in the way health and disease are understood towards a more evaluative approach; the recentralization of public health initiatives to the provincial level; and an overall change in governmental health policy recognizing that many areas of society, and consequently the policies of government agencies beyond a disease-based healthcare system, impact health and well-being.

Table of Contents

Abstract.....	ii
Acknowledgments.....	vii
Dedication.....	viii
Chapter I Introduction.....	1
Health and Health Status: True Objectives.....	7
PART ONE Canadian Values and the Need for Redistribution - An Argument From Fairness.....	17
Chapter II Utilitarianism, Libertarianism and the Market.....	18
Efficiency, the Pareto Principles and Utilitarianism.....	19
The Argument From Efficiency.....	19
Limits of Pareto Efficiency.....	24
Libertarianism and the Free Exchange of Healthcare Services.....	27
Health Care and the Market.....	36
Healthcare Services as Commodities.....	40
Uncertainty of Illness.....	40
External Effects.....	42
Asymmetry of Information.....	44
The Pareto Response.....	48
Chapter III Liberal Egalitarianism and A Social Obligation to Provide Health Care/Health.....	51
Just Health Care.....	53
Life Plans, Normal Functioning and Opportunity.....	54
Shared Responsibility - Community Resources and Fair Opportunity.....	56
Lifting Health Barriers - the Biomedical Model.....	58
Why Fairness? Rawls' Theory of Justice.....	60
The Unsatisfied Libertarian.....	63
The Virtue of Daniels' Argument.....	66
The Broader Determinants of Health.....	70
Unhelpful Abstraction.....	75
The Four Criteria.....	81
Alternative Conceptions of Health: One Possibility.....	83
Summary.....	84

Chapter IV	Canadian Values and Liberal Egalitarianism.....	87
	Values in the History Leading up to the Canadian Health System.....	88
	Objections.....	94
	Present Attitudes Toward the Canadian Healthcare System.....	95
	Delphi Study of Bioethicists.....	96
	Public Opinion Polls and Other Evidence.....	98
	The Canadian Charter of Rights and Freedoms.....	101
PART TWO	Health System Regionalization - Values Applied.....	105
	Review.....	106
Chapter V	Decentralization and the Organization of Health Care in Canada and Alberta.....	108
	An Overview of Decentralization.....	109
	What is Decentralization?.....	109
	Healthcare System Regionalization in Alberta.....	115
	Health Care in Canada.....	115
	The Path to Regionalization in Alberta.....	117
Chapter VI	Ethical Analysis of Alberta's Regionalized Health System.....	123
	1. Enhanced Response to Local Needs.....	125
	Defining Communities.....	127
	Information Gathering/Needs Assessments.....	129
	Regionalization as Centralization.....	131
	Smaller Versus Larger Communities: Competing Interests.....	132
	Other Concerns.....	134
	2. Greater Public Participation.....	135
	The Nature of Public Participation.....	137
	Adequate Information.....	138
	Voluntariness.....	139
	Appropriate Representation.....	140
	Other Concerns.....	142
	Regional Versus Provincial Authority.....	143
	3. Integration and Coordination of Health and Social Services.....	146
	4. Development of Preventive and Primary Care Initiatives.....	148
	5. Health System Cost Containment.....	154
	Reducing and Reinsuring Goods and Services.....	155
	Encouraging Private Enterprise.....	159
	Ideological Concerns.....	164
	Summary.....	168

Chapter VII Ethical Issues Facing Alberta's Regional Health Authorities.....	174
1. RHA Accountability Issues.....	177
2. Procedural Questions for Choosing Between Programs.....	181
Reasonable Access an Medically Necessary Care.....	182
Utilitarian Approaches and Their Limits.....	186
Procedural Values and Value Guidelines.....	188
3. Tensions Between Public Health and Acute Care Programs.....	192
4. Issues of Public Participation.....	197
5. Extra-Regional Effects.....	203
Quality of Care Issues for Rural RHAs.....	203
Funding and Administration Issues.....	206
Issues Arising From Discrepancies in Priorities.....	209
6. Ethics Education.....	210
The Provincial Health Ethics Network.....	212
Motivation to Access Resources.....	214
Recommendations for RHAs.....	215
Chapter VIII Conclusions.....	218
Final Thoughts.....	224
References and Bibliography.....	226

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BJ

For my parents,

Barkat and Parin Jiwani

Chapter I

Introduction

The quintessential property that marks modern, Western, democratic societies is the value these societies place on the freedom or liberty for the self-determination of their citizens. It is this idea of individual freedom that attracts immigrants from other countries to these societies and that emerging nations strive to emulate. However, the way liberal democratic societies interpret this core value of self-determination is largely divergent. The divergence in understanding has much to do with how benefits and burdens in general, and property rights in particular, are distributed in society.

The differences in interpretation are captured nicely by the debate between libertarianism and liberal egalitarianism: two normative political philosophies each of which involve a theory of how wealth in society ought to be distributed. Both philosophies have at their core the values of diversity and the right of the individual to determine for him- or herself the conception of what constitutes a valuable life and the plan by which to achieve this life.

Libertarianism, broadly speaking, takes a negative rights approach to the level of social commitment to freedom. This theory has it that people must be protected as much as possible from having their personal freedom violated. The only time that any intervention is justified is when it is required either to prevent an individual from wrongfully harming another, and thereby infringing on another person's liberty, or to redress an individual for having caused such harm. Wrongful harms are construed as anything involving physical assault, theft or fraud. People are not to be interfered with beyond this criteria, even if such interference is aimed at redistributing the goods in society so as to enable those who are less fortunate to have a better chance at achieving their life goals.

Contrasting this position is liberal egalitarianism which takes a more positive rights approach. Theories of this kind are egalitarian because they argue for a more equitable distribution of benefits and burdens in society. These theories suggest that for one to actually be able to enjoy any genuine freedom or liberty, it is not enough to have the actions of others limited from interfering with one's own. Rather, proactive steps are required to provide individuals with the basic means that are essential to exercising one's liberty. Thus, justice requires that some degree of redistribution of the goods of society must be undertaken to ameliorate the differences between people that are created by chance and that affect their ability to secure their conceptions of a good life. Only in this way can people be given a fair and equitable opportunity to exercise their freedom and thus achieve their life goals.

Apart from this dialectic exists a third distributive theory that purports to be rooted in practical common sense but that is based on utilitarian theory. Proponents of this view suggest that arguments based on moral principles are problematic, everyone has different moral opinions and it is difficult to say who is right and whose theory ought to be followed. On this view, what is required instead is a less morally controversial method of distributing goods. A useful guide in this regard is the concept of efficiency. That is, what we should seek according to this view is the most efficient way of distributing the goods in society. This captures the common sense intuition that the most effective method of allocating a good is the one in which we produce the most benefit with the least expense - an intuition that many people would share. From a philosophical perspective, the distribution of health resources presents an

extremely interesting example within this debate.¹ On the one hand, these resources can be understood in terms of particular healthcare services available to address one's healthcare needs; services regarded as goods to be bought and sold by individuals who desire them, like any other commodity, without interference from any outside source. On the other hand these resources can be seen as essential requirements for achieving one's life plans and for exercising one's freedom; thus as part and parcel of any fair and equitable distribution of the wealth in society.

Questions about the distribution of health resources perplex most countries of the developed world and Canada is no exception. Over the last half century a strong commitment to the provision of quality healthcare services from the common pocket has developed and been sustained in this country. However, economic and other pressures are forcing a reexamination of this commitment and therefore of the values that have led to its creation.

In Alberta, the provincial government has addressed these issues in what many call a radical way. It has tried to decrease spending on the health system

¹ I would like to distinguish the two terms "health system" and "healthcare system" at this point. I define "health system" here as a very broad complex to include everything from the approach taken by a society for addressing the broad health needs of the population to the various programs involved in this approach and the particular services these programs involve. Health resources, then, are any resources allocated by a health system. The "healthcare system", on the other hand, is the group of programs and services intended to meet specific healthcare needs in society. Healthcare programs range from acute care and other services provided in hospital to long term care and care provided in the community and in the patients' home setting. Health care, then, is strongly tied to medical care provided by healthcare professionals. The healthcare system is part of the health system.

This is muddy territory with much room for confusion. I do not wish to become mired in the definitional nuances of these terms at present, as I believe that because of the broad level that this thesis will operate at, the particular distinctions will not matter too much. I will endeavour, nevertheless, to be as clear as possible in using this terminology.

Note: "Healthcare" will appear as one word when it is an adjective and as two words, "health care", when used as a noun. In the latter case, health care will be considered synonymous for the purposes of this thesis with "healthcare system" and "healthcare services" and distinct from "health system" (see above).

while at the same time altering drastically the way in which this system has been structured. The changes in organization involve a move towards a devolved, regionalized health system. The direct tack this government has taken to deal with the question of spending and restructuring is an approach that is being watched closely by all other provinces and by the federal government.²

The overall goal of this thesis is to analyze the values that underlie this restructuring and the move to a regionalized health system. However, the question that arises at the start is, Against what backdrop of values is one to conduct such an analysis? To address this question, I have divided this project into the following two parts.

In Part One, a particular normative theory for the way resources in society ought to be distributed - the principles that ought to guide the direction of distribution - will be developed. The theory I will argue for turns on the importance of providing all people with the basic resources required to plan for, develop and to achieve their life goals. The argument rests on the assumption that all human beings are morally equal and that we have an equal right to a fair chance at human flourishing. From this theory, I will draw out a set of standards that I believe any health system based upon the values underpinning the theory must attend to.

I will argue further that it is not only I who find such a theory appealing, but that there is strong evidence to indicate Canadian values also support such a normative theory as well. Indeed, I will suggest that this theory is required by the values Canadians express, if these expressions are understood as genuine. Therefore, any health system, if it is to bases upon Canadian values, must also

² Lomas, Woods and Veenstra, 1997a

meet these requirements.

In Part Two of this thesis Alberta's particular approach and solution to its health system problems will be assessed against this theory. I will undertake to examine whether or not the values implicit in the regionalization of the health system, as it has been conceptualized and implemented in Alberta, are in harmony with the values I argue Canadians have and the normative requirements these values commit us to.

In light of this overall agenda, following this introduction I will begin in Chapter Two with an examination of libertarianism and utilitarianism. I will find these two distributive theories lacking for their relative inhospitability to the redistribution of resources to those who find themselves in difficult socioeconomic circumstances through no fault of their own.

In Chapter Three I will present the normative account I favour: a form of liberal egalitarianism. I will examine the work of Norman Daniels who argues for the distribution of healthcare services from the community purse. I will build on Daniels' basic assumptions but suggest that the model of health we must use to honour the values of this theory must be broader in several ways than he suggests.

In Chapter Four I will make the case that the theory I have developed is not simply my fancy, but that it is what Canada and Canadians are committed to as well. I will suggest this conclusion is supported by the healthcare system already developed in this country, the various international documents we as a nation are signatory to, and on various accounts of public opinion.

Chapter Five will be concerned with providing an overview of the

process of decentralization in general, and the paths to a regionalized health system for the nation and in the province of Alberta.

In Chapter Six I will engage the ethical analysis that is the main feature of this thesis - a study of the goals of regionalization in Alberta - what values underlie these goals and how these values fare against the values I believe Canadians are committed to.

Then, in Chapter Seven I will examine the situation of Alberta's Regional Health Authorities - the bodies that have been charged with looking after the health needs of the respective regions. I will consider tensions between values that will confront these bodies and offer recommendations as to what they must do in order to deal with these tensions.

The thesis will conclude with a short chapter summarizing the principal arguments supporting a regional organization of the health system, the main worries that these arguments face, and several recommendations as to how some of these challenges may be addressed.

Having laid out this plan, I propose to begin with a slight, but extremely important, diversion from it. That is, I would like to begin with a brief discussion of the importance of health care and its corresponding object: the health and well-being of individuals in society.

Health and Health Status: True Objectives

Over the past few years, there has been a growing perception that the

Canadian healthcare system - the group of healthcare services offered to meet the health needs of Canadians - is in crisis. This worry is not unique to the Canadian experience, as many countries in the industrialized world have also expressed concern over their healthcare systems.³ I would like to lay bare some of the premises that lead to this conclusion. For there is good reason to believe that it is not the *healthcare* system that is in crisis, but the rather the *health* system as a whole.

In a very important article, Richard Evans and Gregory Stoddart point out that conflicts arise over the cost of health care when those paying for it try to reduce healthcare spending. The conflicting parties are often different levels of government and groups of healthcare providers. The question that one must ask is, Why is there the perception that a crisis has emerged in many modern healthcare systems?

One answer is that the cost of health care has reached a point where it is one of the largest 'industries' in many countries.^{4, 5} And while large and increasing portions of the resources of many countries are being directed into their respective healthcare systems, *the health status of the populations in these countries is not being significantly improved.*

Presumably, if our modern, science- and technology-based healthcare systems actually could raise the general health of populations to a degree commensurate with the rising level of the resources these systems consume, there would be a less vigorous call to cut spending in this area. But that there is

³ Haselbach, 1996, Evans, and Stoddart, 1990

⁴ Evans, and Stoddart, 1990 p. 1347, p. 1352

⁵ Much rhetoric has also focused on how the cost of health care is growing at an unacceptable and out of control rate. (This is especially true in Alberta - see Taft, 1997.) But in Canada, the proportion of the GDP consumed by health care has remained relatively stable between 7 and 10% (Health Canada, 1995).

such a loud and resounding call to reduce the cost of health care suggests either that the payers of the system find the marginal utility of healthcare services not worth the extra resources being consumed or, more extremely, that there is *no* utility found in the extra health care that is being purchased with the growing number dollars being directed into the system.⁶

Evans and Stoddart indicate this does not mean that as a society we have become as healthy as we can be or that health care has no impact on the health of a population. Rather, the calls to limit spending on health care suggest that we are reaching the marginal limits of medicine - that the health problems of the community have been addressed as much as they can be through the provision of services from a medicalized healthcare system that has primarily responded to sickness and disease. The problems that remain are beyond the reach of traditional healthcare programs and services and are more likely to be sensitive to changes *outside of* the healthcare system.⁷ So, based on this reasoning those concerned about the escalation of spending on health care are concerned that the return on this investment is not high enough to make the investment worthwhile - especially when there may be other alternatives promising significantly higher rates of return.

This would explain the perception of a crisis in spending and utility for some economists and for payers of health care, including insurance agencies and individual consumers in systems without universal, publicly funded healthcare insurance programs. But we are still in need of an answer as to why there is the perception of a crisis in healthcare spending in the eyes of the general public in the Canadian context where the end users are not end payers - at least not directly. For this perception has been the popular sentiment, not just one

⁶ Evans and Stoddart, 1990 p. 1352

⁷ Ibid. p. 1353

echoing through the halls of policy-making institutions.

A crisis arises in one's life, I would argue, when that which is very important to one is threatened. For example, if the life of a close family member is threatened, one would experience a crisis. Similarly, losing one's job or facing a fire in one's home would, I think it is reasonable to say, count as crises. Now we must ask, Is health care so important to people that when changes to the way it is delivered are threatened we find ourselves facing a crisis? Is it the case that changes in the way healthcare services are provided are akin to losing one's job or facing a disaster in one's home?

The answer to this question depends on who one is in society. For a healthcare provider, any changes to the system could alter one's working conditions or even have precisely the effect of costing one one's livelihood - so there is good reason for alarm. If one is in need of medical attention, or has a loved one who is in such need, decreases in funding for the healthcare system could quite possibly affect the response of the system in providing the required treatment and would also justify serious concern. Similarly, one would have reason to be concerned if one were to believe that proposed changes to the system would impact the potential availability of service or required attention of a healthcare professional in the event that one's health was to become somehow compromised in the future.

These are all very good reasons to be worried about changes to the healthcare system - reasons which might justify the perception of a crisis. But, aside from the first example of relying on the system for employment, notice that what is really of concern to the individual is not the healthcare system itself, but rather the impact, potential or actual, of the system on individual

health. We find no inherent value in the healthcare system, unless we are employed by it (even here the value is not inherent). Instead, our concern over a funding reduction or other change is that as a consequence of this change the system might not be available to respond to our personal health issues, were our health to be damaged somehow.

This point can be illustrated with the following experiment. Imagine that a genie appears and promises that neither you, your family or any members of the society in which you live will ever get sick - that the larger community to which you belong will forever enjoy perfect health. How then would you feel about cutbacks to the healthcare system? I suspect that with such an assurance about society's overall health, one would hardly worry at all about cuts to spending or any other changes in the healthcare system. Indeed, one would probably applaud and encourage action to decrease social spending in this area as this might allow one to enjoy other benefits such as a lower tax rate or increased spending on other social goods that contribute to one's quality of life.

It seems that as consumers, or potential consumers of healthcare services, we are primarily concerned about the healthcare system because of the impact we believe it to have on our personal health status and well-being. We perceive a crisis in health care when changes are threatened or carried out that might compromise the ability of the healthcare system to respond to our health needs,

to restore us to our normal levels of health and well-being.⁸

The assumption underlying this line of thinking is that health care is an important determinant of our health status. That is, our concerns are founded on the belief that the healthcare system is a crucial element in determining our level of well-being. Thus, for our concern about changes to the healthcare system to be justified, this assumption must hold true.

To test this assumption we must ask, What are the factors that determine our level of health? Is health care the main factor contributing to health or are there other causes that are also important? In some cases the care we receive from visits to the doctor's office or the hospital obviously play a very important role. If I am in need of emergency heart surgery to restore my life, then this acute intervention is obviously extremely important to my health and level of physical well-being, at least in the immediate. This is true for many people in situations requiring similar levels of intervention. Health care, then, is a very important determinant of the health status for those in immediate need of physician or hospital services.

In addition, there are many situations where the healthcare system can

⁸ The argument could be made that the healthcare system of a country also has symbolic value - it defines the identity and values of a nation and is important beyond its ability to maintain or restore the population's health. Indeed the value of such definitions of national identity is hinted at in studies that seek to explain why the health of the Japanese population has excelled relative to peoples in other nations, despite facing pressures similar to those in most developed countries (Evans and Stoddart, 1994 p. 1361). The suggestion is that self-esteem at the national level may have some considerable influence on population health.

The question that arises is, How is a positive national identity valuable? And to the extent the answer is that it improves the health of the population, it is in concert with my claim that health care is only valuable in so far as it affects our health status - whether at the individual level or at a broader level. Certainly what is being claimed by those who favour the view that the health system of a nation has some inherent value is that this value extends even beyond having a positive influence on population health even at the broadest level. However, what is required then is an account of why it is inherently valuable. This discussion takes us much too far afield and so I limit my claim to the position that the healthcare system is primarily important because of the effects it has on the health of the people it serves.

play an important role in disease prevention. For example, yearly mammograms can lead to the early detection and treatment of breast cancer in women. And immunization programs can help one to completely avoid many diseases.

But as I noted earlier, the reason the financiers of healthcare systems are concerned over the rising cost of providing these services is not just that healthcare costs are going up, but that there is no commensurate increase in the overall health of the population. Indeed there has been historical doubt over the effectiveness of health care in determining health status.⁹ And this view has been bolstered with much new evidence bringing us to the point where it is becoming generally accepted that health care has a relatively small contribution to make to the overall health of populations and that wider determinants well beyond the scope of health care, such as income and social status, education, employment, social support, personal health practices and choices and the physical and natural environment, have a greater impact on health.¹⁰ In fact, some studies have indicated that our place in the social hierarchy of society - for those individuals living in conditions close to Western standards of poverty right through to those occupying the highest socioeconomic echelons - is proportionally related to how long we will live and the level of health we will enjoy while we are alive.¹¹

If it is the case that health care is but one determinant of individual health, and perhaps a small one at that, then why has public policy on health stubbornly remained focused on the provision of healthcare services? And why

⁹ Evans and Stoddart, 1990 p. 1348

¹⁰ Some examples can be found at Capital Health, 1996 p. 59 - 84; Douard, 1995 p. 134 - 138; Truman and Trueman, 1995; and Evans and Stoddart, 1990.

¹¹ Evans, Barer and Marmor, 1994 p. 3 - 26

is there such public outcry when changes to the healthcare system are proposed? To some extent, this is probably because those most affected by healthcare services, including patients with acute needs and healthcare professionals whose working conditions and livelihoods depend on this economy, are sounding alarm calls.¹² But the larger reason, or so Evans and Stoddart suggest, is that the general public and policy-makers still hold conflicting beliefs about health - that while it is accepted that health care has a limited impact on health and that there are wider, more important determinants of health which deserve attention, the belief still persists that the existing healthcare system must be protected.¹³ The reason for the obstinacy of this view, they suggest, is that the common intellectual framework for understanding what makes us healthy is too limited and does not facilitate understanding of the wider determinants of health status. Thus, these broad factors are easily ignored while that which is easy to focus on is left occupying centre stage - the illness care health system as we know it.

Imagine an infant who is malnourished and also needs some medication to alleviate an acute health problem. Imagine further that two adults are having a discussion about whether the medication should be provided by the state or privately by the family. The disputants must realize that what the baby really needs is a steady diet of adequate nutritional content (among other things) and if she does not get this diet, in addition to the medication, then she is not going to get healthy - no matter how much medicine is provided at whomever's expense. Similarly, we must recognize in our debates over health care that

¹² The concern of healthcare professionals in the health system should not be understood as limited only to matters of personal gain. Changes to the system also affect the environment these professionals work in and thus create concerns about the quality of care available to patients and reasonable access to care that are relevant to the professionals who, by the nature of their professions, are interested in the well-being of their clients - the users of the system.

¹³ Evans and Stoddart, 1990 p.1353

health care itself is but one among many factors determining health. While necessary in some situations (particularly for those with acute care needs) it is not sufficient for preserving, maintaining or promoting the health of the population.

The reason for starting my discussion here is to begin with a clear picture of health care and the role it plays in society. I want to point out that there is no inherent value in the healthcare system. What is important is one's actual health - one's health status. The healthcare system is only valuable to the extent that it is able to impact one's health status - however this is construed.

This is not to suggest that there is no role for a healthcare system in our society. The need for acute care, long term care or rehabilitation care services, is an extremely important factor in the health status of those whose health is already compromised. Nor is this discussion meant to undermine the huge impact treatments such as hemodialysis, organ transplantation and other technological developments have had in extending the lives of many individuals and improving the quality of these lives as well.

What the discussion so far does mean to suggest is that when we engage in debate about health care, we must keep in mind the limits of its ability to determine individual health. And if our objective in developing health policy is truly the enhancement of our health status, we must on the one hand recognize that the debate over health care is but one important element of this policy; and on the other pay attention to the other factors, such as our physical and social environments, the levels and types of stress we face in our lives and our self-esteem and other matters of individual dignity and self-worth, that research is showing as playing an equal, if not more important role in

determining our health status.

In the following section (Part 1) of this thesis I hope to make the case that we ought to be, and indeed that we are, committed as a society to looking after the health of our fellow citizens. This means developing an effective healthcare system for one and all - *and* developing social policies that advance the health of the population beyond what can be achieved by any healthcare system.

PART ONE

Canadian Values and the Need for Redistribution

An Argument from Fairness

Chapter II

Utilitarianism, Libertarianism and the Market

Efficiency, the Pareto Principles and Utilitarianism

In today's economic climate of fiscal restraint, and in light of the demand for and scope of the healthcare system, a limited amount of resources - too small to provide for all healthcare needs - appears to be a long-lasting fixture. Consequently, decisions must be made as to how the healthcare system ought to be financed. Various moral perspectives offer guidance in this matter. Which ought to receive support? To try and answer this question I will consider two such approaches in this chapter. I will begin by examining the utilitarian perspective.

The Argument From Efficiency

Some argue that the best way to pay for modern healthcare systems is that method which maximizes spending efficiency. Proponents of this view suggest that the ethical quagmire represented by the various moral theories that abound in our pluralistic context is too difficult to negotiate. Moreover, these complex and vexing ethical arguments can be easily replaced by the commonly accepted notion of efficiency.

In addition to this, as I noted earlier, what we are after in pursuing good health care is not the care itself, but rather gains in health status. Health care is only a means to achieve an end - better health status. Thus, one might argue, it makes sense to pursue that method which will be most efficient in leading to

this end.

In other words, it is suggested that we need not work ourselves into a tizzy fighting over what moral principles are right when we all generally agree that efficiency is a virtue and that health care is only a means for improving our health status. Therefore, when thinking about how to pay for health care we ought to seek that system which is most efficient. That system will be the one which successfully secures the maximum benefit out of every dollar spent on health care. So what we ought to be looking for is that allocation mechanism which will produce the quality of health care we are looking for at the lowest possible cost.

I will call this the informal version of the efficiency argument. The spirit of this argument is captured by one formal and well accepted (if a little complicated) version of the efficiency position: the Pareto Principles offered by Vilfredo Pareto.¹⁴

The principle of Pareto Optimality with regards to the *distribution* of goods in society has it that a particular distribution of goods and services among the persons in a system is Distributively Pareto Optimal if there is no alternative distribution wherein not any one person is better off and no one is worse off. Similarly, a given distribution of a set of goods, D1, is Distributively Pareto Superior to an alternative distribution, D2, if and only if there is at least one individual in D1 that is better off than in D2 and no one is worse off in D1 than in D2.

The Pareto principles can also apply to the allocation of resources for *production*. A given distribution is Productively Pareto Optimal if there is no

¹⁴ Katz and Rosen, 1994 p. 408-416; Buchanan, 1985 p. 4 - 14

alternative distribution wherein more of one good is produced and no fewer of any other good is produced. A given distribution, D1, is Productively Pareto Superior if there is no alternative distribution, D2, wherein more of one good is produced and no fewer quantities of any other good is produced.

The broader Pareto principles, from which the principles for production and distribution are derived, are as follows.

A state of a given system is Pareto Optimal if and only if there is no feasible alternative state of that system in which at least one person is better off and no one is worse off. A state, s1, is Pareto Superior to another state, s2, if and only if there is at least one person who is better off in s1 than in s2 and no one is worse off in s1 than in s2.¹⁵

So the general rationale behind what I have called the formal version of the argument from efficiency, the Pareto concept of efficiency, is that the ideal distribution of goods is the one where we maximize the benefits of every dollar spent for each individual in society.

This formal conception of efficiency is considered superior to others because of its link to the well-being of the members of society. Other conceptions, such as that of productive efficiency which suggests the most efficient system is that which maximizes the total product from a given amount of input or initial resource investment, fail to take into account the effect on the people of the system when evaluating its efficiency. According to the productive efficiency notion, a state of Society X that produced the exact same quantities of every good as State Y with the exception of producing ten times more of a given dangerous or illicit narcotic substance (say, heroin) would technically be more efficient than State Y - regardless of the impact of the value of the good produced on members of society. The Pareto principles, however, at

¹⁵ Buchanan, 1985 p. 4

least in the broad form above¹⁶ attempt to involve the impact of the distributions on the members of the system as an integral part of its assessment of efficiency.

It should be noted that the idea of efficiency in general, and the Pareto Principles in particular, are used as the second best alternative method to determine the best possible distributions of resources in society by those in favour of this view. The ideal option to do the job, for those who favour this approach, would be the use of the *utilitarian calculus*. For it is assumed that were we able to measure the individual utilities various distributions would produce and the aggregate utilities that would result from the various alternatives, we would then truly be in best position to decide how to distribute resources - the resources required for and resulting from the production of any good.

Utilitarianism is a theory of distributive justice that does not rely upon a moral right to liberty - or any other moral rights. Utilitarian theory focuses on the consequences of an action. It is concerned with maximizing the overall good in society. Good is measured as *utility* which is broadly understood as happiness, pleasure or the satisfaction of individual preferences. So utilitarians in general believe that the best way to distribute a good is whatever mechanism will achieve the best consequences - or the most utility.¹⁷

Utilitarianism comes in several forms. Act utilitarianism holds that individual acts ought to be measured for their consequences. Rule utilitarians, on the other hand, believe that general rules ought to be considered for their merit. Aggregate utilitarianism considers the overall utility of the group for

¹⁶ For this objection to the productive efficiency argument can also be leveled at the notions of Productive Pareto Optimality and Superiority.

¹⁷ For a closer look at this theory see Sher, 1987.

whom the utility is being calculated. This means that in their calculations the overall utility of an alternative distribution equals the total positive utility minus the total disutility. Per capita utilitarianism considers the aggregate utility divided by the number of persons in the society. As aggregate, rule utilitarianism is the most common version of the position, I will be referring to this form when I mention the term from now on.

The reason a utilitarian calculus is not used directly is that it is a matter of immense skepticism whether or not individual utility on some kind of objective scale can be measured. Given that the Pareto Principles obviate this problem in that rather than comparing the utility of different individuals to each other in various distribution schemes, they compare the utility of the same individual to her own utility in the different schemes, this method is considered to be the next best option.

The Pareto method also avoids another fundamental problem of the utilitarian calculus. Under the consequentialist scheme that attempts to maximize aggregate utility, it is only the result of a given distribution that is relevant. So were a large portion of society brought to bear tremendous burdens while a few were to reap fabulous benefits, as long as this distribution resulted in the greatest aggregate utility - measured as total utility minus disutility - it would still be the best distributive option. The problem with this is its incongruence with the common moral intuition that the uniting of individuals to form a social organism, a society, ought to be advantageous, at least to some extent, for all of its members.

Use of the Pareto principles overcomes this counter-intuitive problem of the utilitarian theory by requiring that for a given distribution to be optimally

efficient, it must not make even one of the members of society worse off while improving the lot of at least one person. Hence, it can be argued, the intuition is not offended and this problem of utilitarianism is avoided.

Limits of Pareto Efficiency

Although the Pareto position may appear at first glance appealing, there are several problems with the view as presented.

To begin with, while the Pareto ideals are themselves not utilitarian principles, they do assume that the utilitarian moral theory upon which they are built is the correct moral theory. For the basic assumption of the Pareto principles is that society is properly a machine that ought to strive to maximize overall utility. The whole idea behind using the efficiency argument in the first place was to avoid the problems that are said to accompany moral arguments about resource allocation. Yet the very foundation of the efficiency argument is itself a moral claim about the proper values of society and what its members ought to strive for. Thus, proponents of this view face the task of having to demonstrate why their favoured moral theory is superior to the others it is challenging.

In response, the proponent of the efficiency argument might argue that the Pareto principles cannot be equated with the utilitarian theory because they do not allow any individuals to be made worse off to benefit others, even if this would maximize overall utility. On this approach, utility is not an unconditional good to be sought at any cost. Furthermore, although the Pareto

perspective is not morally neutral, defenders may contend that it need not be. That is, while Pareto Optimality is not completely value-free, it is the least morally controversial of the various normative theories. It is the theory that can capture an intuition shared by almost everyone. Therefore, it is the most universally acceptable. And, indeed, I submit this is a strength of the Pareto thesis. But there remain several critical problems with the Pareto approach.

As I have mentioned, it appears that the Pareto plan avoids the classic utilitarian problem of allowing a few members of the society to suffer great harm so that a large number may benefit in securing overall utility gain. That is, individuals would not have to accept that allocation which would benefit the interests of others over her own interests, because individuals are not required by the Pareto concept of efficiency to do that which will make them worse off. Thus, the conflict of social versus individual interests is averted.

This response, however, is a little misleading. Imagine a society where a large majority of the population is impoverished while a few enjoy great wealth. Redistributing some of this wealth from the rich to the poor appeals to the intuition that society should be to the mutual advantage of all its members. However, such a redistribution would not be Pareto Superior to the existing state because while a great number of people are made better off, some members are made worse off - a condition that is unacceptable under the Pareto concept.¹⁸

What this example brings into clear relief is what I take to be the fundamental problem that faces the Pareto approach. A given distribution can be grossly unfair or unjust and still be Pareto Optimal because the Pareto

¹⁸ One could argue that the wealthy are not really any worse off in losing a small portion of their wealth to secure a great advantage for others less wealthy. However, the Pareto model, it must be remembered, measures outcomes of different distributions to the same people. That is, an individual's well-being is not compared to the well-being of other individuals but only to the same individual under a different distribution.

principles *make no comment on how a state arises in the first place*. Whether an initial state of distribution is just or not is irrelevant for the Pareto proponent. If an initial distribution in a society is the result of fair dealings, political tyranny or what would be considered immoral or unethical activity matters not. The only concern for the Pareto are possible future states of distribution.

Moreover, the well-being of individuals is equated with the satisfaction of an individual's preferences. But no comment is made on what preferences are good or bad to have. No comment is made, for example, on the morality of a person's preference to purchase the services of a prostitute or, even more disturbingly, to abuse young children for pleasure. All that matters when it comes to assessing efficiency is whether or not a person's preferences are met. Thus, the Pareto option is far from being morally uncontroversial.

So while the attempt to avoid moral conflict by resorting to the value of efficiency is a good one, it nevertheless fails to succeed. In addition, the utilitarian/Pareto approach still permits some individuals to remain considerably less well-off than others in the same society - without defining a basic floor of requirements below which it is wrong to allow the impoverished to drop. For these reasons I find the utilitarian approach inappropriate as the general guiding theory for the distribution of goods in society.¹⁹

Based on this approach some argue that the most efficient means of distributing goods is the open market. As I have found the basis of such an argument lacking, in one sense there is no need to further argue against using

¹⁹ There may be circumstances when the utilitarian approach may be quite valuable in allocating resources - perhaps when it comes time to allocate goods once the values that are acceptable for guiding broad decision-making have been clearly articulated. I do not wish to dismiss utilitarian theory altogether here, but elaborating this point any further here is beyond the scope I wish to limit my concerns in this thesis to.

the market to distribute healthcare resources. Nevertheless, at the end of this chapter I will take a brief look at why the market is in fact inappropriate for distributing these resources.

Next, however, I will turn my attention to another account of how goods in society ought to be distributed - the libertarian position.

Libertarianism and the Free Exchange of Healthcare Services

The second distributive account I wish to consider is libertarianism. This account also favours a distribution of goods on the free market. However, this is due not to any notion of efficiency, but rather on the right of individuals not be interfered with.

A weak version of this claim is that if we are to have a system of social cooperation that is to be to the mutual advantage of all members of society, then this system must respect and enforce our basic moral rights. The only system that supports this principle is one involving unfettered market enterprise.

The stronger version of this claim is offered by Robert Nozick.²⁰ He argues that while it may be true a free market system is indeed to our mutual advantage, this is irrelevant to what makes it a superior system. The fundamentally important requirement of any system to which we pledge our allegiance is that it respects our basic rights to freedom and ownership of private property. These are the only relevant concerns for an acceptable theory of social

²⁰ Nozick, 1974

organization.

The fundamental premise of libertarianism is that as individuals, we all own ourselves. Our bodies are our possessions and we ought to have the exclusive right to do with our bodies as we please. The only limitation of this right is that we must limit our actions such that we do not violate anyone else's ownership rights to their bodies. This premise is then extended to the things we justly come to claim as our property or that we have a hand in making.

The way property is acquired is just as long as two conditions are satisfied. First, the good must be acquired without violating anyone else's right to it. This involves, very roughly, mixing one's own labour with it and improving it in some way or discovering a good and appropriating it without infringing on someone else's prior rights to its enjoyment. Second, the transfer of ownership of the good must involve a good that the giving partner has a valid property right to, which involves what it was acquired justly in the first place.

Thus, if I lay claim to some land - say by trading for it or by discovering it in its previously unowned state - build a house and so on, these possessions that I have come to own are extensions of myself. I have exclusive ownership of them and no one ought to be able to infringe upon these property rights of mine. Similarly, I have no justification to interfere with anyone else's property rights.

Narveson points out that any fundamental right can thus be understood as a property right.²¹ For example, the right to free speech is not a right to go around saying whatever one wants wherever one wants without constraint. Rather it is to be understood as the right to determine one's disposition in terms

²¹ Narveson, 1988

of what one says - anywhere that one justly has property rights to.

Based on this fundamental premise, no one, whether individual or state, has the moral right to force another to act in a way he or she does not directly desire. The only time one is justified in transgressing on another's liberty - one's freedom to act as one desires with one's property including one's self - is to prevent or to punish any acts of physical assault, theft or fraud.

Libertarians distinguish between negative and positive rights and put stock in the notion of negative liberty. If liberty means the freedom to do with as one wants, then according to this distinction, negative freedom is the absence of any interference with one's acting and positive freedom is the provision by someone else of the means required to act.²²

So, for example, Conrad's having a negative right to freedom of expression would entail no one's standing in his way as he buys paper, writes his message and places it wherever he has acquired the right to do so. On the other hand, were he to have a positive right to freedom of expression, there would exist an obligation on someone else to ensure that Conrad obtained some paper, had a pen with which to write his message and then had a place to display his expression.

The libertarian argues that political rights must be negative rights. Why? Because were we to start distributing positive rights to people, this would mean that someone would have to provide the materials that would be necessary for empowering others to act. But this would mean transgressing on the fundamental rights of the "providers" - in direct conflict with the notion of basic liberty.

²² Ibid. p. 57

So positive rights impose a duty on others to act even though they may not desire to do so. Thus, a system of positive liberty would enforce the interference of the liberty of some - namely the providers'. A system of negative liberty, on the other hand, allows one the freedom to act in any way one desires and requires only that one refrain from acting only to the extent that the same kind of liberty can be enjoyed by all equally.

What makes this approach of negative rights morally fundamental? In his defense of libertarianism, Narveson argues that it is not only the primacy of the right to own property that leads to a moral system of negative rights and negative liberty, but that such a system is the only one supportable by a practical morality.

That is, Narveson argues that social morality is all about the rules that are to govern human behaviour and interaction. What we want is a set of rules that will apply to all about what kinds of behaviours are and are not acceptable in society. But moral rules are peculiar in some ways. The most important of these is that the judgment of what is and is not morally acceptable is *informal*. There is no formal moral law that is self-evident to all of us that we must accept.

True, many of us have a sense of what is right and wrong behaviour - based on some intuition we have. However, any appeals to morality based on intuition will fall short of practical applicability because we will soon find ourselves disagreeing over what we think is right and wrong. And if all we have to appeal to is our intuitions, then there will be no way to settle these disagreements. Moreover, we will be forced to accept positions that we disagree with because there will be no way to criticize them. If we allow morality to be guided by intuition, then when someone says "I believe stealing from the rich to

give to the poor is right - just because" there will be no convincing response possible.

In light of the fact that we often have differing intuitions about what is right and wrong and there is no moral law self-evident to all of us, any morality, for it to be practical, will have to be able to convince people that it is appropriate. Any moral theory, for it to be acceptable, will have to offer reasons that will motivate everyone in society to behave according to its premises - or so the libertarian contends.

Following this, what makes libertarianism and its accompanying doctrine of negative rights morally fundamental on this view is that it is the only theory that can provide everyone a reason for following it. That is, the only moral theory that it would be reasonable for everyone to accept would be one where everyone has a basic right to own resources and has the freedom to act with those resources as desired, limited only by the duty to respect the same and equal right of others. This theory, of course, is libertarianism.

How are goods in society to be distributed according to libertarianism? The only system that supports absolute negative rights is that of the unfettered market economy. Here people are free to produce whatever they want, to buy and sell goods as they please with no interference whatsoever - whether in the form of taxes, regulations or what have you. Again, this is because any attempt to interfere with a market through coercion of the state, whether it be to reduce inequality or even to provide a basic minimum set of resources to all members by taxing some to benefit others, violates the individual's basic moral right to private property.

The difference between the utilitarian justification of the market and that

of the libertarian, then, is that the utilitarian is arguing that the market presents the most efficient means for achieving a certain end - maximal social utility. The libertarian, on the other hand, is suggesting that whether or not maximum utility is achieved by the market is irrelevant. What does matter is that fundamental moral rights of humans not be violated. And the only system capable of achieving this is the unfettered market.

Regardless of whether or not an ideal market for health care evolves in an unfettered exchange environment is besides the point because the emergence of an ideal market is not the issue. What is important is that people's rights to private property are not violated in any way. If this has the consequence that some people are unable to purchase health care, then so be it.

What then are the implications for the distribution of healthcare resources under a libertarian system? From a libertarian perspective, health care ought to be distributed just like any other good, whether an automobile, a washing machine or a haircut. If people find the need for the good they ought to be free to exercise their right to make their preferences known as long as their actions do not interfere with the rights of others to do the same. If there is a need for health care, then this will cause a market for the good/service to emerge on its own. Any intervention coercing the actions of any parties involved in the trade would be an infringement of liberty and morally unacceptable.

The obvious implication of this approach is that individuals in society are not due anything beyond a freedom from interference. There is no moral obligation to feed a starving man or to clothe or shelter a homeless person.

In response to the charge that this theory is miserly and mean spirited,

the libertarian would argue that this is not so. For charity is an important virtue of the libertarian position. It is not at all a requirement, but certainly is praiseworthy. And people on the whole are altruistic, the libertarian would argue, such that if left to their own devices they would look after the needy and those less fortunate in society. However, in a system where people are already taxed, individuals are not inclined to give more - feeling that that they are already and forcibly being made to give.

What of the basic need everyone has for things such as health care and income when sick or unemployed? Well, the libertarian posits, insurance is the remedy to these concerns. If there is enough interest, if people really are concerned about these issues, then certainly a system of insurance will arise that people can purchase to guard against these potential evils.²³

The only conditions under which any body, such as a state government, would be justified in coercing individuals to act to provide others with basic goods, for example through a tax system, would be if it could be demonstrated that the imposition on liberty was to everyone's advantage. And the nature of governments are such that this justification could never be forthcoming. Governments are too difficult to control, they are too inefficient in spending money and they are too likely to redistribute resources inappropriately (bending to powerful and wealthy lobbies) to ever be justified. Forcing some to pay taxes against their will is as akin to robbery as stealing - and as immoral. It is better to have more freedom with a limited range of choices, than to be forced to fund this range of choices against one's wishes.²⁴

The libertarian position can appear quite compelling. It makes sense that

²³Narveson, 1988 p.245

²⁴ Ibid.

any moral theory, if it is to carry any sway, must appeal to most, if not all, members of society. For what good is a theory if it leaves many unconvinced of the need to cooperate - especially when it is often those whose cooperation is most needed that are most likely not to accept it? However, there are a number of serious deficiencies with the libertarian position.

First there is the observation that while there may be nothing wrong with individual transactions that make intervention justifiable, it is easy to envision how multiple transactions can have the result of concentrating the wealth of a society in the hands of a few people. This might enable those few wealthy individuals to unfairly influence the political situation in society. Thus, these individuals through individual transactions may end up with a disproportionate amount of political power in society. Their trading partners, on the other hand, by entering into trade relationships that on their own seem harmless, end up harming themselves through the cumulative effects of the transactions. In order to avoid this situation and to prevent the consolidation of power in the hands of a few, one might argue, some intervention into individual transactions is justified.

The second objection to the libertarian position I wish to offer questions the voluntariness of certain transactions. Imagine that a family is desperately in need of a good or service for the sustaining of life. This situation allows the person with the good to be traded for to have what might appear an unfair advantage in the trade relationship providing them with the ability to ask for much more than the good might be worth. If the person in need is desperate enough, he or she might be forced to agree with whatever conditions the person that has the good sets out. But to what extent is this a voluntary trade relationship?

Health care is a perfect example of this problem. Imagine that John's father is desperately in need of heart surgery. In a perfectly unfettered market that deifies the right to private ownership, what is to stop the unscrupulous cardiac surgeon from taking advantage of John and his father? Certainly John would likely do whatever it takes to ensure his father receives the appropriate treatment. He would probably pay whatever the cost or do whatever was required to make the treatment available. But certainly there is at least the intuition that taking advantage of John and his father in this moment of hardship is wrong and actions must be taken to ensure such advantage is not taken in trade relationships. But from the libertarian position, the transaction, whatever the terms, is justified as long as what is traded is rightfully owned by the trading partner.

The most important objection to the libertarian program, similar to that with the utilitarian approach, is that it does not account for the fact that individual transactions of trade have a much wider impact that is not limited to the trade partners. For example, transactions entered into will result in a change in the socioeconomic situation of both partners. However, these transactions will also determine the socioeconomic starting points of future generations of the trading partners. But in no way can it be said that those future generations actually *deserve* the socioeconomic starting points, whether it be one of wealth and high status or poverty and social stigma, they will be given. As a result, to ensure some sort of equalization of socioeconomic status for these future generations, some measures are *required*, not only justified.

One interesting feature of Narveson's version of libertarianism is the flexibility he demonstrates towards planned economies that work well. For example, while Nozick would likely take strong issue with the Canadian system

of health care where services are provided to all without direct cost, and are paid for from community coffers that are stocked by a system of taxation, Narveson suggests that the infringement on the individual Canadian's liberty is justified.²⁵ His position is that this justification arises not from any overriding good that is done by the healthcare system. Rather, he defends it on the grounds that it would be inefficient for Canadians to begin to discriminate against those who could not pay for services, because such discrimination would require increased administration problems that would result in higher overall cost. Based on this fact and that most Canadians are generous and don't mind paying a little more so everyone gets care, he finds room within his account of libertarianism for a publicly planned and funded health system.

While this position may offer some hope of reconciling libertarian ideals with socialized health care, I will not explore the possibility here. This is because at bottom such an approach would still be based upon libertarian ideals. But I believe one is forced to reject these ideals and libertarian theory in general on the grounds of the criticisms cited above, particularly the insensitivity of this theory to the undeserved nature of our socioeconomic starting points.

Health Care and the Market

Both accounts considered so far have espoused the free market as the mechanism by which healthcare services ought to be distributed. While I have offered reasons why neither of these accounts ought to be accepted, it is important to consider as well why health care is not like any other commodity

²⁵ Ibid. p. 251

and does not trade well on the market - regardless of what basis this approach is supported by.

As we shall see, the conditions of the ideal market are extremely stringent and it is accepted, even by those offering the argument based on efficiency, that such conditions are never actually met. In other words, the ideal market is never realized. However, it is argued that actual markets come close enough to approximating the ideal markets that make the actual market a much more preferable allocative mechanism than any non-market method.²⁶

For this portion of the argument to hold, its advocates must successfully demonstrate that the departures from the ideal market in the case of health care are unimportant enough to make the imperfect actual market still the preferred allocation mechanism over any non-market alternative.

As mentioned, there are certain conditions that must hold if an ideal market for a commodity is to be realized. These conditions include:

1) The availability of full information about the quality and performance of the traded good. This means that consumers should have access to information about how well the product works, what its use will involve, what repercussions its use will have and so on.

2) It does not cost anything to enforce contracts. In other words, one issue that ought not deter individuals from entering agreements is the concern that the trading partner will renege on the agreement.

3) The individuals involved in trade must be able to make rational choices about their own wants and needs and what means are appropriate for

²⁶ Buchanan, 1985

achieving them. This essentially means that the buyers of the good must be capable of deciding for themselves what their life plans are and how these can best be achieved.

4) There is perfect competition - i.e. free entry into and exit from the market. This condition ensures that there are a large number of producers of the good and sellers enter and exit the market based on their ability to compete for buyers and not because of any other factors, allowing the ideal price for a good to develop.

5) There is homogeneity of product - buyers are not interested in the names of producers. This just means that buyers are not influenced in their purchase by any other factors than the quality of the product and the suitability of the product for the buyer's needs.

6) No external effects are present. This means that the price of the good accurately represents the interest of all parties interested in its purchase. I will say more about this condition shortly.

7) A good cannot be consumed by more than one individual at the same time and the cost of excluding people who do not pay for them from consuming them is minimal.²⁷

8) Transactions must take place at arm's length from the trading partners. That is, trading partners are interested only in their own concerns and cannot directly influence the decisions of their trading partners.

If these conditions hold, the exchange environment is said to be unfettered or free from external influences and it is argued that a natural market

²⁷ Buchanan 1985 p. 14 - 15; Brown, 1996 p. 139 - 140

will result for the traded good. This will result in the emergence of an ideal price for the good. The ideal price is that price which takes into account the preferences of all buyers who would be willing to pay for the product. At this ideal price, an equilibrium of supply and demand is said to exist. That is, the costs of producing the good are balanced with the purchasing power of those interested in buying it.²⁸

This equilibrium point represents the ideal utilization pattern for the good. A good is said to be under-utilized if the price for the product is set higher than its marginal cost. In other words, if the price were lowered, more people would be able to purchase it at a price that was still higher than the cost of the resources required to produce it. A good is said to be over-utilized if the price of the product is lower than its production cost. In this situation, more people are consuming the good than would if the cost of the good was more accurately reflected in its price.

So a good is distributed ideally when the preferences of all those willing to pay for it are taken into consideration in determining its market price. And this price can only emerge when certain conditions (those noted above) obtain. If these conditions do not obtain, an ideal price cannot emerge and the product will be either under- or over-utilized, or it can fail to be produced altogether. In this event, because an ideal utilization pattern does not develop, the good is not distributed ideally and a condition called market failure results. Market failure is the result of a non-ideal utilization pattern.

²⁸ For a closer look at some of these economic arguments, see Buchanan, 1985.

Healthcare Services as Commodities

What we want to know is how health care would fare on the open market. Robert Evans argues that it doesn't fare particularly well as health care is not like any other commodity.²⁹ That is, Evans can be understood to suggest that not only does a market for health care fall short of the conditions for an ideal market, but this departure is even greater than seen with other 'regular' commodities. This is because health care is different from other 'regular' commodities in some very important ways. Evans points to three major peculiarities of healthcare services that lead to market failure in its distribution. These peculiarities violate conditions required for an ideal market to develop for health care. Specifically, the three peculiarities correspond to the following problems: First, the individual's ability to plan for how the product will help achieve their life goals is undermined in the case of health care. Second, distributing health care on an open market involves serious problems of external effects. And third, health care does not permit arm's length transactions between trading parties/partners.

Uncertainty of Illness

Illness can strike anyone at any time. And while it may be possible to predict over time the health problems of a particular group, the actual incidence of illness at the level of the individual is unpredictable. The uncertainty of

²⁹ Evans, 1984 p. 25-26

illness - who will get sick and at what point in their lives this illness will occur - makes it very difficult for people to plan for healthcare expenses.

Unlike expenses such as groceries or even larger purchases like a car, it is difficult to budget for the health care one will need - for one simply doesn't know, for the most part, what care one will require and when it will be required. This might not be such a problem if health care were uniformly and moderately priced. If it were, one might simply develop a little healthcare savings plan - something like a rainy day fund - for use in the event illness strikes. But it is not. Given the range of possible illnesses and the exorbitant cost of much treatment, it is likely that were health care traded on an open market it would quickly impoverish anyone struck with illness and forced to purchase it (along with their families and other supports as well, in all likelihood).

Advocates of the market approach could argue that this problem is not completely paralyzing for the healthcare market as a solution readily emerges: healthcare insurance plans. Agencies appear to deal with the uncertainty of illness which offer insurance coverage so as to pool the risks of illness. This way, those interested in protecting themselves against the potential threat of financial disaster posed by the possibility of ill health can purchase this coverage and make regular payments in the way of premiums to insurance agencies. These premiums can be planned for in a way that direct healthcare costs cannot.

However, privately operated and funded healthcare insurance agencies operating on the free market are not without their own problems.³⁰ They present large administrative costs and still pose significant financial burdens. These burdens are not only substantial enough to prohibit some from joining, they also represent on their own an expensive solution and lead to numerous

³⁰ Stingl, 1996 p. 13

administrative and quality of care problems as well. For example, some organizations of healthcare delivery in a private system (as in the United States) such as some Health Maintenance Organizations, create economic incentives for providers to deliver care in less than acceptable standards. Nevertheless, I will be content for my purposes here to cite the uncertainty of illness problem as a serious challenge for the open market approach even if it is not completely crippling.

External Effects

In an ideal market, the price of a product is set taking into account the interests of all those who are affected by its consumption. With respect to health care, the inability of the market to consider the value of the interests of non-consuming individuals in the price setting of care constitutes significant external effects.

For example, Hussein's interest in Sophie's receiving the attention of a health professional for her illness so as to reduce the chances of Hussein's catching the illness from Sophie cannot be accounted for in a market determination of the price of health care. In addition, neither can Sophie's interest in Hussein's receiving care because in her society they take the attitude that the community are responsible for providing everyone with the basic necessities required to fulfill their individual life goals. Because these interests cannot be taken into account in price setting in the open market, an ideal price for health care does not emerge and an ideal distribution pattern does not result.

So, while in general the price of an automobile, for example, can largely account for the preferences of all those interested in their use, this cannot be said for health care. As a general result, in a market for health care, this 'commodity' would be underutilized as the price at which it would be set (taking as our example the costs for care in the United States which most closely approximates a market distribution of the good) would limit those who would use it were the price to actually reflect the concern of all interested parties.

Evans suggests that in fact the public has an interest in providing care to those of its members who need it.³¹ This paternalistic preference that isn't accounted for in an unfettered market for health care is what has led to the development of healthcare insurance systems in many countries in which the costs of coverage are shared to varying extents by the society at large.³²

One could argue, however, that even in the case of the automobile the price of the product does not really reflect the interests of all affected. For example, the use of the automobile has very important effects upon other members of society. It affects the air quality, the depletion of natural resources that are required for fueling the machine, and the safety of the public. All members of a community where automobiles are manufactured and used, whether involved in the transaction or not, are affected in important ways. Yet, we still permit automobiles to be distributed through market setting. Given the lack of difference between the two, why ought healthcare services not also to be distributed in a market setting?

This is a good example, but what it may demonstrate is a need for the auto industry to be further regulated, as opposed to providing evidence that the

³¹ Evans, 1984

³² Ibid. p. 63-65

healthcare system should be free from regulation. Again, for my purposes I am willing to accept that the problem of external effects is an important if not paralyzing challenge to the pro-market argument.

Asymmetry of Information

The third, and arguably most important, peculiarity of health care from an economic perspective is that buyers and sellers of healthcare services in a pure market do not approach the transaction on equal footing. As discussed earlier, Evans argues that consumers in the market for healthcare services are interested in their health status and not in healthcare services *per se*. However, health status cannot be purchased. Health care, then, is purchased under the assumption that it will improve one's health status. This points to the technical relationship that is specific to each consumer and condition in which health care affects an individual's health status.

In other words, while I (may) know that I am ill in a given situation, I probably (assuming that I am the average, rational, and reasonably well-informed consumer) will not know in most cases what exactly is wrong with me. But let us assume that I do even know this. Still, I do not have the technical knowledge possessed by the healthcare provider about the relationships between various treatment options and various illness conditions. I don't know what treatment I should purchase for my particular ailment, that I may get better.

Again, the healthcare professional, because of his or her vast technical

knowledge (of how certain treatments will impact certain illnesses), has a great advantage in the trade relationship and, in a pure unfettered market, has sufficient economic motivation to exploit this relationship. On the other side of the relationship, the consumer, not interested in the traded good itself - that is, health care - but rather in the potential impact it will have on health status and who must rely on the trading partner (the healthcare provider) to look after the patient's interests as well as his or her own, is poised to be exploited.

And so an expert provider is better informed than the patient/consumer of the structure of that relationship - though only the patient can decide if certain care is worthwhile, once informed of its projected impact on health status. But, one may ask, How is this different from someone buying a car, haircut or washing machine? In these cases too a consumer is relying on the expertise of the seller for information about what certain models or styles of the product do and then deciding which option is preferable based on the needs and values specific to the individual.

In fact, there are several significant differences between health care on the one hand and other consumer goods. First of all, one can take a car out for a test drive or see a washing machine in action before making a final purchase. This way one can get a feel for the features of a particular model and get a good idea of how it fares at meeting one's needs. Most consumer products come with money back guarantees allowing the consumer to return the product if it does not meet one's expectations. Such options are not available for most healthcare treatments. Health care, in most cases, is a permanent purchase. Once you buy it, there's often no turning back. And unlike a haircut, one's health does not automatically return to its previous condition ready to be refashioned after a short while.

Second, consumer goods also usually include a parts and labour warranty for a certain period of time. Once the initial purchase is made, further adjustments are often done for free. Health care, on the other hand, comes with no such warranties. Good performance or bad, one must keep paying for all future maintenance.

Third, the nature of health care is such that when the need strikes, one usually does not have the time to be a good consumer and shop around. In the case of other goods, one can often do without for awhile, either borrowing, renting or somehow acquiring the temporary use of a similar good while one compared options and found a deal that best suited one's needs and budget. When sudden illness strikes, however, the time to compare options is limited if it is there at all. In the most extreme cases we may even be incompetent or unconscious, thus physically incapable of comparison shopping.

Fourth, and I will talk more about this in later sections, health care affects one's well-being in a way that few other consumer goods do. This makes the advice one receives about the care crucially important. One can survive getting bad advice from a car dealer with a car that does not perform the way the dealer said it would. It may not be possible to reach the speeds anticipated and getting stuck in the mud may be more frequent than hoped for, but one's life will probably remain unthreatened.³³ But poor advice about health care can be at worst deadly.

A fifth difference between health care and automobiles is that with the automobile, the aim of the purchase is often to get from place to place. But

³³ Of course, the argument could be made that poor advice about purchasing a car can also be deadly. (My thanks to Michael McDonald for raising this possibility.) While I concede this point, I think it is fair to say that in general poor advice about cars will have less potential for as extremely harmful consequences than will poor advice about one's health care.

driving is not the only way to achieve this end - other options such as public transport, private mass transport and so on could serve this function as well. In the case of health care, there are usually one or two options only: conventional or alternative health care. The choices are significantly more limited. Moreover, many individuals purchase cars for the sheer pleasure of driving. While this may be true in the case of some people wanting healthcare services, I suspect that the number of people going in for surgery and the like for the sheer pleasure of it are much smaller in number.

It seems, then, that the advice one relies upon from a healthcare professional is in many ways more critical to one's life than is the advice from a car salesperson. As such, the healthcare provider is forced to take on the role of agent for the consumer. He or she gives the consumer critical information that allows the consumer to determine for him- or herself the value of the good.

The problem is, in a market setting this agency is incomplete because it forces the healthcare professional to act strictly from the perspective of the patient. But an individual cannot at once be an economic principal and an agent for another economic principal. An individual cannot worry about earning money for him- or herself *and* saving money for another, especially when it is the other from whom the individual is trying to make the money!

It is to try and combat this inherent conflict of interest that the healthcare field has regulated itself to protect providers from competitive market forces. The idea is that curtailing the amount of competition in the marketplace will create an environment wherein the healthcare provider's economic interests are sufficiently minimal as to allow him or her to behave in the interests of his

or her client without having to worry about his or her own economic interest.³⁴

However, this self-regulation of healthcare professionals notwithstanding, the agency is still imperfect. This is because it is impossible for anyone to be a completely selfless agent. Practically, one cannot help but think about one's own interests. And it is to combat this problem that has led to the professionalization of health care and the development of codes of ethics and the like. These interventions are meant to limit the willingness of providers of health care to exploit their positions of power and to motivate seeking the interests of his or her client at the expense of his or her own.

For these three sets of reasons then, health care is not appropriate for distribution in a market setting.

The Pareto Response

To deal with some of the practical difficulties with health care's departure from the way regular commodities operate on the open market, some might offer a weaker version of the efficiency argument. That is, one might suggest that if we guarantee a somewhat fair distribution of income to people and then allow people to buy whatever health care they need on the open market, the market mechanism for distribution would work, even for health care.

The first problem with this alternative is that it presents the problem of having to define the basic minimum amount of care the individual would need

³⁴ This approach has been taken by other fields of expertise, such as engineering and accounting, where individuals may face similar conflicts of interest.

to buy. For without this information, how would we know what the minimum is that everyone should be provided with in order to be able to purchase the required amount of care?³⁵ Second, this solution also involves private insurance schemes which have been demonstrated as inefficient.³⁶ Third, the account doesn't lend itself to an explanation of how non-acute healthcare services such as direct and indirect preventive measures would be bought and sold on the market.³⁷

Lastly, to offer this approach the defender of the efficiency position would be admitting that health care is special and deserves to be treated differently from any other commodity. But in trying to make it fit the market mechanism, this solution makes distributing health care in a just way even less likely. For as Michael Stingl notes, "this suggests an even more insurmountable problem for any proposal tying the distribution of health services to a more equal distribution of material wealth: to the extent that the struggle in both Canada and the US for more egalitarian health systems has been an uphill battle, the struggle for greater economic equality has faced a more nearly vertical climb."³⁸

Given the strength of the challenges raised to this argument and the difference between the workings of health care from other commodities on the market, it is far from clear, indeed there is considerable reason to doubt the hypothesis, that distributing health care on the open market is preferable to any other allocative method.

I have not demonstrated conclusively in this section that health care cannot be distributed in a market environment; for it is possible that with

³⁵ Daniels 1985 p. 21 - 22

³⁶ Stingl, 1996 p. 13

³⁷ Ibid.

³⁸ Ibid.

extensive interventions on the part of the government, some of the conditions that would be violated in an unfettered market for health care might still be restored. However, I believe sufficient evidence has been presented to shift the onus to the other side. I believe I have shown that there are some serious problems with the commodification of health care. The proponent of the market method would now have to justify why these interventions represent a better alternative than having the good distributed in a centrally planned way.

Chapter III

Liberal Egalitarianism and

A Social Obligation to Provide Health Care/Health

A basic premise I believe any distributive theory must account for is the fact that we do not deserve in any way the social, cultural or economic starting points that we are given in life.

For example, a child born to an impoverished family in the developing world, who must seek work at the age of four, often go hungry and survive without direct contact with his or her father who is out working 20 hours a day himself, cannot be understood as somehow deserving to be born into such a life. Neither can the Arab prince, who is born into circumstances of immense wealth and power - with every whim looked after. Nor is the child of a white, upper-middle class family living in Canada with both parents in a land where she or he is of the majority class, in any way meriting her or his beginnings. Indeed, none of us deserve to enjoy or suffer the circumstances we are born into. It is simply beyond our control.

Yet who we are - what our cultural background is, where our families stand in the social hierarchy and what our economic status is - will determine the kinds of lives we can expect to live. If we are a member of a minority group, we will be significantly less likely to achieve positions of power in society. If there is not a strong education background in our family, we will be less likely to pursue higher academic training. If we are children of young, single mothers, we are likely to be poor, to be more susceptible to illness and disease. If we are from an aboriginal background, we are likely to die almost 10 years younger than our non-aboriginal fellow citizens.³⁹

If one is to take these claims seriously, that we don't deserve our starting points, and that these starting points play a critical role in the life plans we

³⁹ Alberta Health, 1996; National Crime Prevention Council for Canada, 1996; Alberta Health, 1995

develop and strive to achieve, as well as in our ability to achieve these goals, then one is led away from accepting either the libertarian or the utilitarian positions as I've described them in the previous chapter. This is because utilitarian theory makes no comment on the acceptability of these beginnings and libertarianism simply regards them as justified luck - whether good or bad.

Whatever approach one does favour should involve some redistribution of resources to those whose ability to flourish is limited by these starting points. My goal in this chapter is to articulate such a position and to identify some of the implications such a position will entail.

Just Health Care

One variant of the liberal egalitarian position is developed by Norman Daniels. I propose to examine Daniels' account and build my own version on his approach. To this end I will begin by presenting his position and then go on to discuss what I think he captures well and to try and work around what I see as the weaknesses of his particular argument.

In his book, *Just Health Care*⁴⁰, Daniels argues that there exists an obligation on healthcare institutions in modern liberal societies to provide equal access to basic care for all citizens. This obligation is based on a larger obligation on society to provide citizens with fair and equal access to a normal range of opportunities. The fundamental justification for this obligation is fairness.

⁴⁰ Daniels, 1985

Life Plans, Normal Functioning and Opportunity

According to Daniels, as humans we develop a conception of what we think is the good life and we develop life plans to enable ourselves to achieve the goals we've set out for ourselves.⁴¹ A person can be said to be happy to the extent he or she is successful in achieving his or her rational life plan. Over time we may revise our understanding of what constitutes this good life and alter our life plans accordingly. And rational people will develop plans that have a reasonable chance of succeeding. Crucial to this process of development and revision and to our ability to achieve these goals are the opportunities that are available to us - for these define the scope within which we make our life plans.⁴²

Daniels continues that we can only be successful in developing our understanding of the good life and in making and pursuing plans to the extent that we have access to a fair share of the normal opportunity range. Because opportunities in modern, Western society are geared towards people with normal capacities to function, to have this fair share of the normal opportunity range we require maintaining the abilities required for normal species-typical functioning. And to protect this normal species-typical functioning, we require other social goods such as health care. Therefore, as humans we have a deep interest in establishing institutions that preserve species-typical functioning.

⁴¹ Ibid. p. 27 - 28

⁴² Of course the definition of the good life is limited for an individual by the assumption that everyone is to have a fair share of basic resources. For, otherwise, one could encounter the problem of those individuals who develop extravagant life plans that are unreasonable. I will not engage the debate over rational life plans here.

In other words, Daniels argues that opportunity in society is geared towards normal people - people with normal functioning abilities.⁴³ For people to be able to have normal goals, they need this set of abilities. Any time this set is unavailable, a genuine need results. Genuine needs are those that people live to function normally.

Consider the following story of two brothers. The first asks his father for money to go see a hockey game with his friend. The second asks his father for some money to buy the medicine that the doctor prescribed at this afternoon's appointment. Both might plead their cases to the same extent. In fact, given the unpleasantness many people feel at having to take medicine, the brother wanting to see the hockey game might offer more fervent supplication. But we would generally regard the two requests as having different moral worth, concluding that the sick boy's desire for medication is more important than his brother's wish to be entertained. Daniels would argue that this is because of the difference in the impact the two requests have on well-being.

Again, on Daniels' account genuine needs, such as the boy's need for medicine to restore his good health, are those that are required for us to function as normal human beings and that enable us to plan for and achieve our normal human goals. Were these to be lacking, we would be unable to have, let alone achieve, these goals.

⁴³Although as a society we do try to make some social adjustments for those who lack normal functioning. For example, we reserve certain parking spaces for the disabled, have audible pedestrian signals, put ramps on sidewalks to make them wheelchair accessible and so on.

Shared Responsibility - Community Resources and Fair Opportunity

So we all have an interest in protecting the abilities that allow us to function normally. But why should we as a community, as a society, work to ensure that these abilities are protected for all members? What justifies working to the betterment of those who are less fortunate? Why not adopt the libertarian notion of negative rights to liberty, allowing those interested in working towards the betterment of others to do so, but forcing no one?

Daniels suggests that this justification is found in liberal political philosophy.⁴⁴ For according to the premises by which this tradition allocates goods in society, it is only morally acceptable to have unequal distributions of important social goods if those vying for the good all have a fair opportunity to get it. 'Fair' opportunity means that morally irrelevant features cannot be the basis of the distribution of the good. In other words, individual rewards ought to be based on relevant skills and talents and ought not to be based on such criteria as religion, race, gender, ethnic origin and the like.

Daniels admits that even 'relevant skills and talents' are the result of factors such as genetic endowment and the environment in which one is raised.⁴⁵ And to the extent that one cannot be said to deserve one's lot with respect to either of these factors, talent and skill are also randomly distributed. Therefore, they are distributed according to morally irrelevant criteria. However, he suggests that there is a limit to the extent society can go in ameliorating all inequalities. Transgressing upon the liberty of parents in order to try and achieve strict equality is, for Daniels, unacceptable. Therefore, he

⁴⁴ Daniels, 1985 p. 36 - 37

⁴⁵ I will have more to say about this later in the chapter.

suggests that society ought to do what it can to remove *barriers* to opportunity. The fuzzy line that this results between respecting freedom and protecting freedom is part of what comes with doing the best to respect liberty in this sense.⁴⁶

In other words, as the libertarian has taken great pains to point out, any time we coerce someone to do something they would rather not, we are limiting their liberty. Accepting this, Daniels focuses on limiting barriers to opportunity rather than forcing equalization.

If society accepts the import of fairness, it must accept that morally irrelevant features ought not to be the basis for the distribution of an important social good. Thus, society must actively work using collective resources to prevent discrimination according to morally irrelevant criteria. And health, or the lack of disease, posits Daniels, is a morally irrelevant feature for the distribution of opportunity because we do not deserve the diseases we get or the factors in our lives that influence their onset.

Stated differently, the level of one's health should not be the criteria according to which opportunity in society ought to be distributed because health is distributed arbitrarily. Thus, in protecting the equality of opportunity of individuals to conceive of the good life and to achieve their individual life goals, individual health must be protected. This means that any diseases or disabilities must be ameliorated to whatever extent possible. By ameliorating health and disease we would be affecting a barrier that unfairly selects who gets opportunities. This effort must be funded by the pooled resources of society. Note that it is opportunity and not health care that Daniels is concerned about distributing fairly.

⁴⁶ Daniels, 1985 p. 40 - 41

Lifting Health Barriers - the Biomedical Model

How is society to achieve this? Well, opportunities in society are geared largely towards people with normal functioning capacities. And what normal functioning capacities are for humans is determined by the biomedical sciences. Furthermore, disease, which is the technical departure from normal species-typical functioning, is the proper object of the various healthcare institutions we currently have in society including physicians' services, hospitals and the scientific research community. So society can help to guarantee fair equality of opportunity by ensuring that the services of the healthcare institutions that are required to enable individuals to access opportunity are available to all without regard for one's ability to pay for them. We must equalize for health as much as possible, in addition to bringing down other barriers to opportunity.

Daniels' solution involves adopting a biomedical model of health. Of this model he says, "the basic idea is that health is the absence of disease, and diseases (I include deformities and disabilities that result from trauma) are deviations from the natural functional organization of a typical member of a species. The task of characterizing this natural functional organization falls to the biomedical sciences."⁴⁷ So while Daniels accepts that the determinants of health include a wide range of factors, he argues that, "this does not mean that we are committed to the futile goal of eliminating or 'leveling' all natural differences between persons. Health care has normal functioning as its goal: it concentrates on a specific class of obvious disadvantages and tries to eliminate

⁴⁷ Ibid. p. 28

them."⁴⁸

The benefit of the biomedical model for Daniels is that it provides fairly objective criteria for what falls under the scope of health care. Science offers what are seen as uncontroversial means for determining what does and does not constitute 'normal behaviour', what deviations from this behaviour entail and how to remedy them. Thus, what society is obligated to provide is fairly cut and dried. If we were to rely on any ambiguous notions of what normal health is for human beings, such as the infamous definition offered in 1946 by the World Health organization that, "[h]ealth is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity"⁴⁹, then our health policies would have to be so expansive as to include policies on every aspect of human life. These policies, if implemented, would probably result in massive increases in expenditure, along with numerous other problems. The biomedical model avoids this problem of inflation.

If the distribution to all of adequate basic healthcare services is accomplished and disease can be eradicated, all people will have a fair share of opportunity and equal scope for developing and striving to achieve rational life plans - not equal, strictly speaking, but fair. Therefore, society is obligated to provide healthcare institutions which themselves must abide by the principle of fair equality of opportunity and which will work to preserve the fair equality of opportunity owed citizens by society.

⁴⁸ Ibid. p. 46

⁴⁹ Evans and Stoddart, 1990 p. 1347

Why Fairness? Rawls' Theory of Justice

Daniels suggests that his theory works for any theory of distributive justice that successfully defends the principle of fairness and of fair equality of opportunity. But why should we as a society be committed to the principle of fairness? Sure the distribution of goods in life - and harms - is unfair. But life in general is unfair. Why should we collectively be committed to fairness, perhaps at the expense of our own liberty?

To provide support for his claim, Daniels attempts to implant his theory of just health care into John Rawls' general theory of justice as fairness.⁵⁰ He uses Rawls' theory because of its purported ability to answer the questions raised above and to demonstrate that health is important to all people in the same kinds of ways, both structurally and substantively. This support would buttress Daniels' claim that certain needs are both objectively ascribable and objectively important to all people, regardless of distinguishing factors.

The aim of Rawls' project is to develop certain principles of justice that self-interested, rational agents with diverse life plans would accept as the basic authority in forming a political unit. "They are the principles that free and rational persons concerned to further their own interests would accept in an initial position of equality as defining the fundamental terms of their association."⁵¹ These individuals are choosing from an initial position that Rawls calls "the veil of ignorance". It is so called because the hypothetical position from which these initial individuals are developing these basic principles do not know the social, cultural or economic classes to which they

⁵⁰ Ibid. p. 42 - 48

⁵¹ Rawls, 1987 p. 454

would belong in the society whose basic rules of cooperation they are deciding. They must develop these principles with the understanding that they could actually be any member of society, from any socioeconomic background, endowed with unknown traits. The idea is that this veil of ignorance masks morally irrelevant criteria.

The principles Rawls suggests such impartial and rational persons would come up with are as follows:

First: each person is to have an equal right to the most extensive basic liberty compatible with a similar liberty for others.

Second: social and economic inequalities are to be arranged so that they are both (a) reasonably expected to be to everyone's advantage, and (b) attached to positions and offices open to all.⁵²

Rawls also offers a more general conception of justice that, "[a]ll social values - liberty and opportunity, income and wealth, and the bases of self respect-are to be distributed equally unless and unequal distribution of any, or all, of these values is to everyone's advantage."⁵³ These are taken to be a list of primary goods which, again, are to be distributed equally unless unequal distribution results in everyone being better off than they would have been otherwise. The level of individual well-being in Rawlsian society is measured by the amount of these primary goods one possesses. The more liberty, opportunity, wealth and self-respect, the better off one is.

In this system, jobs and positions of office are especially important because of their strategic importance in achieving a greater portion of these primary goods and thus, for Rawls, being in a position of greater well-being. To determine who gets these positions according to criteria determined by one's social background or other measures over which one has no control is to focus

⁵² Ibid. p. 460

⁵³ Ibid. p. 461

on morally capricious criteria. This would be tantamount to conferring a moral arbitrariness to certain distribution outcomes which violates the principle of fairness. Therefore, according to Rawls' system, society must take positive steps to ensure fair equality of opportunity for these positions.

So why fairness? Because, according to Rawls, we don't *deserve* our starting points. Therefore we don't deserve the special opportunities that we get or don't get due to our starting points. So it's justified to override the liberty of some because the nature of that liberty - the range of options one has - is not deserved in any way.

And Daniels argues that health care can be seen as a logical extension of this principle of fairness. That is, he suggests Rawls' principle of fair equality of opportunity, if it applies to jobs and careers, must also apply to protecting individual shares of the normal opportunity range as well. This is because health care is also a strategically important factor in that it alleviates disease, returning the individual to normal species-typical functioning, widening the range of opportunity available to the individual and, therefore, giving the individual a greater and more fair share of the primary list of goods. Caring for the health of an individual, Daniels is thus arguing, is to advance his or her well-being.

So health care is different from other goods because, on the one hand, the need for it is distributed by chance and, on the other, it has great strategic importance for accessing primary goods, particularly opportunity. Again, it is important to note, Daniels is not suggesting that health care be added to the primary list of goods, for this he finds problematic on a number of fronts.⁵⁴ Rather, he is suggesting that it is not just institutions that deal with jobs and

⁵⁴ For a discussion of these see Daniels, 1985 p. 43 - 44

offices that must operate with the fair equality of opportunity principle, but healthcare institutions as well - as protectors of the primary good: fair equality of opportunity.

The Unsatisfied Libertarian

This liberal egalitarian position still has some basic hurdles to overcome. The defense of fairness to this point will likely still be unsatisfactory for the libertarian, for the question remains, Why ought we start from a position of impartiality? Why should we begin behind such a thick wall as Rawls' veil of ignorance? What reason is there for any individual to accept this moral theory over another that preserves his or her basic freedom to act without any coercion?

Or, put differently, if a moral theory must be acceptable to most people for it to have any practical bite, then how are we to convince those who will be affected negatively by a theory based on impartiality to accept such a morality? And more fundamentally yet, What justifies the bias in the liberal position in favour of the poor and weak over the rich and powerful? Why are the poor relatively special? These are formidable challenges, to be sure.

The first step I wish to take in defending the position requiring a redistribution of resources in society is to point out that the libertarian position misrepresents who we actually are. That is, based as it is on Western moral tradition, libertarians understand the individuals who are to develop and be affected by a moral theory as self-interested, rational agents - agents concerned

only with advancing their own personal interests in the most efficient way possible.

However, I submit that this is not the case. We are not independent, disconnected, isolated, rational beings that go around making agreements with the sole aim of advancing our own personal interests. Rather, to borrow a Shakespearean phrase, we are all "born of woman". We are all connected in many relationships with different people. We all depend upon others and are depended upon by still others. Hence we are *interdependent* creatures that occupy many positions of power and weakness relative to the others with whom we share our lives. This description, I believe, is more accurate a depiction of who we are.

And what this interdependence does is foster in each of us, given some reflection, an empathy for those in positions of relative weakness. In other words, because we have all been and are likely still dependent on others for care in our lives, upon reflection we can understand and appreciate what it is like to be in need. We have, by virtue of experiences we are all acquainted with, a sensitivity to being in need. If we think about it this empathy, I argue, will lead us to recognize an obligation upon all of us, a moral obligation, to provide for the basic needs of all those who through no fault of their own lack the basic necessities of life.

The libertarian, of course, will argue that this claim is based on intuition. Consequently, it cannot be used as the foundation for a moral theory because it offers no reason for anyone with a differing intuition to accept it. And so the moral theory based on the intuition will not motivate dissenters to accept it - it will have no real power.

I will concede to the libertarian that the position I have sketched is indeed based upon intuition. But notice, though, that this objection can be leveled back at the libertarian. For the libertarian position is also based upon an intuition about the nature of human beings. Therefore, it is equally exposed to its own criticism.

It may well be the case that an important, if not fundamental, part of the moral floor of acceptable action, will be comprised of the negative right to liberty. However, just as critical to this foundation is a set of positive rights that recognizes the relative need of some persons and the relative ability of others to assist in caring for those needs as well as the responsibility of the stronger to assist the weaker. Moreover, as the libertarian recognizes, if it is the case that a group of people agree to have their basic liberty infringed upon, then such infringement is justified as there is no coerced interference involved. If one accepts rules of conduct that infringe upon one's liberty, that infringement is not morally wrong based on a libertarian ideology, because it has been consented to.

And this is what I believe is the case in Canada, today. That is, I believe that people in this society share the fundamental empathy that I described earlier, and agree that resources in society ought to be redistributed in ways that ensure those in positions of need are cared for. The redistribution through means such as taxation is legitimate, then, because there is considerable agreement about its importance.

So my response to the libertarian is that I have a moral intuition that indicates to me a responsibility to provide through common resources for the basic needs of all members of society - based upon the nature of the human agent as an interdependent person and the liberal arguments about undeserved

starting points discussed earlier. I believe that this intuition will be shared by everyone who is in relationships and wish to make an effort to make others realize this - indeed that is what I am engaged in here. This is a fundamental principle of the correct moral theory I accept. Admittedly, everyone might not accept this. But to the extent that that this vision is shared by others, the redistribution of resources, the positive rights that people are accorded, must be accepted as legitimate, even from a libertarian position.

This raises the empirical question - Is there some consensus in this society around the requirement to ensure everyone has their basic requirements fulfilled? I will address this issue in the following chapter. Now I turn to a more detailed examination of Daniels' view, and to developing my own account of what an acceptable distributive theory must look like and what implications this theory will have for the health system.

The Virtue of Daniels' Argument

The main virtue of Daniels' argument is his recognition of the need to move past a negative rights understanding of liberty. That is, what I find appealing about Daniels' account is its sensitivity to the fact that while we all have the same basic requirements for approaching well-being, what we each lack is very different. And oftentimes this lack is distributed through no fault of our own. The claim I am making is that we all do deserve an equal chance at well-being, even though we do not get it.

Again, the native child born to a single mother of five living on a fixed

income with no social support mechanisms in a context of racial inequality and disharmony can no more be said to deserve his or her lot than the baby born to a family in a privileged socioeconomic class in the same social context. And it is unfair to act as though the two were somehow deserving of their social starting points.

Does this mean that we must equalize the lots of the two? Or as Narveson (and Nozick) puts it, that if one of the babes is born with two healthy eyes and the other is born blind that we must give one of the former's healthy eyes to the latter?⁵⁵

In my view, clearly not - for two reasons. The first reason for this is that this extreme example does not distinguish between relatively important and not as important parts of the self. Certainly one would worry about a theory that required one to give up an eye. But this is due to the importance of the part of the self - one's eye - that is in question. Would one have the same negative reaction to the transfer of a few dollars from a wealthy individual to someone less well-off to bring about a significant change in health status? It may be true that we have problems with a theory that demands one to part with an eye, but what if all that was demanded was a few dollars to give to a poor single-mother to provide her with vitamin supplements during pregnancy? This would be less troublesome. And that is because there is a difference between important and not as important parts of the self, such that it is justifiable to ask individuals to part with the latter when significant gains for others are to be had.⁵⁶

The second reason for this is that the *goal* of distribution should be fairness, not strict equality. But why do I favour fairness over equality? If my

⁵⁵ Narveson, 1985

⁵⁶ My thanks to Michael McDonald for calling this concern to my attention.

argument is that the basic goods we all need to achieve well-being are not distributed fairly, but that we all ought to have an equal chance at achieving well-being, then why should society stop at ensuring fairness over equality?

I must confess at this point that were such a thing possible as an equal distribution of the chance to achieve well-being, I might be in favour of it. The reason for this, and I admit it at the risk of having my perspective analyzed through jaded eyes, is my belief in a deeper spiritual equality and the unity of human beings. But spiritual and material life are not easy to practically equalize.

First of all, there is the practical problem of what well-being consists in. Because we often have different understandings of what a good life is and what is needed to flourish, it is next to impossible to equalize without a common definition of what needs are.

Then there is the problem of counting goods. It's easy to count grains of rice and distribute them between people, but some need more than others. Not everyone needs a piano or guitar to flourish. But the musician will suffer if she is to go without the instrument. Therefore, some flexibility is needed within a distributive system. Moreover, how does one count things like love and support which are essential, if not quantifiable? There are also the problems of inequality breeding a lack of incentive to produce and the desire to have room in a moral system for the element of charity.

A libertarian reader might find himself rubbing his eyes at this point, wondering if I have not just agreed with most of the tenets of his argument. For I may be interpreted to suggest that what we need is a basic equalizing of what we all agree to, and then structures to ensure charity for those who wish it. The

problem is, in his conception what is agreed to painfully minimal. We need encouragement to give and if left to own devices would not share.

Thus, I would argue, there is a need to enforce sharing to some extent *and* to allow room for more. This also provides room to accomodate some of the other concerns above. So my balance is shifted over to more forced sharing than is the libertarian's - admittedly at the expense of a degree of liberty.

In addition to these arguments, I also believe that our spiritual goals, while linked somehow, still have to be pursued privately and independently. Part of what it is for us to do this is for us to negotiate our own paths as we walk along in the particular shoes we have been given. However, if we have no shoes to begin with how can we concentrate on the path without being preoccupied with the basic cuts and bruises we will experience? The hungry child unable to concentrate in school because of poor nutrition or worries about serious social problems is going to have much to think about aside from and well ahead of any kind of spiritual reflection.

Thus it is the fairness element of Daniels' argument that I wish to build on: the fact that we all share the need for basic resources, but that the resources we have at our disposal and our abilities to have these needs met are undeserved for the most part. Consequently, we ought to work together to ensure that we all have our basic needs met. In terms of health care, this has the implication that we must work collectively to ensure that each of us receives the kind of care we require to have our basic needs met.

However, Daniels' version of this approach is not without its own problems. The problems I will identify indicate shortcomings with the way Daniels addresses how to practically approach this question of fairness and

equity with respect to health care. Specifically, they highlight shortcomings of the model of health Daniels chooses to use - the biomedical model. I suggest that while Daniels' general attitude is correct, what will be necessary is a model of health that compensates for these shortcomings.

The Broader Determinants of Health

The first incongruity in Daniels' argument is effectively highlighted by the Evans and Stoddart article I have referred to previously.⁵⁷ The problem has to do with Daniels' adoption of and focus on the biomedical model of health.

On the one hand, Daniels suggests that the biomedical sciences are responsible for defining health, construed as species-typical functioning, and the health sciences are responsible for determining and treating diseases, which are departures from normal human functioning required to achieve our biological goals. On the other hand, Daniels suggests that social factors are also important determinants of health.⁵⁸ And in listing the factors which he feels impact health and must be affected in order to affect disease Daniels includes:

- 1 Adequate nutrition, shelter
- 2 Sanitary, safe, unpolluted living and working conditions
- 3 Exercise, rest, and some other features of life-style
- 4 Preventive, curative, and rehabilitative personal medical services
- 5 Non-medical personal and social support services⁵⁹

If one believes that the determinants of health are constituted from a

⁵⁷ Evans and Stoddart, 1990

⁵⁸ Daniels, 1985 p.34

⁵⁹ Ibid. p. 32

broad list of factors including such things as rest, non-medical social support services and adequate nutrition and shelter, and one also believes that we need to attend to these factors in order to affect the health of people, then it does not make sense to focus the attention of public policy exclusively, or even predominantly, on the provision of healthcare services that respond to the treatment of disease.

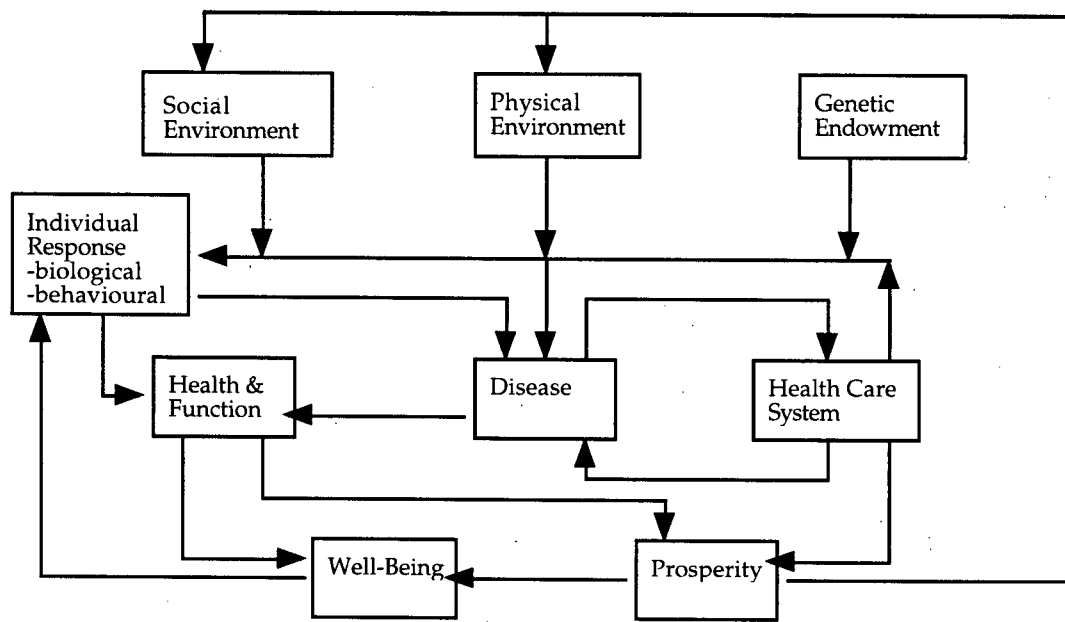
As mentioned in the first section, two of the reasons for holding these conflicting beliefs, according to Evans and Stoddart, are: 1) that disease-based health care is easier to understand and make sense of; and 2) that the belief that health care is the most important impact on health is constantly being reinforced in society.⁶⁰ With respect to the latter, there is much empirical evidence, already amassed and continuing to grow, that health care does not play the central role it is given.⁶¹ But, as the former accurately suggests, the traditional manner in which we understand health care, the framework we use, does not make it easy for us to understand this evidence and a new framework is needed.

To this end Evans and Stoddart offer a framework that does make it easier to make sense of these wider determinants.⁶² This framework distinguishes disease, as defined by the health professional, from individual health and function, as the impact of disease on the individual, and from individual well-being, which is taken to be the overall sense of well-being of the individual - his or her happiness. The distinction between these three facilitates understanding some of the complicated pathways that need to be explained in the empirical evidence for the wider determinants of health.

⁶⁰ Evans and Stoddart, 1990 p.1359

⁶¹ See footnote 7

⁶² Evans and Stoddart, 1990 p. 1359



Reproduction of Evans and Stoddart proposed framework

The framework offers three general areas of determinants of health: a) the social environment, including individual supports, stress and self-esteem factors; b) the physical environment, one's actual living and working surroundings; and c) one's genetic endowment or the predispositions we have at the molecular level in terms of responses to various stimuli. All three of these factors affect the individual and cause some reaction; a reaction which in turn affects health and function. The reaction can be a behavioural reaction, such as a lifestyle choice, or a biological reaction, such as the onset of disease and illness. If the individual presents him- or herself to the healthcare system, and the system decides that the condition warrants treatment, that is, defines the condition as a disease, the system can provide this treatment and affect the disease. But the impact of the healthcare system is not limited to this provision of treatment. For health care also prompts a response from the individual and, therefore, influences individual health and function. The healthcare system

also impacts the overall prosperity of the society, which in turn impact the social and physical environments of the individual. The economic prosperity of society also affects individual well-being. Well-being also causes one to react biologically and behaviourally - and so on.

The pathways in this model are many and complex and need not be discussed here in any detail. The point is that the biomedical model is too limited to handle and address the greater determinants of health. For example, it has been observed that the relative positions we occupy in the classes within our society is directly related to our chances of getting and succumbing to different diseases. A person who is on a lower rung in the social ladder is not only more likely to smoke than someone above who smokes, but is also more likely to get sick and die of a smoking-related illness than someone in a higher socioeconomic class who also smokes.⁶³ This gradient is true even well above what are regarded as standardly accepted (Western) levels of poverty. The biomedical model not only fails to explain this data, it does not allow us any way of interpreting it.

As well, the biomedical model is incapable of addressing what Evans and Stoddart refer to as the social environment determinants of health. It does not facilitate easy understanding of the impact of stress in our lives or the impact of self-esteem. It does not allow us a simple way to understand or respond to the fact that our social and economic environments impact our lifestyles and thus our health.

Were we to pursue Daniels' suggested path adopting the biomedical model, we would face two options. Either we would have to expand the scope of medicine/health care to try and address the elements that research is showing

⁶³Ibid.

do factor on individual health (evidence that Daniels agrees with). Or we would simply have to ignore them. Neither of these options is acceptable.

The problem with the former alternative is that conventional health care simply can't reach many of the areas (poverty is an example) that determine health. Indeed, even if it could, it is questionable whether we would want it to. Medicine has already encroached upon many areas of life, from birth and death to reproduction and, in some cases, even to the provision of nutrition. But there is a limit to how much influence we want our physicians and other healthcare professionals generally to have in determining how we lead our lives.

The second alternative, simply to ignore the broader determinants, is straight-forwardly unacceptable if we are genuinely interested in improving the health of individuals in society. If we ignore these larger factors, our health will not improve and our extra efforts in the area of health care will be for naught. As I suggested early on, this is not to say that there is no need for a healthcare system that is disease-based. We will still need clinics, hospitals, professional healthcare workers and the like. What I am pointing to is the need to recognize that an approach focusing exclusively on the biomedical model is insufficient for meeting our health goals.

In light of this criticism, one requirement of any acceptable model of health is that it be more sensitive to the broader determinants thesis than Daniels' biomedical model.

Unhelpful Abstraction

Michael McDonald points out that there is a deeper problem with Daniels' account. He argues that the very definitions of health and disease that Daniels employs as objective notions are in fact value-laden. Health, McDonald argues, is a socio-cultural construct. Consequently, one cannot appeal to empirical objectivity to establish the universality of health as a value or as a primary social good, as Daniels does. Furthermore, the Rawlsian approach to defining the important healthcare instruments (and Daniels' use of it) takes us in the wrong direction if our goal is to develop and provide relevant healthcare systems in society.

Central to Daniels' claim is that certain human needs are objectively important (that there is a clear way of distinguishing them from other wants or desires - mere preferences) and objectively ascribable (that we can say someone has the need regardless of whether they realize it or not). This is of benefit because it offers a clear standard of what needs are important - a standard that can apply to all human beings. The justification for this Daniels finds in the concept of species-typical functioning.

The problem, claims McDonald, is that in defining the reference point for species typical functioning, how is one to decide what is normal? What reference is to be chosen as the model for normal behaviour? Whatever the answer, the choice of what is "normal" will introduce values.

Daniels relies on Christopher Boorse's account of normal species function. Boorse suggests that the ultimate human goals are survival and reproduction. Normal function is based on what the average biological

organism of a species requires to survive and reproduce. Disease is any deviation from or impairment of normal functioning. And health is the absence of disease. But how is one to determine what is representative of the average human being in a particular reference class? And why are survival and reproduction counted as the only relevant goals when for many spiritual development and having a meaningful life are just as, if not more, important basic human goals? Therefore, the normal-species typical functioning, far from being objective, is in fact value-laden.⁶⁴

McDonald thus challenges Daniels' assumption that health and disease are value-free notions. He suggests that the practice of medicine, which entails both caring and curing, involves two important elements: the social relationships between provider and patient on the one hand, and both the formal and informal organization of societal practices and institutions on the other. In the first case, it is important for caregivers to realize that the meanings of different diseases can vary from patient to patient and can differ from the caregiver's own. In the second case, it is critical to recognize that values underlying present health systems are biased towards supposedly objective biological conceptions of health; that the meaning of health is culture specific; and that people's important goals in life are far from clear and objective.

McDonald writes: "a Western psychiatrist treating a Cambodian refugee in Canada for depression needs to be aware not only of her patient's world-view, but also of her own cultural perspectives as a professional psychiatrist." And, "[t]o address healthcare needs adequately, there needs to be a discussion in each society or community of 'vital goals'...[t]his involves reflection on the diverse cultural, religious, etc. meanings of 'health' and 'health care' that members of

⁶⁴ McDonald, 1999 (forthcoming)

the society have."⁶⁵

Thus, on McDonald's account of health, what counts as a health need will vary from individual to individual depending upon the particular socio-cultural community an individual belongs to and that community's understanding of health.⁶⁶ He believes that Western conceptions of health and health care are heavily influenced by the biomedical model. However, he recognizes that this is a construct based upon the socio-cultural context of this society. The great benefit of McDonald's perspective is that it leaves room for other societies to have different conceptions of health and disease. It also allows for the recognition that the biomedical model that has dominated our very recent Western history and that is predominant today has not always been the way this society has understood the meanings of health and disease, and indeed need not always be in the future.

McDonald also points out that the nature or definitions of our notions of health and disease have crucial implications for the planning and delivery of health care. What we understand health and disease to be will in turn shape the kinds of institutional structures we develop for the planning and delivery of health care. This understanding will determine the training, accreditation and professional organization of healthcare providers and health scientists. It will also impact the practice of ethics education in and around healthcare facilities. And it will inform the way models of health care are developed around the world.⁶⁷

Given these vast implications and the fact that notions of health and

⁶⁵ Ibid.

⁶⁶ My thanks to Michael McDonald for helping me to work through the nature of subjectivity in the definition of health and disease.

⁶⁷ McDonald, 1999 (forthcoming)

disease are evaluative, McDonald argues that Daniels' use of Rawls' original position and veil of ignorance are relatively unhelpful. They serve to decontextualize meanings of health and health care when what is needed is a grounding of these terms in particular communities of people.

Daniels' reason for using Rawls' theory is to support the claim that health is important to us all in the same kinds of ways and we all want the same kinds of things in being healthy. The veil of ignorance successfully demonstrates this in that those of us choosing from the original position, where our social, cultural and economic identities are unknown to us, would be able to empathize with the lots of all individuals in our society and, therefore, to select rules of organization that would benefit the worst off.

My aim in this section is neither to argue that individuals from different socio-cultural communities share nothing in common; nor is it to deny that this empathy is possible. On the contrary, there will exist important commonalities across cultures, both in terms of the strategic role health plays in achieving life goals and in terms of what is required for good health. For example, it is not unreasonable to suggest that basic nutrition (the absence of malnutrition) and peace (the absence of extreme suffering) might qualify as universal prerequisites for any definition of health. Different societies may have different approaches to dealing with suffering, for instance, but it's probably not too outrageous to suggest that no one *wishes* it. To ignore this commonality is to admit the possibility that there can be no such thing as a universal bill of health, even thinly defined - something I strongly wish to avoid.

The problem is that while Rawls' approach does capture these commonalities, it fails to recognize that the meanings of these needs, and thus the kinds of care that will be required to address them, will vary widely

depending upon socio-cultural context. Thus Rawls' account focuses on health care that is still too aloof from the real needs of the actual communities health systems are to serve.

If health, disease and health care are evaluative notions, then rather than decontextualizing these notions and running the risk of developing a putatively objective health science that can (continue to) be hijacked by the biosciences, one ought rather to aim to discover what it is to care and to cure in the context of the cultures of individual communities.

I believe that the criticism McDonald offers is supported by the relational perspective of ethics that I alluded to earlier. Here, right and wrong action are founded upon the complex human relationships we have. In terms of health care, those individuals involved in providing care must do so not simply on their own terms but with an understanding of the needs of a patient in the context of a shared understanding of the goals of care.⁶⁸

From Daniels' perspective, McDonald's argument reintroduces the problem of conflating needs with desires and preferences - a problem that Daniels hoped to avoid by developing his "objective" account of health and disease.

The worry again is that if health and disease are defined in subjective terms, and fairness requires that basic health needs be provided for, then there will be no end to what society will be responsible for providing to all its members through shared resources. This is problematic for many reasons. For example, in practical terms, neither will we ever have enough resources to provide for everyone's preferences, nor will the political will be mustered to address the social injustices that presently exist. And from a theoretical

⁶⁸ Bergum, 1998

perspective, there will likely be no incentive for individuals to work hard and to be a creative, productive force if the state is to be responsible for providing whatever is required to what is in effect the vague and subjective notion of happiness.

While it is true that on McDonald's socio-culturally based account of health and disease what counts as a healthcare need may differ from community to community, it does not necessarily follow that a subjective view of health is any more exposed to these problems than one that is objective. For, either way, in light of other factors such as advances in technology and an aging population, it is likely that there will always be greater demand for health services than can be met. Services designed to meet health needs subjectively defined will probably require prioritizing and rationing just as those designed to meet needs that are objective.

Moreover, Daniels' worry should not mislead one to think that the evaluative notion of health does not offer a universal standard for what needs are important to health. That is, health can still be defined as the ability to achieve one's life goals. What those goals are, and what the appropriate ways of helping to achieve these goals - health needs - may differ to some extent. Health, however, remains strategically important to us all.

In addition to this, the evaluative approach to defining health does not preclude the possibility of interculturally shared intellectual understandings of health and disease. For in the context of the global community, a community that every day is becoming smaller and where interaction between cultures is more and more prevalent, there can be dialogue between cultures whereby we can learn from each other and exchange ideas. This may lead to shared

understandings of important human needs, including health.⁶⁹

Thus, in defining health and disease and in distinguishing between health needs and mere preferences it is inappropriate to treat everyone as being of the same type - as the biomedical model does. There is much diversity in what people think a valuable life consists in and what is necessary for living such a life. Therefore, what counts as a health need and what types of care are required to meet these needs, indeed how care is understood, will vary from one socio-cultural context to another. In defining health, one needs room to allow for this variance if health needs are to be met effectively. This is another requirement of any model of health that is to be acceptable.⁷⁰

The Four Criteria

If the commitment to fairness I have argued for in this chapter is accepted by a society, then I argue that the conception of health adopted by a society and the consequent health system that is developed must be sensitive to at least four considerations:

1. Health services must be available to all members of that society

⁶⁹ Indeed, in Canada and in other societies where there coexist societies of different religious and social cultures, this sharing of ideas will likely be critical to the development of a health system that is to effectively meet the needs of such a diverse population.

⁷⁰ I recognize that the details of how one introduces subjective notions of health and what methods of community involvement are espoused will have important consequences for determining priorities between and within the various levels of healthcare services (acute care, community care, long term care, health promotion etc.). The debate over ways of distinguishing between needs and preferences is by no means decided. However, I will not explore this debate any further than I have already done here. For the purposes of this thesis I believe it is sufficient to contend that there is an important evaluative component to defining the terms "health" and "disease".

based on need and not on any morally arbitrary criteria such as the ability to pay. This is a straight-forward consequence for any health system that is founded on a notion of equity. For an account of health care stemming from the desire to ameliorate barriers that are conferred arbitrarily, the concept of distribution of health resources based on need is a cornerstone operating premise.

2. The health system must be sensitive to the broader determinants of health thesis. What determines the health status of individuals is not just the set of immediate choices within an individual's control. Rather much evidence has been gathered to the point where it is generally accepted that acute health care has a relatively small contribution to make to the overall health of populations and that wider determinants, well beyond the scope of health care, such as income and social status, education, employment, social support, personal health practices and choices and the physical and natural environment, have a greater impact on health.⁷¹

3. The health system must recognize that health and disease are not objective notions to be defined by a value-free, biologically-based, scientifically derived source. Rather, health must be located contextually within local communities where the definitions of different illnesses and diseases are interpreted according to the culture and background of the individual sufferers.

4. The previous consideration requires also that whatever definition of health that is adopted by a health system, it be wary of the conflation of needs and preferences to avoid a situation where society ends up finding itself responsible for paying for extravagancies that appear counter-intuitive, such as Jamaican vacations for some.

⁷¹ Other examples can be found at Capital Health, 1996 p. 59 - 84; Douard, 1995 p. 134 - 138; Truman and Trueman, 1995; and Evans and Stoddart, 1990

Alternative Conceptions of Health: One Possibility

One alternative conception of health in this direction is offered by John Douard.⁷² Douard centres his argument on the freedom or liberty that is the hallmark of liberal democracy. We need freedom, he argues, to achieve our well-being. The more limited is our freedom, the more limited is our capability to achieve desirable functioning.

On his view, health is one's capacity to turn certain resources into achievements. For example, in terms of gaining worthwhile employment, among other things one needs to attend and successfully complete some academic training and to be able to search for a job. Here health, by Douard's account, would be one's ability to do these things: one's ability to attend school, search out job options, etc. If one is lacking these abilities, one's health is compromised.

This model allows Douard to make sense of the wider determinants of health. What affects disease? In fact, Evans' and Stoddart's framework allows us to see a great number of what these things might be. But the relevant characteristic to determine one's needs is not anything that impacts one's well-being, in essence one's desires, but rather those things that limit one's capacity to carry out one's life plans.

Douard argues that capability, freedom and resources are linked in the following way: We need certain resources to have certain capabilities; and we

⁷² Douard, 1995 p. 136

need certain capabilities to turn resources into achievements. We need capabilities to have a wider range of choices and therefore, more freedom. The smaller our range of choices, the lesser our freedom. And what we need to provide true freedom to members in society is multi-pronged social policy. We need to maintain a healthcare system that attends to disease. And we need to pay explicit attention in other areas of social policy - *in addition to* health care - that directly affect our capacity to flourish as human beings.

Douard's account can also be sensitive to McDonald's concerns in that it can be understood as a needs-based account with evaluative room. Health is what we need to have a wide range of choices from which to exercise our freedom. What health consists in or how disease is interpreted can be informed by a scientific understanding of human physiology *and* by an individual's or community's understanding of the meaning of certain diseases in the context of their goals of life.

Thus, human needs are structurally similar for all of us - we all need health in the same kinds of ways. But what health is, how disease impacts us and what goals we choose to pursue remains evaluative - they are based upon individual and community determinations and are not prescribed notions.⁷³

Summary

I have tried so far in this chapter to defend a liberal egalitarian conception

⁷³My aim here is not to defend Douard's formulation of health and disease. I only offer it as a potential definition. The main aim here is to indicate what an acceptable theory of health and disease will have to be sensitive to.

of distributive justice. My argument is rooted deeply in the concept of fairness. The social, economic and cultural backgrounds we are born into, the quality of parenting we receive, and other factors that determine our ability to secure good health are not within our control. These factors are determined for us and we cannot be held responsible for them. Therefore, when these elements work against individuals and their ability to achieve meaningful lives, they must be ameliorated as much as possible. However, the aim should not be to achieve some biostatistical notion of normality. Rather we as society need to ensure that we are all afforded the basic tools that are required to achieve a meaningful life as this is understood within our own particular socio-cultural communities. This is a fundamental responsibility of society.

Again, if the importance of a fair distribution of opportunity to flourish is to be taken seriously, a model of health that takes the following four concerns into account will be required: 1) Whatever solutions to ameliorate health issues are selected, they must be distributed on the basis of need, with the needs of the least advantaged in society given priority. 2) The account must be sensitive to the problem of the broader determinants of health thesis. 3) It must also be evaluative, able to respect the individual meanings of life events that the different backgrounds of people in our society will lead us to have. 4) The model must be to some extent universal, that can be applied to all members of a society in a way that addresses Daniels' concern of conflating needs with desires.

These four criteria must be addressed if we are to going to think about health and develop systems and structures in ways that are sensitive to the real needs of the members of our society, that can effectively meet these needs, and that are based on the principle of ameliorating hardships or impediments to development that are based on chance.

The reason for developing this claim is to provide us with the basic tools for testing the values of a regionalized system of healthcare delivery. That is, whatever health system is adopted by a society that is committed to fairness, it will have to meet these four criteria. Assuming that Canada is such a society, then regionalized structure of health care that is being adopted in many parts of this country must also meet these criteria.

The way a health system is organized and funded implicitly imports a definition of health, even though such a definition is not anywhere made explicit. What I wish to do is to use this model/definition as a backdrop against which to evaluate Alberta's regionalized health system.

But why should we use the definition and model that I have argued for here as the backdrop? The arguments that I have offered represent my values and what I believe a health system should look like. What is required now is to see if these values are also supported by the Canadian public - Are they also Canadian values? I believe that they are.

Thus, the next step in my effort to link broader philosophical social responsibilities to actual distributions is to answer the questions, What are Canadian values? and Is Canada a liberal egalitarian society? If an argument can be made that the public policies, laws or guiding principles of the nation do cohere with the tenets of the distributive theory I have offered, then I can say that to the extent that this evidence is actually representative of the values of the people of Canada, the theory I have developed here is also what Canadians must (and do) accept. Any empirical evidence either supporting or eroding the theory would either buttress or diminish this claim.

Chapter IV

Canadian Values and Liberal Egalitarianism

My goal in this chapter will be to offer evidence that will indicate whether or not Canadians esteem the concept of fairness that I have proposed as a value. That is, while my own intuition is that we have an obligation to redistribute goods to help those in difficult circumstances through no fault of their own, for this to carry any practical sway, it must also be demonstrated as accepted by the rest of society. The question I am asking then is, Do Canadians value fairness in ways I have so far suggested?

To this end, I will review information from three general areas: the values evident in the historical development of the *Canada Health Act* and the present day Canadian healthcare system; the values expressed in the actual attitudes of Canadians today towards their national health system; and the values of Canadian society as expressed in the *Canadian Charter of Rights and Freedoms*. Based on this evidence, I will find that Canadian values are largely in line with these liberal egalitarian ideals.

Values in the History Leading up to the Canadian Health System

Canadian history leading up to the present day healthcare system is strewn with examples of the values of Canadians. Indeed it is suggested that, "[Canadian social] values have been immensely important for developing a healthcare system designed for the common good."⁷⁴

Early in Canada's history, health was largely considered a matter for individual, family, church or community concern. Government agencies were

⁷⁴ Di Marco, M. M. and Storch, J. L., 1995 p. 5.

seen to be responsible only for epidemics of illness, the insane, the orphaned and other situations where the care required was beyond the family's or community's means to provide.⁷⁵

In the period after Confederation in 1867, a belief began to grow that the government ought to have a greater role in promoting individual health - understood at the time in terms of providing healthcare services. As early as 1919 federal political parties had made policies for health insurance part of their platform of values.⁷⁶ With the prosperity of the 1920s came increasing numbers of government health and social programs.⁷⁷ Then in the 1930s, with the development of international statements of human rights and freedoms, the development of health and social programs in other countries, and particularly the onset of the Great Depression, the federal government began thinking about long range health and social programs.⁷⁸

Di Marco and Storch argue that the 1930s depression in particular had an important impact on this development because people began to realize that illness could bring disaster to anyone through no fault of their own.⁷⁹ However, accessing healthcare services involved either seeking care from private providers and facilities, which in turn usually meant having to pay user fees; or finding a charitable organization that would provide services without charge. Consequently, this option was not available to any but the rich who could afford it and the very poor who were able to access services for free.

As a result, social consensus began to develop that those left without access to services ought to be provided for. This realization suggests that from

⁷⁵ Ibid. p. 6

⁷⁶ Canadian Bar Association, 1994 p. 3

⁷⁷ Di Marco and Storch, 1995. p.7

⁷⁸ Ibid. p. 8

⁷⁹ Ibid.

early on Canadians have felt that it is unfair for hardship to be distributed arbitrarily and that collective measures ought to be taken to ameliorate such inequity. In fact a committee formed by the Canadian Medical Association suggested in 1934 that, "government health insurance was necessary and, *in view of the obvious interest of the public in it, probably inevitable*" (emphasis mine).⁸⁰

Then in 1942 a committee was appointed by the federal government to look into the views of a number of national organizations on the issue of health insurance. Among those groups consulted were a number of trade unions, healthcare provider associations and the National Council of Women.⁸¹ The committee found that most groups surveyed were in favour of provincial health insurance programs with government support. This further demonstrates that the values of the Canadian people at the time favoured programs to help those seen as arbitrarily affected by an indiscriminant hardship. That the health insurance program favoured was government run and universal suggests that people were concerned with providing these programs to all who needed them, equally.

By the post war period healthcare insurance was already being seriously debated by both the federal and provincial governments.⁸² After a failed post-war conference on reconstruction in 1945, the province of Saskatchewan passed the Saskatchewan Hospitalization Act in 1947.⁸³ This legislation assured that all members of the province in need of hospital services would be provided with it, regardless of their ability to pay.

⁸⁰ Canadian Bar Association, 1994 p. 4

⁸¹ Ibid.

⁸² Ibid. p.5

⁸³ Di Marco and Storch, 1995 p. 9, 14.

The legislation paved the way for national hospital insurance which came in the form of the federal *Hospital Insurance and Diagnostic Services Act* in 1957.⁸⁴ Under this legislation, the federal government would share the costs of provincial insurance programs for hospital care and diagnostic services in which all citizens of that province were eligible. By 1961, all provinces had joined the federal plan and could boast provincial hospital insurance programs.⁸⁵

The next major step on the path to a national Medicare program was taken in 1959 when the provincial government of Saskatchewan, again leading the way, announced its intention of creating universal healthcare insurance which was to cover care by physicians and surgeons. To this point, the fees for these practitioners were still not included in any legislated insurance program.⁸⁶ The announcement came just before a provincial election and became an important election issue. In the election, the incumbent government received the popular support and was reinstalled. The result: in 1961 the *Saskatchewan Medical Care Insurance Act* was passed.⁸⁷

However, at this point the Canadian Medical Association, in favour of health insurance generally, but long opposed to universal coverage because of the limits it might place on the providers' remuneration for services, asked the federal government to examine the matter of universal healthcare coverage.⁸⁸ The hope was that a system of universal care would be found unnecessary and overly infringing on physician autonomy. Soon after, the government did appoint a Royal Commission to investigate the issue. The commission, headed

⁸⁴ Ibid.

⁸⁵ Canadian Bar Association, 1994 p. 6

⁸⁶ Di Marco and Storch, 1995 p. 10, Canadian Bar Association, 1994 p. 6

⁸⁷ Ibid.

⁸⁸ Canadian Bar Association, 1994 p. 7

by Justice Emmett Hall, released its report three years later, in 1964. The report suggested that, "as a nation we now take the necessary legislative, organizational and financial decisions to make all the fruits of health sciences available to all our residents without hindrance of any kind. All our recommendations are directed towards this objective."⁸⁹ The reaction of the Hall Commission to the concerns of the CMA provides further support yet to the claim that Canadian values cohere with liberal egalitarian ideals.

The report of the Royal Commission set the stage for the passing of the *Medical Care Act* by the federal government in 1966.⁹⁰ This legislation would have the federal government covering fifty percent of the costs of physician services in any province where the insurance program met certain criteria set out in the Act. These criteria included that the coverage be to a comprehensive set of services, be portable through any province, be universal in providing coverage to at least 90% of citizens, and be publicly administered through a not-for-profit agency.⁹¹

Once again, this series of developments demonstrates that the people of Saskatchewan in particular, and Canadians in general, favoured universal healthcare insurance coverage - providing support for people in hardship commensurate with need, at least when the hardship was randomly distributed.

The next step in the process leading up to the *Canada Health Act* came in 1977 with the passing of the federal *Federal-Provincial Fiscal Arrangements and Established Programs Financing Act*.⁹² The federal government was feeling the cost burden of financing half of the expense of provincial programs. This Act

⁸⁹ Canada, 1964-65 p. 10

⁹⁰ Canadian Bar Association, 1994 p. 9-10

⁹¹ Ibid.

⁹² Ibid. p. 10; Di Marco and Storch, 1995 p. 10

altered the way in which the federal contribution was calculated. It went from a percentage of the costs to a provincial per capita grant to be adjusted with economic growth. The result would be lower federal health expenditures and greater provincial fiscal responsibility for healthcare programs.

The 1977 Act would create an important challenge to national healthcare insurance. For with the decrease in federal funding for health care, extra-billing by healthcare providers became a reactionary issue. Canadians were faced with the prospect of having to pay once again out of pocket for healthcare services. However, because of the popularity of the national Medicare system and owing to other political, economic and public pressures, the federal government created legislation which affirmed with some force the value of a national healthcare insurance scheme. This legislation, of course, was the *Canada Health Act* of 1984.⁹³

This Act essentially combined the universal coverage of hospital services from the 1957 Act and the universal health care coverage of the 1966 Act. However, it added two very important features.⁹⁴ First of all, in addition to restating the importance of the four principles required of provincial programs in the 1966 Act, those of comprehensiveness, portability, universality and public administration, it added a fifth and telling principle - that of accessibility. This fifth principle explicitly addressed the question surrounding the acceptability of extra-billing for healthcare services. The practice was deemed not acceptable according to federal government standards. Provincial healthcare programs, "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

⁹³ Canadian Bar Association, 1994 p. 11; Di Marco and Storch, 1995 p. 11

⁹⁴ Ibid.

those services by insured persons".⁹⁵ Secondly, the Act empowered the federal government to enforce adherence to the criteria by the provincial programs. The Act allowed for the federal government to withhold its payments, imposing a dollar-for-dollar penalty, to any province not following any of the five principles.

This response of the federal government to the concerns raised over extra billing and the great public support for the Act together provide still further evidence of the value placed by Canadian people on the equality of persons. In the words of Di Marco and Storch, "Canadians at last had the security of publicly funded, good quality, comprehensive health care. Access to health care for all Canadians supported a strong social value of equality."⁹⁶

Objections

I have argued that the developments leading up to the *Canada Health Act* and the Act itself offer good reason to think that Canadians value individual opportunity to pursue their life goals and seek to ameliorate differences between people when these differences do not arise because of individual choice.

One could challenge this conclusion. For instance, it could be argued that the political processes which predominate the evidence I have offered in this section only reflect the values of the public to the extent that political forces are truly representative of public opinion.

⁹⁵ Wilson, 1995 p. 101

⁹⁶ Di Marco and Storch, 1995 p. 11

I grant that this is true and agree that what I have offered is really only a sketch, and a light one at that. Nevertheless, this evidence does suggest that the values behind liberal egalitarianism are reflected by the attitudes of Canadians - at least to extent that Canadian values are expressed in policies set by provincial and federal governments. While the odd policy may not be very popular with the people, for the most part I would argue that government policies do reflect Canadian values. Evidence of this can be found in the repeated assertions of values. If these values weren't representative, the governments espousing them would not continue to be reelected. This is cursory evidence that requires deeper justification and analysis, no doubt. But it does seem that there is a *prima facie* case for the assertion that the laws of this country do reflect the values of the people they serve and represent.

Present Attitudes Toward the Canadian Healthcare System

As evidence of present day Canadian values, I will begin by offering the results a Delphi study done between 1994 and 1995 carried out by a group of researchers in Edmonton, Alberta.⁹⁷ I will then consider various opinion polls and other data pertaining to what Canadians think of the importance of providing health care to all members of society.

⁹⁷ Wilson, In Press

Delphi Study of Bioethicists

The Delphi technique is a common research practice used in the social sciences that involves a number of repeated-series surveys to look for consensus among an available and willing group of subjects that are often within a common field of interest.⁹⁸ The subjects for this particular study were all members of the Canadian Bioethics Society and healthcare professionals. Thus, the 350-plus respondents to this survey all had some knowledge of the Canadian healthcare system and/or of health ethics. The researchers assumed consensus was reached on a question if 80% or more of the respondents answered the same way to a survey question.

The findings of the study indicated that the respondents fully supported a healthcare system that was universal, accessible, portable and publicly funded. In particular, the report suggests,

Respondents were committed to the Canada Health Act. This Act, in particular, appears to address or exemplify the prevailing social values of Canadians. Consensual Canadian values of participants in relation to health care were found to be (in descending order of participant agreement):

- (a) basic health care should be available to all without serious personal economic peril,
- (b) collectivism, with collective responsibility believed to be more important than individualism,
- (c) genuine concern and caring or compassion for other persons,
- (d) acceptance of the need for a social welfare state, based on an understanding that all persons do not have an equal opportunity.⁹⁹

In short, the survey found that, "[t]he Canada Health Act, besides [having] received widespread support by respondents, also appeared to address and

⁹⁸ Ibid. p.2

⁹⁹ Ibid. p. 4

exemplify the social values of Canadians,"¹⁰⁰ and that, "these values are in keeping with the ethic of egalitarianism."¹⁰¹

The results of this survey seem to confirm that Canadian values resonate with what I have described as liberal egalitarian ideals. One might object to the conclusion I have drawn from the results of this survey on the basis of the limits of the survey. Do the opinions of a large number of people conversant with bioethics fairly approximate the values of the society at large? Don't many of these individuals have a vested interest in the healthcare system that would jade their views? Couldn't we expect far different results were a group of economists surveyed?

I would like to grant that these are valid concerns. Certainly the findings of this survey are limited and more research needs to be done, as the authors suggest, to stay abreast of the values of Canadians. But this does not mean that we should simply disregard the findings of the survey. Certainly the results stand on their own merit and I would be happy to submit the qualification that, to the extent that they truly reflect the values of Canadians, they indicate a coherence with the fair equality of opportunity principle - that we ought to ameliorate at collective cost the difficulties imposed randomly upon some in order to allow greater equality of opportunity to pursue our individually determined life goals.

¹⁰⁰ Ibid. p. 65

¹⁰¹ Ibid. p. 66

Public Opinion Polls and Other Evidence

Besides this survey, which I have already accepted may not be completely representative of all Canadians, there is much other evidence of broader Canadian values and the agreement of these values with the concerns of fairness I have raised. Many public opinion polls, for example, provide ample support for this conclusion.

One such study, a health policy survey done in 1996 as part of a Focus Canada Report, found that, "Today, 79 percent of Canadians say governments should pay for health care for all people. Fifteen percent believe governments should pay only for those with lower incomes and just four percent say families and individuals should pay their own health care costs. All these findings are virtually unchanged from 1994."¹⁰²

This poll suggests that 94 percent of Canadians believe that those who cannot afford health care ought to have it paid for by the community. This is strong evidence in favour of the hypothesis that Canadians value liberal egalitarian ideals. The Environics poll example is consistent with many other surveys of Canadian values. The document *Health Canada Outlook 1996-97 To 1998-99*, summarizes well that this is the common view:

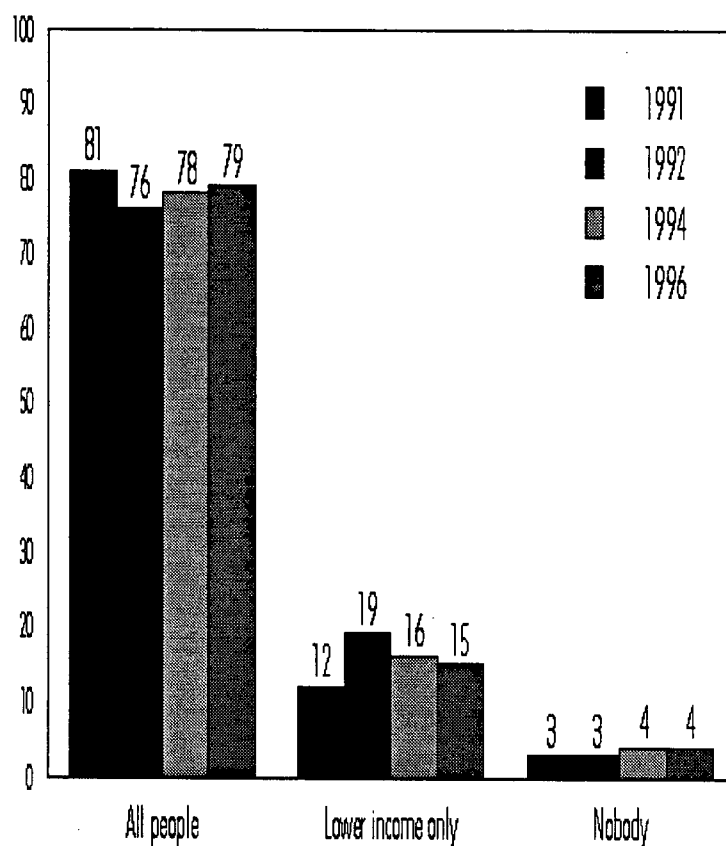
An *Ekos Research Associates* survey found that 79 percent of respondents prefer that the federal government maintain or increase its involvement in health care. The 1995 *Canada Health Monitor* found 89 percent support the universality principle of the *Canada Health Act*. When asked in a *MacLean's* and *Decima* poll what most unites us as a nation, Canada's health system was rated number one by 75 percent of respondents. Canadians clearly look to the federal government to protect their national health system.¹⁰³

¹⁰² Environics Health Policy Survey (1996 - 3) p. 82

¹⁰³ Health Canada, 1996

Universal Medicare

1991 - 1996



ENVIRONICS

Environics Health Policy Survey (1996 - 3)
(Part of Focus Canada Report)

The question: Currently Canada's system of Medicare is supported by tax dollars. Do you think governments should pay for health care for all people as they do now, just for lower income people, or should individuals and families pay their own health care costs?

Certainly these polls provide evidence that is not subject to the criticism of inaccurate representation - at least not to the extent that the Delphi study above is exposed to it. The polls demonstrate that while it is true that Canadian values are not unanimously, without exception, committed to the value of fairness, it appears quite evident that a large majority of Canadians do are committed to this value. To this extent I believe it is fair to say that Canadians in general support the principle of fair distribution of resources based on need, when needs arises arbitrarily.

Other examples of the present attitudes of Canadians towards their healthcare system can be found in the mass of anecdotal evidence suggesting that Canadians have come to expect the provision of high quality health care based on need alone and not on financial considerations for the individual, such as the ability to pay for these services.¹⁰⁴ These examples are pervasive and often cited by those most wanting to see changes in the health system.

One could argue that the reason Canadians have such expectations is that this is precisely what the system has led them to depend on. But this is because what has been provided so far has been based on values Canadians agree with. If Canadian values were not like this, then, such a system would not have developed and these expectations would not exist in the minds of people.

There are good reasons, then, to believe that Canadians do value the healthcare system they've come to know. This is a system that aims to provide equal access without discrimination against morally irrelevant criteria. Therefore, at least theoretically, it is in line with liberal, egalitarian values.

¹⁰⁴ There are numerous such examples. Some can be found at Canadian Bar Association, 1994 p. 4; Wilson, 1995 p. 97; Alberta, 1993 p. 4.

The Canadian Charter of Rights and Freedoms

The third source I offer positing that Canadian values do covet the fair equality of opportunity principle is the *Canadian Charter of Rights and Freedoms*. This document is part of the Canadian Constitution and sets out the basic rights of Canadians and for Canadian Society. The rights it details are called 'entrenched' rights meaning that they are given guaranteed protection with very few exceptions.

The relevant section as far as fair equality of opportunity is Part Three - Section 36. It reads:

(1) Without altering the legislative authority of Parliament or of the provincial legislatures, or the rights of any of them with respect to the exercise of their legislative authority, 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 quality to all Canadians

(2) Parliament and the government of Canada are committed to the principle of making equal payments to ensure that provincial governments share sufficient revenues to provide reasonably comparable levels of public service at reasonable comparable levels of taxation.¹⁰⁵

This section of the Charter appears to represent a clear national commitment to the principle of equality of opportunity. It indicates that the nation's values recognize the importance of redistributing goods such that opportunity to develop "well-being" is equalized.

¹⁰⁵ Canadian Bar Association, 1994 p. 20

Thus, the Charter, on its own, seems to suggest that Canadian values are in harmony with the ideal of fairness. One question, however, that needs answering is whether these rights are taken as negative rights, merely indications of where the government must refrain from interfering with the individual in the specified areas so as to refrain from hindering the individual in his or her search for the good life, or whether they are understood as positive rights, rights which, to be respected, must involve distribution of the means necessary for the full enjoyment of them.

There are good reasons to suggest that the Charter rights are seen as not entirely negative; that they involve a positive understanding. But even taken as negative rights, from the way they are written it is evident that what follows from them is a commitment to the principle of fair equality of opportunity.

Nevertheless, as I mentioned, there is reason to believe that the rights presented in the Charter are meant as positive rights entailing action to provide what is necessary for their enjoyment. In the *CBA Task Force Report on Health Care Reform in Canada*, the authors point out that while a positive interpretation of the rights in the Charter is generous, it is in line with various international documents which Canada has endorsed and been a signatory.¹⁰⁶

One example of such a document is the 1948 Universal Declaration of Human Rights. Article 25 of this documents states:

Everyone has the right to a standard of living adequate for the health and wellbeing of himself and his family, including food, clothing, housing and medical care and necessary social services and the right to security in the event of unemployment, sickness, disability, widowhood, old age or other lack of livelihood in circumstances beyond his control.¹⁰⁷

Another international document to which Canada is a signatory and

¹⁰⁶ Ibid. p. 23

¹⁰⁷ Ibid.

which also involves more than a lack of interference in the individual pursuit of the good is the International Covenant on Economic, Social and Cultural Rights. Article 12 of this document states:

1. The States Parties to the present Covenant recognize the right of everyone to the enjoyment of the highest attainable standard of physical and mental health.
2. The steps to be taken by the States Parties to the present Covenant to achieve the full realization of this right shall include those necessary for:
 - c. The prevention, treatment and control of epidemic, endemic, occupational and other disease;
 - d. The creation of conditions which would assure to all medical services and medical attention in the event of sickness¹⁰⁸

Together, these international declarations develop positive rights approaches to well-being. And Canada, again, endorses this approach by virtue of signing the documents. While not legally binding, the Supreme Court of Canada has upheld the view that, "[w]here the text of the domestic law lends itself to it, one should also strive to expound an interpretation which is consonant with the relevant international obligations."¹⁰⁹

I conclude that Canadian society is more in line with a liberal egalitarian political philosophy than any other. This is because, on the one hand, individual rights and liberties are a very important part of Canadian culture. We value the individual's right to decide his or her own life plans, how to go about achieving them and, as manifested in the *Canadian Charter of Rights and Freedoms*, strive to provide an environment sufficiently free from coercion to pursue them. So in that our society cherishes the richness of individuality and promotes this by providing these basic liberties and freedoms, it is a liberal society.

¹⁰⁸ Ibid.

¹⁰⁹ Ibid. p. 24

As well, in Canada we feel strongly about the equality of persons. Hence the liberties and freedoms protected by the *Canadian Charter of Rights and Freedoms* extends these goods to all members of society equally, regardless of distinguishing features such as ethnic background, religion, colour or disability. Furthermore, our social policies are directed in large part to attending to the basic needs of all Canadians equally. Health care is an example that stands strongly in support of this claim. The Canadian single tiered healthcare system that has the explicit aim, as embodied in the *Canada Health Act*, of serving all Canadians as equals regardless of income, age, ethnic origin, colour or any other distinguishing characteristic is indeed a testament of Canadian values. Health care is seen as something that we all need. And given that our common values as a society suggest that we are all moral equals, we feel that it is alright to limit the liberties of some, for example through taxation, to ensure that we are all provided with this basic need.

PART TWO

Health System Regionalization

Values Applied

Review

In the first part of this thesis, I have argued in favour of a liberal egalitarian theory of distributive justice. This theory is supported largely on the foundations of justice as fairness and the premise that one's initial starting points in life, from which life plans are developed and pursued, are not distributed based on any kind of merit or desert criteria. Given that these starting points determine one's ability to develop and pursue life plans, action is required by society to ameliorate as much as possible the barriers to basic well-being that this arbitrary initial distribution creates.

If this commitment to fairness is accepted, then I have suggested that any resulting health system must be sensitive to at least four considerations:

1. Health (including health care) services must be available to all members of a community based on need and not on any morally arbitrary criteria such as the ability to pay.
2. The health system must be sensitive to the broader determinants of health .
3. It must be recognized that health and disease are not objective notions to be defined by a value-free, biologically-based, scientifically derived source. Rather, health must be located contextually within local communities where the definitions of different illnesses and diseases are interpreted according to the culture and background of individual sufferers.
4. The previous consideration also requires that whatever definition

of health adopted by a health system, it be wary of the possible conflation of needs and preferences.

The aim of Part Two of this thesis is to examine the process of regionalization, identify the goals it is meant to achieve and compare the values of these goals with the considerations mentioned above. Part Two is largely descriptive in nature, identifying points of harmony and of tension between the goals of regionalizing a healthcare system and the requirements of a health system that is to be based on a liberal egalitarian account of distributive justice.

The first chapter of Part Two will consist of a discussion of regionalization as a variation of the larger process of decentralization. The move towards a regionalized health system in Alberta will then be traced. Ensuing this will be the promised analysis of the goals of regionalization. This will be followed with a chapter on the ethical issues faced by the actual bodies forced to make allocation decisions in Alberta's regionalized healthcare system - the Regional Health Authorities. Part Two will conclude with a summary of the arguments for and against regionalization as an approach to structuring the health system.

Chapter V

Decentralization and the Organization of Health Care in Canada and Alberta

An Overview of Decentralization

What Is Decentralization?

In the most general terms, decentralization refers to a shift in power and authority away from a central government to more peripheral government bodies. In other words, decentralization involves the way that power is distributed between two extreme levels of government: the central governing body and various local bodies. At this level of discussion, decentralization can apply to any government service and need not exclusively refer to a state's healthcare system.

In a study of health system decentralization commissioned by the World Health Organization¹¹⁰, Mills suggests that when considering the decentralization of healthcare systems what is at issue is the particular balance of power that is being struck between the two levels of government, what that balance entails, and how it is brought about. The question is not, With which of the two extremes will the power lie? For, Mills argues, at least in the case of health care, the involvement of both levels of government is required for an effective national health system. A central body of control is required for, among other reasons, the allocation of national resources in an equitable manner and the maintenance of certain standards of care across the geography of the state. On the other hand, local bodies of government are essential for involving community participation in the delivery of care and promoting a

¹¹⁰ Mills, 1990

sense of local self-reliance.¹¹¹

Mills identifies four general forms that decentralization can take when it comes to the restructuring of health systems.¹¹² These are deconcentration, devolution, delegation and privatization. The actual form of decentralization adopted in a state will depend upon a number of factors specific to the particular circumstances of that state. As such, the four forms are not necessarily mutually exclusive and elements of more than one can be found in the particular decentralization model of a given nation. But the breakdown of decentralization into these four forms is valuable in that it facilitates an understanding of what the broad concept can mean.

Deconcentration amounts only to a change in the location where administrative work is carried out. It involves moving some of the administration from the central office to local offices. But the local offices are just satellite locations of the central Ministry which still maintains the political authority for providing healthcare services. Hence the full responsibility for the provision of these services remains with the central body. This is the most moderate form of decentralization.

Devolution, on the other hand, is a more radical form of decentralization. It involves the creation or strengthening of sub-national levels of government that are independent of the central level with respect to certain defined functions of the health system. The local levels of government often have clear legal status, recognized geographic boundaries, a specified list of functions and in many cases the legal authority to raise and spend money.¹¹³ Though far from

¹¹¹ Ibid.

¹¹² Ibid.

¹¹³ Ibid. p. 19

completely autonomous, devolved levels of government tend to have a large measure of independence from the central government. Mills notes that a problem often associated with this level of decentralization is the cost associated with providing healthcare services. Often these costs are too high for the limited tax base of the geographic area the local body is responsible for to support. Financing from the central government is required which limits the autonomy of the local government body.¹¹⁴

Unlike Deconcentration and Devolution, which refer to a vertical shift in power from the central government to local levels, Delegation and Privatization refer to a more horizontal or peripheral spreading of the responsibility to provide services.

Delegation involves the central government body transferring managerial responsibility for specific functions within the health system to outside organizations. In such cases, the non-governmental organization is often given broad discretionary control over the administration of the function, but the responsibility still remains with the central government. This represents more of a horizontal shift because the organizations to whom the managerial responsibility is delegated need not be locally oriented.

These organizations may also have a centralized structure with little local management. The benefits of this form of decentralization are purported to include better cost control, the avoidance of government inefficiency, the possibility for a more responsive and flexible organization and the ability for the function in question to remain aloof from the threat of political maneuverings.¹¹⁵

¹¹⁴ Ibid. p. 21

¹¹⁵ Ibid. p. 22

Mills notes that usually the management of only certain functions of the healthcare system are delegated - such as work related disability claims for insured employees.¹¹⁶ In circumstances where this is the case, problems such as the duplication of services, a lack of coordination between services financed by the private work-related insurance claims and public services paid for by the central government, and the development of a bias towards curative services have been reported.¹¹⁷

As opposed to delegation where organizations are hired to perform certain functions of the central government, **privatization** of services is a mechanism whereby the government withdraws from certain areas and leaves the functions to be fulfilled by voluntary organizations, private, not-for-profit organizations or private, for-profit organizations. Mills argues that in general, this form of decentralization still requires some degree of government involvement - at the very least to monitor the quality of the services provided and to ensure that all areas of the state are being provided for.¹¹⁸ I will take a closer look at this form of decentralization a little later in this chapter.

Again, the four forms of decentralization mentioned above are not to be understood as a comprehensive list of distinct and mutually exclusive ways that decentralization can occur. There can be significant overlap between them and the decentralization of a healthcare system in a specific context can involve elements of any or all of these four. This list is meant to be a useful tool for understanding the various general forms that the process can involve.

What is actually experienced in a particular context will depend on a large variety of factors that include:

¹¹⁶ Ibid.

¹¹⁷ Ibid.

¹¹⁸ Ibid. p. 23

1. the size of the state or region for which services must be provided
2. the level to which authority is decentralized
3. composition of local bodies
4. mechanisms for community participation
5. sources of finance at the local levels
6. budgetary practices
7. methods of control and supervision
8. the approach to planning taken
9. attitudes of civil servants to decentralization
10. methods of interagency collaboration
11. the 'political culture' of the country
12. the historical experience of the country¹¹⁹

The question to be asked is, How does healthcare system regionalization fit within this broad notion of decentralization? Yeo defines regionalization in the Canadian context as, "the creation of geographical sectors in which the delivery and, to a lesser extent, the financing of health care is the responsibility of local boards of directors."¹²⁰ In other words, regionalization is a devolutionary form of decentralization. It shifts the authority and power for administering the healthcare system away from the central (provincial) government and focuses it on local boards responsible for a given geographic area.

In 1993, The Task Force on Devolution, part of the Ontario Premier's Council on Health, Wellbeing and Social Justice, undertook a survey of

¹¹⁹ Ibid. p. 25-38

¹²⁰ Yeo, 1996 p.22

regionalized systems of health care in Canadian provinces and in several other nations.¹²¹ Their report concurred with Mills' conclusion that each model of regionalization adopted in the various different states represents a response to the unique characteristics and circumstances of the particular area where that model has been developed.

However, the report suggested that some common themes could be distilled from the examples of regionalized health care in the various cases examined. In particular, the study indicated that bodies in charge of health care in a regionalized system were commonly given the responsibility for the planning, management and delivery of health services, the allocation of funds and resources, and revenue generation.¹²²

In addition, from the national and provincial states surveyed it was determined that if a decentralized strategy for health care was to be successfully implemented, it would require a strong commitment from the central government, the ongoing involvement of key stakeholders, the definition of clear goals and objectives for the health program and of the roles and responsibilities of the decentralized body, and an overall plan for the implementation of the program.

Another common theme was found in the rationale that motivated the adoption of regionalized health care. The Task Force's study found five basic reasons why strategies of decentralized health care were adopted. Decentralization was seen in most cases: i) as an opportunity to develop a better response to health needs at a local level; ii) to facilitate greater community participation in the healthcare system; iii) to offer the potential for integrating

¹²¹ Premier's Council on Health, Wellbeing and Social Justice, 1993

¹²² Ibid. p. i

health services with other social services; iv) as providing the opportunity to focus more on primary and preventive healthcare services; and v) as a way of reducing the cost of providing health care.

I have to this point provided a short survey of the process of decentralization, described what regionalized health care means in general terms and considered briefly some of the reasons motivating its adoption as a healthcare strategy. In the next section I will describe some of the important events that marked the development of regionalized health care in Alberta and provide a glimpse into what the new system looks like.

Healthcare System Regionalization in Alberta

Health Care in Canada

In Canada, the idea of decentralization in the case of health care is at least as old as Confederation when the responsibilities of the provincial and federal governments were first delineated.¹²³ Making the provinces responsible for overseeing healthcare initiatives, even before the advent of Medicare and a publicly funded and administered health system, was in fact a decentralization strategy.

The federal government then began to exercise some influence in the way

¹²³ Although at the time most health services were delivered by non-governmental organizations, what health care was to be delivered by the state was seen as provincial responsibility. See Di Marco and Storch, 1995 p. 5.

care was delivered by offering financial incentives to those provinces who met certain guidelines for delivery of care in hospitals and for physician services.¹²⁴ However, this option was not forced upon any province and each had the power, at least theoretically, to accept or reject the national standards. The practical authority this provided the provinces was of course limited by the degree to which the financial support offered by the central government was dispensable. In the context of a health system with high costs, the real power of the provinces to reject the funding help and thus the influence of the central government can be questioned. This is especially true in the case of those provinces with a small population base and therefore a small tax base from which to finance healthcare expenditures. In the same way, as federal funding has abated, the place of the federal government in setting the standards for healthcare delivery has come under greater scrutiny.

Nevertheless, the central point to be made here is that the Canadian system of health care started out as a devolved one with the authority over health service delivery in the hands of the provincial governments, leaving the federal government no legal jurisdiction over it. Thus, each province determines how health care is to be delivered for itself. This freedom is constrained only by the entrenched rights offered all Canadians as listed in the *Canadian Charter of Rights and Freedoms* and, arguably optionally, by the conditions that accompany accepting financial support from the central government as outlined in the *Canada Health Act*.

In general, all Canadian provinces, including Alberta, have had similar

¹²⁴ This was done first for hospital services with the Hospital Insurance and Diagnostic Services Act in 1957. Physicians services were targeted later with the Medical Insurance Act of 1966. The two were later consolidated with the Canada Health Act in 1984. For a review of the development of Medicare in Canada, see Chapter Three of this thesis or Di Marco and Storch, 1995 or Canadian Bar Association, 1994.

ways of providing and financing health care. Provincial governments fund various hospitals for their activities, providing global operating budgets. These governments also work with professional medical associations to determine fee schedules for providing physician services. It is these two activities that are subject to the conditions of federal government standards as set out by the *Canada Health Act*. A third component of provincial health systems is the combination of all the other healthcare services including the various preventive and public health measures provincial governments opt to take. This cluster of activities is determined wholly by priorities set by the provinces and is not controlled by national government priorities.^{125, 126, 127}

The Path to Regionalization in Alberta

Before regionalization, health care in Alberta spanned numerous services and institutions that were overseen by 27 public health units in 230 offices with 190 hospital boards.¹²⁸ Health services included 136 long-term care facilities and 126 acute care hospitals, in addition to the services of physicians and other health professionals. Health services also included a number of mental health clinics and centres which were divided into six regions with 54 permanent clinics, 40 visiting clinics, two extended care centres and several community and

¹²⁵ Brown, 1996 p. 137

¹²⁶ However, one of the most important issues about decentralization, at least in the Alberta experience, is that as the system of delivery becomes centered more in the home and outside the institution, the authority of the federal government in terms of the *Canada Health Act* becomes increasingly unclear. This is because the Act is written to exclusively cover access to physicians' services and hospital-based care.

¹²⁷ The paths of the provinces' healthcare systems continue to converge as Lomas et al. report that health system devolution is being pursued in every Canadian province except Ontario (Lomas et al. 1997a).

¹²⁸ Alberta Health Planning Secretariat, 1993 p. 38

other programs. Also part of the Alberta health system were various alcohol and drug treatment and awareness centres. It was argued that the boundaries of these various health programs and services overlapped significantly and that there was minimal coordination at the local level among healthcare providers.¹²⁹ For the '93-'94 fiscal year, spending on health care in Alberta was in the order of 4 billion dollars, roughly 30% of the overall provincial budget.¹³⁰

Responding to challenges facing the healthcare system such as increased incidence of chronic disease, an aging population and the rising cost and influence of high-tech medical care, in 1987 Don Getty, then Premier of Alberta, established the Premier's Commission on Future Health Care for Albertans.¹³¹ The aim of this Commission was to examine the existing health system and make recommendations that would ensure it would continue to meet the needs Albertans in the years to come. After several years' work, the Commission reported back with a three volume book entitled *The Rainbow Report*, which was released in 1990. According to the report, the Commission found that the health system in Alberta was in general structurally sound and adequately funded; however, some refinement and better management was required.¹³² In addition, the Commission offered some 21 recommendations that they held would provide a solid health system for the future of Alberta.

Premier Getty then created the Cabinet Task Force to assess and respond to the recommendations made in *The Rainbow Report*. The Task Force was composed of 12 cabinet ministers and was chaired by the Minister of Health.

¹²⁹ Alberta, 1991 p. 38

¹³⁰ However, it is noted that the reason this percentage is so high is not due to increased spending on health care, but as a consequence of the massive cuts made to other areas of social spending (see Taft, 1997 p. 17). Moreover, the percentage of GDP spent on health care in Alberta for the same year was 7.9% as opposed to the Canadian average of 10% (Health Canada, 1995).

¹³¹ Alberta Health, 1991 p. 1

¹³² Ibid.

"This Task Force was to ensure that any recommendations accepted and implemented would support the principles of universality and reasonable access, provide for the continued provision of basic health services, support health promotion, take into account environmental and economic factors and not restrict access to health services because of an individual's inability to pay."¹³³

The Task Force heard from about 200 private individuals and 179 interest groups as part of their study. The result was the document *Partners in Health: The Government of Alberta's Response to the Premier's Commission on Future Health Care for Albertans*.¹³⁴

One of the recommendations made in *The Rainbow Report* was, "that the province be divided into nine autonomous administrative areas within defined boundary structures, accountable through appropriately named Health Authorities."¹³⁵

The authors of the report suggested that this solution would be better able to serve the particular health needs of local communities, that it would foster interagency collaboration that would be tailored to the needs of individuals localities and that it would return greater responsibility and accountability for the provision of health services to the communities.¹³⁶

In *Partners in Health*, the Cabinet Task Force rejected this recommendation. It reported that the general public and the various interest groups it consulted were wary of such a move for a number of reasons. These included an uncertainty about how the public and interest groups would fit into a regionalized scheme of health care, concern that the result would simply be

¹³³ Message from the Premier in *Partners in Health*. Alberta, 1991

¹³⁴ Alberta, 1991

¹³⁵ Premier's Commission on Future Health Care for Albertans, 1989 p. 40

¹³⁶ Ibid.

the creation of another level of bureaucracy, concern that local autonomy would actually be reduced, that the boundaries would be unworkable and that the proposal represented too radical a change in existing accountability mechanisms.¹³⁷ Given these considerations, the government stated that it did not support the creation of Regional Health Authorities to manage the province's health care.¹³⁸

In December 1992, Ralph Klein replaced Don Getty as the leader of the Conservative Party and as Premier of the province. In May 1993 the Conservative government was reelected, this time with Klein as the leader. The Klein government, intent on reducing the government's spending deficit, decided that all social programs in the province would be cut by 25% and that there be "no sacred cows" when it came to budget reduction.¹³⁹

From August to October of 1993, eleven "Roundtables on Health" were held in various parts of the province to discuss how best the health system might be restructured to cut costs and ensure that the health system was more "efficient, effective, accessible and affordable".¹⁴⁰ Each Roundtable consisted of an open session where the public could come and express their views and a private session for invited guests only.¹⁴¹ The results of the Roundtables were published in the Summary of Roundtables on Health where it was reported that, "one consistent theme came through at every Roundtable session - the need to restructure the health system."¹⁴²

¹³⁷ Alberta Health, 1991 p. 38

¹³⁸ Ibid. p. 39-41

¹³⁹ Alberta Health, 1993b

¹⁴⁰ Alberta Health, 1993c

¹⁴¹ This process has been denounced in a criticism of the workings of the Klein government in general as simply a sham to give the appearance of public involvement in what is an ideological desire to privatize health care and other government services. See Taft, 1997.

¹⁴² Alberta Health, 1993c p. 4

Then, in *Starting Points: Recommendations for Creating a More Accountable and Affordable Health System*,¹⁴³ the Alberta Health Planning Secretariat recommended the adoption of a regional health structure assuming the primary responsibility for promoting "wellness" - the new language the government had shifted to in talking about health care. This message was reinforced in Alberta Health's, *Healthy Albertans Living In A Healthy Alberta - A Three Year Business Plan*.¹⁴⁴ This document promised that, "the fundamental character of the health system will change over the next several years"¹⁴⁵ to conform with a number of principles listed within the paper.

Soon after, in 1994, the Klein government passed the *Regional Health Authorities Act*. The province was divided into 17 geographic sectors, and boards called Regional Health Authorities (RHAs) were created to look after the health needs of their regions. According to the Act, the RHAs were given responsibilities to:

- (i) promote and protect the health of the population in the health region and work towards the prevention of disease and injury,
- (ii) assess on an ongoing basis the health needs of the health region,
- (iii) determine priorities in the provision of health services in the health region and allocate resources accordingly,
- (iv) ensure that reasonable access to quality health services is provided in and through the health region, and
- (v) promote the provision of health services in a manner that is responsive to the needs of individuals and communities and supports the integration of services and facilities in the health region.¹⁴⁶

¹⁴³ Alberta Health Planning Secretariat, 1993

¹⁴⁴ Alberta Health, 1994a

¹⁴⁵ Ibid. p. 5

¹⁴⁶ Alberta, 1994

Thus, regionalization became the official strategy for the organization and delivery of health care in Alberta. Reviewing the changes that have occurred in Alberta's health system, two documents, *Health Care '97 - A Guide to Health Care in Alberta*¹⁴⁷ and *Understanding Alberta's Restructured Health System*¹⁴⁸ indicate six significant ways in which the system has been altered. This list of changes includes: the creation of 17 RHAs to replace over two hundred health boards and administrations; a shift to community-based care; the establishment of Community Health Centres in place of a number of hospitals; increased emphasis on health promotion; an increased opportunity to be involved in health care decision-making; and an overall reduction in health spending.¹⁴⁹

Having looked back over how regionalization has come about in Alberta and the goals this restructuring is meant to achieve, I will now turn to an assessment of these goals against the requirements I articulated in Part One of a health system in concert with Canadian values must meet.

¹⁴⁷ Alberta Health, 1997a

¹⁴⁸ Alberta Health, 1997b

¹⁴⁹ Again, this approach is common in Canada as Lomas et al. write, "most provinces are using devolution as the latest panacea for the woes of their health care systems." (Lomas et al. 1997a)

Chapter VI

Ethical Analysis of

Alberta's Regionalized Health System

So far I have considered what decentralization involves, reasons offered to justify its adoption as a strategy for the delivery of health services, how the Canadian system is decentralized and how further decentralization of health services has arisen in the Alberta context. What I have reviewed to this point is *how* regionalization has come about.

Now what I wish to do is evaluate this strategy keeping in view the four considerations I have argued are required of any health system that is committed to liberal egalitarian ideals. I have defined such a society as one committed to providing care based on the central goal of ameliorating barriers to the development and achievement of life plans; barriers that are due to the positions individuals in society start out occupying; barriers that cannot be understood in any way as deserved. Again, the four requirements that an acceptable health system will meet are: the distribution of services based on need; a sensitivity to the broader determinants of health; the defining of health from a socio-cultural community perspective; and concern over the conflation of needs and preferences that this evaluative definition may result in.

I propose to conduct this analysis by examining the five reasons the Ontario Premier's Council suggest are commonly offered to justify regionalization, examining each within the context of the Alberta experience. Again, these five reasons for regionalization are: 1) better response to local needs; 2) more public participation in healthcare decision-making at the local level; 3) the potential for integrating health services with other social services; 4) the development of primary care and preventive health services; and 5) the potential to limit or cut the cost of the delivery of health care. Each of these reasons has been echoed in one form or another in Alberta's regionalization process.

For each of these objectives, I will begin by trying to determine the basic values that the objective supports. I will then compare the objective and its values with the four requirements I have set out and discuss points of tension and cohesion. The aim of this comparison will be to determine whether the respective goals of Alberta's regionalized system of health care are consistent with the requirements of a health system based on liberal egalitarian ideals, as I have argued Canada's health system must be. In this context, I will raise various ethical concerns that exist with the regionalization of Alberta's health system.

It is important to note that my aim here is not to provide solutions to the challenges I will identify, for each issue would require at least a chapter of its own. Rather, the aim is to highlight possible areas of concern that will have to be addressed by those in charge of the health system itself. This responsibility must fall to the provincial Minister and Ministry of Health.

1. Enhanced Response to Local Needs

It is argued that if the body in charge of allocating health care resources is located at a level below the central government and closer to pockets of regional communities, these bodies will be better able to focus upon the particular health needs of the regional communities they serve. For example, if a particular geographic community has a large elderly population, with a regionalized system of health care the authority responsible for that community can develop strategies specifically designed for the special needs of this group - programs that may be inappropriate, for one reason or another, to operate from the perspective

of a centrally organized healthcare system. In this way the regionalized system is able to address the needs of such a community better than would a more central government structure.

This rationale has been reflected in Alberta in a number of different documents, beginning of course with the *Regional Health Authorities Act*. The Act charges RHA boards with the responsibility to be, "responsive to the needs of individuals and communities."¹⁵⁰ This benefit was also suggested by the Alberta Health Planning Secretariat as one of the reasons why a regionalized approach to health care was endorsed. Their recommendations suggest that, "health needs vary from region to region, and [regionalization] gives providers and consumers the freedom and flexibility to customize delivery to meet those needs."¹⁵¹

The value this justification appeals to is that of efficiency. If we are spending the collective resources of the community to provide health care for the people in our society, then it makes sense that we should be spending the money to meet the real needs of society's members. For, given the scarcity of resources and the fierce competition for them, any time money is spent without meeting a real need of the public it also has the opportunity cost of not meeting other important needs of the community. Therefore, the resources are being wasted and efforts to achieve the goal of better health for the population, thwarted. And if we have a choice between two ways of meeting those needs, all else being equal, certainly it makes sense to choose the alternative that is more efficient because, again, the resources being used to pay for these services are community resources and there exists an obligation to use these resources with as little waste as possible.

¹⁵⁰ Alberta, 1994 p. 4

¹⁵¹ Alberta Health Planning Secretariat, 1993 p. 17

Because the goal here is to maximize the overall benefit of the way we spend each of our healthcare dollars, this can be understood as a utilitarian consideration. And at first glance it seems entirely compelling to suggest that if a regionalized system of health care does allow local needs to be met better, then it seems clear that the process is valuable, on the basis of the political responsibility to use common resources as efficiently as possible.

One could argue that this utilitarian objective is also clearly sensitive to the notion that health and disease ought to be defined within the context of particular communities. That is, it is plausible to assert that only in a regionalized system can healthcare programs be developed according to the needs of individual communities. However, there are several reasons to be concerned with this alleged harmony.

Defining Communities

The first of these concerns highlights the need for clarification about what is meant by the term "community". The argument from McDonald that I have presented and supported suggests that defining health will require the extensive involvement of particular *socio-cultural* communities. However, regionalization, at least in Alberta, has been based on geographic concerns. That is, regionalization delineates groups of individuals based on geographic boundaries between communities.

Unless these geographic boundaries happen to map onto specific socio-cultural boundaries, it does not automatically follow that a regionalized

approach will meet the requirement of fostering an evaluative definition of health and disease. Indeed, discussion will still have to be facilitated at the socio-cultural community level within these regional communities about what McDonald referred to as the "vital goals" of the cultural communities if the values of these groups are to be reflected in the way health needs are defined.

The question that must be asked is, Will regional authorities be better able to facilitate this discussion than would provincial authorities? While it may be possible that the answer to this question will be in the affirmative, it is far from being clearly so. What the answer actually turns out to be will depend upon a number of factors including the financial constraints the authority is forced to work under; the intellectual framework used by the authority in conceptualizing health needs and this framework's sensitivity to the need for an evaluative notion of health; and the political will of the authority to actually change the way it construes health and disease.

I will address some of these factors shortly. What is important to note, however, is that these same constraints are what would determine whether or not a *provincially* controlled health system would be able to embrace an evaluative notion of health. That is, the same factors, from political will to financial restrictions, will decide at both levels whether an evaluative notion of health is adopted. While one can argue that these factors will be easier to control at one level or another, there is no a priori reason to favour the regionalized approach.¹⁵² The solution will depend upon empirical evidence about the ability and constraints of regional versus provincial authorities.

¹⁵² Lomas et al., 1997d

Information Gathering/Needs Assessment

Another concern pertaining directly to the issue of understanding health needs according to the values of particular socio-cultural communities is the way that needs assessments are performed. If an RHA is to provide programs that are more appropriate for the needs of its respective region, it must first ensure that mechanisms are in place for assessing the needs of the region. And the RHAs or the Ministry of Health or some other body must decide what these mechanisms will be.

When the RHAs were initially introduced, the boards were given information by the Ministry of Health about the kind and quantity of services that had been provided in the past. The RHAs were to base their future decisions at least in part on this information. If the benefit of creating programs tailored to local needs is to be realized, these needs must first be understood. And RHAs must be sure, again because of the value of fairness that I have argued is at the crux of Canadian beliefs about the way health care ought to be delivered, to ascertain the needs of all of the residents of the community - not just those members who happen to be the most vocal. RHAs must know who the residents in the communities they serve are, and how to get access to these individuals so as to assess their needs. This issue will be revisited in the *Greater Public Participation* section of the next chapter.

However, the issue is yet more complicated than it already appears. For it is not just obtaining information that will lead to programs that will meet the genuine health needs of individuals. Rather, one must attend to the nature of the information being sought and one must have the support and

understanding of the scientific community and groups of healthcare providers whose research and practise will be critical to the development of programs that are sensitive to the health needs of individuals from particular socio-cultural communities as they see them.

The point being made here is that if we accept that current healthcare services are based on, or at least heavily influenced by, the biomedical model of health, then it is no good to seek out information about the health needs of individuals without recognizing both the inherent biases in the conventional approaches to addressing health issues and the need to avoid these biases and to be sensitive to more subtle, if different, types of needs. It is not sufficient, in other words, just to find out how many sufferers of cancer there exist in a community with an eye to developing regimens of chemotherapy for each. Rather, one must develop ways of understanding how this disease impacts the lives of these sufferers within their socio-cultural views of the meanings of life and death. And one must develop healthcare programs accordingly. I will not dwell on this point any further, though I take it to be an essential element for understanding the evaluative nature of health and for developing ways of understanding what health is according to different cultural communities.

The other possible tension with the needs assessment issue is one of responsibility. Performing needs assessments requires financial and human resources. Because the RHAs have been given budgets that have been significantly reduced, it may be expedient for them to argue that it is the provincial government and not the RHAs that have the duty to research the needs of the members of the community.

It is clear from the mandate of the RHAs as given in the *Regional Health*

Authorities Act that this responsibility technically rests with these local bodies as they have been charged with understanding and responding to the needs of their regions. The problem with this is that the financial resources to carry out this assessment necessary, apart from the intellectual understanding or political will required, may not be readily available. When an RHA is forced to choose between providing a service for an acute health need or carrying out a needs assessment, the value of the assessment may be minimized against the possibility of alleviating clear and vivid pain and suffering. It may be difficult to choose to spend money on researching what the needs of a community are instead of on reducing the waiting list for cancer surgery and thereby meeting a need that is evident and difficult to ignore.

Thus, a great deal will be required for RHAs to conduct thorough and sensitive needs assessments for their regions, both initially and on an ongoing basis. And yet without the information such assessments provide, the goal of offering programs that cater to local needs may be beyond reach.

Regionalization as Centralization

Another reason to question the use of regionalization in Alberta as a means of increasing sensitivity to health as a value-laden concept has to do with the fact that regionalization does not always represent a movement towards the grass roots of the community as one might expect. For regionalization has not only meant a move away from provincial health bodies, it has also represented a shift away from local healthcare planning boards.¹⁵³ Decisions that once were

¹⁵³ Ibid.

made at the level of small geographic communities, (local hospitals, for example) or at the level of programs for small communities of sufferers (community speech pathology programs, for instance) are now being made at the more distant, regional level.

This is not to imply that there are no other benefits to be gained by such restructuring. However, if the contention is that only by bringing decision-making authority to a level closer to the community can the real health needs of individuals be understood, then regionalization in some instances represents a step backwards. To this extent, this strategy will be less likely to locate defining health needs in particular communities.

Smaller Versus Larger Communities: Competing Interests

Sensitivity to a community definition of health and disease can also be in tension with another of the requirements of a health system based on liberal egalitarian ideals: the requirement that the need of all individuals be met equally. For it is entirely likely that a health region will be unable to provide a limitless number of healthcare programs to meet the needs of its residents. RHAs will be forced to choose to fund some programs and to sacrifice others.

So the ethical tension in question is one of weighing the needs of different members of a given geographic community, or of members of different socio-cultural communities. It is at bottom an issue of resource allocation. What RHAs must be aware of is the possibility of ignoring the needs of those not in any majority group within the geographic community. In other words,

the benefit of regionalization is that it may enable the development of programs appropriate for smaller pockets of communities within regions. But RHAs must ensure that those members of the community they serve who do not have health needs similar to the rest of the group are not left without necessary care.

The reason for this is that fairness requires that to whatever extent possible, society has an obligation to allow individual members the opportunity to achieve their life goals equally. This entails improving inequalities between individuals that are conferred arbitrarily. To the extent that meeting the healthcare needs of individuals eliminates morally irrelevant differences between people, healthcare services must be provided equitably to individuals in society. All members of society must have equal access to the services that would eliminate that factor - poor health - which distinguishes him or her unfairly from the other members in society.

But it is also unfair, then, to deny individuals access to health care they need by not providing those healthcare programs altogether. This is tantamount to denying care on the grounds that those who need it are not part of the majority or vocal group. It is the same as conferring inequality arbitrarily - precisely what a universal healthcare system is designed to overcome.

Focusing on the health needs of some can result in the marginalization of the needs of others. This could limit the access of the marginalized groups to care they require and thus provide unequal access to services. And this would not meet the social obligation we found earlier.

In Alberta, the Ministry of Health has tried to make this task easier by establishing a set of core health services that all RHAs must provide. These services must either be made "available", which is to say that they are to be

offered within the region, or "accessible", which means that they are to be offered elsewhere in the province but can be accessed by individuals in the region. However, "with the core services set out, an RHAs job is to decide how to organize and deliver services that reflect the unique nature of the region and the needs of community members."¹⁵⁴

Other Concerns

There are two further concerns with providing services at the local level. First, it may be the case that some programs are not feasible to operate at a regional level or at the community level when the population of the community or region is relatively small and is spread out over a large geographic area (this applies particularly to rural communities and health regions). This situation can create serious problems for access as well.

For example, the cost of providing certain services can be very high. Consequently, a region may not be able to offer the service. (A common example is the MRI technology which is often prohibitively expensive for some regions to purchase.) And if it is able to offer the expensive service, the region may have long waiting lists for using the service and/or exhibit other symptoms of under-servicing. This would result in limiting access to these services for the members of that region relative to individuals residing in other regions. Questions such as, Do two people, one living a ten minute drive away from a hospital with full emergency and secondary care facilities while the other is a four hour drive from such a facility, have equal access to healthcare services?

¹⁵⁴ Alberta health, 1994 p. 22

must then be confronted.

This can create a situation, the second concern, where it may be more feasible for patients, particularly in rural settings, to make use of services available in larger centres. This is because waiting lists may be shorter and the quality of care may be better, especially for acute care services, in the larger centres. This issue will be considered in more detail in the following chapter.

2. Greater Public Participation

Regionalization is also promoted as a way of allowing individuals and communities greater participation in the decision-making about their healthcare system. The idea is that in addition to the public being consulted to determine what their genuine needs are, it must also be consulted to help make difficult decisions in allocating healthcare resources. This would thereby allow the decisions taken to be a representation of the community's values - for better or worse. Those in charge of allocating the resources could then say, "Yes, it is a tragic situation and yes it's true that people are hurt by it - but this is what the people want. These allocations have been determined by the public as the way it wants its resources distributed and we are only here to facilitate their decisions."

In *Getting Started, An Orientation for RHAs*, one of the reasons offered for restructuring the health system is to, "bring decisions closer to the customer; put more decision-making power into the hands of communities."¹⁵⁵

This justification is grounded in the value of democracy - the freedom for

¹⁵⁵ Alberta Health, 1994 p.7

self-determination at the level of society.¹⁵⁶ As with the doctrine of informed consent, which rests on the value of freedom for self-determination at the individual level where it is believed that the individual ought to be allowed to determine for him- or herself what is in his or her own best interest, the idea here is that the public also ought to be given the freedom to determine what is in its own best interest.

So when this freedom is challenged - for example on the grounds that community participation will actually result in greater harm to the community, perhaps due to the anxiety it may raise within the community if it is to be involved in concerns over health care, or that the public is too emotionally involved to make rational decisions or not well-informed enough to make correct decisions - the response to be given is that like many medical decisions, judgments of resource allocation are not simply technical in nature. Rather, they involve values. And where values are concerned, the public has just as much right to determine the solutions as those persons formally in charge of the system with decision-making authority. Indeed, the public can be seen to have more of a right to involvement in decision-making because they are the ones who are affected by it and who must live with the consequences of the decision. In this way, the public can be seen to own the decision. As Yeo points out, "by right of autonomy and self-determination, the rightful locus of authority for value decision-making *about* the public *is* the public, however it expresses its will."¹⁵⁷

Whether or not particular government policy decisions ought to be made by the public directly, or influenced by the public on a policy by policy basis, is by no means a debate decided. A discussion of this question would take us too far

¹⁵⁶ My discussion in this section builds on the work of Michael Yeo. See Yeo, 1996b

¹⁵⁷ Yeo, 1996b p. 45-46

afield into broader questions about democracy than I wish to engage here. However, if one does accept the premise that the public ought to be involved with making healthcare resource allocation decisions, then one must recognize that the form of public input will bear directly upon the requirement I have suggested of the health system - that it meet the needs of all members of society. To this end, two questions must be confronted in the context of the present evaluation. The first is, What should this public participation to look like in order to meet this requirement? And the second is Why is a regionalized system of health care better suited to achieving this goal than a centrally run system?

The Nature of Public Participation

As in the case of informed consent at the micro level, where the right of self-determination does not mean that the authorities involved need respect just any request of the patient, resource allocation policy decision-makers need not accept just any expression of public sentiment. Rather, in both cases the decision-making authority must honour only those requests that meet certain criteria. In the case of the greater public, Yeo offers three such criteria, modeled on informed consent, that must be fulfilled for there to exist the obligation that public expressions be honoured: they must be informed, voluntary and representative.

Adequate Information

If expressions of public opinion on matters are to be taken seriously by policy makers, the expressions must be adequately informed. That is, it is not enough for the public simply to be given alternatives and made to choose one or the other. For this would not be an accurate gauge of what the values of the public really are. As Doyal points out, in such a rough and ready form public opinion depends as much, if not more, on the wording used to frame the questions in a questionnaire as it does on the actual values held by the people being consulted.¹⁵⁸

Rather, for the decision to be truly self-determinative it must be made after sufficient discussion, dialogue and education about the benefits and burdens of various options. The public must be educated about the issues at stake and then allowed to express their values with as little pressure to conform to the opinions or ideals of those in power as possible.

In terms of decision-making about the health system, the requirement of full information is especially challenging (and by virtue of this especially important) as simply elucidating the various healthcare program options and opportunity costs involved in a particular allocation decision cannot satisfy it. This is because the very development of healthcare programs and services is based upon assumptions about the nature and meaning of health and disease in the context of fundamental human goals.

However, in pluralistic settings such as found in most Canadian communities, there is no reason to believe that all of the socio-cultural

¹⁵⁸ Doyal, 1995 p. 274

communities living together here will share the exact same understanding of what constitutes a meaningful life and what is required to support working towards this life. Therefore, in the Canadian context any public consultation endeavours will have to be sensitive to the possibility of this variation in understanding, seek to make the assumptions behind the existing health system and available healthcare programs plain, and work towards facilitating a discussion both within and between different socio-cultural groups about what the vital goals of human life actually are and how these goals can best be supported by the collective community.

Voluntariness

This leads to the second criterion - the request must be voluntary. The expression of public opinion must not be made under threat or force of harm to the members of the public. Neither can the decision be the result of coercion through power dynamics for it to be truly voluntary. For example, Mills notes that in health systems in the developed world, power often lies with medical specialists practicing in high technology hospital facilities. These people are able to sway public opinion in favour of programs with a high technology bias such that boards of health have a hard time trying to resist these alternatives. Indeed any resistance seems unjustified in such a situation because of the public's ostensible support of the specialists' views.¹⁵⁹

The problem is not limited to experts in positions of power. Another version of this concern is that those who end up gaining power as

¹⁵⁹ Mills, 1990 p. 32

representatives of the public may in fact not use their influence to promote the best interests of the community at large. Instead, these individuals may use this new influence and power to advance their own interests or the interests of some particular group in society.¹⁶⁰ Thus, public opinion is manipulated and voluntariness is undermined.

Appropriate Representation

The third measure Yeo suggests is that the decision must be representative. In the case of informed consent, it is clear who is affected by the decision to be taken - the patient, and sometimes the family of the patient. Consequently, who "owns" the decision and the right to make it is also fairly straightforward. In the case of resource allocation policy, the public is affected at large with some individuals more directly impacted than others. But the public is comprised of many people with different faces occupying various social, cultural and economic positions in society - each with their own concerns. For there to exist the obligation that the voice of the public be respected by the decision-making authority, that voice must represent the concerns of the public at large. It must harmonize the cacophony of disparate public interests and opinions. And it must pay special attention to those individuals whose concerns are easily marginalized in society, whose positions may be considered politically unattractive or whose needs may be disproportionately large. For it is often these individuals and groups who are least able to express their own interests in public fora.

¹⁶⁰ Marchand et al., 1996 p. 117

Clearly the issue of representation is an extremely thorny one which raises a great number of questions. For example, which public is to be represented in making healthcare decisions? Is it the perspective of the users of the system that needs to be considered? Or is it the position of the average taxpayer whose dollars support the system? What method will best render a fair representation of the public's views? How is it to be insured that the views of all the stakeholders in the system will be given a voice? Who will speak for the voiceless - those people who often most need attention but are unable to communicate their concerns with the rest?

This is the point where one great benefit may come of regionalization. For perhaps the public's participation in the setting of priorities can be done in conjunction with, somehow coordinated with or facilitated by the discussion of the vital goals of the various socio-cultural communities in the region. But how to identify these communities and how to ensure that marginalized groups are given an equally prominent voice are questions that will have to be grappled with.

The questions I have raised here will have to be addressed if the value of having the community participate in healthcare decision-making is to be realized. Moreover, they will have to be addressed keeping in mind the fact that regardless of what group individuals fall into, all those needing health care to remedy impairments to their health and ability to function have an equal claim for attention in a liberal society that supports the ideal of providing all members an equal or fair opportunity to fulfill their life goals - a society such as ours.

The challenge of regionalization, then, is to create mechanisms to develop this informed, voluntary, and representative public opinion if it is to

achieve the good of greater self-determination with respect to the healthcare system.¹⁶¹

Other Concerns

There are two other concerns that need to be considered with respect to the participation of the public in decision-making about the health system. First, It is important to note that Yeo's model of informed consent that I have used to elaborate the standards required of community participation is imperfect. This is because one critical feature of informed consent is that it allows personal values to guide decision-making up until the very last moment, enabling the individual to change his or her mind at any time. However, at the policy level one does not want such an "opt-outable at any time" approach. Rather a lasting agreement is what is necessary in developing policy. Therefore, what is required is a process that can lead to a socially negotiated, binding agreement. Nevertheless, the three standards identified by Yeo are still a critical part of this process, in addition to the requirement that policies not be subject to arbitrary changes of will.¹⁶²

Second, and this *almost* goes without saying, there must be a commitment by those in positions of authority to take public input that satisfies the criteria set out above seriously. Soliciting public input may result in the

¹⁶¹ Some argue that this challenge can't be met - it is not possible to develop a voice or group of voices that is truly representative of public values. Some voices will always remain unheard and with the result that the needs of those individuals will remain unmet. Thus, public participation ought to be limited to involvement in needs assessment activities, monitoring of patient rights in patient-healthcare provider relationships and the like. See Doyal, 1995.

¹⁶² My thanks to Michael Burgess for alerting me to the limits of the informed consent model.

expressions of opinions and judgments that the authority may not wish to hear. It may be easier in these cases simply to ignore the results of public consultations. But if these consultations, whatever their form, are to be meaningful in any sense, authorities must be prepared to listen and respond, all the while keeping in mind the fundamental values guiding the health system so as to protect against any group being discriminated against.¹⁶³

Regional Versus Provincial Authority

So we have an idea of what public participation must look like. Now I must examine whether or not a regional approach to soliciting public input into making allocation decisions is better than a centrally controlled one.

As with understanding local needs, there seems no theoretically required reason why the regionalized approach is superior to the provincially controlled health system. So if the regional approach is found to be superior, it will be because it practically manages to achieve this kind of involvement better. The main reason for thinking it would is linked to the regional authority's greater ability to understand and meet the real needs of the particular socio-cultural communities within it. If the region is in fact able to determine the real needs of the regional community it serves and develop programs specifically designed to cater to these needs, the list of services available to choose from will likely be unique to that particular region. Consequently, the regional community will be choosing between programs that more accurately reflect its needs and will be better able to judge what is and is not expendable. Thus, in a regionalized

¹⁶³ Lomas et al., 1997d

approach, the public involvement in making allocation decisions will be more genuine and will better reflect the values of the people.

But a practical problem is raised by the community involvement issue. Because this public participation is hard to define, let alone achieve, it may be seen as a threat to the efficient running of the Regional Health Authorities. As such, it may be neglected by an Authority and priority may be shifted to management efficiency at the expense of the greater public participation.

The role the community will have and the form this role takes will clearly have important implications for issues of access to health services. On the one hand, if the concerns of all those who need care are not fairly heard, programs may not be developed to meet those needs. The result will be that those who need care and who have an equal claim to it will either not have access to required services or will have their access challenged, for instance by having to travel great distances to receive required attention from a medical professional. On the other hand, if actual decisions are left to the public to make, those in the region's minority may have their needs ignored by virtue of the morally arbitrary criteria of not being part of the majority group. While this allows the autonomy of most of the population to be honored, it violates the moral right to care of the rest.

In the Alberta context, the RHA legislation has attempted to help facilitate obtaining community input by introducing Community Health Councils. The official purpose of these councils is to, "encourage community ownership, responsibility and accountability for health through citizen involvement in the decision-making process and the health reform process."¹⁶⁴

¹⁶⁴ Capital Health, 1995 p. 1

However, the terms of reference for Community Health Councils (CHCs) are sufficiently vague that they do not prescribe the way public opinion is to be garnered or who is to represent public opinion, except to suggest that CHC board members, to be determined by a selection committee, must represent the interests of the particular communities they serve and are accountable to these communities. On their own, the terms of reference do not address the potential ethical problems that accompany greater public participation. Neither have evaluations been performed to assess the function and success of these bodies, such that their work may be analyzed for the way public consultation has progressed.

For example, Community Health Councils are charged with, "acting as an advocate for marginalized or disadvantaged groups within the region"¹⁶⁵. Certainly this is extremely important, as indicated earlier, to ensure that the needs of the politically voiceless or the weak of voice do not go unaddressed. But the possibility that the voice of the Council may be commandeered still exists. And the only way to ensure that the voiceless are heard from and represented is by somehow ensuring that the Community Health Councils are representing all the people in their communities. As Doyal points out, "rules do not interpret themselves; they must be applied to particular problems after deliberation about their most appropriate interpretation."¹⁶⁶ Mechanisms will have to be put in place to ensure all bodies understand their appropriate roles and to safeguard against manipulation by those in positions of power.

It may be possible for this kind of public participation to be achieved in an unregionalized system. But it may be easier to accomplish in a situation where smaller pockets of communities are defined and boards responsible for these

¹⁶⁵ Ibid.

¹⁶⁶ Doyal, 1995 p. 279

communities are created. However, the success or failure of a region's ability to facilitate public involvement in decision-making will depend upon several practical concerns. The benefits of devolving public participation to the regional level will only be reaped to the extent each regional authority is successful first at performing its needs assessment and developing programs specifically tailored to meet the needs of the socio-cultural groups within that region.

3. Integration and Coordination of Health and Social Services

Regionalization is also justified on the basis of the integration of health and social services that is thought to be facilitated by regionalized health care. This can mean two things. First, it can mean having programs of the Ministry of Health and other Ministries such as Education and Social Services work together. The foundation of this belief is that while it is difficult to get coordinated services at higher levels of government because of the rivalry between ministries for the same resources, such rivalries do not exist at lower levels. The idea is that at local levels, there can be more informal contact between sectors. As well, local leaders of ministries may be in better position to appreciate the particular circumstances in individual regions than are those at higher levels and this would encourage cooperation between ministries.

This justification for regionalization can also mean getting the various institutions and programs within the health system to work together to achieve the broader health goals of the region. Collaboration and cooperation is seen as valuable because ideally it would eliminate some duplication and waste, and

would also allow the needs of each community to be met in a more comprehensive rather than piecemeal way.

Both of these interpretations are once again based on the value of efficiency. That is, if by coordinating services the needs of individuals can be better met, either by increasing the benefits we get from the resources we put in or by maintaining the same level of benefit by using fewer resources, then we are using common resources more efficiently with less waste. As a result, some members of society may derive greater direct benefits or there will be more resources for use towards other important social goods. Either way this results in better use of our resources.

It is the latter of the two justifications that Alberta's health care restructuring has focused on. According to the Alberta Health Planning Secretariat, "[regionalization] encourages institutional and professional cooperation within and between regions."¹⁶⁷ If acute care facilities, public health offices, home care programs, etc. can be coordinated such that they work better together, then there will be fewer "stovepipes" in the health system: individual competing interests can be harmonized into an integrated system of services and programs.

This objective seems straight-forwardly positive with few ethical concerns. The problems arise if and when institutions are forced to come together in the absence of a master plan of how the new relationships will work. For without such a plan, it is entirely possible that some needs which used to be met by a given institution might get "lost in the shuffle". In other words, access issues can arise when all required services provided by existing institutions are not provided for in the new scheme. In this way, holes appear in the network

¹⁶⁷ Alberta Health Planning Secretariat, 1993 p. 17

which aims to ensure proper access to services - holes that those in need can easily fall through.

Integrating and coordinating health services itself is a laudable goal that raises few ethical concerns. The concerns surface when plans to achieve this goal are not made with due care and attention.

4. Development of Preventive and Primary Care Initiatives

Another positive consequence that is generally offered in support of a regionalized system of health care is that it will facilitate the development of preventive and primary care initiatives as well as health promotion activities. In Alberta, that this shift in attention is the desired goal is evident from a number of sources, not the least of which is the global mandate that has been given to the RHAs to look after all of the health needs of the region - from acute care and long term care services to community care, illness prevention and health promotion activities as well.¹⁶⁸ In *Understanding Alberta's Restructured Health System: Questions and Answers*, it is made further clear that a shift towards programs of health promotion has been a key element in Alberta's restructuring of the health system.¹⁶⁹

Not only is the hope in this province that primary care and preventive services will be developed by regionalization, but better health promotion and public health initiatives are expected as well.¹⁷⁰ The effect this is purported to

¹⁶⁸ Alberta, 1994b

¹⁶⁹ Alberta Health, 1997b p. 4

¹⁷⁰ Alberta Health, 1994b p. 4

have is one of a coordinated and integrated assault on the causes of illness and consequently an emphasis on and promotion of the wellness of individuals. The focus on health promotion and illness prevention particularly is aimed at reducing the need for acute healthcare services (and thereby the cost of the health system as a whole)¹⁷¹.

This goal appears at first glance to be sensitive to the broader determinants of health requirement. However, a plan which involves such a refocusing in combination with a regionalized approach to all health services in a context where health budgets have been significantly reduced can potentially pose a number of serious problems.

First of all, an assumption is made when an emphasis is put on greater grass roots community involvement in decision-making. It is that by having the community help make choices about the kind of services they desire, the shift in focus from that of an illness-based health system to a social model of health may be facilitated more easily. However, there is no reason to think that the community will be any more likely, or find it any easier, to choose the various options offered by the social model of health over the biomedical model. It is entirely possible, if not more likely, that it will be as hard for citizens to give priority to health promotion activities to save statistical lives over acute healthcare services to rescue that tangible life in peril as it is for healthcare professionals and other decision-making authorities.¹⁷²

Second, if one is to view a healthier population as one with a decreased need for acute care services in general, this may have the tendency to link

¹⁷¹ It is argued that the cost of preventing disease and disability is far less than the cost of providing curative services required to address these conditions once they have occurred. As such, this line of argument suggests that it makes sense to shift focus of the health system to disease prevention and health promotion.

¹⁷² Marchand et al., 1996 p. 117

individual health with lower utilization of the healthcare system. This can have the effect of suggesting that those in need of healthcare services are irresponsible consumers - without regard to the broader social determinants that have led to the individual's need for the healthcare services.¹⁷³ So a shift in public opinion to thinking that health promotion activities are really the most effective and that acute care services are wasteful of resources may have the result of unfairly stigmatizing those who continue to need acute care services.

The focus on health promotion as a possible cost-saving measure highlights another tension with the popular attention given to the broader determinants of health. The thought is that if we focus on preventing illness, costs will decrease because illness prevention mechanisms are cheaper than acute care services. This ignores the fact that what evidence in population health studies is indicating is the limited effect healthcare systems seem to have on the overall health of populations *and* the fact that much has yet be understood about what the real determinants of health actually are and how these determinants operate. In other words, what is becoming clear is the need to spend more money on research to understand what really does make the health of populations rise and fall and what the biological pathways are through which the real causes impact individual health status.¹⁷⁴

There is another reason to doubt the idea that focusing on health promotion and illness prevention programs can result in cost-savings: some health problems are simply not avoidable and by adding health promotion and illness prevention programs one may end up extending the lives of those already facing serious illness. As such, health costs will actually rise as not only will funding be required for the health promotion activities, but money will

¹⁷³ Burgess, 1996

¹⁷⁴ Evans, Barer and Marmor, 1994 p. 3-26

also be required to pay for the acute care services required to maintain the lives of the ill for longer periods and, at the later stages of life, for other interventions that may not have been required had the health promotion activities not been initiated.¹⁷⁵

Another issue with respect to health system cost and health promotion services is the political uncertainty over paying for these services. The *Canada Health Act* is aimed at ensuring that all Canadians have access to medically necessary services provided by physicians and health institutions - hospitals in particular. I would argue that the values that lie behind the Act require that all services, from health promotion to acute care, be paid for from community resources without regard for the ability of those in need of these services to pay for them.

However, as it stands, that Act does not explicitly cover the cost of illness prevention and health promotion services. The question that becomes evident is, Who ought to be paying for such services? If the answer is that it is the province's responsibility, then one must realize that this will mean that any national standards may become sacrificed, owing to the provincial authority over the healthcare system. This issue will take us too much of a tangent to explore here, but it is important enough to mention.

Efforts to increase the funds devoted to the health promotion activities that are focused on decreasing overall spending tend to be blind to these financial tensions. But there are still more problems with having a regionalized health system where regional bodies are responsible for the global health needs

¹⁷⁵ Although I recognize the crass nature of this argument, the aim is not to suggest that there is no value in health promotion activities or that the additional costs that may result are not worth paying. My point is only that health promotion activities do not, in themselves, automatically result in cost savings.

of their constituents with budgetary constraints.

For example, there is the very important issue of present need. That is, even if more health promotion activities would have the consequence of a decreased need for more costly acute care services, this effect will not happen over a short time but will require months or years to become manifest. The money taken away from the acute care service branch and put into health promotion activities may not reduce the need for those services, at least in the immediate. The level of need for services would remain unchanged while the resources required to run the needed services are reduced. So in the short term, the cost of servicing the health system will actually rise until such time as the effects of the health promotion and illness prevention programs begin to be felt.

If sufficient funding for both the public health and acute care services is not provided, as is the case in Alberta, then resources for some acute care services would have to be reduced to fund the population health efforts. This would have the result of affecting the access to those services. The services would have to be rationed tighter resulting in longer waiting periods and other problems of under-servicing. The ability of those with genuine need to obtain services will be compromised - an affect that I have argued goes against the values of Canadians. Again, it may be true that the ideal approach to our healthcare problems would have us substantially mitigate or reduce the need for acute healthcare services and thereby obviating the access issue. But this goal is still some distance into the future. In the short term, the needs of a few are still being served unfairly.

There is a larger problem yet with assigning the responsibility for both health promotion and acute care activities to the regional level. As discussed

earlier, many of the determinants of health are broad factors such as economic status, social environment, stress management abilities and supports and the like. By making the regional level responsible for all health-related activity, these broad determinants are left beyond the grasp of the regional authorities. One could argue that this is a good thing as we don't want doctors running the whole of society. And it would be positive as long as two conditions were met. First, enough attention would have to be paid to these broader determinants by other arms of government. And second, the necessary budget for performing both the acute care services and the illness prevention/health promotion activities was provided to the Regional Health Authorities. In Alberta, neither of these requirements were met.

By definition the bodies responsible for health promotion in this province are the RHAs. This absolves any other bodies from responsibility for the health of Albertans, resting the responsibility securely upon the regional bodies. And the budgets provided to the RHAs have been reduced significantly, rather than increased.¹⁷⁶

Not only does this successfully remove the larger government from the spotlight - at least for looking after the health of the populations; but it also results in greater medicalization as the regional bodies, forced to act as both hospital board and health board, find themselves dealing with programs ranging from cardiac surgery to school lunch initiatives. That is, while the broader determinants of health are left beyond the RHA's effective grasp, these bodies are still saddled with the responsibility to take steps to affect them. So they are left to do whatever they can - medicalizing (bringing activities considered not related to medicine under its umbrella) whatever the bodies can

¹⁷⁶ Alberta Health, 1994. For a review of budget cuts to Alberta's health system see Taft, 1997.

reach so as to give the impression that at least some steps towards population health activities are being taken.

Burgess argues that the way to salvage this conflict is first to return the responsibility for public health from the regions back to the provincial government, in effect *recentralizing* it, where the broader determinants of health can be affected.¹⁷⁷ After this one must ensure that discussion at the community level regard the broader determinants of health takes place and one must have the fruits of these discussions shared with appropriate levels of government to inform public policy.

Regionalizing public health can allow the various public health initiatives to be tailored to the needs of specific communities. However, explicit attention to public health issues by the central government where larger policies are developed must accompany any such regional approach if the broader determinants are to be truly respected.

5. Health System Cost Containment.

There is little doubt that, while not the sole reason offered for the restructuring of health care in Alberta, perhaps the most significant justification for regionalizing the healthcare system was to reduce costs. This is made clear in the document, *Getting Started, An Orientation for Regional Health Authorities* where, in explaining to new RHA board members the problems of the health system before regionalization which the restructuring is supposed to

¹⁷⁷ Burgess, 1995

help solve, it states, "in blunt and simple terms - the costs are high and we're not getting the results we want and expect for the dollars we're spending."¹⁷⁸ The document goes on to say, "the province and the people who pay the bills - Alberta taxpayers - simply cannot afford to spend any more."¹⁷⁹

The annual cost of health care in Canada is in the range of 72 billion dollars.¹⁸⁰ According to Health Canada 72% of health care costs in Canada are paid from various public purses at various levels of government. The remaining 28% is paid by private individuals either directly or through various extended health insurance programs.¹⁸¹

In Alberta, the expenditures on health care for the 93/94 year totaled just over 4 billion dollars. Of this amount, 47.4% was spent on hospitals and other acute care services. Another 31.6% was spent on the fees of physicians and a few other health professionals. 11.8% was spent on long term care services. 6.6% was spent on public health initiatives, 1.2% on mental health services and 1.4% on various other services.¹⁸²

Reducing and Deinsuring Goods and Services

If the aim is to cut costs, one way of achieving this is by reducing the monies paid to or the cost of running various categories of programs in the health system.

¹⁷⁸ Alberta Health, 1994b p. 4

¹⁷⁹ Ibid.

¹⁸⁰ Northcott, 1995 p. 55

¹⁸¹ Ibid.

¹⁸² Alberta Health, 1994b p. 5

With respect to the acute care services, costs can be reduced through a number of different initiatives. These include: reducing the length of time patients stay in hospital for various procedures and types of care; increasing the number of surgeries performed on an outpatient basis as opposed to requiring that patients remain in hospital overnight; reducing the number of beds available in a hospital and thereby the number of staff required to look after the patients who otherwise might have occupied those beds; closing some hospitals, redefining the roles of other hospitals and altering the relationships between hospitals in a regionalized system; and moving care that has traditionally been provided in an institution setting into the patient's home.

All of these initiatives have been undertaken in Alberta. For example, the RHA for the Edmonton region, the Capital Health Authority, notes in a "summary of accomplishments" for the period from April 1, 1995 to March 31, 1996¹⁸³ the closure of one hospital, the merger of three others into a referral hospital system and the conversion of three others into community health centres. It reports that while the average length of stay in hospital for patients in 93/94 was 7.2 days, this had dropped to 5.6 days in 95/96. As well, the number of active beds has come down from 2551 to 1650 over this period. Further, it notes that 40% of management positions have been eliminated and 4300 staff positions have been purged over a three year period. In total, 163.2 million dollars, or 16.6% of the RHAs budget has been reduced over a three year period.

Each of these adjustments have important ethical consequences of their own. For example, changes in the number and function of hospitals may have important repercussions for access to some services, such as emergency care facilities, requiring individuals to travel greater distances to receive care and

¹⁸³ Capital Health, 1996a

having to wait longer after arriving at the emergency room. Decreasing the number of beds available can have similar impacts on waiting periods for other kinds of treatments as well.

Reducing the average length of stay for patients can raise questions about the quality of care received, especially if patients are perceived to be discharged before they are ready to be cared for out of hospital. This change also has the consequence of shifting the burden of responsibility in caring for patients to family members and others providing support in the home. This has important costs, from financial to emotional, for those who must shoulder the responsibility.

Some of the costs of more home care initiatives are obvious. Examples include the emotional strain on the family members caring for the patient, the financial cost of care due to lost wages, and the change in lifestyle for caregivers. But decreasing the length of stay, and shifting to a home care model in general, also has the affect of deinsuring other professional services and material supplies. For instance wheelchairs and the like that would have been provided at no additional cost were the care to be given in an institutional setting, while still necessary, must now be provided for at home. Similarly, the care of professionals such as nurses, physio- and other therapists which would have been readily available at no additional direct cost to the patient in the hospital are now up to the patient and caregiver to obtain and finance.

In the institution itself, eliminating staff positions also can have very important ethical ramifications. For instance, fewer staff in hospitals generally means there are fewer individuals available to provide care and to ensure that the quality of care received by the patient is maintained at acceptable levels.

The second largest expense in Alberta's the healthcare system, comprising 31.6% of the 93/94 budget were doctors' fees and the services of other health professionals. This can be altered by limiting the doctors' fee schedules, limiting medical school enrollment and thereby, the number of doctors in society, limiting the number of doctors that immigrate into the province and limiting the number of doctors practicing in some areas.

In Alberta, while the goal of regionalization was intended to include assigning the responsibility for doctors fees to the regions, this has not taken place.¹⁸⁴ As such, the regions do not have any control over the remuneration conditions of physicians. Therefore, one large factor in the cost of health care - physician initiated demand, is left beyond the control of the regions. The regions can only exercise control over the behaviour of physicians indirectly such as by developing guidelines and strategies to change doctor behaviour and restricting the availability of new technologies.¹⁸⁵

The third largest expense for the healthcare system is prescription drugs. This cost can be reduced through the use of generic drugs, by more judicious prescribing practices by doctors, and by deinsuring selected prescription drug coverage. A shorter length of stay for patients can also have the effect of shifting drug costs that would have been taken care of by the hospital to the individual as he or she is released earlier than would have been otherwise.

¹⁸⁴ Brown, 1996; Lomas et al. 1997a

¹⁸⁵ This does have the advantages of allowing the province to establish minimal uniformity in physician payment schedules across the province and of keeping the various regions from having to deal with numerous interest groups.

Encouraging Private Enterprise

Another way of reducing the costs of health care, apart from simply cutting budgets for existing services, is by creating an environment of competition where providers of care must bid for contracts to provide services. It has been suggested that the measures taken in Alberta are aimed at trying to do just this, based on similar reforms in Britain and New Zealand which are themselves based on a strategy of privatization.¹⁸⁶

In the UK and New Zealand, the concept that has fueled reforms has been that of economic rationalization.¹⁸⁷ The general idea behind this theory is that when market failure occurs, the most efficient and feasible option is for the public sector to intervene and construct a managed market. A managed market is one where forces are artificially created to motivate the various individuals involved to behave in predictable ways such that a true market price will emerge for the traded good. This theory assumes that a free market is the ideal method of distributing goods in society and that where a free market does not evolve, the costs of developing a managed market are still fewer than those of government planned methods of distribution. Distribution of goods is just, according to this theory, to the extent that goods distributed in the pure market environment are just.

The particular model for creating a managed market in health care that has been used in the healthcare reforms of England and New Zealand is that of AC Enthoven's. Enthoven's solution to the market failure created by the asymmetry of information in the healthcare market is to create a market

¹⁸⁶ Brown, 1996

¹⁸⁷ Ibid.

manager or market sponsor. This agent would be responsible for defining a basic healthcare package, rating the consumers of health care according to risk status and inviting competitive bids from an open market of insurance companies for price of the premium for the basic package of health services for the lowest risk subscriber. Consumers would then be allowed to purchase insurance from any insurance company they desired. However, if the company they decided to go with offered more expensive premiums than the lowest bid, the consumers would be responsible for the difference. The insurance companies would in turn contract out to those healthcare providers who offered the least expensive rates for their services in what is a privatized healthcare delivery system.

Enthoven's model indicates incentives for insurance companies to keep their prices down, providers of health care to keep their costs down and minimize unnecessary treatments, and subscribers to choose the least expensive insurance companies or least inefficient providers. Thus, it ostensibly provides solutions for meeting some of the basic conditions of the ideal market. However, at least two groups of problems exist with this model. The first involves defining a basic package of health care. The second concerns how to provide sufficient motivation for the market manager to behave in predictable ways.

Reforms in the public health care context have modified Enthoven's model into the purchaser-provider split model. Here, the idea is that the government is the market sponsor. The Regional Health Authority is given the task of buying a set of contracts that will fulfill all of the healthcare requirements of the region within the budget determined by the government. The transactions, then, are a highly individualized set of contracts. The benefit of

this system is purported to be that in bidding for contracts, providing agencies will offer services at more competitive rates resulting in savings for the RHAs. In this way the health system could take advantage of the potential cost benefits promised by the market mechanism of allocating resources.

There are two fundamental problems with using the privatization mechanism within health care in the Canadian context. The first has to do with the numerous departures from the ideal market that the peculiarities of health care create - even in the purchaser-provider split model. I will review some of these in what follows. The second problem is an ideological conflict with Canadian values. I have already considered some of these in Part One of this thesis and will briefly review the issue again in the next section.

As I pointed out in Chapter One, there are a number of conditions that must hold for an ideal price for a good to arise and for cost savings through privatization to be realized. Brown suggests that there are several problems with the purchaser-provider split model that represent important enough departures from the ideal market setting to make the possibility of realizing these benefits questionable.¹⁸⁸

First of all, the package of services that RHAs must purchase is not itself a traded good on the market. A traded good is a discrete item that is purchased by agents and sold by producers at a negotiated price. The contents of the package of services that RHAs must provide are a list of required services that must be purchased within a given budget. Brown likens the situation to that of someone constructing a house.

When one builds a house, it is not just important to get individual

¹⁸⁸ Ibid.

contractors independent of one another to be responsible for different aspects of the building process. For, it is also important to obtain a set of contracts such that the entire house will be built within a given budget. The consequence is that factors apart from the value of individual contracts will influence the purchasing decisions of the construction manager or general contractor - factors that represent deviations from ideal market conditions.

In the case of Alberta's Regional Authorities, the RHAs will have to provide a complete set of services according to the moral obligations that I have argued they are faced with. Even aside from this moral responsibility, RHAs have the legal responsibility to provide at minimum the list of core services that is to be identified by the Ministry of Health. What could result is that two providers may offer a similar but not identical set of services, but the one that is chosen may end up being the more expensive and less efficient of the bidders because the bid provided by the more expensive contractor includes the services required of the RHA to provide.

A second problem has to do with entry level costs. Due to the nature of healthcare services and the current economic environment, a provider's contract with an RHA could represent the bulk of that company's work. In the ideal market there are many producers and many consumers. But in an economic climate with limited consumers of healthcare services and just one payer it could be difficult for producers of services to stay in business. Getting the contract to provide services for an RHA could mean the difference between financial solvency and bankruptcy. As a result this would deter the emergence of a number of providers, which would work against the forces of competition. And competition is precisely the engine that is to be responsible for bringing about the cost savings in Enthoven's market setting.

Furthermore, in the ideal market, buyers of goods are not supposed to be interested in the identity of the supplier. All that matters is the nature of the good itself - its cost, quality, performance, and so on. The name of the producer, where the company is based, the impact of the company on the community where it is located, its proximity to the buyer's home or workplace, the religious background of the supplier, the language in which the services are provided, the company's financial standing and other such concerns are factors that must remain irrelevant from an economic perspective. But it may be hard, and in fact it may be undesirable in some cases, for an RHA to be blind to these issues. For example, a given RHA might find it difficult to purchase services from one provider if it means that the provider that does not get the contract will be forced to go out of business. This would be especially true if the cost savings were relatively small or if the second company was providing other services for the RHA and their closing down would mean a disruption of services in another part of the system.

These deviations from the ideal market conditions serve to undermine the argument that privatizing healthcare services would lead to decreased expenditure on the health system. Limiting acute care services and engaging in the deinsuring of goods and services that results has a number of ethical implications. Similarly, adopting a system with greater private enterprise to cut costs will also involve confronting a number of ethical challenges.

As those who developed and forwarded this regionalized system, who are responsible for the overall budgets RHAs receive and who bear ultimate responsibility for the provincial health system, the provincial Ministry of Health will have to pay close attention to the ethical concerns involved with limiting services. As well, this body will have to address the obstacles that are

presented by the privatization of healthcare services before pushing Alberta's version of the purchaser-provider split model further towards its logical end point.

Ideological Concerns

In a brief statement at the end of his paper, Brown implicitly suggests that due to the speed with which the Klein government introduced a regionalized model for healthcare delivery, it might be that what motivated this shift is more an ideological move towards a privatized system of health care than one motivated by the possibility of significant financial savings.¹⁸⁹

Wilson also offers evidence to suggest that Alberta's conservative government is heading in the direction of allowing for private delivery of healthcare services.¹⁹⁰ She points to Bill 41, the *Government Organization Act*, which gives the government authority to privatize any or all services and to Bill 57, the *Delegated Administration Act*, which would have permitted the delegation of responsibility for healthcare services to non-government organizations. Although only the former of the two was eventually introduced and passed into legislation, Wilson argues that both are clear signposts of the government's desire to shift responsibility for health care into the private sector.

There are, to be sure, a number of possible advantages to a privatized system of healthcare delivery. For example, it is argued that such a system would be able to access funds that might be unavailable to a centrally planned

¹⁸⁹ Ibid. p. 150

¹⁹⁰ Wilson, 1996 p. 172

and delivered system. The resources of charitable organizations, for example, could be accessed in a way that the present system might not allow for. Also, sections of the private sector could be relied upon for funding and consumers themselves could be asked to contribute portions in the way of user fees and the like. The list of advantages also includes the possibility for government to avoid controversial areas of health care, such as infertility treatments for couples and the performing of abortions. The government could also escape costly areas of care by privatizing these. And such as home and hospice care could be left to agencies better suited to this kind of work such as religious or charitable organizations.¹⁹¹

In short, the government could, by getting out of the business of planning and providing health care, remedy both the financial and social headaches that maintaining these responsibilities so ironically causes.

When one talks of privatization, as I have done here, it is important to be clear about what exactly is being discussed. Are we talking about having the private sector take over the provision of all health services or just some? And does this mean that these services will be paid for from our common coffers? Or will individuals be responsible for taking care of their own healthcare expenses? If the public is to be responsible for paying for their own health care, will the insurance companies remain publicly administered as they are now, or will we also move to a system of private insurance companies, much like they have in the U.S.? Finally, who will administer or manage health care?

All of these questions demand attention so that in the public debate we can be clear about the terms we are discussing. I will focus my comments concerning the privatization of health care in the Alberta context on the ethical

¹⁹¹ Mills, 1990

dimensions of a system where individuals must pay out of pocket for services.

As I suggested in Chapter One, the two fundamental values that form the basis of liberal democratic societies are the commitment to freedom and to democratic self-determination. Given these values, which I argued in Chapter Four Canadians are committed to in a positive sense, arguments that favour market mechanisms for the delivery of healthcare services either fail to consider important features of health care as a commodity or are not sensitive to certain moral aspects of health care.

Accounts focusing on efficiency, based on utilitarian principles, fail to recognize some important features of health care that result in its market failure and that therefore make it inappropriate for distribution on the market. Moreover, they concentrate their attention exclusively on the consequences of various distribution options, leaving unaddressed the ethics of both the initial distribution of goods such as income in society and the difference in moral worth between different kinds of needs and desires.

Libertarian perspectives of how health care ought to be distributed fail to take into consideration the unfairness with which impediments to health are themselves distributed. The fact that one cannot be said to be responsible in any way for the socioeconomic class one is born into or the parenting and childhood-nurturing environment one is raised in is not considered relevant by the libertarian. But a society committed to giving its members an equal and fair chance at developing and achieving their life goals must address those hardships that are distributed to its members arbitrarily.

Thus, the only account that is appropriate for handling the distribution of this good is offered by liberal egalitarian theory. And this theory commits us to

the provision of necessary healthcare services through communal resources. In other words, there may not be a philosophical problem with a system of health care where the providers are not contracted out directly by the government. A healthcare system that is run in this way may face problems of efficiency and cost-effectiveness, but may not be inherently ethically troublesome.

However, problems do arise when the system is not publicly funded or when other barriers to care such as user fees are erected. For when this happens, access to care is limited by the morally arbitrary criteria of the patient's ability to pay. And this violates the principle that health care must be offered to those who suffer from health impediments without regard for any morally arbitrary criteria. The only absolute criteria is need.

The difficult part of the argument however, comes when we go to identify need. For it is argued that the notion of need in health care is confused by a number of factors. These range from the fact that needs can become easily confused with wants, that technological means are becoming available to treat, at least to some extent, all kinds of ailments at a pace far greater than society's ability to pay for these treatments, and that these technologies are advancing so rapidly that having the technology available to address an issue is turning out to be what defines the very existence of a need.

I am content to admit here that many questions still lay ahead that must be addressed. We must develop as a society an acceptable definition of need and of how to cope with the rate of technological progress. We will have to face questions of the ethics of a multi-tiered healthcare system that is based on the biomedical model. But I will not engage these questions any further here. And as I said at the outset of this chapter, my aim is to point out some of the ethical

tensions associated with regionalization - not necessarily to resolve them.

What I will be happy to conclude, again, is that to the extent a health system focusing on acute care services does affect the health status of individuals, access to these services must be financed from communal resources without any impediment to access for individuals on the basis of any morally irrelevant criteria such as the ability to pay. This follows from our commitment as a society to the individual liberty of our citizens. As such, any move to a health system that pushes the responsibility for paying for care to those who require it is ethically problematic.

Summary

I will briefly summarize here my analysis of how a regionalized health system fares against the four elements required of any Canadian health system. I will leave a discussion of the broader conclusions of this thesis for the final chapter of this work.

1) Services to be Provided According to Need

This is perhaps the most fundamental requirement of any health system that supports liberal egalitarian ideals. Is Alberta's regionalized health system better suited to meeting the needs of all members of this provincial community than would be a centrally operated one? The main reason to think that it would hinges on this system's ability to assess the health needs of the various socio-

cultural communities that exist within the individual regions. If it is the case that the regional approach can be more successful at developing needs assessment strategies that are sensitive to the nature of health as a value for these communities than would other approaches, then it is plausible that the regions will also be better able to meet the real health needs of their constituents, as these individuals understand them.

The problem is that it will be far from easy for RHAs to develop the political will or the insight required to favour a revisioning of the way health is understood. Indeed there is no reason to think that such a revisioning will be easier to develop at a regional level than at a more central level. Given the political and fiscal context within which regionalization has taken place in Alberta, there may also be significant worries for the ability of this system to meet the health needs of all Albertans.

To begin with, whatever the structure of a health system, if the primary motivation behind change is a reduction in the cost of the system, it is a likely possibility that needs will be met less well. A regionalized health system has the potential to cut down on duplication in many ways and to identify and respond to more genuine needs as defined in communities. However, if the focus remains on the cutting of cost and not on trying to meet needs better, then it is possible that more health needs will go unmet as a result of any changes and this important ethical requirement of the health system will go unmet itself.

Furthermore, if the system fulfills its promise to involve more public participation in the making of healthcare resource allocation decisions, and it has yet to do so, there could be further concerns as regard meeting health needs. For if the considerations highlighted in this chapter are not addressed, it is likely

that this participation will not be adequately representative of the public's values. It is possible further that the needs of those least able to voice their concerns with the rest, often individuals in most need and therefore with the most compelling ethical demand for care, will go unaddressed. If so, this will be a fundamental ethical difficulty for Alberta's health system.

2) Sensitivity to Broader Determinants of Health

There is a deep seated problem with developing a regionalized approach as a strategy to make sense of and affect the broader determinants of health. On the one hand a focus on cost reduction, which itself leads to a focus on utilization of health services, tends to identify health problems at the level of the individual. And on the other, by definition, the broader determinants are factors that must be affected by bodies with global concerns such as the provincial governments. Regional boards simply have neither the means nor the scope of control to affect factors such as income levels and social support mechanisms. Moreover, not enough is known about how these broader determinants are manifest in terms of actual biological pathways; more research must be done, research that regional bodies do not have the means to undertake.

The only solution if a health system is to be sensitive to this consideration is the sequestering of health programs, which aim at larger population health issues, from healthcare programs which focus on immediate health related concerns. In other words, a centrally controlled body, likely provincial, must be put in place to look after the broader health needs of Albertans, leaving the managing of healthcare services to the regions. In

addition, there must be recognition on the part of the central government of the fact that it is not just healthcare programs that affect the health of individuals, but rather broader governing policies, from wealth distribution to social support, that have significant impact. The healthcare system in general and the RHAs in particular cannot be understood as the primary controllers of health policy.

3) Community Definition of Health and Disease

It is plausible that this requirement may be the one most likely to meet by having a regionalized approach to health care. That is, while it may not follow directly that a regionalized healthcare system will be more sensitive to the health needs of particular socio-cultural communities, one can imagine that regional boards responsible for health care may be more inclined to have this sensitivity simply by virtue of being situated geographically closer to these communities. I believe this is indeed a potential virtue of the regionalized approach. That is, regional boards of health will be more likely to have the sensitivity in question.

But many changes will have to occur for this benefit to be realized. Simply going about doing conventional needs assessments or asking for public input in the developing of priorities will not be sufficient. First of all, a recognition of the biases inherent in conventional approaches to developing care programs must take place. This will require a shift in the mind set of everyone from the organizers of the system and the actual healthcare professionals who are the providers of care, through to the community of health scientists researching different care programs. A situation will have to

evolve wherein the very options in terms of care programs that are available must themselves be up for question.

Following this, individuals and communities must be engaged in a discussion of what the important life goals of that community are in order that an understanding of what diseases themselves are can be developed and what care is required to address them can be fostered.

And for any of this to occur, regional boards will have to be afforded a degree of fiscal and political breathing room. In order to be able to have the insight to change the way one thinks about health and health care and to then embark upon a comprehensive program of needs assessment, one will require the resources to provide existing programs for meeting present need adequately and for financing these longer term endeavours. These are enormous challenges for Alberta's health system. But they must be met if the system is to genuinely allow for the community definition of health and disease.

4) Worry of Conflating Needs and Desires

While this worry is indeed theoretically troublesome, in Alberta's context of cost-restraint, the practical concern it raises is minimal. When cancer surgery is considered elective, having to provide for extravagant holidays is simply not a relevant concern. This question may yet have to be sorted out. But given the realities of health care in the current fiscal climate, the debate will in all likelihood remain one for coffee shops and classrooms. It will not appear - and perhaps it ought not to - in the board rooms of healthcare institutions or RHAs.

The obligation to consider the broader issues which have been the focus of this chapter must fall with the government body that is responsible for the actual restructuring of the health system - the provincial government in general, and the provincial Ministry of Health in particular. These bodies must ensure that the changes made make the health system better than it was before while remaining in keeping with Canadian values; particularly the values of liberty and of self-determination. They are responsible for attending to the ethical concerns that elements of regionalization raise.

The obligation to make resource allocation decisions at the meso-level - or the level of the institution - rests with the Regional Health Authority. Therefore, these bodies must be concerned with the ethical issues that emerge from their appointed tasks. I will look more closely at some of these issues in the following chapter.

Chapter VII

Ethical Issues Facing Alberta's Regional Health Authorities

The allocation of resources happens at three levels. These are referred to as the macro, meso and micro levels respectively. When governments decide what areas will be funded and to what degree, allocation decisions at this level are referred to as macroallocation issues. Here different areas of social spending compete for government dollars. Governments must choose between areas such as education, welfare, infrastructure development and economic incentives for industry; and, of course, health. It is at the macro level that governments determine the portion of the total government budget to be spent on the health system.

On the other end of the spectrum are microallocation issues which concern the user of health services, the patient. For example, the decision to prescribe more or less cost-effective but therapeutically similar medications is a microallocation concern. This level of decision-making is usually undertaken by physicians or teams of healthcare providers. The decision usually takes place close to the bedside and is often time-sensitive involving a certain degree and sense of urgency.

In between these two degrees of allocation questions is the meso level. The matter at this level is to decide what particular programs to fund within the budget determined at the macro level. In a regionalized healthcare system such as Alberta's, the responsibility for making mesoallocation decisions falls to the regional level. For it is the responsibility of bodies at this level to plan for, select, finance and monitor a set of programs that will meet the health needs of the regions they serve. The regional body has the responsibility to the best it can within such constraints as guidelines set by higher levels of government, a budget determined by the provincial health ministry, the laws of society, social values and the demands of citizens.

In this Chapter, the aim is to extend my ethical analysis of regionalization in Alberta to the newly created local bodies that have been assigned the task of making the province's health decisions. For although the issues identified in the previous chapter are beyond the grasp of a regional board, these bodies still face a number of challenges themselves.

The regionalization of health care in Alberta has resulted in the creation of 17 Regional Health Authorities (RHAs). Couched in the terminology of creating "business plans", these RHAs have been given the broad mandates of providing for the global health needs of their regions.¹⁹² This language might lead one to think that the decisions to be taken involve straight-forward economic considerations. However, this is far from the case. The decision to provide funding to programs that will help some, at least in a context where resources are not sufficient to fund all available programs, will have the opportunity cost of not funding programs that could have helped others. The question thus becomes, Whose health needs will be met and whose will go unaddressed? To make these decisions will require discriminating against some groups and/or individuals. Therefore, these decisions involve values and not mere facts.

From this fundamental question there arise a number of different issues. The goal I have for this chapter is to point out some of the areas of ethical tension that RHAs must be aware of. I have divided the chapter into sections that correspond to six broad themes under which I argue ethical issues may present themselves. I acknowledge that these categories are somewhat artificial as many issues overlap. However, they represent a helpful way of understanding the issues involved with regionalization. Each theme will be

¹⁹² Alberta, 1994; Alberta Health, 1994b

explored for the particular problems that arise within it, given the mandate of the RHAs and the values of the various Canadians they are to serve. The six themes are:

1. RHA Accountability Issues
2. Procedural Questions For Choosing Between Programs
3. Tensions Between Public Health and Acute Care Programs
4. Issues of Public Participation
5. Extra-Regional Effects
6. Ethics Education

1. RHA Accountability Issues

RHAs have been formed as a means of creating bodies that are clearly responsible for meeting the province's health goals. If these goals are not achieved in a particular region, that region's Regional Health Authority must answer for the failing.

By putting these boards in charge of providing for the health needs of the regions, the provincial government is concentrating the moral responsibility of the state's obligation to look after the health of the population in these seventeen local bodies. Two questions thus arise: 1) Whose interests do the RHAs have the responsibility of representing (to whom must they be accountable)? and 2) How is this accountability to be achieved?

In *Getting Started, An Orientation for RHAs*,¹⁹³ where it describes for new members of RHAs the sources of guidance RHAs are to rely on it states, "on the one side, you have Alberta Health. Setting the expectations and standards, assessing outcomes and allocating resources to the RHAs. On the other side, you have your community members."¹⁹⁴

This appears to indicate that RHAs are accountable to the provincial government for fulfilling their mandates within the budgetary restrictions, core services and guidelines for actions as defined by the provincial Ministry for Health. As well, RHAs are responsible for representing the interests of the communities within their regions. The very existence of the Community Health Councils, also legislated as part of the *Regional Health Authorities Act*, seems to support the claim that RHAs are morally responsible for gathering and interpreting needs assessment information and providing for the needs of the members of their regions.

A third group of people that I argue RHAs have the moral responsibility for representing the interests of is the national public. This responsibility is legislated insofar as the federal government gives the provinces funds to support provincial healthcare programs as long as the provinces provide programs that are in line with the values of the national public as they are manifest in the *Canada Health Act*. In Alberta's regionalized healthcare system the provincial government is no longer in exclusive charge of making decisions about the delivery of health care. It has devolved these decisions to the RHAs. However, although RHAs are not directly accountable to the federal government, because they are using the federal funds earmarked for health care, they are obliged to ensure that programs and policies reflect the values of the

¹⁹³ Alberta Health, 1994b

¹⁹⁴ Ibid. p. 14

national public.

So RHAs must develop priorities and programs that are in line with regional values, that fall within the goals and values of the provincial government and that are in line with national values as expressed in terms of the standards for health care described in the *Canada Health Act*. RHAs are morally responsible for protecting and advancing the interests of all these bodies.

It seems that the first question is answered. Now I will turn to the second question - that of how accountability is to be ensured.

The first step necessary for enabling RHAs to protect or represent the values of these three groups is that RHAs must become aware of what values it must be guided by. Only then can they develop guidelines and mechanisms to ensure the adherence to the values they must represent. Knowing what these values are in the case of the national public is fairly clear - the *Canada Health Act* can be taken as a direct representation of these values. Though the five terms of the Act still require some interpretation, it is still fairly unambiguous what these values demand.

In the case of the provincial government, it is also fairly clear what is expected. Provincial health policies, standards and guidelines are available to RHAs through various documents provided. These largely focus on the adherence to a fiscal plan and, somewhat grudgingly, on the principles of the *Canada Health Act*. The challenge comes when we get to the values of the region. This raises issues of public participation which we will address in the following section.

Once the RHAs know the values they are committed to, the question becomes, How do these bodies ensure that their actions remain consistent with the values of those they must represent and thereby remain accountable?

With respect to national values as these are represented in the *Canada Health Act*, RHAs can explicitly make these five principles binding values in their business plans - the documents which are to guide their operations for three year periods.¹⁹⁵ With respect to provincial and regional values, to facilitate accountability RHAs must ensure that their decision-making is done in a clear and transparent manner such that the values which guide their decisions are made plain and are open to the closest public scrutiny. Transparency, then, must be a guiding procedural value that RHAs must espouse. More will be said about procedural values in a later section.

Two other issues that RHAs will have to pay close attention to both involve explicitly addressing difficult subjects that it may be easier not to articulate. First, it is likely, if not inevitable, that the demands made by the different groups RHAs are to represent will sometimes be in conflict. For example, trying to meet the needs of all members of the region (a federal requirement) may conflict with exercising fiscal restraint in terms of a limited budget (a provincial requirement). When the demands being placed upon it conflict, RHAs will have to summon the political will to call attention to these tensions.

Secondly, RHAs will have to develop mechanisms to ensure that certain issues and questions known to be ethically sensitive are brought to bear close scrutiny. That is, it may appear expedient at times to ignore certain negative consequences of various allocation decisions or other failings. Nevertheless,

¹⁹⁵ Plain, 1996

claims and arguments cannot be ignored or eschewed just because they may be politically undesirable or unpopular with the public.

In order, then, to facilitate having RHAs and other regional bodies actively pursue this goal of accountability, they must develop and codify their guiding values. Furthermore, they must make explicit that all members and staff must adhere to or manifest these values, they must define principles of rational communication that are to be followed and they must create bodies that have the explicit task of reviewing policies to ensure that the rationing decisions taken are equitable, are based on acceptable principles and values and can stand up to close public scrutiny.¹⁹⁶ Again, this is part of what it is for the RHAs to be accountable in their allocation decisions.

2. Procedural Questions for Choosing Between Programs

My argument so far in this thesis has been that Canadian society is committed to liberty in the stronger positive rights sense. That is, the nation and therefore its governments are obligated to be proactive in ensuring that all Canadians have the equal opportunity to develop and to achieve their life goals. I have suggested that the limits of this commitment may be unclear but that it extends at least as far as ensuring that all Canadians have equal access to required healthcare services. And I concluded that all bodies responsible for making decisions about health care - no matter at what level - must ensure that their decisions are informed by this commitment. This argument is borne out to some extent by its codification in the five principles of the *Canada Health Act*.

¹⁹⁶ Yeo, 1996a

Again, the Act requires any health insurance plan covering medically necessary physician and hospital services to satisfy the criteria of: public administration, comprehensiveness, universality, portability and accessibility.

Indeed, according to the RHA legislation which appears in concert with this argument, RHAs are mandated to develop a set of programs such that the needs of all of the residents of their respective regions are provided for - with a reasonable level of access.¹⁹⁷ However, the provincial government of Alberta has also made one of its guiding values that of limiting government spending. This had been done with an initial 25% reduction in the health budget.¹⁹⁸ The foundation of the provincial values is unclear as arguments for both libertarian and utilitarian motivations can be made. Nevertheless, it is not so much why the government has developed these priorities as the very fact that it has that creates the ethical tension for RHAs. For regardless of the ideological justification, to understate the issue, RHAs are also forced to be committed to the value of efficiency - they must make the most of every healthcare dollar.¹⁹⁹

Reasonable Access and Medically Necessary Care

RHAs, then, have the unenviable task not only of having to provide for

¹⁹⁷ I say that the legislation "appears" to be in concert with the principles *Canada Health Act* because the *Regional Health Authorities Act* falls short of legally requiring the RHAs to be constrained by the federal legislation. Indeed, Wilson points out that when given the chance to make the CHA part of the RHA legislation, Alberta's Progressive Conservative government voted against including the federal Act in the regionalization legislation. See Wilson, 1996 p. 173.

¹⁹⁸ Alberta Health, 1994a

¹⁹⁹ In the context of a growing population, an aging population, increasing healthcare needs and increasing expectations of the health system, the pressures faced by RHAs will extend beyond just requiring efficiency. Rather RHAs may be forced to go further, taking funding from some important areas to support others. This can be understood as exceeding just trying to make the most of every dollar spent.

the global health needs of their regions with a limited budget, but also of having to ensure that reasonable access is provided to all in need of necessary healthcare services. One question that arises immediately is, Is this even possible? Can providing for everyone's health needs with reasonable access to required services be accomplished with fewer funds than were available before? Although this is a very important question, because of the immediacy of the challenge that is faced RHAs may not have the luxury of being able to focus on it.²⁰⁰

Instead the question they are forced to contend with is, How is it to be done? How are these values of efficiency and equity to be balanced? To answer this question, RHAs will have to develop a definition of "reasonable access". Is a three month wait for hip replacement surgery providing reasonable access? What about an eight month wait? Is it providing reasonable access to have someone wait eight hours for treatment in an emergency room? How about two hours? Is making someone have to drive five hours to a large centre to see a specialist providing reasonable access? What if the drive is only three hours? Is the fact that the person is disabled in some way relevant? How about the person's age or financial position?

In order to balance providing for needs fairly as required by Canadian values and within a given budget as required by provincial fiscal restraint, RHAs will have to come to terms with what providing reasonable access to care means. Because the issue of defining this term is beyond the scope of this discussion, I do not wish to grapple with it at any length here. However, it is important to point out a pitfall that RHAs will have to avoid in defining this

²⁰⁰ This does, however, raise another extremely important issue that will face RHAs. That is, mechanisms will have to be forged that allow an RHA to suggest to the Ministry of Health which is responsible for setting its budget to point out that their tasks are not feasible, if this is the case.

term.

Because of the immense political pressure to provide services within a limited budget, RHAs may find it expedient to define reasonable access according to what conventional healthcare programs can be provided within the budget restrictions they are faced with. The problem with such a tack, of course, is that on the one hand any community-based definition of health will be sacrificed; and on the other hand poor quality of service and/or lengthy waiting lists for some services of a nature that is unacceptable in light of the values of Canadians may become validated. RHAs must find the political will to admit that accessibility to certain services is at an unacceptable level given the budgetary restrictions they face, if this is case. As Calabresi and Bobbitt point out, this will have the cost of forcing society to look squarely into the eyes of the monster of tragic choice.²⁰¹ However, only in such an environment of honesty can values be assessed and genuine public opinion be formed.

Similarly, RHAs will have to tackle the question of what constitutes "medical need". For example, are eye examinations and prescription eye wear true medical needs or can they be left outside the package of services publicly subsidized?

And, there are pitfalls RHAs must avoid in the case of defining medically necessary care that are parallel to those for reasonable access. That is, RHAs might find it convenient to define medical need in terms of the conventional biomedical model of health and what healthcare programs can be afforded within a given budget instead of with regard to goals of the health system - the creation or restoration of a reasonable level of health for the population.

²⁰¹ Calabresi and Bobbitt, 1978

Defining medically necessary care is especially important because of its potential for providing a legal escape for administrations and governments to pay for care. What is important in looking at the issue of this definition is that patients of health care are different types of consumers. That is why they have been given the special name - "patient" - and what causes a twist in the ethical implications of the situation. Patients are forced to rely upon the expertise of the healthcare professional, as I pointed out in the second chapter, for information about what is best for them. Therefore, patients are in a position of relative weakness. It is for this reason that Plain argues for the development of some standards in the defining of medical need to ensure that it is developed with a view to medical need and not any other consideration such as economic concerns.²⁰²

Actually defining the terms "medically necessary" and "reasonable access" at the regional level will have the potential benefit of permitting a sensitivity to the fact that the meaning of health and disease depend in large part upon the culture of a community. But this flexibility can also be problematic. For example, what happens if the regional community is divided in its values? How are the different values of two differing cultural communities within the same region to be reconciled? Furthermore, what if two different RHAs define these terms differently?²⁰³ Certainly, more work must be done to understand what it means for need and access to be defined locally yet safeguarded by basic standards.

Perhaps even prior to these definitional issues, RHAs will have to develop a procedure for deciding what programs they will provide that keeps in view the importance of the two ideals: meeting financial targets and providing

²⁰² Plain, 1997

²⁰³ I will have more to say about this issue in section five of this chapter.

for all with medical need. That is, these bodies will have to develop mechanisms for evaluating various program options and make decisions in a rational and consistent manner that allows them to balance the values of providing the needs of all the members of their region with a limited budget.²⁰⁴

Utilitarian Approaches and Their Limits

Regional Health Authorities have been established by Alberta's provincial government to look after the health needs of their respective regions. The fundamental tasks of this job involve assessing needs and planning, implementing and evaluating programs the RHA will fund in order to achieve this goal. The basic ethical challenge that this presents is having to struggle to balance utilitarian and deontologic ethical goals and principles.

Again, as I indicated in the second chapter, utilitarianism is a distributive ethical theory positing that goods in society ought to be distributed in that allocation pattern that results in the most good for the most people. Utilitarianism, then, is a consequentialist theory. What is right according to it will depend upon the consequences of the actions being considered. In allocation questions based on this theory, the right distribution will be the one that results in the best outcomes for the most people.

A deontological ethical theory, on the other hand, is rights based. Here,

²⁰⁴ The assumption I am making here is that RHAs will have to redevelop a scheme of services that will meet the needs of their respective regions. The alternative is simply to continue to fund programs which have been instituted in the past. This alternative, however, seems clearly unfeasible given the budget cutbacks and the inclusion of other health services within the RHAs' mandate that previously were taken care of by other government bodies.

the results of an action are not the determining factor of the morality of the action. Rather, what will determine whether or not a given behaviour or action is correct is the compliance of the action with relevant rights and the duties these rights entail.

These two theories come into conflict when healthcare services must be allocated in the face of reduced fiscal resources. In this context, utilitarian theory would propose that the best allocation pattern is that one that will achieve the most good for the most people given the resources available. But how is the term "the most good for the most people" to be construed here?

One utilitarian alternative is to say that cost-effectiveness represents the most good for the most people. That is, only those programs that are most cost-effective ought be funded. Therefore, such programs that achieve the best health outcomes and that consume the fewest resources ought to be implemented. This, of course, assumes that some objective standard is available to measure outcomes of various treatments between people that is able to also measure the value of the treatment and the ensuing restoration of health or prevention of further harm to the recipient of the care.

Another utilitarian alternative is to say that referenda or other fora for democratic public involvement ought to be held so that the public can elect what programs are and are not to be funded. In this way, the most good is achieved by doing whatever is in the best interests of the most people according what they themselves have decided represents this best interest.

The primary difficulty with both of these options - and most such utilitarian constructions - is that whatever alternative from the utilitarian program is chosen, some people who are in need of medical care will not

receive it - either because it is deemed that the value of their receiving the treatment does not justify its expense or because they are not part of the majority whose interests alone are to be considered, or some such reason. And this result is not acceptable to the deontologist who argues that where there is a duty or obligation to provide care, it is wrong for care then not to be provided.

In the case of health care, there is an obligation to provide care to those who require it - as we have seen from the arguments in Part One. Hence to violate this obligation is ethically unacceptable - even though utility outcomes (leaving aside the question of whether achieving these objective analyses are even possible in the first place) may be maximized.

And here lies the tension that RHAs must address. RHAs must develop a procedure for providing cost-effective care while respecting the right to that care of all who have it.

Procedural Values and Value Guidelines

One solution for addressing this tension is offered by Doyal.^{205,206} It consists in the development of a set of procedural values. That is, Doyal argues that in order to reconcile providing quality health care with not having the resources to meet the needs of the whole population, the body facing the decision of how to use the available healthcare resources (RHAs in our case)

²⁰⁵ Doyal, 1995

²⁰⁶ My aim here is not to assess or support the particular procedural values Doyal offers. Indeed these may be valuable guides, but their content is not of primary relevance here. Rather, what is most instructive is the very notion of procedural values that Doyal employs.

must develop a series of value statements that will help guide them in making the decisions in such a way as to remain as close as possible to the ideals the body is committed to. They remind the decision-making bodies that discriminating against certain criteria is not acceptable and provide the rationale behind these values.

He argues that the first step in the process of deciding what programs to fund such that all needs are met within a given budget is defining what the term "need" means. The reason for this is that if there is an obligation to provide for the healthcare needs of a population, one must first determine what this commitment is actually to. For Doyal, this definition turns out to be, "the requirement for specific clinical intervention to avoid sustained and serious disability."²⁰⁷

The next step in the process is carrying out needs assessments so that the actual needs of the population may be determined. Once this is known, the decision-making body (again, RHAs) can determine how their allocated budget fares against what it would cost to provide for the total healthcare needs of the population. If the budget is large enough, the ethical tension is dissolved. But if the funds in the budget fall short of the requirements as they usually do in health care, then the RHA must turn to its set of procedural values.

The following is the set of procedural values that Doyal proposes in the context of Great Britain's National Health Service²⁰⁸:

- (1) Healthcare needs should be met in proportion to their distribution within the population.
- (2) Within areas of treatment, resources should be prioritized on

²⁰⁷ Ibid. p. 276

²⁰⁸ This example is particularly valuable as the British experience mirrors the Canadian one to the extent that both societies face the challenge of balancing similar notions of efficiency and equity.

the basis of extremity of need.

- (3) Those in morally similar need should have an equal chance of access to healthcare.
- (4) Scarce resources should not be provided for ineffective healthcare.
- (5) Lifestyle should not determine access to healthcare.
- (6) Rationality should be optimized in the allocation of healthcare.
- (7) The public should advise but not determine policy concerning the allocation of healthcare.²⁰⁹

Whenever a decision is considered, the decision-making body must test to see if any of the normative requirements in this list of values is being violated. Any violation represents a departure from the values the body and the society it represents hold dear.

Doyal's particular solution to rationing healthcare resources is to *not* discriminate against sufferers of particular types of diseases or injuries, but rather to provide all of the programs there is a need for and then to discriminate *within* each program according to severity of need. In this way, the needs of heart surgery patients and the needs of patients suffering severe forms of acne need not be compared to determine which has a stronger claim. His position is that if anyone is to not get due attention from the healthcare system, it should be he or she with the least urgent need relative to sufferers of similar conditions with similar needs. So the needs of different acne sufferers are compared with each other as are the needs of heart surgery patients; but both programs would be funded and those within each with the most need would get treatment.

The problem with this is that it pushes resource allocation decision-making to the level of the provider who must now act as a gatekeeper to services as well as the advocate for patient care. Providers will have to select

²⁰⁹ Doyal, 1995 p. 276-280

which heart patient is deserving of patient and which will, therefore, not be so deserving. This will compromise the provider's ability to advocate fully for every particular patient. He, she or it (for the provider need not be an individual healthcare worker as this tension is true also for institutions and program coordinators as well) will now have to be both judge and advocate. Some see this as an untenable conflict of interest, while others see this as a reality of modern health care.

Doyal's list of values allows him to maintain a strict adherence to the ideal that no one ought to be denied access to health care for any morally irrelevant or arbitrary reason such as lifestyle or suffering a condition that is either expensive or that carries a social stigma. And his list reminds the decision-making body that ruling by public opinion always leaves the needs of some unfairly addressed and, therefore, is an inappropriate way of dealing with difficult problems.

This process of defining values is particularly important because membership on these boards often consists of individuals from sectors other than health care. Therefore, it might be easy for such individuals not to recognize that health care is a unique commodity and is not governed by the conventional rules of most business practices.

I am arguing here that RHAs must also develop their own set of procedural values to help them make their allocation decisions in a consistent manner, forcing them to conform to the ideals they are committed to. In introducing Doyal's solution my aim is to provide one example of what such a list of procedural values might look like. Doyal's list represents a very good starting point for RHAs; however, what a particular RHA's list of procedural

values will actually look like may change, to some extent, depending upon the circumstances of that individual RHA. Whose values RHAs must represent has been addressed in the first section of this chapter, *RHA Accountability Issues*.

*3. Tensions Between Public Health and Acute Care Programs*²¹⁰

The list of procedural values that Doyal offers works well for local bodies that are responsible for allocating the healthcare resources of a region in the context of a definition of health care that is based on the biomedical model. Again, Doyal's solution to balancing equity and efficiency is to fund all programs that meet the qualifying needs and then to discriminate within individual programs according to severity of need. His reasoning behind this is that it is unfair to discriminate against someone because of the type of health impediment that they suffer. It is more fair to distinguish between like cases and to treat those with relatively less urgent need within like cases differently.

But the job of the RHAs is not quite as easy. For the programs they must choose from range from the acute care-oriented to health promotion activities. And in the latter case, it is very difficult to judge medical need. What is the medical need of the child who requires a stable and nutritious diet to grow up healthy and strong? And how is his or her need to be judged against the need of an elderly patient for a kidney transplant?

²¹⁰ As this section deals with the difficulty of choosing between public health initiatives and programs aimed at providing acute care services, it may seem more appropriate as part of Section 2 of this chapter. However, because of the different dimension involved with choosing between such programs and the importance I attribute to this issue I have chosen to present it in its own section.

Doyal's solution of course seems to obviate these kinds of comparisons. That is, all programs across the broad spectrum that the RHAs are responsible for ought to be funded and then the triage concept ought to be used to distinguish between the needs of individuals within each program. So his approach might be seen to apply most appropriately in the RHAs' case.

The problem of course is that public health programs differ in some very important ways from programs that focus on acute care. For example, much more is known about the types of acute care services that are appropriate and the success of these programs at restoring health, than is known about what public health programs are or can be most effective.²¹¹ It is becoming increasingly clear that broader factors such as socioeconomic status and levels of social support have an enormous impact on individual health status. But further research is required to investigate the mysteries of exactly what these broader factors are, what their relative importance is and what the biological pathways are through which these factors manifest themselves.²¹² RHAs can readily assess and administer acute care programs. But can it be their responsibility to fund the type of research that public health initiatives require?

One possible response is that RHAs must limit their involvement in public health initiatives to those that are known to work. The research, then, should be left up to higher levels of government to fund or up to independent researchers to be supported by other funding services. The problem that arises is that, in Alberta, the provincial government has shifted complete responsibility for public health programs to the RHAs so the research if not done by RHAs is left to the academic world to pursue through non-government channels. This

²¹¹ This is not true for some illness prevention/health promotion programs. For example there is good evidence to suggest that preventing smoking leads to decreased incidence of many heart-lung conditions.

²¹² Evans, Barer and Marmor, 1994

might be acceptable if it were not for the strength of the evidence pointing to broader factors as having a significantly more important role in determining the health of a population than acute care-based medical services. If this evidence is to be accepted, then it would mean that the primary factors influencing health are being unaddressed by the bodies responsible for affecting the health of individuals in society.

Another important difference between acute care and public health initiatives is that the former come easily within the grasp of the RHAs, while the latter are often unreachable. For example, it is relatively easy for a Regional Health Authority to control the waiting lists for certain surgeries, to develop long term care initiatives and to create home care programs for those leaving hospital earlier than they otherwise would have. The reason is that all of these services, for the most part, happen at the community level. The services are delivered at institutions or in the homes within the respective regions, again for the most part, the RHAs serve. However, it is not so easy, indeed it is impossible, for an RHA to make changes to the levels of income people enjoy or to the jobs that they have. These things are determined by factors affected only at much higher levels of government due to the larger sections of the population they involve.

So if the RHAs are going to be responsible for matters of public health, then crucial factors of this area of health care will remain necessarily beyond their grasp. The RHAs can face no real issue here in that there is simply very little if anything at all that they can do about these broader factors. They can develop programs taking into account these factors, but they cannot deal with them directly. Nevertheless, they will face the tension of knowing that there are factors of their mandate that they simply cannot touch. The best that they can

do is bring these issues to the attention of the Ministry for Health.

Still another difference between acute care and public health programs is that in the case of acute care services, the beneficiary is easy to identify. It is this patient suffering these and these particular problems. But in the case of public health initiatives, the beneficiaries are not always as easy to spot. Affecting an individual's income may lead to a better standard of living and also lead to better health.²¹³ However, the children of the individual will also benefit as their socioeconomic starting points will likely be better, they may have more supportive and nurturing environments within which to grow and develop, will probably have a better education and will likely enjoy a wider scope of opportunities all around. So public health initiatives may have external effects that are not as easy to see and therefore not as easy to add into the equation when weighing different possible initiatives.²¹⁴

So the problem of including public health initiatives in the responsibilities given to the regions that were indicated in the last chapter become manifest for the regions in terms of how to choose between those services that are based on an acute care model, such as primary care, hospital care, long term care and home care programs, and services based on the public health model that focus on future, often statistical lives. RHAs will have to determine how to compare the relative values of these two very different kinds of health initiatives. They will have to find a way to compare apples and oranges.

²¹³ Alberta Health, 1996

²¹⁴ It is true that acute care services also have an impact beyond the patient. The classic example is the impact that taking care out of the hospital may have. On the negative side, this could shift the care and cost burden to families of the individual needing care. On the positive side, this could allow the patient to convalesce in a more familiar loving and supportive environment. However, the secondary effects of public health programs, I argue, are much more far reaching than those of acute care. This is because public health programs have the potential to affect the development of individuals in a way that acute care programs do not.

This leads to one of the most significant and yet subtle issues that RHAs will be forced to wrestle with: that of identity. These committees will be forced to think about what kind of board they are meant to be. Are they the equivalent of a hospital board shifting spending to acute care services to the best of their ability at the expense of public health initiatives? Or are they a health board with the aim of looking after the long term health status of the population they are responsible for?

This dilemma is exacerbated when one must think about funding new and expensive technologies with an acute care focus. A good example of this is found with the ECMO or extracorporeal membrane oxygenation project. This technology - essentially a heart-lung machine - has the ability to maintain the lives of patients in the short term until transplantation can be made available for them. It has been used for neonates and is being expanded to older patients. Recently, the technology received attention from the Edmonton media for saving the life of a fourteen year old boy whose heart was destroyed by a viral infection.

This is the way Pediatric Intensive Care Unit Director Dr. Alf Conradi frames the issue for a local newspaper. "The question, says Conradi, is in an environment of tight health care spending, should you be directing \$500,000 to keep 10 children alive who have a 40-per-cent chance of survival? Or is the money better directed at vaccinations say, or some other mass care program?"²¹⁵

The answer to these types of dilemmas, according to Burgess as pointed out in the previous section, is that this type of decision must be removed from the purview of the RHAs by restoring responsibility for public health initiatives

²¹⁵ *Edmonton Journal*, July 21, 1997 p. A7

to a centralized body in charge of public health initiatives.²¹⁶ The functions of healthcare services and public health initiatives must be sequestered. Until this is done, however, RHAs will continue to have the responsibility to fairly address the needs of the various stakeholders in the healthcare system.

The question that will continue to perplex will be, Who are these people? The existing population in need of acute care services? The chronically ill who require long term care? The young children of the community who need adequate nutrition to grow healthy and strong and hopefully avoid some of the health problems of the undernourished? Or the unborn children who will face illness if environmental factors known to influence health status are not addressed? Until remedied, these questions will continue to haunt RHAs.

4. Issues of Public Participation

One of the groups whose values an RHA is responsible for representing is its regional community.

As I discussed in earlier chapters, the importance of public participation stems from the values of liberty and self-determination that Canadian society is committed to. The argument is that individuals have a right to make decisions for themselves to the extent that these decisions will have an impact on their own lives. In the case of healthcare resource allocation, the idea is that because it is the public that will be affected by allocation decisions, at first glance it is the public that has the final right to make the allocation decisions.

²¹⁶ Burgess, 1996

The problem this raises for an RHA is that, as in the case of informed consent at the micro level, not every expression of the public's values must be accepted by those in charge of allocation decisions. Only public opinion that is truly and equitably representative of the interests of the public, that is fully informed of the benefits and burdens of the various allocation alternatives, and that is free from coercive forces must be heeded by those in the relevant positions of authority. Expressions of public values must then developed through a process into an enduring socially negotiated agreement.

And even this is not enough, for, as I demonstrated in the previous section with some of the utilitarian approaches to decision-making, in having the public democratically determine what healthcare programs to fund some people with genuine need will still remain unserved by the healthcare system that has its priorities democratically established. Yet we are committed to the value that the needs of all must be fairly addressed as it is wrong to discriminate against anyone just because they are part of a voiceless population.

So the problem RHAs will face in addition to juggling the values of efficiency and equity is making sense of the value of public participation that has been mentioned often but explained relatively little in the rhetoric of regionalization. One reading of this problem is that the challenge for RHAs, if they are truly intent on having the public's values provide guidance for their allocation decisions, is to cultivate public participation mechanisms that meet these requirements - after, of course, developing programs that are sensitive to the genuine needs of the socio-cultural communities within individual regions. Right away the difficulty of inefficiency presents itself. For some might argue that developing such mechanisms is a waste of the time, resources and energy of an RHA and that in the interest of efficiency, the search for such participation

ought to be abandoned.

This is because all of the criteria that must be met are extremely stringent and difficult to achieve. Informed consent requires that the public be educated and given access to some objective debate on the issues. But how is this to be achieved? What kind of fora must be provided? Voluntary consent requires that the public act without any kind of coercion. But how is this to be achieved? Explicitly coercive efforts can potentially be deterred through the setting of rules and guidelines. But how is the subtle persuasion to be deterred or countered?

And, most difficult of all, how is appropriate representation to be achieved? What formats are to be used to garner public opinion? Who is to represent the interests of the public? How can one ensure that the interests of the voiceless will be expressed and heard? Will the taxpayer's interests be represented and who will represent them? And how can one assure that those chosen to represent a particular group will, having gained a position of power and influence, use this new position to represent that group and not pursue some other agenda or speak for some other group?

The Community Health Councils, created as part of the *Regional Health Authorities Act*, in and of themselves don't solve these problems. They may be helpful in that at least having these bodies available may facilitate having these questions answered. However, the terms of reference themselves for these bodies are sufficiently vague as to leave the many questions mentioned earlier unanswered.²¹⁷

RHAs must contend with these questions before any obligation arises to follow the public's opinion. But the questions are large and present a

²¹⁷ Capital Health, 1995

considerable obstacle to efficient management of healthcare resources. So much so that Doyal offers a completely alternate reading of the importance of public input in resource allocation decision-making. He argues that public participation must be limited to four basic areas: 1) needs assessment activities, 2) treatment evaluation for new and existing therapies, 3) monitoring abuse of patient rights, and 4) helping make purchasing decisions.²¹⁸

Doyal's solution limits the control real communities have in the setting of priorities and in the actual choosing between different health programs offered by a region. In his scheme, the public's input is considered essential - but only so those in positions of decision-making authority can have accurate information with respect to the actual needs of the community when making decisions. This solution does address the problem of having to gather public opinion in a manner that satisfies the strict criteria described earlier. However, one could argue that it does so at the expense of limiting the freedom for self-determination of regional communities.

But this is really not so. For the decisions are still being made by members of the region: the RHA board members. Moreover, the RHAs must be guided by the values of the provincial government - which regional communities help to determine - and by federal guidelines which are also determined, at least in small part, by the members of the regional community. So Doyal's solution is not without merit. It successfully addresses the difficulty with gathering voluntary, informed and representative public opinion; although admittedly it does rely heavily on the faith that RHAs will in fact act in accord with provincial and national values.

Individual RHAs must come to terms with the question of which

²¹⁸ Doyal, 1995

alternative to follow for themselves and determine the level of public participation appropriate in their particular circumstances. Whatever they decide, the point remains that the oft touted and much heralded greater public participation that regionalization is meant to create will not happen without having RHAs engage some very difficult ethical questions. Thus RHAs will have to achieve some sort of medium between over- and under-participation from the public.

Another question with respect to public participation has to do with membership on RHA boards. When the RHAs were formed in 1994, the members of the boards were appointed by the provincial government. The intention was that within a reasonable amount of time half of the board's members would be democratically elected.

What the composition of membership on RHA boards ought to be is a very complicated question. On the one hand, having board members elected democratically by members of the region can be seen as another way of increasing community involvement in decision-making around health care; another way of having the people choose how to allocate their allotted health dollars. Furthermore, having an elected board would provide better assurance against having the board simply reflect the values of and seek to fulfill the agenda of the provincial government who has appointed them, at the expense of national and community values. Indeed, an elected RHA Board can be seen to offer a challenge to the values of the resource allocation experts whose decisions are guided by values from a particular sociopolitical perspective.²¹⁹ Moreover, an elected board may be seen as the correct option, assuming good input from the community health councils, to act as the medium required for

²¹⁹ Mills, 1990 p. 31

sensitivity to community defined need and access.

On the other hand, having a democratically elected board also poses a number of problems. For some argue that making allocation decisions requires at least a degree of expertise that an elected board might not have. As well, to pursue the idea of an elected board will involve a financial cost that may be considered a waste of funds in such a fiscally restrained climate. Perhaps the biggest problem with having a democratically elected board is the potential for social hijacking that it brings. The worry is that the elected representatives, once in power, may abuse their influence to advance personal causes or the causes of special interest groups. And of course there remain the concerns pointed out before about having a public democratically determine health priorities and the unmet needs of the minorities within these groups that will likely result.

Clearly both solutions offer the potential for abuse. In Alberta, although this question is still at issue, the initial solution to the problem was thought to lie with having a mixed board of elected and appointed members. This would have the result of ensuring the required expertise was available, that the government's interests would be represented and that a certain degree of community involvement was also facilitated.

However, Mills points out that:

Because the health authority is neither fully elected and thus accountable to a local electorate, nor composed of appointed members with no local allegiances and owing complete loyalty to the Minister, it has been described as occupying a "twilight zone" in public administration between central and local government. It is criticized for lacking clear accountability because it has no clear constituency, but the links of members to local groupings (e.g., to local government) render accountability to the minister weak.²²⁰

The RHA boards in Alberta remain appointed by the government so this

²²⁰ Ibid. p. 30 - 31

issues has still to be resolved.

5. Extra-Regional Effects

Alberta's health system before regionalization was constituted of a complicated network of services and programs with numerous points of overlap. As I have pointed out, the inefficiency that some of this overlap was thought to entail was one of the factors that led to the reform of the previous system. But moving from a highly integrated system to one with discrete geographic units of care can result in numerous problems of its own. This, of course, is especially true when the number of geographic units is relatively high and serve such diverse ranges in population size as in Alberta.²²¹ Certainly, amid these problems lie a number of serious ethical concerns.

For Alberta's plan of regionalization to be successful, therefore, RHAs will have to work together in several important ways. By pointing out three basic pitfalls RHAs will have to avoid, I hope to elucidate some of the particularly important aspects of the relationship between RHAs that will have to be addressed for regionalization to be effective.

Quality of Care Issues for Rural RHAs

²²¹ The populations of the regions RHAs serve range from 17682 and 20211 in regions 17 (Northwestern Region) and 14 (Peace Region), to 753856 and 832031 in regions 10 (Capital Region) and 4 (Calgary Region) respectively. (Figures from Alberta Health Care Insurance Plan, Registry 96 March 31)

A necessary consequence of having a large number of regions with such varied population size is that it will only be efficient to offer certain services, especially high technology services which tend to involve very high cost, in larger centres where programs can be run for enough people to make providing the service reasonably cost-effective. To compensate for this, the provincial government has introduced a new model for determining the budgets to be given RHAs - called population-based funding.²²²

²²² According to the population based funding strategy, users of health care are first broken down into different categories, first by age (20 categories), then by gender, and then by socioeconomic group (welfare/native/non-premium payer/premium payer). Then the total number of persons in the province in each individual category are determined (for example x non-premium paying males between 20 and 25 years) and the total cost of serving the health needs of these individuals is tabulated. After this, the total cost for each category is divided by the number of individuals in the province within that category to achieve an average cost for serving the health needs of one person in the category.

Then, in developing the budgets for each health region, the number of people in the various categories each region has is calculated and multiplied by the average cost for treating one person in each category. The total is the health budget that the region is to work with - almost.

For several other factors are also involved. First, it is not really the total number of individuals within a region that the budget is tabulated for. Rather, historical usage pattern data is consulted to determine how many people and from what categories actually use health services within the region. The difference between the actual population numbers and the usage patterns are used to adjust the budgets each region receives. If more people are treated than reside in the region, this is reflected in an additional amount included in a region's budget. If fewer people than reside in the region use that region's services, the RHA's budget is reduced by that much. The approximate figures are then tested at the end of the fiscal period and adjustments are made depending upon their correspondence to actual usage patterns and based upon average costs.

In addition, the RHAs serving Calgary and Edmonton, the two largest centres (based on population) in the province receive an additional amount to compensate for the more complicated cases these regions generally see and to compensate for the number of high cost interventions such as transplants that are not factored into the normalized cost per category but that are funded exclusively to each program.

Finally, a separate calculation is also developed for lab work, community rehabilitation services and the cost of the extra-billing certain clinics within the province engage in which used to be paid for by the users of the facilities but which are now paid by the province because of the federal government's contention that these fees contravened the *Canada Health Act*. Each region's budget is also made to reflect these costs depending upon their relevance to that particular region.

(A description of the population-based funding formula is not available in published form anywhere. This description is put together from conversations with those at Alberta Health and the University of Alberta who administer the formula.)

However, regionalization is being adopted in Alberta in addition to other shifts in the way health services are being planned and provided. One of these concurrent shifts is a move to greater community- and home-based care. Accordingly, patients spend less time in hospital and are released earlier and sent home to be cared for by a health team in the patient's home surrounds.

This can become problematic in situations where individuals from smaller regions go to larger regions in order to receive expensive specialized care unavailable in their home region. Then, when they are ready to leave, the home care team in the patient's own region which is supposed to assume responsibility for the patient upon release from the hospital is either unequipped or unable to handle the sophisticated nature of the care required by the patient.

An example of this in the case of a baby born in Spruce Grove, a suburb of Edmonton but not part of the Capital Health Authority (CHA), the RHA responsible for Edmonton, Alberta's capital. Because the baby was born with several complications including spina bifida - the result of faulty embryological development in the spinal chord and vertebral column - and hydrocephaly - a condition where fluid collects in the brain - she was brought to the intensive care unit in a hospital in the Capital Region for treatment. This is, of course, consistent with the principle that physicians ought to be able to direct patients to wherever the best care is available in the province. Once the baby was stabilized in the neonatal ICU, the time came when she could be released from hospital and cared for in the home. The baby was able to breathe on her own, but required round the clock care and various equipment to be set up in the home. The problem was that the home care team in the baby's home region was ill-prepared to handle such a complicated case.

The result was that the home care team for the Edmonton region extended themselves to help set the baby up in her home and provided enough support such that the home care team in the baby's region was comfortable assuming control. The extra care given by the CHA's home care team did not cost the region any extra dollars, but had the opportunity cost of time spent on patients of the CHA region who also required the services of the home care team.

This type of case clearly puts a burden on the home care team of the region for the larger centre as it is forced to provide care for individuals from smaller regions in difficult cases. Or if the team members choose not to extend this care, either the patient will end up staying in hospital longer than he or she ought to, or will return home to an environment of sub-optimal care.

In the case of the baby in question here, part of the motivation for the CHA's home care team in ensuring that the baby was set up properly in the home environment was to do its best to ensure that the baby would not require further care in hospital. For this too would have meant a further use of the Capital region's limited financial resources. This brings me to the next extra-regional effect problem.

Funding and Administration Issues

This problem starts out as an administration problem that results in an ethical tension for smaller RHAs. A study by Plain suggests that almost one out

of every three patients served in the CHA comes from outside the region.²²³ This makes sense because, as I noted earlier, some programs can only be provided cost-effectively in centres with large populations. The high number of out-of-region patients is supposed to be addressed by the new population-based funding formula. Again, according to this model health dollars are supposed to follow patients to whatever region they are served in within the province.

The problem, according to Plain, is that the CHA bills out of region patients based on an estimated average cost. This is because the CHA does not have the administration system in place that would be required to bill according to the real cost of the services rendered. There are several difficulties that this situation creates.

First, because the CHA only bills for the average cost of services and yet deals with the toughest cases, it ends up under-billing for the services it provides. If left unaddressed, over time this will have the cumulative effect of eroding the quantity and quality of services that are available in the region due to the net fiscal losses it will suffer. Or it will result in a substantial increase in administrative costs to ensure that the region bills appropriately for the services it delivers.

Second, because health care dollars follow patients to wherever they are treated, individual regions will have a financial incentive to develop their own services so as to increase income. More income of course means that more services can be provided or better access can be offered to members of the region. The result will be that the smaller regions will develop those services that are most cost-effective to offer and let the larger regions - the CHA and the Calgary Regional Health Authority (CRHA)- handle all of the rest. In addition, this will

²²³ *Edmonton Journal*, July 21 p. B1

result in the duplication of services which will have the effect of making the overall health system less efficient.

The solution, according to Plain, is an administrative change: increasing the geographic size of the CHA to absorb the smaller outlying regions and thereby making issues of underpayment disappear. However, until a solution is actually developed and adopted, a particular ethical dilemma is presented to the smaller regions. They will be forced to decide whether to exploit the larger regions and develop services that will increase their revenue while shuffling the costly cases off to the CHA or CRHA; or to somehow try to balance on their own the services required by residents of the region and the monies paid out for those services. The question as phrased by Plain is, "will that [low cost] region work and cooperate and try to plan or assist in any manner, shape or form the other high cost region which is providing services to [the low cost region's] residents"?²²⁴ The advantage of such exploitation is being able to provide better care in one's own region.

One might suggest that the answer to this dilemma is obvious - the smaller regions are ethically obliged to work together with the larger RHAs and ensure that all regions are fairly remunerated. But, while perhaps the ethical obligation on the smaller RHAs does exist, it is not so easy to resist the urge to exploit. This is especially true in an environment of cost-constraint where there is an ever growing demand for services and an ever-diminishing availability of resources to provide important health programs. Again, it may be true that there exists an ethical responsibility on the smaller RHA not to exploit the health system, but the incentives in place make it very easy to continue the status quo.

²²⁴ Plain, 1996

Issues Arising From Discrepancies in Priorities

Another challenge to inter-regional cooperation that may arise springs from having to choose between acute care-based services and public health-based initiatives. It will concern the gap between regions that may result from the choices different RHAs make. It is easy to imagine a situation where in one region, Region A, the RHA has decided to make a clear effort to decrease heart trouble in the adult male patient population. To this end, they have decreased the funding for cardiac bypass surgery and devoted those funds to public health initiatives that have been proven effective at decreasing the need for this surgery by 10 percent. After a one year period, the public health initiatives are successful and the incidence of heart trouble in the target population has in fact been reduced by 10 percent. However, as a result of the funding cutbacks, the waiting period for bypass surgery has grown to, say, over five months.

The neighboring region, Region B, on the other hand, has decided to dispense with the public health initiatives and has focused exclusively on offering better acute care programs. So it has devoted all of its funds to open operating rooms for bypass surgery. The result is that while the incidence of heart trouble is 10 percent higher than in Region A, the waiting period for surgery is less than half as long, say, at only two months.

The problem arises when someone who is suffering from heart trouble and requires bypass surgery but who resides in Region A learns that if he or she can somehow finagle an appointment with a specialist in Region B, he will get

his much needed treatment faster. This problem can occur in a wide number of areas of care and can make it exceedingly difficult for RHAs to plan for what programs they will fund.

These three examples illustrate some of the obstacles to inter-regional cooperation that might develop and demonstrate the ethical challenge RHAs will be forced to confront. RHAs, therefore, will have to work together, in some cases overcoming incentives to do just the opposite, in order to facilitate regionalization's success as a feasible health system scheme. This may be interpreted as the need for some central planning to coordinate the cooperation between Alberta's RHAs.

6. Ethics Education

From all of the areas of contention that have been identified in this chapter so far, it is fairly clear and uncontroversial to suggest that RHAs will need to develop a basic understanding of and become conversant with issues of ethical conflict and ethical problem solving. Specifically, board members will have to understand some of the fundamental ethical principles and concepts of resource allocation and be able to understand and evaluate various alternatives and deal with these concepts. Furthermore, they will have to be able to identify areas of ethical conflict and be able to develop solutions to deal with these.

In order to have the facility to engage in these types of ethical discourse and to direct their behaviour in a consistent and rational manner, RHAs will have to develop a set of values they are committed to (this can be done along

the lines of the procedural values argued for in a previous section) and a decision-making framework for helping to gather and assess the relevant information and values.

The question RHAs will face is that of the means by which they will develop these ethical tools. One solution is offered by the newly created regional bodies in charge of making health care decisions in Prince Edward Island.

As it developed its draft vision, mission and values statement and began to consider how to establish priorities for allocating its increasingly scarce resources, the Queens Region Board realized that it was dealing with ethical issues in which its members had relatively little proficiency. Accordingly, the board instructed its CEO to arrange a full-day ethics workshop in July 1995 to help it with these issues.²²⁵

So the solution the Prince Edward Island board adopted, at least initially, was to have ethical consultants brought in to conduct workshops wherein the board developed its basic values and a decision-making framework. There are a number of other options that RHAs can also pursue. For example, by developing ethics committees to help them with their work, by hiring a staff person or a consultant to carry out ethics education workshops and to provide support on an ongoing basis, or by setting up networks through which resources can be shared, RHAs may be able to address some of these concerns.

Apart from developing basic procedural values statements and decision-making frameworks, RHAs will also have an ongoing need for support to deal with challenging issues as they come along that might present ethical considerations not easy to understand. (This is not to suggest that RHAs need ethical support to make hard decisions for them. The RHAs must assume ultimate responsibility for their decisions. The ethics support can help to

²²⁵ Yeo, Williams and Hooper, 1996 p. 23

facilitate an understanding of some of the deeper ethical issues that various allocation problems may cause to arise.)

And, if the staff which usually carries out the RHAs decisions will be making decisions on its own, there will be a need for some degree of ethics education for them as well so as to ensure that their actions are in accord with the values of the committee and inappropriate means to achieve desired ends are not taken.

In addition, the RHAs must develop codes of conduct to set the terms of behaviour acceptable for both staff and members to ensure that individuals represent the appropriate interests they are meant to serve and not use their position of influence to achieve other goals.

The Provincial Health Ethics Network

Many of the problems that RHAs face fit more appropriately under the rubric of organizational ethics or the ethics of public institutions, rather than bioethics, *per se*.²²⁶ Consequently, support from experts in these fields may be more appropriate for RHAs in grappling with the structural issues raised in this chapter than experts in health ethics. However, in light of the fact that these organizations operate in the context of the health system, and that much of the tension they will face will involve the actual undertaking of ethical decision-making, there is also an important role for *health* ethicists in assisting RHAs. To this extent Alberta's Provincial Health Ethics Network (PHEN) may also be a

²²⁶ My thanks to Michael Burgess for bringing this concern to my attention.

very useful resource for RHAs.

The 1989 *Rainbow Report* recommended the establishment of an ethics centre in the province. This suggestion was supported in the 1991 document reviewing the Rainbow Report - *Partners in Health*. Consequently, in 1992 Alberta Health developed a discussion paper proposing a provincial health ethics network and invited input from three consultants involved in health ethics in the province. Then, in 1994, Alberta Health released a three-year business plan which established the Network as part of a strategy to achieve the goal of, "[increasing] individual accountability and public acceptance of responsibility for maintenance of their own health."²²⁷

PHEN officially began operations in 1996. Its mission is, "to facilitate examination, discussion and decision-making in respect to moral and ethical issues in health and health care."²²⁸ The network has identified four aims it wishes to accomplish. These are summarized in the four terms connection, coordination, education and dialogue. Therefore, the body has been created as a clearinghouse of information to facilitate the discussion of health ethics issues in the province. It is intended to serve administrators, healthcare providers and the general public.

Because of this broad mandate, there is much that PHEN has to offer RHA boards. In a recent article in PHEN's monthly news update *In Touch*, Board member and steering committee participant Michael King suggests, "Much has been done so far - PHEN has come a long way...[T]he Network has set up its offices, developed a core of excellent training modules for ethics education and discussion, delivered workshops and symposia around the province, and

²²⁷ Alberta Health, 1994a p. 11

²²⁸ Steering Committee for Phase II Planning, 1995 p. 5; King, 1998

started the process of linking people around Alberta for ethics discussion and consultation."²²⁹

So, from offering workshops on Corporate Ethics in Healthcare Resource Allocation to providing information on ethics resources (human and material) available in the, PHEN is designed to help meet the needs of its constituents - whatever these may be. This may involve PHEN's providing the requirements themselves or directing the bodies to where the resources can be found.

Although there are numerous other ethics resources in the province, RHAs have a direct and ready source to help direct and guide its ethics education. It is of course up to the RHAs to request help from this body. PHEN, again, is not designed to actually develop health policies or make healthcare decisions. However it is in very good position to provide direction on how this can be done and to guide at least initial thinking about ethics, health care and resource allocation in Alberta.

Motivation to Access Ethics Resources

The key to RHAs becoming sensitive to the wide array of ethical issues that face them will not be the availability of resources. Rather, of crucial importance is the RHAs' motivation to access these resources. If this step is taken, then many resources can become available. Unfortunately, however, it can take some exposure to formal ethical issues for this initial impetus to develop. This can result for an RHA in being blind to important ethical

²²⁹ King, 1998

problems until such time as that initial exposure takes place.

Therefore, what would be of enormous benefit is some kind of initial requirement by the provincial Ministry of Health that every RHA engage in some kind of explicit and formal ethics workshop to develop, at least initially, a basic set of procedural values and a decision-making procedure that is sensitive to the importance of the ethical aspects of the types of choices these bodies will have to make.

One recommendation that would help introduce PHEN and its services to the RHAs is for the Ministry of Health to mandate the RHAs to hire PHEN's services for a number of modules every year. This would ensure some degree of exposure and facilitate a step, albeit a very, very small one, to the recognition of the RHAs of the important ethical nature of an RHAs work.

Recommendations for RHAs

As must be evident by now, RHAs are forced to confront a number of very serious ethical tensions. In this chapter I have mainly focused on describing the nature of these dilemmas while offering little direction on how the RHAs ought to resolve them. I submit, though, that the key to addressing these tensions is to be found in the nature of ethics discussion that RHAs engage in.

Perhaps the main difficulty to be faced by these bodies is the tension between the utilitarian values embodied in the cost-conscious plans of the

provincial government and the more deontologic values of the federal government and, as I have argued earlier, of the national public.

The first step in dealing with this conflict must be in the identification of a set of procedural values such as Doyal has presented. This will help to make clear what the guiding values of each individual RHA are. These values must then be open to public scrutiny so that they are transparent to the public at all levels and are open to criticism. Furthermore, RHAS must facilitate dialogue and discussion about the appropriate values by which they ought to be guided.

However, even with the codification of a set of procedural values, RHAs will still be faced with questions of how to allocate scarce resources - except that the ethical issues behind these choices will hopefully be more evident and the various values being balanced will be clearer.

To help deal with the ethical dilemmas that persist I would offer four recommendations:

- 1) Because of the utilitarian climate wherein these decisions are made, particular attention must be paid by the RHAs to those individuals and groups whose voices might be easily subjugated in expressing their need for services.

- 2) Again, whatever decisions RHAs takes should be open to close public scrutiny such that the democratic machinery of our society may be activated and social values can be developed as this new operation of the health system unfolds.

- 3) Because many of the problems RHAs will face are affected by the provincial body responsible for the health system - the Ministry of Health - RHAs should make a concerted effort to be vocal in expressing the ethical

tensions they face and in lobbying for those individuals who are left inappropriately served by the present system.

4) Individual RHAs ought to see themselves as cogs in the wheel of the health system serving the provinces and strive to work together to effectively mould the system into a coherent whole making use of the advantages regionalization has to offer while making every effort to identify and address the problems inherent within their system. This will include challenging the provincial authority whenever it is required to ensure the interests of all stakeholders each RHAs represents are served.

Regional Health Authorities have a daunting task to be sure. But these bodies also occupy an essential and strategic place and have the potential to have a very positive effect on Alberta's health system.

Chapter VIII

Conclusions

Where does this analysis leave us? The first conclusion I must draw is that there is no a priori reason to believe that in order to meet the four requirements set out in the first part of this thesis a regionalized health system must be adopted. If a regionalized approach to overseeing the provision of health services is to be supported, then, it must be on the basis of evidence to suggest that such an approach achieves the desired goals of the health system in a manner that is superior to a centrally organized health system.

What arguments support such a conclusion? The strongest case in favour of a regionalized health system is based on the intuition that being located closer to individual socio-cultural communities will lead to a better understanding of the health needs of such communities. This increased sensitivity to the genuine needs of a community based upon an internal discussion of its vital goals instead of on any ostensibly objective understanding of health and disease will lead to the development of health services that are better able to meet these health needs. Once this set of services is identified, the regional community can then be involved in the decision-making of priorities among these services, keeping in view the fundamental Canadian value of fairness. In this way, the values of the regional public will truly direct the quantity and nature of health services available in the province. Thus, by supporting a regionalized health system conceived of in these terms, one would be supporting the values of self-determination and equal human worth in the most genuine way.

How compelling is this argument? Unfortunately for the proponent of this devolutionary approach, one must conclude that there are a number of serious challenges that it must address for it to be accepted. I have summarized four main types of concerns that the argument for regionalization will have to contend with:

1) Facilitating Needs Assessments and the Definition of Health and Disease by Different Socio-Cultural Communities

While I share the intuition that health boards operating at a level closer to individual socio-cultural communities will likely be more sensitive to the needs of these communities, it does not automatically follow that this sensitivity will be realized. One must first of all recognize the implicit assumption this argument makes that there exist a number of discrete socio-cultural groups scattered throughout the province. But this is not the case. That is, there exist various socio-cultural groups in numerous pockets of communities throughout Alberta. Attending to the discussion of needs within these communities would probably require a trans-regional approach that would likely be unworkable given Alberta's seventeen different RHAs.

Even if there did exist discrete pockets of socio-cultural groups within the province, and even if these groups did happen to fit nicely within the geographical boundaries of the RHAs, it still does not follow that the regionalized approach would automatically result in a sensitivity to the health needs of these communities. For this to be realized would require a critical change, a paradigm shift, in the intellectual framework used to understand health and disease by those in control of the decision-making, by the providers of care, and by the researchers involved with developing healthcare programs. In light of the almost exclusive focus in Alberta on fiscal restraint, it is doubtful that such a shift in thinking will be facilitated or take place under the present political leadership.

2) Public Participation and the Challenge of Egalitarian Ideals by Democracy

Regionalization is meant to increase the participation of the public in setting priorities within the health system. This, however, hinges upon both the ability of RHAs to develop a set of programs that meet the health needs of regional communities and the ability of RHAs to develop and respond to mechanisms to ensure that expressions of public values involve socially negotiated agreements between informed participants, free from coercive forces that are truly representative of the various communities within the respective regions.

Given the skepticism that has been cast over the possibility of successful needs assessments, and the stringent, almost impossible to achieve, standards of public involvement, there is good reason to doubt whether this objective can be achieved. But assume for the moment that these requirements can be met. Even then, a strong challenge faces the goal of increasing public participation in healthcare decision-making: the possible estrangement of marginalized groups within society that can result.

That is, while having the public decide what healthcare priorities ought to be may support democratic ideals, it could do so at the expense of another critically important value: fairness. Having healthcare priorities democratically determined runs the risk of leaving the needs of those in minority groups, be they socio-cultural communities or communities of sufferers, unaddressed. But as I have argued fairness demands that the health needs of all individuals be met equally based on the need, not upon any morally arbitrary criteria. And being a member of a minority group is as morally arbitrary as not being able to pay for services. Thus, a regionalized system that covets democratic ideals may offend the values of fairness leaving unattended the politically weak and the

voiceless.

3) It's a *Healthcare* System, Not a Health System

The third challenge, particular to Alberta's regionalized strategy, is that it is not a health system as I have been describing it in this summary, but a *healthcare* system. That is, by subsuming the area of public health within the mandates of RHAs, regionalization has forced the medicalization of some activities and left unaddressed, indeed unacknowledged in any serious way, the broader determinants of health. What has resulted is a system of healthcare services ready to attend to the healthcare needs of Albertans, but ill-equipped to do anything about factors beyond the healthcare system that not only affect the health of individuals, but that arguably have a greater impact on health than do healthcare services.

4) Questions of Motivation: Is the Primary Goal to Reduce Expenditure or to Develop a Better Health System?

What I have argued for in the first part of this thesis is the need for something of a radical shift in the way the health system is understood, if the health needs of Albertans, indeed Canadians, are to be met in accordance with new evidence about the nature of health, a more accurate understanding of how health and disease ought to be defined and with a commitment to liberal egalitarian ideals. For this paradigm shift to occur, a genuine commitment on the part of the leaders of the province and of the health system at large is essential.

In Alberta it has been evident that the commitment of the political leaders has been to the reduction in the cost of the healthcare system. The desire to enhance the healthcare system has been at best a secondary concern.

Consequently, efforts of RHAs, especially with provincially appointed board members, have been, and will likely continue to be, aimed at keeping the existing system going as well as possible. This will mean that the radical change I have suggested is required will likely go unrealized.

Can These Challenges be Met? What Would be Required?

In spite of this rather damning set of conclusions, I believe that there is much potential for a regionalized approach to addressing the health needs of Albertans. However, this potential can only be realized if important changes, some drastic, take place. The following is a list of some of the more significant changes that would be required:

- Perhaps the most important change would be required of the political leadership in Alberta. This would entail not only changes in spending on health, but a radical shift in thinking. Leaders would have to be the first ones to recognize the limits of a health system focused on the biomedical model, the need for attending to health issues in setting broader provincial policies beyond the health system, and the need to involve socio-cultural communities, not just geographical ones, in ascertaining the meanings of health and the the programs developed to care for health needs.

- Responsibility for those health services aimed at the broader population would have to be removed from the mandates of RHAs and restored to a central government body. This would be to ensure that the tasks charged to an RHA are within the RHAs scope of control, and to obviate the need for RHAs to have to compare the value of health promotion and illness prevention activities against more acute care-based services.

- Procedural values in decision-making, in particular, the transparency of values guiding decisions would have to be championed and inculcated into the

actions of all healthcare decision-making bodies, from the provincial Ministry of Health to RHAs, right through to individual healthcare providers.

- The number of regions would likely have to be reduced in order to address extra-regional concerns.

- RHA boards would have to be led through a strong program of education around the ethical issues involved in its operations, both in terms of organizational ethics and the ethics of health and health care.

- The value of public participation would have to be elaborated upon for the RHAs and set in the context of the greater value of meeting the health needs of all members of society equally, with priority given to those in greatest need. How public participation is to be fostered would also have to be articulated in more clear terms to ensure consistent and systematic representation.

- More attention would have to be given to the coordination of the various kinds of health services available, from acute care to long term care to care provided in the community to ensure that no gaps in the provision of care existed.

- All of these types of care, if deemed medically necessary, would have to be paid for from the public purse to ensure recipients of care were not discriminated against by any morally arbitrary criteria such as the ability to pay.

- Finally, extensive evaluations of the health system would have to be conducted to ensure that the objectives of the system were being met according to acceptable standards. These evaluations would have to be open to public scrutiny.

Final Thoughts

I have, I accept, attempted a very broad analysis in this thesis. One

consequence of this is that there are many areas I have either not been able to touch on at all, or have not addressed in as much detail as required. This is admittedly an important limitation of this work. Nevertheless, I believe that there is some merit in such broad analyses as this one. It is not always enough for us to examine our political structures and institutions for particular concerns. Rather, I submit, sometimes it is necessary to place them against the very broad landscape of the values of our society and to wonder about whether this is the kind of picture we want to support. I hope that I have made a small contribution in this regard.

References and Bibliography

Alberta, *Partners in Health. The Government of Alberta's Response to the Premier's Commission on Future Health Care for Albertans*. Edmonton: Alberta Health, 1991

Alberta, *Regional Health Authorities Act*. Edmonton: Queen's Printer, 1994

Alberta Health, *Health Care '97: A Guide to Health Care in Alberta*. Edmonton: Alberta Health, 1997

Alberta Health, *Understanding Alberta's Restructured Health System: Questions and Answers*. Edmonton: Alberta Health, 1997

Alberta Health, *Report on the Health of Albertans*. Edmonton: Alberta Health, 1996

Alberta Health, *Strengthening the Circle: What Aboriginal Albertans Say About Their Health*. Edmonton: Alberta Health, 1995

Alberta Health, *Healthy Albertans Living in a Healthy Alberta. A Three Year Business Plan*. Edmonton: Alberta Health, 1994

Alberta Health, *Getting Started, An Orientation for Regional Health Authorities*. Edmonton: Alberta Health, 1994

Alberta Health, *Health Goals for Alberta: Progress Report*. Edmonton: Alberta Health, 1993

Alberta Health, *Our Bill of Health. A Roundtable on Health*. Edmonton: Alberta Health, 1993

Alberta Health, *Summary of Roundtables on Health*. Edmonton: Alberta Health, 1993

Alberta Health Planning Secretariat, *Starting Points: Recommendations for Creating a More Accountable and Affordable Health System*. Edmonton: Health Planning Secretariat, 1993

Baker, Robert. "Rationing, Rhetoric and Rationality: A Review of the Health Care rationing Debate in America and Europe." In *Allocating Health Care Resources*. eds. James M. Humber and Robert F. Almeder, 55 - 84. Totowa,

New Jersey: Humana Press Inc., 1995

Bergum, Vangie. "Relational Ethics. What is it?" *In Touch - The Provincial Health Ethics Network* 1, 2 (1998)

Brown, Malcolm C. "Changes in Alberta's Medicare Financing Arrangements: Features and Problems." In *Efficiency Vs. Equality: Health Reform in Canada*. eds. M. Stingl and D. Wilson, 137 - 152. Halifax, Nova Scotia: Fernwood Publishing Co. Ltd. 1996

Buchanan, Allen. *Ethics, Efficiency and the Market*. Totowa, New Jersey: Rowman & Allanheld, 1985

Burgess, Michael M. "Health Care Reform: Whitewashing a Conflict Between Health Promotion and Treating Illness." In *Efficiency Vs. Equality: Health Reform in Canada*. eds. M. Stingl and D. Wilson, 153 - 162. Halifax, Nova Scotia: Fernwood Publishing Co. Ltd. 1996

Calabresi, G. and Philip Bobbitt. *Tragic Choices*. New York, NY: W. W. Norton and Co. Inc., 1978

Canada, *Report of the Royal Commission on Health Services*. (Commissioner E. Hall), Ottawa: Queen's Printer, 1964-65

Canadian Bar Association Task Force. *What's Law Got To Do With It? Health Care Reform In Canada*. Ottawa: Author, 1994

Capital Health, *Community Health Councils Terms of Reference*. Edmonton: Capital Health, 1995

Capital Health, *Annual Report 95/96*. Edmonton: Capital Health, 1996

Capital Health, Population Health and Research 1996. Prepared by P. Lightfoot, J. Edwards, N. Fraser-Lee, and C. Drixler. *Health Status in the Capital Region*.

Daniels, Norman. *Just Health Care*. Cambridge: Cambridge University Press, 1985

Di Marco, Meluccia M. and Janet L. Storch. "History of the Canadian Health Care System." In *The Canadian Health Care System*. ed. Donna Wilson, 5 - 16. Canada: Author, 1995

Douard, John. "Health Care Allocation: A Deflationary Account." In *Allocating Health Care Resources*. eds. James M. Humber and Robert F. Almeder, 121 - 144. Totowa, New Jersey: Humana Press Inc., 1995

Doyal, Len. "Needs, Rights and Equity: Moral Quality in Healthcare Rationing." *Quality in Health Care* 4 (1995); 273 - 283

Evans, Robert G. and Morris L. Barer and Theodore R. Marmor. *Why Are Some People Healthy and Others Not? The Determinants of Health of Populations*. Hawthorne, New York: Aldine De Gruyter 1994

Evans, Robert G. and Gregory L. Stoddart. "Producing Health, Consuming Health Care." *Soc. Sci. Med.* 31, 12 (1990); 1347 - 1363

Evans, Robert G. *Strained Mercy: The Economics of Canadian Health Care*. Toronto, Ontario: Butterworth & Co., 1984

Haselbach, Dieter "Difficulties of Cutting Public Health Expenditure: Health Reform in Germany and Canada." In *Efficiency Vs. Equality: Health Reform in Canada*. eds. M. Stigl and D. Wilson, 123 - 136. Halifax, Nova Scotia: Fernwood Publishing Co. Ltd. 1996

Health Canada. *Health Canada Outlook 1996-97 to 1998-99*. Ottawa: Minister of Supply and Services Canada, 1996

Health Canada. *National Health Expenditures in Canada, 1975-'93*. Ottawa: Minister of Supply and Services Canada, 1995

Katz, Michael L. and Harvey S. Rosen. *Microeconomics*. Burr Ridge, Illinois: Irwin, 1994

Kieser, Doris and Donna M. Wilson. "The Canadian Health Care System: Trends, Issues and Challenges." In *The Canadian Health Care System*. ed. Donna Wilson, 87 - 96. Canada: Author, 1995

King, Michael, "The Network. It's Out There." *In Touch - The Provincial Health Ethics Network* 1, 6 (1998)

Lomas, Jonathan and John Woods and Gerry Veenstra. "Devolving Authority for Health Care in Canada's Provinces: 1. An Introduction to the Issues." *Canadian Medical Association Journal*. 156,3 (1997); 371-7

Lomas, Jonathan and John Woods and Gerry Veenstra. "Devolving Authority for Health Care in Canada's Provinces: 2. Backgrounds, Resources and Activities of Board Members." *Canadian Medical Association Journal*. 156,4 (1997); 513-20

Lomas, Jonathan and John Woods and Gerry Veenstra. "Devolving Authority for Health Care in Canada's Provinces: 3. Motivations, Attitudes and Approaches of Board Members." *Canadian Medical Association Journal*. 156,5 (1997); 669-76

Lomas, Jonathan. "Devolving Authority for Health Care in Canada's Provinces: 4. Emerging Issues and Prospects." *Canadian Medical Association Journal*. 156,6 (1997); 817-23

Marchand, Robert and Jacques Durocher and Pierre Tousignant. "Assessing the Effects of Health Service Reform on Population Health: A New Role For the Public Health Directorate in Quebec." In *Efficiency Vs. Equality: Health Reform in Canada*. eds. M. Stingl and D. Wilson, 111-120. Halifax, Nova Scotia: Fernwood Publishing Co. Ltd. 1996

McDonald, Michael. "Health, Health Care and Culture: Diverse Meanings, Shared Agendas." In *A Cross-Cultural Dialogue on Health Care Ethics*. eds. H. Coward and P. Ratankul. Waterloo, Ontario: Wilfrid Laurier University Press, 1999 (forthcoming)

Mills, Anne. *Health System Decentralization: Concepts, Issues and Country Experience*. Geneva: World Health Organization, 1990

Munson, Ronald. *Intervention And Reflection: Basic Issues in Medical Ethics*. Belmont, California: Wadsworth Publishing Co., 1992

National Crime Prevention Council of Canada, *The Determinants of Health and Children*. Ottawa: Author, 1996

Northcott, Herbert C. "Paying For Health Care." In *The Canadian Health Care System*. ed. Donna Wilson, 53 - 64. Canada: Author, 1995

Nozick, R. *Anarchy State and Utopia*. New York: Basic Books, 1974

Powers, Madison. "Hypothetical Choice Approaches to Health Care Allocation." In *Allocating Health Care Resources*. eds. James M. Humber and Robert F. Almeder, 145 - 176. Totowa, New Jersey: Humana Press Inc., 1995

Premier's Commission on Future Health Care for Albertans. *The Rainbow Report Volume 1*. Toronto: Queen's Printer, 1989

Premier's Council on Health Strategy. *Local Decision-Making For Health and Social Services*. Toronto: Queen's Printer, 1991

Premier's Council on Health, Well-being and Social Justice. *Devolution and Decentralization of Health Care Systems*. Toronto: Author, 1993

Rawls, John. *A Theory of Justice*. Cambridge: Harvard University Press, 1971

Sher, George Ed. *Moral Philosophy, Selected Readings*. Orlando, Florida: Harcourt Brace Jovanovich, 1987

Steering Committee for Phase II Planning, *Proposal for a Provincial Health Ethics Network*. Edmonton: Provincial Health Ethics Network, 1995

Stingl, Michael. "Equality and Efficiency as Basic Social Goods." In *Efficiency Vs. Equality: Health Reform in Canada*. eds. M. Stingl and D. Wilson, 7-19. Halifax, Nova Scotia: Fernwood Publishing Co. Ltd. 1996

Storch, Janet. "Foundational Values in Canadian Health Care." In *Efficiency Vs. Equality: Health Reform in Canada*. eds. M. Stingl and D. Wilson, 21-26. Halifax, Nova Scotia: Fernwood Publishing Co. Ltd. 1996

Strauss, Anselm L. and Juliet Corbin. *Basics of Qualitative Research: Grounded Theory Procedures and Techniques*. Newbury Park, California: Sage Publications, Inc., 1990

Rawls, John. *A Theory of Justice*. Cambridge, MA: Harvard University Press, 1974

Taft, Kevin. *Shredding the Public Interest*. Edmonton: The University of Alberta Press, 1997

Truman, Corrine and Gregg Trueman. "The Determinants of Health." In *The Canadian Health Care System*. ed. Donna Wilson, 29 - 38. Canada: Author, 1995

Wilson, D. M. and Vangie Bergum, John Dossetor, Janet Ross Kerr. *The Place For Ethics In Decision Making In Health Care*. In Press

Wilson, Donna M. "Where Do We Go From Here? The 72 Billion Dollar Question." In *Efficiency Vs. Equality: Health Reform in Canada*. eds. M. Stingl and D. Wilson, 165 - 178. Halifax, Nova Scotia: Fernwood Publishing Co. Ltd. 1996

Wilson, Donna M., ed. *The Canadian Health Care System*. Canada: Author, 1995

Yeo, Michael, John R. Williams and Wayne Hooper. "Ethics For Regional Boards." *Leadership*. 5,4 (1996); 22 - 26

Yeo, Michael, "The Ethics of Public Participation." In *Efficiency Vs. Equality: Health Reform in Canada*. eds. M. Stingl and D. Wilson, 39 - 54. Halifax, Nova Scotia: Fernwood Publishing Co. Ltd. 1996