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LEGAL and ETHICAL CONSIDERATIONS of ALTERNATIVE HEALTH CARE DELIVERY SYSTEMS IN CANADA

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Legal And Ethical Considerations Of Alternative Health Care Delivery Systems In Canada

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The focus of health care reform is to contribute to better patient health and maintain an equitable access to the system while at the same time achieving a more effective and efficient use of increasingly scarce health care dollars. Due to budgetary and other restraints provincial governments are either spending less on health care or are looking to change the delivery and management of the health industry.

How the Canadian health care system responds to the challenges depends upon the interpretation of a number of factors. Three basic factors which are linked to any health care delivery system are financing, delivery and allocation of resources with the altering of one of these components affecting the others.

Has there developed a right to health care and if so, would this foreclose a curtailment of health care services? If there is no *right* to health care, can the courts or the *Charter of Rights and Freedoms* be used to protect the existing system? Is it possible for public interest groups, or others, to utilize judicial intervention to force a government, either at the provincial or federal level, to spend more on health care or change their health care policy? What if a patient is affected by decision affecting health care delivery, does this bring in civil liability?

This thesis will review these areas in an effort to understand, articulate and ascribe values to Canada's health care system and provide a legal and ethical analysis of alternative health care delivery systems.

Considérations juridiques et éthiques concernant la mise en place de nouveaux systèmes de soins de santé au Canada

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L'objectif principal de la réforme des soins de santé est d'améliorer la santé de la population tout en assurant un accès équitable au système et en utilisant de façon plus efficace et rentable des ressources financières de plus en plus rares. En raison de compressions budgétaires et d'autres restrictions, les gouvernements provinciaux attribuent moins de fonds aux soins de santé ou cherchent à modifier les méthodes de prestation et de gestion des services.

La façon dont le système canadien de soins de santé s'adaptera à ces changements dépend de l'interprétation d'un certain nombre de facteurs, dont les trois principaux dont le financement, la prestation des services et l'allocation des ressources. La modification de l'un de ces paramètres influe nécessairement sur les autres.

Le droit aux soins de santé est-il acquis? Dans l'affirmative, ce droit acquis doit-il empêcher les gouvernements de réduire les services médicaux? Si l'accès aux soins de santé n'est pas reconnu comme un droit, peut-on recourir aux tribunaux ou à la *Charte canadienne des droits et libertés* pour protéger le système en place? Est-il possible que des groupes d'intérêt public prennent des mesures judiciaires afin de forcer un gouvernement provincial ou le gouvernement fédéral à consacrer davantage de ressources aux soins de santé ou à changer ses politiques en matière de santé? La question de la responsabilité civile se pose-t-elle dans les cas où un malade est personnellement touché par une décision concernant la prestation des services?

Cette thèse examine ces questions dans le but de comprendre et de définir les valeurs que nous attribuons à notre système de soins de santé en plus de faire une analyse juridique et éthique des autres méthodes possibles de prestation de services de santé.

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Health care reform together with a comparison and examination of various health care delivery systems have recently become topical issues for politicians, journalists and the public. Many countries are reviewing how health care is delivered and what reforms can be implemented. These reforms look to contribute to better patient health and maintain an equitable access to the system while at the same time achieving a more effective and efficient use of increasingly scarce health care dollars. Canada is, therefore, not alone in its current reflection on medicare and the fixation by the politicians, the media, and the public on what the system was, what it is, and where it is going. In turn, academics, analysts and health care professionals in other countries are reviewing Canada's medicare system to analyze its benefits and drawbacks.

Within Canada virtually all provincial governments are looking at some sort of restructuring of how health care is delivered. Budgetary and other restraints are forcing the provincial governments to either spend less on health care or look to change the delivery and management of the health industry. Integration of health services; deinsuring procedures; devolution of health care authority; the possible evolution of a two-tiered system; managed care; managed competition, these are the current challenges of health care reform in Canada. In Ontario the traveling *Health Services Restructuring Commission* has put out a vision paper detailing how they see health care being delivered in Ontario. On a more practical basis they have also been holding hearings and announcing the closure of hospitals and the forced merger of others.

The federal government, while stating its desire to maintain the current system, is simultaneously reducing the percentage of funds it commits to the provinces to fund health care. To address concerns about the health care system the federal government, after the 1993 election, commissioned the *National Forum on Health*. In 1996 the *Forum* released their report which stressed that the health care system was fundamentally sound.

Despite this rhetoric, governments appear to put a greater priority on balancing budgets than on health care. All this is taking place against a backdrop of the general

public who fear that their health care system is falling apart, yet who wish to maintain the current system and level of service.[1]

In order to understand the legal and ethical considerations of health care delivery and any potential reform, one must understand what is in place and how it developed. In addition, for successful health care reform the issues must be understood and articulated while societal values must be ascribed and debated. What must be reviewed are the effects, ethics, liabilities and other considerations of health care delivery reform at the macro level (government decisions), meso level (hospitals, administrators) and micro levels (between health care provider and patient). However, it must also keep in mind that health care is an issue that touches all citizens and at times defies political logic. Despite the desire to cut health budgets, and the cutting of the budgets, politicians remain sensitive to the mood of the country and will echo that the medicare system is sacrosanct.[2]

With such an emphasis and importance on health care one may question whether there has developed a right to health care. If so, would this foreclose a curtailment of health care services? If there is no *right* to health care, can the courts or the *Charter of Rights and Freedoms* be used to protect the existing system? Furthermore, can the Charter play a role in protecting the existing system? Is it possible for public interest groups, or others, to utilize judicial intervention to force a government, either at the provincial or federal level, to spend more on health care or change their health care policy? What of other legal remedies; would a reduction in spending at the macro level, which affects decisions at the micro level, import civil liability if a patient suffers. If so, who would be responsible - the doctor who must practice within the constraints of the

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[1]Michael Posner 'Feeling the pinch' *Maclean's Magazine* December 2, 1996 pp. 44-47.
[2]Recall the 1988 Canadian federal election and the assertion by the Liberal party that the Free Trade Agreement that the Mulroney Progressive Conservative government had entered and on which the election was principally fought, would threaten medicare. The Conservatives responded to this preceived threat with rhetoric similar to the Liberals. The recent 1997 federal election, while less dramatic, had all major parties expressing their committment to the sanctity of the health care system with health care as a corner stone of all campaigns.

decisions made at the meso and macro levels, or those who are responsible for the decisions?

In this study of the Canadian health care system, I propose to begin by examining its roots. For, as indicated earlier, to understand where the health care system is going one must understand what is in place and how it was attained. The *Canada Health Act (CHA)* currently sets the federal government's standards for federal funding for health care. By briefly tracing the history of the *CHA* I will show how the system has come into existence and the reasons why conflict is beginning to develop between the provinces and the federal government over where Canada's health care system is heading.

The second part of this thesis will examine the issues of whether there is an ethical or legal right to health care. While acknowledging that this topic in itself is complex and diverse, I propose to simply examine the topic on a broad scale to determine whether ethical considerations or legal arguments can be made to assist in examining the health care system.

Next, the pressures on the system will be reviewed and the various alternatives will be examined. Some have suggested that Canada needs an overhaul of its health care system while others, such as the *National Forum on Health*, have indicated that the system is fundamentally sound. How the Canadian health care system responds to the pressures depends upon the interpretation of a number of factors. Three basic factors which are linked to any health care delivery system are financing, delivery and allocation of resources. It must be understood that the altering of one of these components will affect the others. These three basic factors are therefore inextricably bound to any consideration of a health care delivery system.

Another set of factors which will affect the system's response involves expectations of the public and of the health care providers, which are both convergent and divergent depending on the circumstances. Similarly, the pressures both within and external to the health care system must be heeded. These include issues such as: cost

control; the aging population; technological expansion; questions of expansion and contraction of human resources; and, the effectiveness and efficiency of the delivery systems themselves.

A final factor is the question of health care delivery in its traditional sense versus the delivery of health promotion to reduce the overall cost of the system.

In response to these factors, pressures and considerations alternative ways of delivery, management, allocation and financing of health care will be examined.

The forth part of this thesis will review the legal implications of decisions involving the financing, delivery and allocation of health care resources. By reviewing past legal precedents together with the potential role of the Charter, administrative law and the civil tort system in any legal challenge, an understanding will be gained as to how the legal system can intervene in one of two ways. The judicial system can either resolve differences between patients and the health care profession or it can review the provision of health care services to ensure that their provision is fair and equitable.

Finally, following an understanding, articulating and ascribing of values to Canada's health care system, an argument will be made that Canada's health care system will continue to be respected by those who use it, provide it and study it in other parts of the world.

PART 1 - THE CANADIAN HEALTH CARE SYSTEM

i) Overview - Pre Canada Health Act

The Canadian health care system, like any other mechanism that is in place to regulate dealings between members of society, has evolved over time. In 1867 health care was not a priority of government. In ascribing powers to either the federal or provincial levels, the drafters of the *British North America Act* put "The establishment, maintenance and management of hospitals, asylums, charities and eleemosynary institutions in and for the province, other than marine hospitals" in the hands of the provinces.[3] The federal government was given jurisdiction over quarantine and marine hospitals.[4] Thus health care *per se* was not delineated but was accepted as primarily a provincial responsibility with the current system beginning to develop after the second world war.

Others have written on the development of the Canadian health care system and its history will only be briefly touched upon.[5] Two basic points will be stated prior to a brief recital of the history of health care legislation in Canada. The first is that the *Canada Health Act* was essentially built upon earlier federal acts which had laid its philosophical ground work. Secondly, as the Canadian system has developed it can be seen as a public system in payment and a private system in health care delivery. It is a private system in delivery in the sense that the patient and the physician both have a choice in whom they attend for medical services and who they accept. However, it is a public system in payment in that physicians and hospitals are paid from the public purse for those medical services that are covered under health insurance legislation.

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[3]*Constitution Act, 1867*, s 92(7).
[4]*Ibid.*, s. 91(11).
[5]See for example a good brief summary in The Canadian Bar Association Task Force Report *What's Law Got To Do With It? Health Care Reform in Canada* (Ottawa: The Canadian Bar Association, 1994) pp. 2-19 and John K. Iglehart, "Health Policy Report: Canada's Health Care System" *N Engl J Med* 1986;315(3):202 at p. 206. A detailed history of health insurance in Canada is contained in Donald Swartz. "The Politics of Reform: Public Health Insurance in Canada" *International Journal of Health Services* 1993;23(2):219-238.

In 1957 the federal government passed the *Hospital Insurance and Diagnostic Services Act.*[6] This *Act* was the first legislative attempt by the federal government to use a funding act to promote a national agenda in health care. As the name implies, this *Act* set up a system whereby the federal government would share the costs of hospital care and diagnostic services with any province in which all the residents of the province were eligible. As compared to later acts, the *Hospital Insurance and Diagnostic Services Act* focused more on the quality of care and on the availability and effective utilization of resources. It was also an attempt to establish and maintain services and resources.[7]

The next step occurred in Saskatchewan[8] when in 1961 the reelected Cooperative Commonwealth Federation (CCF) government passed their controversial *Medical Care Insurance Act.* Earlier, in 1959, the government had indicated they would be introducing a medical care insurance program. The physicians of Saskatchewan and the College of Physicians and Surgeons opposed the idea and the election of 1960 was fought principally on this issue. After the passage of the *Medical Care Insurance Act.* there ensued a strike by the physicians of the province which lasted 23 days. The strike was settled when an agreement was reached whereby the physicians could choose one of four options with respect to participating in the medical care insurance.[9]

While the provincial governments were implementing health care insurance the federal government appointed a Royal Commission to study the issue of medical care insurance. The commission was headed by Justice Emmett Hall who heard submissions and conducted hearings from 1961 through to the production of the commission's report in 1964.[10] The commission found that approximately 60% of Canadians had some form

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[6]5-6 Eliz.II, c. 28.
[7]C.P. Shah. *Public Health and Preventive Medicine in Canada 2nd Ed.* (Toronto: University of Toronto Press, 1990) p. 78.
[8]As had the first, when in 1947 the Saskatchewan government was the first jurisdiction to introduce universal hospital insurance.
[9]Malcolm G. Taylor. *Health Insurance and Canadian Public Policy, 2nd ed.* (Kingston and Montreal: McGill-Queen's University Press, 1987) p. 324.
[10]Canada. *Report of The Royal Commission on Health Services* (Ottawa: Queen's Printer, 1964-65).

of medical insurance coverage, but that approximately 30% of this coverage was inadequate.[11] In the report the Commission noted:

> ...the field of health services illustrates, perhaps better than any other, the paradox of our age, which is, of course, the enormous gap between our scientific knowledge and skills on the one hand, and our organizational and financial arrangements to apply them to the needs of men on the other.
>
> What the Commission recommends is that in Canada this gap be closed, 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 toward this objective.[12]

After the production of the Royal Commission Report, the federal government introduced the *Medical Care Act* in 1966.[13] This again was a funding act with funding tied to provisions which affected how health care was delivered. Under the *Medical Care Act*, the federal government would pay 50% of the medical care costs incurred by the province so long as four criteria were met. These four points would later be repeated in the *Canada Health Act* and required that the plan be publicly administered, comprehensive, universal, and portable. These four criteria, while providing the federal government with some control over how the various provincial health care systems were enacted, nevertheless did provide the provinces with enough flexibility to determine how they would finance and manage their individual plans. Financing varied from premiums to sales taxes. The meanings for these terms will be discussed subsequently when the *CHA* is reviewed.

During the 1970's problems began to appear in the operation of the health care system and, in particular, the financing provided to the provinces. The federal government's contributions were open-ended in that they paid for half of the cost of insured hospital and medical care costs. This was expensive for the federal government and in many ways unpredictable and therefore hindered federal planning.

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[11] *Id.*
[12] *Id.*
[13] 14-15 Eliz.II, c. 64.

Correspondingly, the provinces found the system to be inflexible and it restricted their ability to develop alternatives to the standard method of health care delivery as the federal money was tied to the use of traditional hospitals.[14] In order to remedy these problems a new financing agreement was reached in December 1976 at a first ministers conference. In March of 1977 the *Federal-Provincial Fiscal Arrangements and Established Programs Financing Act, 1977*[15] was enacted. This *Act* set block funding amounts to the provinces for established programs such as hospital insurance and medical care. This money was no longer tied to the actual services used by the provinces, but rather was a fixed amount based on the province's population and it consisted of block cash grants and a transfer of personal and corporate tax points to the provinces. In essence, this new financing arrangement linked the federal contribution to the provincial health insurance plans to the annual growth of the gross national product. If the economy grew slower than the provinces' share of health care costs, then the provinces would be forced to absorb the difference.

Under this new financing arrangement the federal money was still theoretically subject to the four criteria that had applied to the *Medical Care Act.* However the provinces found that during the late 1970's and early 1980's health care costs had increased faster than the gross national product which, led to the provinces introducing cost containment measures. These included hospital bed closures and a reduction or restriction in the fees paid to physicians for the services they performed. The response of the medical profession was to "extra-bill" their patients directly for medical services performed. In addition, hospitals and other institutions implemented "user-fees" for the facilities which were utilized. This, in turn, led to charges by the public and public interest groups that the system was failing and that it had to be reviewed. The response of the federal government was the appointment of another commission to again review

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[14]Shah, *supra.*, note 7 at p. 79.
[15]25-26 Eliz.II, c.10.

Canada's health care system. Again Justice Emmett Hall was appointed a commissioner.[16]

In his report Justice Hall focused on the issue of accessibility of the Canadian public to the health care system. The report concluded that access to the health care services and the uniformity of Canada's health care system were being threatened by extra-billing and the implementation of user-fees. It was therefore recommended that these practices be banned and that physician's fees be set by negotiation with binding arbitration, if necessary, between the various provincial governments and their respective medical associations. In addition, if a physician wished to bill their patients directly, then they would have to opt out entirely of the provincial health insurance program.[17]

The response of the government was the tabling of the *Canada Health Act.* in 1984.

ii) Canada Health Act and Beyond

The *Canada Health Act* (*CHA*)[18] replaced both the 1957 *Hospital Insurance and Diagnostic Services Act* and the 1966 *Medical Care Act.* Although the *CHA* consolidated these two acts, it also went beyond them. It included the four criteria of the *Medical Care Act* and added a fifth: accessibility. It also provided explicitly that "extra-billing" and "user-fees" would be banned by indicating that funding to the province would be reduced by the amount either extra billed or charged in user fees.[19]

Turning specifically to the *CHA*, the preamble and section 4 set out the intent and purpose of the *Act.* The preamble states in part: "...that continued access to quality health care without financial or other barriers will be critical to maintaining and improving the health and well-being of Canadians"[20] In addition section 4 states:

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[16]Shah, *supra.*, note 7 at p. 80.
[17]Emmett Hall. *Canada's National-Provincial Helath Program For The 1980's "A Commitment For Renewal"* (Ottawa: Health And Welfare Canada, 1980).
[18]R.S.C. 1985 c.C-6.
[19]*Ibid.*, ss.18 and 19.
[20]*Id.*

> The purpose of this Act is to establish criteria and conditions that must be met before full payment may be made under the Act of 1977 in respect of insured health services and extended health care services provided under provincial law.[21]

Sections 7 through 12 of the *Act* set out the five program criteria that each provincial health insurance plan must meet in order to qualify for funding. The five criteria are:

i) public administration;
ii) comprehensiveness;
iii) universality;
iv) portability; and,
v) accessibility.

i) Publicly Administration. The requirement criterion for a publicly administered system ensures administration on a non-profit basis by a public authority that is accountable to the provincial government.[22] This provision has never generated much debate as it has been one of the cornerstones of the Canadian health insurance system since its inception. In addition, when the insurance system was first put in place, the private insurers were relatively undeveloped in this area so there was little opposition or competition. As it turns out, it is the cost of the administration of the health care insurance business in the United States which accounts for much of the escalation of the cost of health care.[23]

ii) Comprehensiveness. Comprehensiveness requires that: "...the health care insurance plan of a province must insure all insured health services provided by hospitals, medical practitioners or dentists, and where the law of the province so permits, similar or additional services rendered by other health care practitioners."[24] The key to understanding both this section and one of the developing problems of the health care system is contained in the term "insured health services". This is defined in section 2 of

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[21] *Ibid.*, s. 4.
[22] *Ibid.*, s. 8.
[23] Robert G. Evans, "The Canadian Health-Care Financing and Delivery System: Its Experience and Lessons for Other Nations" *Yale Law & Policy Review* 1992;10:362 at p. 377-379.
[24] *Canada Health Act, supra.*, note 18 at s. 9.

the *Act* and includes "hospital services", "physician services" and "surgical-dental services", "hospital services" are also defined. It incorporates those services provided to both in-patients and out-patients, "if the services are *medically necessary* for the purpose of maintaining health, preventing disease or diagnosing or treating an injury, illness or disease" (emphasis mine) and includes accommodations and meals, nursing services, diagnostic procedures, drugs and the use of various hospital facilities.[25] Physician services are simply defined as "any *medically required* services rendered by medical practitioners."[26](emphasis mine)

Nowhere in the *Act,* or currently in any provincial legislation, are the terms *medically necessary* or *medically required* defined.[27] It could be argued that many of the procedures that are performed by physicians or admissions to hospital may not meet this criteria. However the practice has been that if a physician orders the treatment or admission, and the patient accepts it, then it is medically necessary or required. Looking at the routine flu shot provides a good example of the application of this definition and specter of the problem to which it may lead. In most jurisdictions influenza vaccines are free for the elderly or other designated high risk groups on the grounds that they are medically necessary. However those that do not meet this arbitrary criteria are required to pay for the inoculation. Flu shots are a small example, but what if the procedure was more costly or involved a higher risk/benefit ratio, ie; a non-experimental surgical procedure, chemotherapy or other treatment? To the patient the services may be medically necessary or required but they have no say in having them defined as such.

Another example can occur where the province "deinsures" a procedure which it believes (presumably based on medical advice) has no demonstrable health benefit. In these cases the patient would be required to pay for the treatment as it was not medically

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[25]*Ibid.*, s. 2.
[26]*Id.*
[27]It is interesting that in the English version of the *CHA* the terms, *medically necessary* and *medically required* are used as indicated. In the French version of the act, only one term is used in both places *médicalement nécessaires*, therefore it can be assumed that there is no real difference in the terms.

necessary or required. Deinsurance has been applied to a number of treatments over the past 10 years. A few examples are routine neonatal circumcision and elective cosmetic surgery.

iii) Universality. Universality has likewise been one of the key reasons for the universal health care system. All residents of Canada should be covered by health insurance. However when the first legislation was enacted for hospital and then medical insurance programs the criteria allowed for 5% of residents to be without coverage. This was to decrease over time and now the *CHA* provides that 100% of the insured persons in a province must be covered by the provincial insurance program on uniform terms and conditions.[28] Insured persons are defined in section 2 to exclude members of the Canadian forces, members of the RCMP who have rank or a person serving time in a penitentiary. There also is an allowance for a residence requirement prior to eligibility for, or entitlement to, insured health services. The minimum period of residency or waiting period shall not exceed three months

iv) Portability. This last point regarding universality relates to the criterion of portability. Portability means that Canadians will be covered for insured services by their home province regardless of where they receive medical treatment. In addition, provinces can not impose a waiting period or minimum period of residency longer than three months before the person is covered by that province's health insurance. Despite the fact that the portability criterion appears straightforward, it has had problems, although these have been mostly political and relate to payments between provinces for services rendered to an insured in another province.

A second area is one of Canadians receiving medical treatment outside of Canada. Many Canadians spend winters in the southern United States, and recently several provinces indicated that they would cap the amount they would provide for medical services rendered to these individuals. This would mean that these Canadians would be

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[28] *Ibid.*, s. 10.

required to either obtain additional private medical insurance or pay for the additional amounts from their own funds

A third, more visible, issue of portability and coverage occurs where a particular medical procedure is either more readily available in the United States or is unavailable in Canada. Upon closer examination this issue is due to the nature of funding to the hospitals rather than a real question of portability. Hospitals are funded, not on the basis of particular items of service utilized, but rather on the basis of an annual global budget which pays for all staff (including salaried physicians, other health care professionals, orderlies etc.) and the costs of equipment and supplies. These global budgets are to cover operating costs only. For the purchase of new equipment or technology, the hospital must obtain approval, but then the day-to-day operation of the new equipment and the personnel to both service and operate it must come from the global budget. Therefore there is a limitation built into the Canadian system to limit the services provided by hospitals. In the United States the facilities and technology are not so limited. Consequently, there generally is a surplus of beds and facilities in the United States to which some Canadian physicians will recommend their Canadian patients. If the Canadian patient then goes to the United States for treatment, either to avoid the wait in Canada or to receive the unavailable treatment, then they will have to pay directly those amounts beyond those covered by their home province's plan. In the case of unavailable treatment, there often is media and political pressure to provide full payment. But for those who attend in the United States simply to avoid the wait and who can afford the additional cost, a two tier medical system is developing.[29]

v) Accessibility. Accessibility was the criterion added to the *CHA* and, as was noted above, this was in response to the perception that the Canadian health care system was developing problems of accessibility to some Canadians. Accessibility is set out in the *Canada Health Act* as follows:

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[29]Evans, *supra.*, note 23 at p. 370 and 376.

> **12.** (1) In order to satisfy the criterion respecting accessibility, the health care insurance plan of a province:
>
> (a) must provide for insured health services on uniform terms and conditions and on a basis that does not impede or preclude, either directly or indirectly whether by charges made to insured persons or otherwise, reasonable access to those services by insured persons;
> (b) must provide for payment for insured health services in accordance with a tariff or system of payment authorized by the law of the province;
> (c) must provide for reasonable compensation for all insured health services rendered by medical practitioners or dentists; and
> (d) must provide for the payment of amounts to hospitals, including hospitals owned or operated by Canada, in respect of the cost of insured health services.[30]

Later, in sections 18 and 19, the legislation specifically outlaws extra-billing and user fees. Section 20 then prescribes the penalty in the form of deductions in cash contributions to the province equal to the amount determined to have been extra billed or applied in user fees.

Whether the imposition of these sections has in fact improved 'access' in the broader sense to health care must be examined. Robert Evans in an article in the *Yale Law & Policy Review* entitled "The Canadian Health Care Financing and Delivery System: Its Experience and Lessons for Other Nations" begins his discussion regarding accessibility by asking two questions relating to extra billing and user fees. He states:

> Do direct charges to patients impede access to needed care and violate the principle? And do attempts to moderate the expansion of beds and technology constitute a form of "rationing" which effectively does the same, even if care is "free?" To date, the short answers given by Canadian opinion and practice to these questions are, "Yes," and "Not necessarily."[31]

Accessibility, as indicated, is composed of both a technological component and what can be called a human component. The technological element can be seen to include the physical structures of hospitals and the equipment that is now part and parcel of health care. In terms of hospital bed usage, Canada is known to have a relatively large

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[30]*Canada Health Act. supra.*, note 18 at s. 12.
[31]Evans, *supra.*, note 23 at p. 373.

supply with 6.75 public general hospital beds per thousand people, two thirds in short-term units and one third in long-term units or extended care hospitals. [32] These rates are above corresponding American averages. In recent years there has been a push in public policy to achieve shorter stays in hospital and reduce the corresponding use of the hospitals.[33] As for the technology side, as indicated above, the restraint imposed on hospital budgets has curtailed the expansion of technology in health care, relative to the United States.

However, despite these restraints imposed on the non-human side of accessibility, the human side has continued to expand. The increase in the supply of physicians together with patient demand for newer, and presumably better, technology has caused a perceived decline in accessibility. In almost all cases physicians are paid by the provincial health insurance plans on a fee for service basis, which means that it is in the physician's self interest to see as many patients as she can and, in the case of specialties, to utilize technology that is publicly funded. Thus there is pressure to expand the system, and the lack of expansion is seen by many to be a cutback, when in fact Canada is second only to the United States in terms of health care expenditure compared to other OECD (Organization of Economic Coordination and Development) States.[34]

As Evans succinctly puts it in his aforementioned paper:

> It is generally agreed that "access" means, not the provision of all services imaginable, for everyone, but rather services according to need. The political struggle is then over the processes by which need is to be defined. To the medical profession, need is whatever a physician says it is. If that requires more, and more costly, services then so be it. Someone - the government, the patient, the rest of the community - should raise the necessary funds. Governments, on the other hand, are arguing increasingly that the test of necessity is the demonstrable effect of intervention on health outcomes (effectiveness) not merely a physician's opinion, professional or otherwise. Furthermore, they are becoming increasingly aware of the large and growing body of research evidence which indicates that there is often little or no connection between the

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[32] *Ibid.*, p.374.
[33] *Id.*
[34] *Ibid.*, p. 375.

physician's opinion, and the demonstrated effectiveness (or lack of it) of the services provided.[35]

iii) Conclusion

The *CHA* has been in place now for approximately 14 years. The provisions regarding extra-billing and user fees were eventually instituted across the country within the time frame provided in the *Act*, despite intense opposition from physicians. For example, in Ontario physicians went on strike for 25 days in June and July 1986 in opposition to the provincial government's legislation prohibiting extra-billing and user fees. Additional teeth were put in the federal government's ability to control provincial health care policy in 1991 when it was evident that, because of the reduction of the percentage of federal contributions to health care, the provinces were attempting to restructure their health care delivery. The *Budget Implementation Act*[36] of 1991 entitled the federal government to withhold or deduct from a province that did not comply with the provisions of the *Canada Health Act* any federal cash payment under any act, arrangement or agreement, thereby ensuring compliance with the federal government's view of how Canada's health care system should operate by tying the *CHA* to every federal cent that is paid to the provinces.[37] After 14 years the question can be asked: Is it time to change the *Canada Health Act* or are the perceived deficiencies not sufficient to warrant alterations?

To answer this question perhaps the *CHA* should be rethought, as the *Act* may not correspond to the circumstances of today. It should be remembered that the *Canada Health Act* is not sacrosanct. It was, and is, an Act of Parliament and can be repealed or changed if the circumstances warrant. It would seem that the federal government's adherence to the *CHA*, as if it were written in stone, may be part of the problem. The five pillars of the *CHA* all are being changed by the practicalities of today's world, yet there is

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[35]*Id.*
[36]40 Eliz., c. 51.
[37]Canadian Bar Association, *supra.*, note 5 at p. 12-13.

no debate on what is happening because the government is refusing to talk about changes. This is similar to the conclusions of the Canadian Bar Association in their task report on Canada's health care system and its reformation.[38]

In response, the government of Jean Chrétien has pledged that Canada's health care system will not be allowed to become a two tier system whereby those that have the financial means will receive a different level of health care than those that do not.[39] However, the Prime Minister has said that the current level of spending by Canada as a whole on health care as a percentage of the GDP will have to be reduced. How this is to be achieved has not been specified.

Where then are we to go? Is there an inherent or emergent right to health care in ethics or law that legitimates the federal government's stance?

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[38]*Id.* See recommendations for a summary at page 115-118.
[39]See for example Scott Feschuk "PM rejects Klein's medicare ideas" Globe & Mail; April 14, 1995 p. A1.

PART 2 - IS THERE A RIGHT TO HEALTH CARE?

Why is there a need for an argument that there is a 'right' to health care? Determining that there is a right to health care, whether it be grounded in ethics, morality or law, will not define how the system will be set up or operate and, in practical reality, will not guarantee good 'health' to all members of society. Correspondingly, if it cannot be shown that there is a 'right to health care', then the collective will to provide some sort of health care plan for those who are the most in need will not likely disappear. So why then has so much been written about a 'right to health care'? Simply stated, it is due to a perceived need by many in our society to ensure that all have access to health care by advocating that a 'right' to it exists. On a more fundamental level, it is because of the place that "health", in its broadest sense, has in our society.

Health and health care are components of a larger framework. There are two basic tenants to a discussion of health. Firstly, the need for health to be a productive member of society and to live life would not be denied by anyone. Similarly, there is no argument that there is a need for basic health care by all. The fundamental difficulty in this area is determining what is meant by the terms 'health' and 'right'. The word 'health' is a simple word and used often in many contexts. The problem in this context is twofold:

a) how is it defined in the area of health care; and,
b) what level of access is needed with a corresponding level of service.

With respect to defining the term 'right', the issue is whether there is a moral consensus about how the need by one person for health care creates an obligation on the part of another to provide the needed service.[40]

As for the ethics of this debate, again there are a number of arguments that can be presented. It is not my intention to produce a summary of the arguments or a survey of

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[40]Thomas J. Bole, III., "The Rhetoric of Rights and Justice in Health Care" in Thomas J. Bole, III and William B. Bondeson Eds., *Rights to Health Care* (Dordrecht, The Netherlands: Kluwer Academic Publishers, 1991) p. 1.

ethical theories. What I do intend to do is to identify the ethical principles that apply in any ethical analysis and some of the leading philosophical bases.

Moral or ethical rights are grounded in moral theories. Generally a moral theory of health care would involve the concept of duties. Philosophers such as Immanuel Kant, W.D. Ross and John Rawls have postulated theories that are intended to articulate and justify duties and principles that can be used as guidelines for actions and decisions taken by those in society as well as principles to guide society.[41] Moral or ethical theories do not have the force of law, nor are they universally accepted. Their purpose is as a point of departure for legal application or for philosophical discussion.

The principles which are used in ethical analysis apply to a discussion of a right to health care for they are used in conjunction with the broader moral theories and allow for standards to be applied in a variety of situations. The four principles are: beneficence, nonmaleficence, justice and autonomy.[42]

i) Primary Considerations

a) Health

Before entering the discussion regarding a right to health care, consideration must be given to what is meant by the term 'health care'. Within this term it must be determined what is to be considered by the word 'health'.

Health and health care, as was evidenced by the preceding section on health care in Canada, are a major concern of both federal and provincial governments. The amount of money spent on health care by both governments and individuals is enormous. In 1994 $72.5 billion was spent on health.[43] This does not take into account the amount spent on ancillary elements of health care, such as, the education of physicians and other

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[41]Ronald Munson *Intervention and Reflection Basic Issues in Medical Ethics 4th Ed.* (Belmont Cal.: Wadsworth Publishing Company, 1992) p. 2.
[42]See *infra.*, pp. 24-26.
[43]*National Health Expenditures in Canada 1975-1994* (Ottawa: Health and Welfare Canada).

health care professionals. Health and health care, as social goods, are seen as important elements in the development of society.

How is health defined influences the way health care dollars are utilized. In their article entitled, "Producing Health, Consuming Health Care", Robert Evans and Gregory Stoddart discuss this concept. Typically, health has been defined by the people and institutions involved in the provision of health care to be the "absence of disease".[44]

However this definition is at odds with that of the World Health Organization (WHO) which defined 'health' years ago as follows: "*Health is a state of complete physical, mental, and social well-being, and not merely the absence of disease or injury*".[45] A right to health care which incorporates this broad definition of health would look at the socioeconomic factors that influence disease as well as the disease state itself. Therefore, health policy would correspondingly encompass many other aspects aside from strictly medical or medically related areas. Furthermore, it would be considered self-evident that there are factors outside of 'medicine' which affect health and these are often not reflected in health care policy.

Generally the concept of a right to health care does not utilize such a broad definition. However in 1974 the then Minister of Health, Marc Lalonde, authorized a report on the health of Canadians in which an acknowledgment of the broader determinants of health was articulated. *A New Perspective on the Health of Canadians*[46] acknowledged that lifestyle, environment and human biology all play a part in the health of Canadians. However, despite this endorsement, Canadian health care policy *per se* still involves principally the treatment of disease from a medical sense rather than the amelioration of the societal causes of disease.

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[44]Robert G. Evans, Gregory L. Stoddart, "Producing Health, Consuming Health Care" *Soc. Sci. Med.* 1990;31(12):1347-1363 at p. 1347.
[45]*Id.*
[46]Marc Lalonde. *A New Perspective on the Health of Canadians: A Working Document.* (Ottawa:Minister of Supply and Services Canada, 1974).

Thus health in the context of the debate regarding the right to health care usually focuses on the physical aspects. These physical aspects are both literal and figurative: firstly, physical health - the absence of disease; and secondly, those infrastructures that provide for physical health - a health care industry which is composed of both health care professionals and structures such as hospitals.

In addition, because of the breadth and implications of health care policy, there are both macro and micro policy implications to any consideration of health care issues. These macro and micro policy decisions are not strictly limited to considerations of health expenditures and questions of equity and access, but due to the implications of these issues, they are the primary focus.[47] The macro issues generally are concerned with the allocation of resources to health care as compared with other areas such as education, national defense, infrastructures (e.g.. roads or sewers) or police and fire protection. The micro considerations are essentially more individualistic for they deal with the individual's share of the total allocation of health care resources.[48]

b) Rights

The next preliminary consideration is the definition of the word 'right'. The concept of a 'right' brings into question an entire gambit of implications and applications. As a legal and political term, *Black's Law Dictionary* includes the following in the definition of 'right':

> As a noun, and taken in an *abstract* sense, means justice, ethical correctness, or consonance with the rules of law or the principals of morals. In this signification it answers to one meaning of the Latin *jus*, and serves to indicate law in the abstract, considered as the foundation of all rights, or the complex of underlying moral principles which impart the character of justice to all positive law, or give it an ethical content. As a noun, and taken in a *concrete* sense, a power, privilege, faculty, or demand, inherent in one person and incident upon another. Rights are defined generally as "powers of free action". And the primal rights

[47]Rashi Fein, "Entitlement to Health Services Reappraised" *Bull. N.Y. Acad. Med.* July-Aug 1990;66(4):319-328 at p. 320-321.
[48]*Id.*

> pertaining to men are enjoyed by human beings purely as such, being grounded in personality, and existing antecedently to their recognition by positive law. But leaving the abstract moral sphere, and giving to the term a juristic content, a "right" is well defined as "a capacity residing in one man of controlling, with the assent and assistance of the state, the actions of others."...
>
> That which one person ought to have or receive from another, it being withheld from him, or not in his possession. In this sense "right" has the force of "claim," and is properly expressed by the Latin *jus*.[49]

Thus from this starting point we can see that the question of a 'right' involves the abstract concept of the moral authority to legitimize an action or position. Secondly, it also involves the issue of the justification for the enforcement of one person's position or action upon another.

Another way of viewing this concept is to refer to this relationship as involving a *claim-right*.[50] A legal right involves a definable duty owed by one to another, and this duty is enforceable by legal remedy if it is not performed. In addition there are the concepts of negative and positive rights. A negative right is the right to be free from some action or activity. A positive right is the right to be provided with a particular good or service. However a distinction should be drawn between a question of a person's 'rights' and those privileges, personal or group goals, acts of charity or other actions that do not entitle the rights bearer to demand that either society or an individual member of society respond.[51]

A different way of stating this issue of the enforcement of a right is stated by Charles Fried in his article entitled "Equality and Rights in Medical Care". Fried states:

> A claim of right invokes entitlements; and when we speak of entitlements, we mean not those things which it would be nice for people to have, or which they would prefer to have, but which they must have, and which if they do not have they may demand, whether we like it or not.[52]

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[49]Joseph P. Nolan and Jacqueline M. Nolan-Haley. *Black's Law Dictionary 6th Ed.* (St. Paul: West Publishing Co., 1990) pp. 1323-1324.
[50]Munson, *supra.*, note 41 p. 2
[51]Tom L. Beauchamp, "Right to Health Care in a Capitalist Democracy." in Bole, *Rights supra.*, note 40 p. 57.
[52]Charles Fried, "Equality and the Right to Medial Care" *Hastings Center Report* Feb. 1976;6(1):29-34 at

In the context of this discussion regarding a right to health care, those opposed to the characterization of such a right invoke the thought that a pronouncement, either constitutionally or otherwise, of a 'right' to health care would force those in the medical profession to treat those whom they do not want to treat. This position can be shown to be wrong. A right may justify a demand, but it does not justify force. A right to free speech does not allow for the detention of an audience so that a speaker's rights may be exercised. Applying this analogy to this context, a right to health care is a claim against the government, not against the medical profession. The government would be required to supply the required resources to provide for health care. This would include the provision of facilities and personnel.[53]

It has been argued that the use of the term 'right' is inaccurate, with the more appropriate term being an 'entitlement' to health care.[54] Rights, in the political sense of the word, encompasses all of the above; the *claim-right* and the justification of a demand by one upon another. In fact, without a legal (ie. legislative or constitutional) bases for the right, then the most one has is an entitlement to the good sought.

This point is clearly seen in the United States where in 1983 a President's Commission released a report concerning access to health care.[55] The Commission would not declare that there is a right to health care, only an obligation to provide access. This report stated that ultimately the responsibility lay with the federal government to ensure that society's obligation for access to health care was met. In directly discussing rights the Commission stated:

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p. 30.

[53]William Ruddick, "Why Not a General Right to Health Care?" *The Mount Sinai Journal of Medicine* May 1989 56(3):161 at p. 161.

[54]See Beauchamp, *supra.*, note 51 at p. 58 and Canadian Bar Association,*supra.*, note 5 at p. 40.

[55]President's Commission for the Study of Ethical Problems in Medicine. *Securing Access to Health Care* (Washington. D.C.: Government Printing Office, 1983). See also a discussion of this report as it pertains to a right to health care in: Baruch A. Brody, "Why the Right to Health Care is Not a Useful Concept for Policy Debates." in Bole, *supra.*, note 40 at p. 113-131. and Beauchamp, *supra.*, note 51 at p. 53-81.

> The Commission has chosen not to develop the case for achieving equitable access through the assertion of a right to health care. Instead it has sought to frame the issues in terms of the special nature of health care and of society's moral obligation to achieve equity, without taking a position on whether the term obligation should be read as entailing a moral right.[56]

In addition, in philosophical terms, the notion of a moral right is often translated into the language of duties, obligations and the principal of justice.[57] Therefore many would argue that an entitlement to health care is the more appropriate term to be used.

c) Ethical Principals

Earlier four ethical principles were enunciated. Before examining the arguments for an ethical right to health care these four principles should be defined.[58]

Beneficence is defined as acting in ways that promote the welfare of other people. Some philosophers doubt whether there is a positive duty to help others. However the duty of beneficence is inherent in the role of the health care professional.

Nonmaleficence can be described as acting in ways that do not cause needless harm or injury to others. It is accepted that there is inherent risk in many medical procedures. The principle of nonmaleficence tells the health care professional to avoid needless risk and when there is the inherent risk to minimize that risk as much as is reasonable. Acting with 'due care' is often a term that is used in discussion this princple. Acting without due care violates the princple of nonmaleficence, even if no harm results. Similarly, where due care is exercised and harm results, the principle is not violated.

These two principles are often considered in tandem and are seen as such in the Hippocratic oath where it states, "As to diseases, make a habit of two things - to help or at least to do no harm." The second part is the principal of nonmaleficence while the first is included in the principle of beneficence. In addition these two principles are often

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[56]President's Commission, *Securing Access. ibid.*, p. 32.
[57]Beauchamp, *supra.*, note 51 at p. 58.
[58]Munson. *supra.*, note 41. This discussion of the principals is a summary of pages 31 - 45.

viewed with a fifth consideration, that of the principal of utility. This principle states one should act in such a way as to bring about the greatest benefit and the least harm. Utility is used to enhance the principles of nonmaleficence and beneficence. Social planning requires that all three principles (beneficence, nonmaleficence and utility) be utilized to come up with the most complete socially desirable solution. When there are conflicting social needs, the principles of nonmaleficence and beneficence are also in conflict and therefore of little use; utility is used to remedy this conflict. It can be used in both large scale decisions involving social goods; medicare vs. defence spending, and small scale decisions; one test versus another to screen for potential diseases.

The principle of justice involves a number of considerations mostly involving the principles of distributive justice. A basic definition of justice is the concept that dealings between individuals should be fair and equitable, as should any dealings with institutions. At the core of all theories of justice is the maxim that similar cases ought to be treated in similar ways. There are also two other aspects to justice; noncomparative and comparative justice.

Noncomparative justice is concerned with ensuring that people receive what they are entitled to and that their rights are recognized and protected; whereas comparative justice is concerned with the application of rules and laws and with the distribution of burdens and benefits in society. This distribution would involve social services such as medical care, taxation, welfare and other public services and is sometimes called distributive justice

Finally, autonomy can be briefly described as the principle that self-determination is a right of all rational individuals. People act autonomously when their actions are the result of their own choices and decisions. They are also uniquely qualified to decide for themselves what is best for them. People are ends in themselves and not a means to some other ends and should be treated as such to respect their autonomy - they have an inherent worth and should be treated as such.

Of these four principles it is beneficence, nonmaleficence (and therefore utility) and justice which are particularly involved in the discussion regarding a right to health care.

ii) Moral/Ethical /Philosophical Rights to Health Care

In reviewing the literature on a right to health care, it appears that there are two main philosophical bases in arguing that there is such a right. These two are based essentially on egalitarian principals and upon justice. For those argument based on justice, it is the work of John Rawls in his *A Theory of Justice*[59], which is most often cited as laying the ground work.

a) Egalitarianism

The basis for an egalitarian theory for a right to health care in society is predicated on three points.

1) As a result of all individuals in society having equal moral worth, all should have the same access to equivalent medical services.
2) As health is a necessary condition for equality of opportunity in society, all should have equal access to health services in order to avoid disadvantage.
3) In order to ensure that all have an equal opportunity, the distribution of the medical resources should also be equal - no more or less to all in society.[60]

It should be noted that under an egalitarian conception it is the degree of illness and not socioeconomic factors such as race, income or geographic location which would determine the access to care. Therefore the use of the term 'health' in this context should be distinguished from the aforementioned WHO definition of health. Egalitarian formulations of a right to health care stipulate that this is an equal access to health

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[59]John Rawls. *A Theory of Justice* (Cambridge, Mass.: Harvard University Press, 1971).
[60]Theodore R. Marmor, "The Right to Health Care: Reflections on its History and Politics." in Bole, *Rights supra.*, note 40 at p. 6 and at p. 23.

services and not an amelioration of the other factors which contribute to health status. In other words, it is equality of access to health care and not equality of health.[61]

Critics of an egalitarian formulation cite the fact that society itself is unequal as their fundamental opposition. Individuals have differing amounts of resources or are willing to spend unequal amounts on their own health care. To arbitrarily state that some must give up their own resources so that all have an equal level of health care is to deny autonomy to those who wish to spend more.[62] In addition there has been a number of articles written on what equality of access really means in practical terms. This has been a criticism of the Canadian system and shall be explored in greater detail in the next section.

b) Rawlsian Theory

A similar line of argument has developed from John Rawls' *A Theory of Justice* as it applies to health care.[63] Like an egalitarian approach, the theory states that all in society should have comparable liberties and advantages. However, it differs in that there is an allowance for an uneven distribution of resources. According to Rawls, resources can be unevenly distributed so long as the least advantaged in society can benefit by the inequality and that there is a basic equality in the opportunity for access to resources.

The basis for Rawls' theory is a hypothetical society that is characterized by a group of persons who are behind a 'veil of ignorance' so that they do not know who they are or what they have - essentially they are, for all intents and purposes, equal as they have no knowledge about themselves or their social position. The people who are part of this group, those in the 'original position' as termed by Rawls, cooperate with each other, follow a sense of justice or fairness and adhere to the principles they agree to adopt.

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[61]In many ways Canada's universal health care program fits into this formulation. The basic underpinning of Canada's health care system is that all have an equal opportunity to access the services which are covered under the health insurance plan.
[62]Bole, *supra.*, note 40 at p. 7.
[63]Rawls, *supra.*, note 59. See also Bole, *ibid.*, p. 7-8 and a summary of Rawls in Munson *supra.*, note 41 at p. 23-25. The summary of Rawls' theory presented here is essentially from Bole and Munson.

Finally, they all desire primary goods: the rights, opportunities, powers, wealth, etc. that are both worth possessing in themselves and necessary to securing the more specific goods any individual may want.

The principles of justice chosen by such a group will be just, for the persons in the original position are ignorant of any advantage they may achieve. Therefore their eventual choices will be fair. They will not choose a position that may be disadvantageous to them when the veil of ignorance is lifted (i.e.. slavery) because it would not be rational or logical for them to choose a position that may lead to their disadvantage.

Rawls says that the people in the original position will agree on two principles of justice:

1) Each person is to have an equal right to the most extensive total system of equal basic liberties compatible with a similar system of liberty for all.

2) Social and economic inequalities are to be arranged so that they are both:
(a) to the greatest benefit of the least advantaged;
(b) attached to offices and positions open to all under conditions of fair equality of opportunity.

The first principle has priority and guarantees a system of equal liberty for all. The second principle governs the distribution of social goods other than liberty. A society modeled on this theory would not be egalitarian for in a just society differences in wealth and social position can be tolerated only when they can be shown to benefit everyone and to benefit, in particular, those who have the fewest advantages. A just society is not one in which everyone is equal, but one in which inequalities must be demonstrated to be legitimate. The only restraints placed on the citizens will be those expressed in the principles of justice.

Critics of this theory, with respect to its application to health care, point out that the definition of the least advantaged may be problematic for is the least advantaged to be

classified by economic criteria or health? If health is the criteria then other areas may suffer as a result of the resources needed to treat the very ill.

c) Other Ethical/Philosophical Arguments

The Rawlsian and Egalitarian justifications for a right to health care are but two theories that support adoption in society of a minimum, guaranteed level of health care for all. Other authors have used different theoretical principals for postulating a right to health care in our society or have built upon the Rawlsian justice-based model.[64]

An example of this is demonstrated in an article in the *Public Affairs Quarterly* in which David DeGrazia has argued that the right to health care should be grounded in self-respect and self-esteem.[65] He builds upon Rawls' theory which states that self-respect is a primary social good - something that all in the original position would wish to have. A lack of health care, along with other social ills such as bigotry, unemployment and a lack of access to education, all contribute to an undermining of self-esteem and self-respect.[66] If there were a minimum right to health care, then the self-esteem of those in society would be raised. This would in turn allow all members of society to be more productive and fulfilled.[67]

There are others who theorize that a free market model, which utilizes preference utilitarianism, would satisfy the health care needs of society. Preference utilitarianism is the theory that the greatest good for the greatest number can be determined by utilizing the preferences of the population. In a free market system, health care would be available to those who can purchase the services. Correspondingly, those that provide the services

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[64]See for example two Leonard M. Fleck's articles: "Just Health Care (I): Is Beneficence Enough?" and "Just Health Care (II): Is Equity Too Much?" in *Theoretical Medicine* 1989;10:167-182 and 1989;10:301-316, respectively, in which he questions whether a right to health care should be based on beneficence or justice. He concludes that a right to health care is properly based in an egalitarian argument as presented by John Rawls and based in justice.

[65]David DeGrazia, "Grounding a Right to Health Care in Self-Respect and Self-Esteem." *Public Affairs Quarterly* Oct. 1991;5(4):301-318.

[66]*Ibid.* p. 304.

[67]*Ibid.* p. 310.

would be permitted to offer their services at whatever level the market would bear. Those that cannot purchase the services would be dependent upon the charity of those in possession of the services. Presumably the free market would respond to the needs of society and the least well off in society would, in the long run, be helped by those with the resources. It is also presumed that the preference of those in society would be that there be charity for those without.[68] A criticism of this theory arises from this presumption for it places great faith in the altruism and charity of those in society who have the ability to provide either the resources or the funds to supply the resources.

In the President's Commission Report[69] the essential bases of the social obligation of the government to provide health care can be seen to be rooted in the ethical principal of beneficence. In Leonard Fleck's discussion of a right to health care in *Theoretical Medicine*, he theorizes that the President's Commission's conclusion that there was only a moral obligation upon society to ensure that health care was provided was simply an expression of moral minimalism. A member of society who is unable to provide for their own medical coverage has no demand on another to provide the required services, only the beneficence of society. While it would be indecent of society to allow the poor or elderly to suffer and die needlessly because they could not afford medical care, it is only through the kindness and compassion, which is freely given by others, that they receive the needed attention.[70] Fleck analogizes the medical needs of those in society who cannot afford medical care to those who have suffered from some natural disasters. As he states:

> Given these political and economic realities, we might construe the reasoning of the President's Commission as follows: an affluent society that considers itself decent and humane will not allow its citizens to suffer and die needlessly as a result of health problems, merely because they cannot afford to purchase personally needed health care services. Health crises at the individual level are, for the most part, unpredictable, just like natural disasters. But at the societal level they are quite predictable, which permits society to plan a more coordinated and effective response to such

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[68]David Friedman, "Should Medicine be a Commodity? An Economist's Perspective." in Bole, *Rights supra.*, note 40 at p. 259-305.
[69]President's Commission, *supra.*, note 55.
[70]Fleck, "Just Health Care (1): Is Beneficence Enough?" *supra.*, note 64 p. 170.

> crises. Individuals who suffer such health crises are indeed unfortunate, and they would be doubly unfortunate if their society failed to create a system for providing the health services needed to meet such crises. Still, such a society could not be charged necessarily with being unjust, for no one has a strict right to have those health services provided to them. Rather, it is a matter of social beneficence. That is, we all agree with one another that we should have a system of mutual beneficence, though this is *limited beneficence.* (original author's emphasis)[71]

Under this view the beneficence of society with respect to health care would be limited because health care is simply one of many social goods which the government is required to provide. With limited resources, a government is required to provide for health care, defence, education, housing and other infrastructures. As such, if those in need of health care are limited to the beneficence of others then there is no right, or even entitlement, to health care since the beneficent providers can withdraw their services at their discretion. A further critique of this position can be seen if questions were raised concerning the marginal poor - those who simply cannot afford to pay for adequate health care or health care insurance. The beneficence of society would have to extend to them as well.

In a second article entitled "Just Health Care (II): Is Equality Too Much?", Fleck asserts that a justice-based obligation is needed in order to assure adequate access to health care for all. This is primarily due to the moral stringency associated with the many claims being made for access to health care. Secondly, he states that the concept of justice that is required is one of *health care justice*, rather than an all purpose concept of justice.[72] This is principally due to the fact that health care, as a social good, is different from other social goods provided by the government. This can be seen to go back to the World Health Organization's definition of health as well as the Lalonde White Paper on the health of Canadians.[73] Health and health care pervade so many areas of society that it is obvious that it is different than education or other infrastructures.

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[71] *Ibid.*, p. 171.
[72] Fleck, "Just Health Care (II): Is Equality Too Much?" *supra.*, note 64 at p. 302.
[73] See *supra.*, p. 20.

In a justice-based obligation to provide health care services, the prominent consideration is that of a fair equality of opportunity.[74] In this Fleck applies the arguments set out by Norman Daniels in his book *Just Health Care*. Fair equality of opportunity is not the same as an opportunity that is equal for all persons. This is because from the start all members of society are unequal due to genetics, social stature etc. While effective opportunity may be unequal (due to an inherent difference in people) it will not be unfair since there should be fair equality of opportunity to utilize health care services. This is similar in principle to the *Canada Health Act* in which the critera have developed so that there should be fair equality of opportunity to access the health care system.[75]

If health care is to be provided to all as a matter of social justice, then how much health care is an individual entitled to? Justice in health care requires that consideration be given to those problem areas that must be addressed in a comprehensive theory of just health care. These problem areas are discussed in greater detail in the ensuing sections and include: financing, cost containment, use of and development of technology, and access.[76]

As indicated earlier, a theoretical right to health is perceived to be needed in order to ensure an access to health care for all members of our society. If it is a fundamental right, it is argued, then it cannot be denied to anyone. I turn now to the reality of Canada and the United States. While it would appear that in practical terms there is an access to health care, as of yet this is not a 'guarantee' or a 'right' by way of a constitutional provision or declaration. Until a 'right to health care' is fully recognized by the people of our society, theorists will attempt to find justifications for ensuring that all have a right to health care.

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[74]Fleck, *supra.*, note 64 at p. 302.
[75]See *supra.*, pp 10-16.
[76]See the next Part entitled "Pressures and Responses".

iii) Political/Legislative Rights to Health Care

The various governments in Canada and the United States do provide a variety of health care services to their populations. While they do provide access to health care, there is no explicit recognition of a right to health care. The exception to this is the province of Quebec. In the Quebec the legislation with respect to health services and social services provides the following,

> 4. Every person has the right to receive adequate, continuous and personal health services and social services from a scientific, human and social standpoint, taking into account the organization and resources of the establishments providing such services.[77]

This provision is unique in Canada and the United States for it recognizes in legislation a right to health care. However it is not an unqualified right. The legislation is explicit that the right to health services is to be taken in conjunction with, and is limited to, *the organization and resources that are available to provide the health services.* Therefore, while the right to health care is legislatively enacted, it has its limitations. Firstly, it is simply an Act of the legislature and therefore can be revoked by way of the statutory process. Secondly, and more importantly, it is contingent upon the organization and resources available. This means that the people of Quebec may have a right to health care but it is limited to what government can afford to organize and provide.

With respect to hospitals, the legislation in both Ontario and Quebec which establishes hospitals mandates that the institutions shall take patients who present themselves for treatment.[78] While this is not a right to receive care in a public hospital, it is evidence of a commitment by the governments to ensure that the public is entitled to access to care.

As for the various provincial health insurance acts, as indicated earlier, none have defined what is 'medically necessary' or 'medically required'. The provinces use the

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[77] *An Act Respecting Health Services and Social Services,* R.S.Q., c. S-5, s. 4.
[78] In Quebec; *An Act Respecting Health Services and Social Services,* R.S.Q., c. S-5, and in Ontario; *Public Hospitals Act,* R.S.O. 1980, c. 410.

regulations promulgated under the health insurance acts to simply classify services as medically necessary or required without defining the term or referring to any substantive criteria.[79] As a result, it would be a fair assumption that anything not on the list of insured services would not be considered medically necessary or required. Obviously, there is discretion as to what is added and taken away from the list of insured services, which would allow for the potential of political or economic influence in proscribing what the users of the health care system must pay for themselves.[80]

The Canadian Bar Association's Task Force which examined the Canadian health care system had written to the various provincial Ministers of Health in order to determine what services were insured or deinsured and how this was accomplished. They received a response from every provincial and territorial government except Prince Edward Island. As indicated above, no provincial government had set out criteria to determine what treatments or procedures would be considered medically necessary or required.[81] In determining who made the decision, it was learned that typically a joint commission of representatives of the government and the provincial medical associations would make recommendations to the Minister of Health as to insured and deinsured services. As the Canadian Bar Association's Task Force concludes; "Criteria for such changes is not set out in legislation. Public consultation is not mandatory, nor is it common practice. *This reveals a great weakness at the core of the entitlement to health care in Canada*"[82](emphasis mine)

The role of the *Charter of Rights and Freedoms* (hereinafter the Charter)[83] in the delivery and provision of health care in Canada will be discussed in greater detail later.[84] As an introduction at this point it simply should be pointed out that there is no explicit Charter right to health care. If health care were to be interpreted as a protected right, then

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[79]See Canadian Bar Association. *supra.*, note 5 at pp. 37-40 for a summary of provincial statutes.
[80]*Ibid.*, p. 37.
[81]*Ibid.*, p. 38.
[82]*Ibid.*, p. 39.
[83]*Constitution Act, 1982*
[84]See *infra.*, Part 4 at pp. 74-87.

it would most likely be found in either sections 7 or 15 and supported by section 36.[85] These sections read as follows:

> **7.** Everyone has the right to life, liberty and security of the person and the right not to be deprived thereof except in accordance with the principals of fundamental justice.
>
> **15.** (1) Every individual is equal before and under the law and has the right to the equal protection and equal benefit of the law without discrimination and, in particular, without discrimination based on race, national or ethnic origin, colour, religion, sex, age or mental or physical disability.
>
> **36.** (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 reasonably comparable levels of taxation.

As indicated earlier, in the United States the federal government has addressed the question of access to health care. In 1983 a series of Presidential commission reports dealing with ethical problems in medicine were released. One was entitled, *Securing Access to Health Care*.[86] The passage cited earlier demonstrated that in the United States it is presumed that there is a moral obligation upon the federal government to provide health care services and the reliance upon beneficence for others in society. There is one

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[85]Canadian Bar Association. *supra.*, note 5 at pp. 19-20. For a good discussion of the relationship between the Charter and health care see this section of the CBA Task Force report at pp. 19-26 and further at pp. 45-59 wherein enforcement of an entitlement to health care by individuals is discussed.

[86]President's Commission *supra.*, note 55. See also a discussion of this report as it pertains to a right to health care in: Baruch A. Brody, "Why the Right to Health Care is Not a Useful Concept for Policy Debates." in Bole, *supra.* note 40 at p. 113-131. and Beauchamp, *supra.*, note 51 at pp. 53-81.

group of persons in the United States who have a constitutionally protected right to medical and health care. Following the decision in *Estelle* v. *Gamble* prisoners are entitled to health care.[87]

The health care system in the United States is set up as what has been called a free market health care system. In this the physician and patient are expected to arrange the contract for medical care between themselves.[88] This is not to say that every patient and every physician contract individually. There are government-run health systems for the poor and the elderly known as medicaid and medicare, respectively. It has been said that the American system is an uncoordinated combination of public and private programs which emphasizes the American society's ambivalence toward the role the government should take in ensuring the medical care of its citizens. The debate is whether medical care is a social good that the government should provide or a benefit that employers should purchase for employees and their dependents with government insurance for those outside the work force.[89]

Medicaid and medicare ensure that basic health services are provided for those groups who are either poor or elderly. Medicaid eligibility is based on a combination of income, assets and categorical eligibility. These categories include families with dependent children; those that are aged, blind or disabled; and, in some states, those that are medically needy.[90] Medicare is a federally funded medical program for those who are disabled, elderly and those with end stage renal disease. There is no financial eligibility requirements for medicare. The disability requirements are the same for medicare and medicaid, however there is a waiting period for medicare the program. Under the

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[87] *Estelle* v. *Gamble* (1976),429 U.S. 97 103.
[88] For a general discussion of the health care system in the United States see: Marmor, *supra*. note 60 and John K. Iglehart. "Health Policy Report: The American Health Care System" *New England Journal of Medicine* April 2 1992;326(14):962-967 and an article also by Iglehart on the private insurance available in the United States entitled, "Health Policy Report: The American Health Care System, Private Insurance." *New England Journal of Medicine* June 18 1992;326(25):1715-1720.
[89] Iglehart, "American Health Care" *New England Journal* 1992;326(14):962-967 at p. 962.
[90] Harvey J. Makadon et al., "Paying the Medical Cost of the HIV Epidemic: A Review of Policy Options." *Journal of Acquired Immune Deficiency Syndromes* 1990;3(2):123-133 at p. 125.

medicare program individuals be disabled for 2 years and there is an additional 5 month waiting period prior to receiving benefits.[91]

Those that do not qualify for medicare or medicaid have other options. They can purchase individual health insurance just as one can purchase home, automobile or life insurance from an insurance company. In exchange for premiums paid, the insuring company agrees to pay any medical expenses if the insured requires health care. However, as with any insurance contract, there may be limits on the coverage or the premiums may reflect the risk that the insured is assessed to pose to the insurance company. Another option is for insurance coverage to be a benefit of employment. Employers can arrange for group health insurance for their employees. Again this coverage may be subject to a number of conditions or limitations, not the least of which would be continued employment with the contracting employer.

A growing trend for both private and group health insurance is the use of health maintenance organizations (HMO). In the next section the term "managed care" will be used. This is essentially how a health maintenance organization operates. Generally, in health insurance policies in which a HMO is utilized, there is a provision which includes a clause that the insured persons will only use particular components of the health care system. These may include particular physicians, hospitals and other diagnostic services which are specifically set out. Aside from emergency situations, the insured person must use these specified providers or institutions otherwise the policy will not provide coverage. Similarly, the health care provider and institutions are ususally either employed or affiliated with the HMO for their reimbursement.

Estimates for those Americans who are not covered by any insurance range between 31 and 37 million people with the group growing at a rate of approximately 1 million per year.

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[91] *Ibid.* p. 126.

Therefore when one considers the United States, there are a number of different facets as to how health care is delivered. Correspondingly, to discuss 'access' to health care in the United States one must identify what health care delivery group is under consideration.

iv) Conclusion

In Canada, aside from Quebec, there is no legislative right to health care. However it can be said that there is an entitlement to health care given the status health care has taken in the public's attitude and the political response. Furthermore, the role that the Charter may play in ensuring that health care is provided to Canadians by their governments is developing. While not explicitly set out as a protected Charter right, health care and any decisions relating to treatment could be subject to a Charter challenge under either sections 7 or 15.

From an ethical perspective, the health of an individual is key to that person becoming and remaining a productive member of society. Therefore it is incumbent upon the government to adopt a health care policy that reflects the fact that health is more than simply the absence of disease.

The Canadian Bar Association Task Force on health care reform summarized the issues of a right to health care quite simply in their document. They said:

> Ideally, the right to health care should be defined not just by a list of services, nor by an idealistic statement of a right, circumscribed by budgetary realities. A more desirable approach might be a pragmatic and principled combination of the two. It would begin with the articulation of a right to health care, including a clear commitment to the important principles underlying this right, such as the right to informed consent, to respect for individual autonomy, to equal access to health care, regardless of region or socioeconomic class. Next, it would set out the criteria to be used in determining which services must be provided by the state. These criteria might combine a consideration of clinical practice standards, assessment of outcomes effectiveness, economic constraints and ethical priority-setting.[92]

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[92]Canadian Bar Association, *supra.*, note 5 at p. 42.

The issues that the CBA sets out are part of the consideration of the pressures and responses on the system which will be addressed in the next section.

PART 3 - PRESSURES AND RESPONSES

The media, politicians and health care reform advocates talk of the 'crisis' in Canada's health care system. The crisis essentially comes down to the issues of the provision of universal access to health care and the control of national spending on health care.[93] This is no different from the problems perceived in other industrial nations who also are reviewing their health care systems. The factors are the same in Canada and elsewhere: health care providers desire to treat their patients to the best of their ability using the available technology with the expectation that they be adequately compensated. The consequence of this is that the percentage of gross domestic product spent on health care is substantial. Patients, in turn, seek the maximum degree of health and health services from their health care providers, but, collectively, they seek to minimize the proportion of GDP yielded for the price of their care.[94] If these are the parameters of the dilemma then the financial figures can be reviewed in an attempt to determine whether it is true.

Looking at health care spending figures obtained from the *National Health Expenditures in Canada 1975-1994*, it is evident that by 1994 the federal share of total health care expenditures had fallen to 25.5%, whereas in 1975 it was 30.9%. Additionally, in 1994 Canada spent $72.5 billion on health, which translated to 9.7% of the gross domestic product (GDP).[95] In 1992 and 1993 this percentage was 10.1% of the GDP. This continued to fall in 1995 and 1996 with these figures being 9.3% and 9.1%, respectively.[96]

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[93]See for example Ellen N. Thompson, "Canada can't afford its generous service" Editorial, *Ottawa Citizen* August 16, 1996 p. A13 or issues of *Macleans* magazine such as the July 25, 1994 edition entitled "Conditional Critical" and accompaning articles regarding health care or their December 2, 1996 edition again detailing the crisis in health care. In addition, in the National Forum on Health's final report entitled: *Canada Health Action: Building on the Legacy*, (*infra.*, note 144) the introduction indicates one of the reasons why the forum was struck was to provide information to dispel the preceived crisis.

[94]Uwe E. Rienhardt, "Reforming the Health Care System: The Universal Dilemma" *American Journal of Law & Medicine* 1993;19(1-2):21

[95]*National Health Expenditures in Canada 1975-1994* (Ottawa: Health and Welfare Canada) pp. 4-9.

[96]*Id.*

Concurrent with this decrease in public financing of health care was an increase in the private money spent by Canadians on their health. Often forgotten is the fact that there is a significant portion of the health care costs of Canadians paid either personally or through private insurers. In the figures from Health Canada, it is shown that in 1994 the private sector share of all health care expenditures climbed to 28.2%. This equaled $20.4 billion dollars spent and was a 5.6% increase over the previous year.[97]

These figures do not show by themselves why some consider the health system in crisis. The answer regarding why the system is perceived to be in crisis can be found in the inherent nature of the health care system itself. The financing of the system certainly is key. The mantra of "fiscal restraint" combined with the large portion of provincial and federal budgets spent on health care necessitate that governments rethink how their systems are organized. They also must reflect on a number of factors:

i) the number of health care providers which are necessary;
ii) what they should be paid for and how they should be paid;
iii) which infrastructures are necessary and which are not; and,
iv) how their systems can be reorganized to provide the financing delivery and allocation of resources more efficiently and effectively.

Some have argued that the status quo in Canada must not remain. At the Canadian Medical Association annual meeting in Winnipeg in 1995 the future of Canada's system was discussed. What ensued from the meeting was a series of articles following up on this debate. Medical issues writer Charlotte Gray detailed some of the issues in an article in the *Canadian Medical Association Journal* entitled, "Visions of our medicare future: status quo has become a dirty word in Canadian health care". She begins her article by relating the story of the 'health care pig'. She writes:

> A farmer had a barnyard full of animals, but felt particular fondness for one pig. This pig was brilliant: it had squealed for help when the farmer was trapped under his tractor, it had pulled a toddler out of a pond, it had alerted neighbours when their farmhouse caught fire, After hearing about the lifesaving heroics, a traveler asked to see the pig.. He was surprised to discover that the animal was missing a leg.

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[97] *Id.*

"What happened?" he asked.
The farmer shrugged. "A fine pig like that," he said, "you don't butcher all at once."[98]

She cites several areas that are targeted for change, while recognizing that there are wide variations in cost cutting strategies and alternative delivery systems. These include reviewing, or re-engineering, the biggest consumers of health care funds: the hospitals and other institutional care settings. Others issues include changing the way health care professionals are compensated and changing the role various health care professionals play in the physical delivery of services. Finally, there is the question of what is 'medically necessary' or 'medically required' under the *Canada Health Act* with the corresponding deinsuring of various treatments and the increase in the role of private insurers in taking up those services not covered by provincial health plans.

In response to these pressures a number of alternative delivery systems have been postulated. In addition, a review of the steps taken by other countries in an attempt to resolve their own perceived health care problems can add to the discussion. Putting the various systems broadly on a spectrum, one can see that the two extremes may be described as follows:

1. The individual patient (or consumer) is responsible for the financing of their own health care as it is a *private consumption good.*
2. As a *social good*, health care should be collectively financed and be available to all regardless of their ability to pay.[99]

Another broad point which should be considered prior to looking at alternative delivery systems is to identify a trend in the evolution of health care policy, for this trend is influential in determining where the system is headed. Since the inception of national health care policies and delivery, there has been a gradual shift from expenditure driven financing of health care to, what can be described as, a budget driven delivery of health care.[100]

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[98]Charlotte Gray, "Visions of our medicare future: status quo has become a dirty word in Canadian health care" *Can. Med. Assoc. J.* 1996;154(5):693.
[99]Reinhardt, *supra.*, note 94 at p. 22
[100]*Ibid.*, p. 32

Until the mid 1980's Canada operated under an expenditure driven financing of health care. Money, it appeared, was no object when it came to the provision of health care or the expansion of health care technology. Essentially, heath care providers would treat a patient and present society with the bill which was paid without question. As technology expanded the field of medicine, anything new that could benefit the patient was immediately 'medically necessary' for the treatment of the patient. In this sense invention became the mother of necessity. Benefit-cost ratios were not reviewed due to the philosophy that the benefit was what mattered and not the cost. Additionally, any consideration of cost may impose 'rationing' which was considered unethical.[101] Those days came to an end when it became apparent that money was not unlimited as deficits began to become a focus.

The provision of health care is now budget driven. Health care providers are given a budget and told they must do their best within these constraints. This budget is generally based on historical usage and often tied to an arbitrary criterion such as the percentage of GDP or annual growth rate.

With these points in mind consideration can now be given to an examination of alternative health care delivery mechanisms. The alternatives which will be viewed are by no means exhaustive but are simply alternative suggestions put forth by various parties. In addition, they are not mutually exclusive as elements of each are contained in all. The areas that will be examined are the following:

i) Regionalization and decentralization
ii) Integrated health systems/ managed care/ managed competition
iii) Single payer versus two-tiered

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[101] *Id.*

i) Regionalization and Decentralization

It has been said that Canada's system is already regionalized as it is built around a federal-provincial structure that allows for broad regional differences in the delivery of health care. Traditionally, the physical delivery of health services was a matter of local concern with municipal hospitals and other charitable or religious institutions providing the locus for care.[102]

Regionalization and decentralization of health care delivery decision-making is premised on the idea that devolving some authority to local levels will contain costs, improve health outcomes, increase the flexibility and responsiveness of care delivery and better integrate and coordinate services. Provincial governments can see three objectives for divesting themselves of some health care decision-making - they can find allies for further health care restructuring by empowering communities in the process; they can integrate services; and, as spending is cut they can contain some of the resentment.[103] Regionalization can be seen to represent the transfer of decision-making power or authority to some intermediate level. The term decentralization would be used to refer to the transfer of this power or authority from a higher level to a more local level. In some contexts regional reforms are in fact centralizing power as decisions are shifted from local hospitals upwards to a new intermediate level of authority such as a regional board.[104]

Devolution is a term that is used to encompass both regionalization and decentralization and has been defined as the transfer of decision-making to a local authority with only broad principles to be left with the central government. It has also been described as follows:

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[102]John L. Dorland and S. Mathwin Davis, "Regionalization as Health-Care Reform" in John L. Dorland and S. Mathwin Davis Eds., *How Many Roads...? Regionalization & Decentralization in Health Care* (Kingston:Queen's University School of Public Policy, 1995) p. 4.
[103]Jonathan Lomas, "Devolving authority for health care in Canada' s provinces: 4. Emerging issues and prospects" *Can. Med. Assoc. J.* 1997;156:819.
[104]Raisa Deber, "International Experience with Decentralization and Regionalization" in Dorland *supra.*, note 102 at p. 53.

> Devolution of health and social services involves the transfer of greater control and decision-making for some or all of the planning, funding, management, revenue generation and delivery functions. The degree of devolution lies along a continuum between full central control and full local/regional control.[105]

Three additional considerations in devolution of authority to make health care decisions include scope, function and authority.[106] In choosing what function to delegate (ie. planning, management, resource allocation, delivery, etc.) the delegating province must also decide where the authority will lie - the provincial, regional or local level. In looking at the scope it must be determined what is to be devolved: limited or all health care programs, social services, attendant health care considerations (ie. housing, poverty etc.). Finally, what information and whose values will be used to formulate policy and allocate resources - those of provincial bureaucrats, stakeholder interests, administrators or local representatives? The policy of devolving command and control of health care has resulted in more than 100 new regional or local bodies in Canada with powers and scopes of authority that vary.[107] Additionally, 9 of the 10 provinces (all except Ontario) have instituted the devolution of some health care decision-making to some sort of local authority.[108]

Devolution of power is never easy. However, because of the involvement of the provinicial government, health care providers and the local population devolved authorities gain their legitimacy and credibility. Generally at issue are what powers the provincial government will delegate, the relinquishment of management rights of the health care providers and the needs and wants of the local population.[109] A granting by the provincial government of the authority to plan and allocate funds provides legitimacy. The input and cooperation of the local health care providers and institutions provides

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[105]Richard Fraser, "Accountability and Regionalization" in Dorland *supra.*, note 102 at p. 37.
[106]*Id.*
[107]Jonathan Lomas, "Devolved Authorities in Canada: The New Site of Health-Care System Conflict?" in Dorland *supra.*, note 102 at p. 26.
[108]Jonathan Lomas, John Woods, Gerry Veenstra, "Devolving authority for health care in Canada's provinces: 1. An introduction to the issues" *Can. Med. Assoc. J.* 1997;156(3):372.
[109]*Id.*

devolved authorities with the ability to manage and reform local health care delivery. Finally, credibility comes from the input of the local or regional population whose needs and wants are to be listened to and considered.[110] However, because there are three distinct groups involved, there are bound to be competing interests and expectations with corresponding tension.

What devolution has done is to move up to the local decision makers some of the informal power of providers while devolving down some of the formal power and authority of the provincial ministries of health. With the control provided to devolved authorities comes the responsibility to impose a 'management' upon the system. If dollars are to flow through the local health care authority to pay for the services rendered by the providers, then it is incumbent upon them to review the utilization and allocation of resources. What, or whose, objectives however are to influence the board - those of the source of the dollars: the provincial government, or the "needs and wants" of the community? Local influence may result in differences between regions and may not reflect government health objectives, while a deference to provincial objectives renders the devolved authority nothing less than simply an enforcer of government policy within the local community.[111]

This last point is a particular criticism of the devolution of authority. Provincial governments do not need to devolve authority in order to reduce health care expenditures. In other words, the regionalizing and decentralizing of some health care decisions will not result in cost savings or containment. It will, however, be a convenient way for a budget and fiscally conscious government to either shift the blame or provide a buffer for the effect on the population of its health care expenditure decisions.[112] In many ways, this is exactly what the federal government has done by reducing transfers to the provinces while insisting that standards as set out in the *Canada Health Act* for health

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[110]*Ibid.*, p. 374.
[111]Lomas, *supra.*, note 107 at p. 29.
[112]Lomas, *supra.*, note 103 at p. 821.

care delivery be maintained. In the survey conducted by Lomas et al. and reported in the *Canadian Medical Association Journal,* the authors found that more than half of the devolved authority board members acknowledged this fact. The authors concluded the following after reviewing their survey:

> However, initial assessment suggests that most devolved authorities favour system rationalization as a primary objective and can claim some success in integrating institutions. They are tolerating the expenditure reduction requirements imposed upon them but are exchanging the role of provincial government ally for aggressive lobbyist against underfunding once such reductions exceed acceptable thresholds. Finally, they are trying hard to represent, although not necessarily empower, their communities.[113]

In essence, a decentralization of decision-making power may hinder the efficient operation of the health care system, in the sense that equity in the delivery of health care services may vary across regions. Local needs may be influenced by a variety of factors, not the least of which are the historical interest groups (providers and their associations, institutions, corporate/pharmaceutical interests, and various patient groups). Secondly, there is no evidence that the concerns of financing, cost containment and the efficient use of resources would benefit by decentralization or regionalization of decision-making. Other alternatives will address these issues.

ii) Integrated Health Systems/Managed Care/Managed Competition

It is within these alternatives that the issues of cost containment, efficiency and an effective allocation of resources are most likely to be met. The basic theory is that market forces will generate competition which will in turn produce the incentives to achieve the above goals. Before discussing the role these alternatives can play in the delivery of health services, the terms should be defined.

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[113] *Ibid.*, p. 822.

a) Definitions

i) Integrated health systems . This term has been stated to describe "an organization or a network of organizations that provide or arrange to provide a co-ordinated continuum of services to a defined community and is held clinically and fiscally accountable for the outcomes and health status of those served."[114] Synonyms for integrated health systems include integrated delivery systems or organized delivery systems. In such systems there is a full range of services such as primary, ambulatory, acute and residential care functions together with the necessary health care professionals, all integrated to provide care to a roster of patients. Integrated systems can also be limited as in horizontal integration (hospitals and other institutions sharing rationalizing services). An example of an integrated delivery system is the general practitioner fund-holding (GP fund-holding) model as practiced in the United Kingdom. Under this GP fund-holding model a group of physicians are provided with a set amount of money to meet the health needs of patients on their roster. Some costs of the treatment are borne by the physician group, others may be added. In this sense the rostering and capitation payment are the responsibility of the GP. This forces those within the GP fund-holding group to manage themselves and thereby keep costs contained.[115] Recently the *Health Services Restructuring Commission* set up by the Ontario provincial government advocated the setting up of an integrated health system for Ontario. This proposal and the response by the medical profession will be addressed subsequently.

ii) Managed Care / Managed Competition. Some would state that managed care and managed competition are subsets of an integrated health system. However, these terms will be addressed and defined individually in order to gain a

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[114]Ted Boadway, "An introduction to integrated health systems" unpublished information document prepared by the Ontario Medical Association Health Policy Department, 1997 p. 2. This definition also appears in Peggy Leatt et al., "Integrated delivery systems: Has their time come in Canada?" *Can. Med. Assoc. J.* 1996;154:804.

[115]*Ibid.*, Boadway, p. 1.

familiarity with the ideas.[116] The concept of a managed care system is that a comprehensive range of services (as opposed to a number of services) will be provided for a predetermined amount of money. These services will be provided, as required, to a defined group of individuals with the delivery organized, monitored and controlled. Another definition of managed care and managed competition is as follows:

> "Managed competition" is frequently confused with "managed care," but these terms relate to entirely different concepts. Managed care refers to the external monitoring and co-managing of an ongoing doctor-patient relationship to ensure that the attending physician prescribes only "appropriate" interventions. The term "appropriate" excludes procedures with no proven medical benefit, but may also eventually exclude beneficial procedures with a low benefit-cost ratio.
>
> Managed competition, on the other hand, refers to a highly structured and highly regulated framework that forces vertically integrated, income-seeking managed care systems to compete for patients on the basis of prepaid capitation premiums and quality; the latter is to be measured by clinical out-comes and the satisfaction of patients. In other words, the central idea is to put competing managed care systems into transparent, statistical "medico-fishbowls" that can be compared by both patients and those who pay on behalf of patients - for example, government agencies or business firms procuring health insurance coverage for their employees.[117]

As discussed in the previous section, health maintenance organizations (HMO) in the United States are an example of managed care.

b) Application of these concepts

In introducing the parameters for a discussion of integrated health systems the health policy department of the Ontario Medical Association (OMA) stated that managed care could be identified by a roster of patients receiving their care through a particular managed care organization. These organizations would employ or contract with various health care professionals and institutions to meet the clients' needs. Treatment decisions must often be pre-authorized by an administrator prior to delivery. There also are practice guidelines and other directives relating to the care to be administered by the

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[116] *Id.*

[117] Reinhardt, *supra.*, note 94 at pp. 34-35.

health care provider. Utilization reviews are conducted to ensure that providers are following these guidelines and directives. In this sense, the system's incentive to be efficient and contain costs is achieved by managing the provider. In theory, market forces are considered to be what makes managed care and managed competition systems work. By assuming the financial risk, it is presumed that the organization delivering the care will be as efficient as possible in providing health care to its clients. Due to this risk, these managed care systems have the incentive to monitor the usage and implement management strategies to identify and correct any inappropriate utilization.[118]

The proponents of these types of delivery systems cite the potential for cost containment and the continuum of care for a defined population as important reasons to consider an integrated/managed system.[119] In addition, the role of the primary care physician as a gate-keeper would be amplified in an integrated/managed system with its consequent cost containment implications.

The government of Ontario has embarked on a process to overhaul the health care system in that province. As indicated earlier,[120] Ontario is the only province which has not instituted some form of devolution of health care delivery or authority to local bodies. Instead, the government has set up the *Health Services Restructuring Commission* with a mandate which is stated as follows:

> The Commission has the authority to restructure hospitals in Ontario. In addition to directing hospital restructuring, the Commission makes recommendations to the Minister of Health on restructuring other elements of the health services system.
>
> The Commission's recommendations include advice concerning funding needed both to restructure hospitals and to enhance other health care services to meet the goal of developing an integrated health services system.[121]

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[118]Marianne Lamb and Raisa B. Deber, "Managed Care: What is it, and can it be applied to Canada?" in Raisa B. Deber and Gail G. Thompson, Eds., *Restructuring Canada's Health Services System: How do we get there from here?* (Toronto: University of Toronto Press, 1992), p. 160.
[119]Leatt, *supra.*, note 114 at p. 804.
[120]See *supra.*, page 44 and accompanying notes.
[121]Health Services Restructuring Commission, *A Vision of Ontaario's Health Services System* (Toronto: Health Services Restructuring Commission, 1997).

The vision of the *Restructuring Commission* is one which fosters diversity among both its elements and the decision-making by the people affected. It also is to be constituted of sectors (long term care, home care, primary care, hospital etc.) that will work together to provide the full spectrum of health services needed to promote health and provide health care for the population of Ontario.[122] The *Commission* sees the current system as hospital centred with all other elements of the health delivery system dependent upon this institutional framework. They envision an integrated system with a 'rostered population' at the centre. In this integrated system the roles of the provincial government would be as follows:

1) Provide direction for system and set level of funding within which the system must operate;
2) Develop and maintain an information system to link all components together;
3) Invent and promote incentives/disincentives, performance targets, evaluation measures etc., in order that the system operates efficiently;
4) Provision of funding on a capitation basis to the system;
5) Fund directly those institutions who proved teaching, research etc. and highly specialized and/or low-volume specialty and sub-specialty services.[123]

In turn, the responsibility and accountability for the operational decision-making, program and service delivery, and the performance outcomes will rest with the regionally oriented integrated health systems (IHS) and integrated academic health systems (IAHS). Their roles will be:

1) Set up the IHS by forming alliances between a number of health service providers such as hospitals, community agencies, long-term facilities and health care providers (referred to as 'primary care' organizations);
2) Meet the health service needs and be held accountable for the health of the population served (rostered population);
3) The IHS should be built upon the following features;
    a) be geographic based, or in large municipalities; faith-based, ethnic or some other base (size:100,000 to 500,000) (rostered population);

[122] *Ibid.*, p. 1.
[123] *Ibid.*, p. 5.

b) manage a fixed predetermined pool of funds to service the needs of the rostered population (capitation funding);
c) provide or purchase defined services of behalf of rostered population;
d) provide defined services in exchange for payment.

Services would be a full range of primary and secondary services, long-term, community, facility-based and palliative care.

4) The IAHS will be responsible for specialized care for the regional populations as well as education of future health care professionals.[124]

The *Commission* has also set out three models which they propose as suggestions only. They recognize that there are a variety of centralized and decentralized structures possible and that their development should be encouraged in order to meet the needs of the rostered population. They propose a partnership model in which a group of providers come together to form an IHS by way of a partnership agreement. They will develop a decision-making structure for allocating a funding envelope, based on capitation funding, to the members of the group. In other words, they themselves will determine how much each provider receives by way of payment for their services. This partnership will also provide central management by way of system/network integration for specific functions such as shared information systems, payment mechanisms and support functions.[125]

At the other end of the spectrum they suggest a merged corporation model in which the ownership of all parts of the IHS are controlled by one non-profit organization. In this model the group of providers merge to form a corporate IHS with a single board which would oversee all the constituent parts of the IHS. This board would be the decision-making structure for allocating the capitation payments for services and providing central management for all functions of the IHS. Between these two models would be a hybrid in which the providers come together by way of a federation, with the decision-making structure being a combination of the two.[126]

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[124] *Ibid.*, pp. 5-6.
[125] *Ibid.*, p. 7.
[126] *Ibid.*, p. 8.

Proponents of integrated/managed care structures believe that it is the consumers of health care who will make the system work. As the system is capitation based, if a consumer is dissatisfied with the services received from one IHS or other type of managed care institution, they will leave and take their capitation-based revenue with them. To counter the arguement that a capitation based system will allow for under provision of services, proponents argue that if the provider attempts to save costs at the expense of outcomes or quality, then the client/consumer (patient) will withdraw from that particular IHS and enroll in another, thereby threatening the revenue of the IHS. Furthermore, because the IHS or other managed care structure would be monitored for utilization and outcomes, clients would be provided with an opportunity to compare their provider with others and leave if another appears to be better. Lastly, because stakeholders would have a say on the management board, there would be consumer input into the management and utilization of the structure. If services were being reduced or inappropriately provided to save costs, then this would presumably be brought to the attention of the other stakeholders.[127]

As indicated earlier,[128] another example of an integrated health system is the one introducted in the United Kingdom. The system in the United Kingdom was radically altered in 1991 to bring in an element of an 'internal market'. This new system was designed to supposedly mimic the operations of a competitive market within the framework of a publicly funded service. Included in this was a subsystem which has become known as the general practice fund-hold (GP fund-holding). In this system general practices above a certain size could opt to hold their own budgets for buying health care for their patients directly from other providers, thereby essentially becoming similar to managed care structure themselves.[129]

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[127]Leatt, *supra.*, note 114 at p. 806.
[128]See supra., page 47.
[129]Rudolf Klein, "Big Bang Health Care Reform - Does it Work?: The Case of Britain's 1991 National Health Service Reforms" *The Milbank Quarterly* 1995;73:301.

A brief review of the U.K. system demonstrates the sweeping changes which took place. Before 1991 the district health authorities (DHAs) were responsible for the provision of health care services for those within their region. In other words, from funds provided by the central government they directly ran and managed all hospitals and community services. They were also accountable to the central government for the provision of these services. The reforms changed the role of the DHAs. They were now to receive funds on a per capita formula basis which, in turn, was based on population and other demographic characteristics. These funds were to be used to purchase health care for their region with the freedom to purchase the services from whomever they pleased, including the private sector. The money followed the patients instead of being attached to the facilities. The hospitals and community services, the traditional providers of health care, were now considered independent National Health Service Trusts - each with their own governing body and accountable to the Secretary of State for Health. These institutions also had to earn their own way by attracting customers. Providers were now in competition with each other, although still technically considered public bodies.[130]

c) Analysis of Integrated/Managed Care Themes

There are several related themes to the integrated/managed care reform paradigm. These themes can be used to understand the attraction for this type of delivery system.[131]

1) Separation of purchaser and provider roles. In this system the integration of responsibility for the financing and delivery of services is separated. Where formerly a body would both fund and provide the provision of health services, they would now do one or the other. In the U.K. the DHA now purchases health services for those within their community, with the provision of hospital and community health

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[130]*Id.*

[131]Chris Ham and Mats Brommels, "Health Care Reform in The Netherlands, Sweden and the United Kingdom" *Health Affairs* 1994;13:110.

services being assumed by the NHS trusts. This is designed to create an incentive for fund holders to deliver care directly to patients whenever possible.[132]

2) Competition among purchasers. In the U.K. the DHAs do not compete with each other as they are only able to purchase services for those within their geographic location. A citizen can only change their health authority by changing residence. There is, however, competition between the DHA and the GP fund-holders as GPs are able to purchase certain services for those in their practice and these funds are deducted from the relevant health authority's allotment of funds. In addition, there is competition between the various GP fund holders within a given area.[133]

3) Competition among providers. The key aspect of this element of health care reform is the introduction of competition amongst providers. The introduction of market economics into health care was in response to the perceived shortcomings of centralized planning and management of health care.[134]

4) Emergence of regulated or managed markets. Although one of the reasons for the reforms was to remedy the shortcomings of the former method of planning and management of health care, the U.K. health care system has not abandoned the use of centralized authority to regulate health care. However, they have sought to combine some market incentives with a framework of rules to guide competition while maintaining the capacity to intervene when necessary. An example of the government maintaining its role was seen when a number of London's teaching hospitals were in financial trouble due to competition and the reduction in purchasing power of the health authorities. As a result, the British government set up an independent board of inquiry to oversee the process of change.[135]

5) Use of budgetary incentives. This, like the aspect of competition, is a key to the U.K. reforms. Budgetary incentives are used to stimulate improved

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[132] *Id.*
[133] *Ibid.*, p. 111.
[134] *Id.*
[135] *Ibid.*, p. 112.

performance of hospital care, primary care and community-based care. In the U.K. the reforms to the NHS funding allowed for three main mechanisms to fund hospitals: block contracts, cost and volume contracts, and cost per case contracts. Most hospitals received block contracts which were similar to those received prior to the reforms. However, subsequent to the reforms of 1991, patients were required to utilize those hospitals under contract with the DHA where they lived. GP fund-holders did not have a similar restriction. They generally relied on cost and volume and cost per case contracts, and therefore had the flexibility to make their purchasing decisions sensitive to the needs and wants of their patients.[136]

6) Role of public health. As indicated at the beginning of this paper, health has been defined as the absence of disease. In addition, the traditional orientation of health care has been to treat the illness and not necessarily the cause. Public health has a focus of looking at the methods for improving health and at the morbidity and mortality of the population. In the U.K. public health is an important component of the DHA. Each authority appoints a director of public health who assesses the health needs and evaluates the cost effectiveness of different services. Therefore there is an influence by the public health officials in the purchaseing of health care by the health authority, and in particular, the impact of purchasing for health improvement and not just health services.[137]

7) Patient Choice. Patients have always been able to choose their GP since the inception of the NHS in 1948. In turn, the GP was able to refer the patient to a specialist of their choice. The reforms have not altered the ability of a patient to choose their GP, but it has limited the patient's ability to choose a hospital as they must use the one under contract to their DHA. If a patient is under contract with a GP fund-holder, then the fund-holder is able to choose any hospital. The consideration of patient choice raises a concern regarding the U.K. model. The issue is whose preference should shape

[136]*Ibid.*, pp. 113-114.
[137]*Ibid.*, p. 115.

priority. In the U.K., with the GP as the gatekeeper and purchaser and the DHA as an additional purchaser, there is an implicit understanding that the patient's demands and preferences will not have priority.[138]

8) Rationing. This is both an element of the integrated/managed care model and a criticism of it. Rationing is a feature of all health care systems as it involves priorities, the provision of treatment, and the development of services. National health care systems have differing definitions of the term and their style of rationing. Implicit rationing involves the limiting of physical capacity and the use of triage (based on a combination of those waiting for treatment and the medical judgment of the health care personnel) to determine the allocation of resources. Often in this type of rationing the resources are said to be scarce; however, this is artificial as the scarcity is brought on by considerations other than the true availability of the resource.[139] The other type of rationing often seen is one of explicit rationing which is set by price and the ability to pay.

While integrated/managed care has its proponents, it also has its opponents. In a document prepared to identify the issues surrounding integrated health systems by the Health Policy Department of the Ontario Medical Association, four areas were recognized as consistently arising when these types of systems are discussed. These four areas are:

i) governance - As identified earlier when the Ontario government's IHS proposal was discussed, there are at least three models to be considered in setting up an integrated/managed care system; the partnership, corporate and hybrid models.[140] In the United States most managed care type systems are set up on corporate lines. The U.K. system also has features of corporate structure. This fits the market orientation of this alternative.[141]

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[138]*Ibid.*, p. 116.
[139]Reinhardt, *supra.*, note 94 at p. 31.
[140]See supra., pages 49-52.
[141]Boadway, *supra.*, note 114 at p. 2.

ii) funding - As part of the three considerations for any health care delivery system (financing, delivery and allocation of resources), funding, or the financing of the system, is a key concern for any jurisdiction considering implementing an integrated system. As the OMA document states:

> Issues around funding are critical at the local level, and communities looking to develop an IHS are going to have to determine the degree to which they will financially support the developing IHS infrastructure. In addition, they will need to decide whether they are willing to see all of their funding moved into the IHS funding envelope.[142]

iii) information technology - The success of an integrated health system is the ability of the constituent parts to utilize information about the patient so that the optimum care can be efficiently provided. As with any technology, expectations often do not equal reality to the extent that the rapid change in what has developed, is developing, and will develop affects the impact of technology. The OMA document acknowledges the importance of information technology not only for an IHS, but also for patient care in general.[143]

iv) access to services - The gatekeeper role of the family/general practitioner is a key aspect of an integrated system. As in the U.K., it is acknowledged that the system will work efficiently if the patient receives the appropriate care and that one health care professional is responsible for the continuum of care for the patient.[144]

The OMA has produced a response to the *Health Services Restructuring Commission's* "Vision of Ontario's Health Services System".[145] In general, this critique covers virtually all aspects of the document, despite the fact that in the preamble to the response the OMA acknowledges its commitment to work with the government to examine issues surrounding the implementation of integrated health systems and the

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[142] *Id.*
[143] *Id.*
[144] *Id.*
[145] OMA Executive Committee, "OMA Comments on the HSRC vision of Ontario's health services system" *Ontario Medical Review* 1997;64(3):18-20. See also Barb LeBlanc, "Integrated Health Systems: key questions for physicians" *Ontario Medical Review* 1997;64(4)18-23.

implications for the delivery of medical services for the people of Ontario. The OMA finds fault with the conceptualization put forth regarding the current 'system' in place in the province. It alleges that the current system's components are coordinated and already working together for the betterment of the patient, not isolated and operating in 'orbits' with a hospital as the centre, as envisioned by the *Commission*.

Secondly, the issue of patient rostering is criticized as being unclear. What is necessary, the OMA Executive Committe contends, is for the term to be clearly defined. What is the population to be served; what services are to be covered with what limitations; if there are limitations, how are these to be funded? In addition the document points out - what of patient accountability and the responsibility for the utilization of services? These must also be defined and addressed.

With respect to the issue of information technology and the information system cited in the document, the OMA document points out that the *Commission* had stated that the government will be responsible for the development and maintenance of the system. The OMA criticism is that the government is not an appropriate body to be entrusted with this responsibility as it is the most distant from patient care and therefore least able to identify systems and processes which would enhance patient care. They are also concerned that a system driven by the funder of the system would be inordinately focused on system management and audit functions. Funding is of critical importance to the OMA as they feel that 'envelope' and capitation funding will not provide for adequate care for the patients served by an IHS.[146]

The OMA does see a role for the government in defining management data and as an overall manager of the system. In this role it would establish health data which could be shared, clinical nomenclature, and communication and security standards. It could fund the establishment of the information network and allow a competitive market environment to develop to meet the various needs of the IHSs and providers.[147]

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[146]OMA Executive, *Ibid.*, p. 18.
[147]*Ibid.*, p. 19.

A further critical argument against managed care appeared in the *New England Journal of Medicine* in July of 1995. In this article entitled, "Managed Care and the Morality of the Marketplace", the author begins by noting that there is a growing trend in America for large, well-financed corporations dominating the delivery of health care through managed care structures. He sees this as a threat to both society and the medical profession. He writes:

> ...Market-driven care is likely to alienate physicians, undermine patients' trust of physicians' motives, cripple academic medical centers, handicap the research establishment, and expand the population of patients without health care coverage.
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> ...Market-driven health care creates conflicts that threaten our professionalism. On the one hand, doctors are expected to provide a wide range of services, recommend the best treatments, and improve patients' quality of life. On the other, to keep expenses to a minimum they must limit the use of services, increase efficiency, shorten the time spent with each patient, and use specialists sparingly, Although many see this as an abstract dilemma, I believe that increasingly the struggle will be more concrete and stark: physicians will be forced to choose between the best interests of their patients and their own economic survival.[148] (author's footnote omitted)

His arguments are based upon a number of criticisms of managed care. He begins by citing the way health care professionals are compensated under the managed care system. He sees an economic self-interest conflict for the professional who must choose between the patient's treatment and the guidelines imposed by the managed care organization. Secondly, he sees the tracking of treatment and utilization reviews as restricting care for certain patients in certain situations. As insurers or managers find that certain procedures or certain patients are not cost effective, then services will be curtailed. He also cites how the competitive market place will require those more expensive plans to trim benefits in order to compete. Thirdly, he cites the difficulty medicine has in general with marginal decisions. If the goal of managed care is to make medicine more efficacious and cost-effective, how can a managed care organization deal with the situation where the treatment's benefits are specific to the patient or their family?

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[148]Jerome P. Kassirer, "Managed Care and the Moraliaty of the Marketplace" *N Engl J Med* 1995;333:50.

In other words, he questions how to place a value on a human life and decide how much you are willing to pay for it.[149] He concludes by calling on the politicians to reject market values as a framework for health care. Instead they should try again for a national health policy that will provide health care to all. In the end, he rhetorically asks what was the oath or promise the medical profession made; one to restrict care or to provide it?[150]

iii) Single Payer versus Two-tier Systems

In this last section I will examine an alternative which many propose as an alternative to the existing system in Canada. This alternative is described as the ability of those who wish to purchase health care outside of the medicare system to be able to purchase it. This is called by many a "two-tier" health care system as those who can pay will receive a different level of health services than those who utilize the medicare system. In other words, there would continue to be the existing publicly funded and administered health care systems whilst a parallel system would operate for those who could afford to purchase health care services on the open market.

I will examine this proposal in the context of reforms proposed for the current system. While there are those who call for the 'free market' to come to health care, there are also the proponents of the current system who acknowledge that the fiscal reality demands a change, but not so dramatic. These proponents of the current system have put forth proposals that would change the orientation and focus of how health care is delivered, but not the underlying principles or goals.

a) Modified single payor system

The *National Forum on Health* was commissioned in October of 1994 by the federal government of Jean Chrétien with a mandate to advise the federal government on

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[149] *Ibid.*, pp. 50-51.
[150] *Ibid.*, p. 52.

innovative ways to improve the health system and the health of Canadians. It also was a method by which Canadians could become involved in the process of reviewing and (possibly) reforming the health care system. Over two years the *Forum* heard from public discussion groups, held conferences, met with experts, commissioned papers, and sought the input of Canadians through letters, briefs and submissions. In the end, the *Forum* issued a final report which summarized their findings and provided recommendations. A companion report which contained the working group synthesis reports and papers was also released. It was also noted in the *Forum* report that there is a plan to release a series of background papers which were used in the consulation process.

In their final report the *Forum's* authors state:

> Over the past two years, we have become keenly aware of Canadians' deep concerns about their health and their health care system and about what they feel is hurting the system. At the same time, people hold a common view of the system they want. They want a flexible health care system that maintains the five principles of the *Canada Health Act*, is integrated, is supportive of community action, and is driven by information. They will accept change to the system as long as it is accompanied by a plan and they understand what this change is to accomplish. And change is long overdue. The financial environment is making change necessary, but if the sytem is going to work it needs to change constantly.[151]

The *Forum* found the system to be fundamentally sound. A health care delivery system, financed through general taxation, which supplies care for 'medically necessary' treatments without charges to the patient provides the best possible coverage. First, it ensures that ability to pay will not determine what treatment is received. Second, twelve coordinated single-payer health insurance plans, in contrast to many private insurers, reduces administrative costs, promotes economies of scale, and provides more effective bargaining power in dealing with health care providers and the health care industry. In addition, the concept of profit in health care is contrary to the view of health care as a

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[151]National Forum on Health, *Canada Health Action: Building on the Legacy - Final Report of the National Forum on Health Vol.1* (Ottawa: Minister of Public Works and Government Services, 1996), p. 7.

public good and leads to inequities in access and quality. Fairness and value for money is best achieved by way of a public not-for-profit funding and administration of health care.[152]

The system's funding, according to the conclusions of the *Forum*, is adequate when one looks at both the public and private components of health care financing.[153] At approximately $72 billion annually, or just under 10% of the GDP, Canada's system is one of the most expensive in the world. Some would question the share of public versus private percentages, or the relative shares that are spent on physicians, hospitals and drugs, but overall, the *Forum* concludes that enough is spent both publicly and privately to provide adequate access to needed health care. It also states that doing more with fewer resources is not going to improve the health care system. Of the $72 billion spent, roughly $52 billion comes from governments and the remaining $20 billion from individual Canadians for services such as drugs, other health professionals, and upgraded hospital accomodations. When public funding is reduced the system typically responds, not by doing things differently, but by transferring the costs to others or simply doing less. In any event, the authors indicate, in one way or another since it is all public money (ie.; either raised through taxes or provided directly by individuals) it is irrelevant what the public/private split is in terms of funding. If the focus is on total costs and value for money, then the *Forum* suggests that the evidence indicates that an increase in the scope of public expenditure may be a key to reducing the total costs.[154] Principally, the *Forum* recommended that the government expand the medicare system to include a national pharmacare plan. This is their recommendation:

> Because pharmaceuticals are medically necessary and public financing is the only reasonable way to promote universal access and to control costs, we believe Canada should take the necessary steps to include drugs as part of its publicly funded health care system.[155]

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[152] *Ibid.*, pp. 11-12.
[153] *Id.*
[154] *Ibid.*, pp12-13.
[155] *Ibid.*, p. 22.

It was pointed out that *total costs* may decrease, through economies of scale etc., even if the government's share of health care expenditure increases because, in fact, Canadians are already spending this money privately through their own payments for drugs or private insurance plans.[156]

A second key funding recommendation made by the *Forum* relates to the way physicians are paid for services rendered. In the report it is stated that funding should be to the patient and not for the services, in other words, a form of capitation funding. This is expanded upon by indicating that the remuneration method would not be based on the volume of services provided by physicians, but would promote a continuum of preventive and treatment services that utilize multidisciplinary teams of health care providers.[157]

In looking at improving the delivery of health care, the authors indicate that the evidence provided to them suggests that the system can be used more effectively and efficiently. A number of examples are cited as to where the system could be improved. Included were variations in surgical rates across the country that were unexplained; practice patterns which were slow to respond to evidence regarding the effectiveness of particular interventions; hospital stays which were longer than they needed to be in some acute care situations; drugs which were inappropriately used, - and, as the authors indicated, many more examples could be noted.[158]

In looking at improving the system, the *Forum* indicated it would start with the way the system is organized and delivered. If the *Forum* were allowed to construct an entirely new system, it would build a system that focused less on doctors and hospitals and more on community-based services which utilized multidisciplinary teams with an emphasis on the prevention of disease and illness rather than the treatment. This new system would also develop better links between intervention and health outcomes so that

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[156] *Id.*
[157] *Id.*
[158] *Ibid.*, p. 12.

the effectiveness could be better monitored. However, acknowledging that it is not possible at this point to construct a health care system from scratch, the authors indicated that there must instead be a focus on change that is gradual so that all Canadians could maintain their confidence in the system.[159]

The *Forum* indicates that the key for Canadians, with respect to the maintenance of the health care system as it is known, is equitable access and high quality of care. In order to maintain this the *Forum* recommends that funding must be stable; the federal government must refrain from imposing any further cuts to the transfer of funds to the provinces for the delivery of health services. Second, the system itself must adapt to changes in technology and therapeutic advances over the past 30 years. The focus of health care must shift from the traditional avenues of care, doctors and hospitals, to the utilization of community-based care and a broader array of health care providers. The role of the various health care professionals must be adapted in order for the system to operate for, as the *Forum* states:

> Restructuring means fundamentally reorganizing the system and changing the distribution of work. It does not mean simply doing more with less. It means integrating the funding and delivery of health care services through primary care reform and other organizational reforms. It also means reviewing the activities of all health care providers and taking down barriers that prevent the best use of the system's human resources. The status quo is a dead end we can ill afford. Neither can we succumb to the temptation of off loading public costs onto private budgets, either by arbitrarily deinsuring services or by implementing user fees in any form for medically necessary services. These "quick fix" solutions only undermine public support for the system and inflate total expenditures, while leaving the more fundamental issue of system structure unresolved.[160]

In keeping with this line of thinking, the *Forum* looked at the other determinants of health. Recall the earlier definition of health as issued by the World Health Organization whereby health was defined as, not just the absence of disease or injury, but a person's complete physical, mental and social well-being. The *Forum* builds upon this

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[159] *Id.*
[160] *Ibid.*, p. 14.

by looking at the social and economic determinants of health and concludes that the governments should be looking at: child poverty and welfare; the impact of unemployment and underemployment and health; changes in the labour market and the principal effect this has on women; and aboriginal health issues, which must include a review of unemployment rates, lack of education and welfare dependency.[161]

The last major recommendation from the *Forum* concerns the use of information in medical decision-making. They recommend that an evidence-based health system should be developed in which decisions are made by health care providers, administrators, policy-makers, patients and the public on the basis of appropriate, balanced and high-quality evidence.[162]

The *National Forum on Health* is not the only public body issuing reports regarding the direction health care should take in Canada. The Canadian Medical Association (CMA) has also produced material which addresses the issues of core and comprehensive health care services. In this publication, together with a series of articles in the *Canadian Medical Association Journal*, they have attempted to provide a reference framework to assist in the debate regarding the provision of health services in Canada.[163] This work by the CMA does not promote any particular alternative other than indicating that the framework for decision-making which they are proposing should be used whenever health care issues are being debated. Their focus looks at the three levels of the health care equation. The macro level - government decision makers or where decisions are made that affect the entire system; the meso level - the institutional level

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[161] *Ibid.*, p. 15-16.
[162] *Ibid.*, p. 28.
[163] Canadian Medical Association. *Core and Comprehensive Health Care Services - A Framework for Decision-Making* (Ottawa: Canadian Medical Association, 1994) and also: Ruth Wilson, Margo S. Rowan and Jennifer Henderson, "Core and Comprehensive Health Care Services: 1. Introduction to the Canadian Medical Association's Decision-Making Framework" *Can. Med. Assoc. J.* 1995;152:1063-1066; David J. Walters and Donald A. Morganm, "Core and Comprehensive Health Care Servcies: 2. Quality-of-Care Issues" *Can. Med. Assoc. J.* 1995;152:1199-1204; Douglas M. Sawyer and John R. Williams, "Core and Comprehensive Health Care Servcies: 3. Ethical Issues" *Can. Med. Assoc. J.* 1995;152:1409-1411; and, Michael Wyman, John Feeley, Glenn Brimacombe and Kevin Doucette "Core and Comprehensive Health Care Services: 4. Economic Issues" *Can. Med. Assoc. J.* 1995;152:1601-1604.

which would include not only hospitals and other traditional institutions, but also the professional level and community; and the micro level - which would involve the individual decisions about health care delivery made by the patient, physician and other health care professionals. It is evident that all three levels are dynamic and relate to each other in multifaceted ways.[164]

This CMA approach goes on to state that there are three other considerations that should be taken into account at each level. They believe that the quality of treatment, ethical issues, and economic factors relating to the provision of medical service should also have consideration when alternative financing and delivery of health care are under discussion. They expand on this by stating that the following questions should be included in the debate: is there evidence of effectiveness and efficiency of the proposed treatment (quality); what is the risk/benefit ratio and what effect will this have on the allocation of resources to others (ethics); and, what are the issues of funding and affordability (economics)?[165]

The real focus of this approach is to look at what medical services should be deinsured. By defining what services are core and comprehensive with respect to medically necessary care, the implication is that the balance of medical treatment would not fall under the criteria of the *Canada Health Act* and, therefore, could be billed directly to the patient by way of some other reimbursement mechanism. (ie. private insurance) By utilizing an analysis at the three levels and taking into consideration the quality, ethics and economics of a proposed treatment, the CMA believes that decisions can be made which will enhance the delivery of medical services. Those treatments that do not satisfy the analysis should be deinsured, in which case other considerations may come into play. As the CMA document concludes:

> In making choices on publicly funded health care services, it was felt that decision-makers must consider a wide range of factors including the

[164]Wilson, *Ibid.*, p. 1064-65.
[165]Canadian Medical Association, *supra.*, note 163 at pp. 67-69.

> quality of care provided to patients, ethical criteria by which fair and reasonable decisions can be made for all members of society and economic factors such as affordability and implications for physician remuneration. The flexible nature of this framework recognizes that there may be times when one criterion outweighs others.
>
> Some key issues generated in this document include:
>
> • In making decisions about insuring or deinsuring a health care service, should the entire service be (de)insured or should (de)insuring be based on a guidelines approach ("partial deinsurance" method)?
> • What should the role of the public be in making decisions about core health care services?
> • If a health care service is deinsured, should it be made available through private insurance?
>
> The key to resolving the issue of defining core and comprehensive health care services will be in the approach to the problem. By providing decision-makers with knowledge and tools to assist in this process, we hope that the first and foremost concern will continue to be the quality of patient care that we have come to value so highly as Canadians.[166]

Deinsuring a particular treatment, as mentioned earlier[167] is a method by which health care costs can be contained. In addition, the *Canada Health Act* does not define 'medically necessary' or 'medically required' - the two key definitions necessary to trigger the application of the *CHA*. Many have called for a statutory definition of what is medically necessary and medically required in order for there to be clarity and predictability with respect to the provision of health care services. In addition, this definition should be arrived at through cooperation and negotiation involving all levels of government so that there would be uniformity across the country.[168] Others have commented that this exercise would be wasteful and that it would be extraordinarily difficult to establish which services should be covered. One suggestion to remedy this problematic issue is to approach the question of what to deinsure by determining what medical or health outcome is to be achieved by the procedure. In this way, those procedures with outcomes that do not fit what is desired (which itself opens another area

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[166] *Ibid.*, pp.72-73.
[167] See supra., pp. 11 and 34.
[168] See The recommendations contained in the Canadian Bar Association's Task Force Report *supra.*, note 5 at pp. 41-42.

of problematic definitions) would be either deinsured or have a reduced priority for provision.[169]

b) Two-tier System

Is a two-tier system an alternative that should be considered? Firstly, what is a two-tier system? Generally a two-tier system occurs where there are two levels of care available to the health care consumer. One level is funded publicly and administered by the government - the system in Canada today - with a parallel level that is funded privately by individuals either with their own funds or through a private insurer. Other features would include an overlap between what was available in the private system and public. In other words, the consumer would have a choice as to which system they would seek medical services through.

The philosophy behind the parallel private system is one of utilitarianism. In discussing the option of a parallel private system the chair of the Canadian Medical Association's Board of Directors quoted historian Michael Bliss: "What do you do if you promised to supply people's needs for something and then find you can't afford to do it any more? You have two choices: you can fund only a certain percent of everyone's needs or you can fund the needs of those who have nowhere else to turn and ask the well-to-do to fend for themselves. In the first scenario, no one's needs get fully satisfied. In the second scenario, everyone's do."[170]

This second tier, or private system, is essentially what now occurs in the United States and the United Kingdom. Opponents of a second tier cite the increase in

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[169]Michael M. Rachlis, "Defining Basic Services and De-insuring the Rest: The Wrong Diagnosis and the Wrong Prescription" *Can. Med. Assoc. J.* 1995;152:1403. It should be pointed out that this is in fact what the State of Oregon has undertaken in reforming the delivery of medicare and medicaid in that state. Oregon used a formula based on cost-utility which also incorporated public attitudes and values. Using this explicit process the Oregon Health Services Commission ranked 714 condition-treatment pairs. Payment for treatment was then based on this ranking. Oregon's reforms have been the subject of much analysis and are beyond the scope of this paper.

[170]As cited in Charlotte Gray, "Visions of our Health Care Future: Is a Parallel Private System the Answer?" *Can. Med. Assoc. J.* 1996;154:1085.

administration costs in the United States and the use of reviews to chart the course of patient treatment and the direction given to health care professionals by the managed care organizations as negative consequences of private delivery of medicine.[171] In the U.K. it is noted that the private sector allows for some patients to jump the queue for faster service. In the U.K.'s private health sector a patient can be seen by their NHS family doctor, be referred to a private specialist and then to a public hospital where the same specialist then performs the required procedure.[172]

Others cite that the public system's support would erode as middle and upper income earners resent funding a public system which they do not utilize.[173]

Proponents of a second tier have their own list of advantages, which include:

> • increased incentive for the public sector to be more cost effective as a result of competition;
> • recapture of money now spent by Canadians in pursuit of health care outside Canada, most principally in the U.S. on private diagnostic and specialist services;
> • a private sector would reduce the waiting list for public sector patients
> • new money would be injected into both the health care industry and the Canadian economy in general as the private sector upgrades buildings and technology.[174]

Those in favour of trying a private component to health care also cite the fact that the current system has the implicit supply side rationing which was discussed earlier.[175]

iv) Conclusion

At the beginning of this section the story of the 'health care pig' was related. In many ways the dilemma facing Canadians is reflected in this story. The health care system has defined how Canadians see themselves - a quality service that is equally distributed. It also has literally saved lives with no cost consequences to the recipient of

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[171]Michael Gordon, Shelley Sternberg and Ty Turner, "Should Specialists Support Canada's Single-Payer System?" *Annals RCPSC* 1996;29:399.
[172]Gray, *supra.*, note 170 at p. 1085.
[173]*Id.*
[174]*Id.*, see also: Kenneth Sky, "Re:Should Specialists Support Canada's Single-Payer System?" *Annals RCPSC* 1996;30:12-13, and R.W. Gunton, "It's Time to Re-introduce a Private Component to the Funding of Health Care" *Annals RCPSC* 1996;30:9-11.
[175]See supra., page 43.

the health care service. Canadians also take for granted their health care system and may see it 'butchered' - not all at once but, like the pig, one part at a time. Others would say that they are not 'butchering' the pig, but making it a better pig - either way it will not be the same.

What if the alternatives discussed here are implemented? If there are macro decisions that negatively effect someone at the micro level, is there any recourse? Fundamentally, are these decisions subject to challenge? What of legal and ethical considerations of these decisions? Given the developing litigious nature of our society, the courts will become involved. The question then becomes: should the courts become involved in health care delivery issues?

These are the questions that flow from the discussion of pressures and responses on the system.

PART 4 - LEGAL CONSIDERATIONS

> ..... the law, although only one factor among many affecting the structure and delivery of health care, is a very relevant and significant factor, meriting its own analysis. Any health care system is an outgrowth of the political culture, the social and moral values and the economic imperatives of the society it serves. One cannot make neat distinctions among the legal, ethical, clinical, political and economic factors which all play a role in shaping a country's health care system.[176]

The above excerpt is from the Canadian Bar Association's Task Force on health care reform. In 1994 they published their report which examined the health care system in Canada in order to answer a number of questions relating to legal and ethical interests and the enforcement of these interests. The legal aspects of health care delivery are often overlooked in examining health care delivery reform. When any one of the three basic aspects of health care reform - financing, delivery and allocation - are altered, groups or individuals will be affected. These policy decisions are generally made at the government level which then force subsidiary decision-makers, such as hospital administrators or physicians, to implement these policy choices which often result in an effect on the health care consumer. These decisions themselves, the process by which they are made, and the results of the decision are all potentially open to some kind of legal challenge. What it often comes down to is a question of society's interest in the efficiency of the health care system balanced against the interest of the individual and the level of care they receive. This is also a traditional role the courts have played when they must intervene to arbitrate between the interests of society and those of the individual.

In looking at legal considerations, first I propose to return to a brief review of questions of allocation and rationing as these are often the areas where legal and ethical issues arise. Then I will look at the three areas of the law in which the courts have become involved.

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[176]Canadian Bar Association, *supra.*, note 5 at p. 2.

i) Allocation and Resource Issues

Issues of allocation and rationing touch three of the five cornerstones of the *Canada Health Act*. The requirements of *comprehensiveness* - all medically necessary services must be insured; *universality* - all insured persons must receive insured health care services on uniform terms and conditions; and, *accessibility* - all insured persons must be provided with reasonable access to insured health care services, are all affected by decisions to limit health care due to policy decisions or budgetary constraints. Cost containment and the unavailability of a particular test or procedure due to a lack of funds are areas where a health care professional may be personally exposed to civil liability.[177] At the meso level decisions regarding the allocation of funds to various areas of health care may potentially be reviewed and at the macro level policy issues and decisions have the potential for court challenge. The important factors in any court challenge will be the identity of the decision maker, the procedures followed in reaching the decision, and whether there is a direct effect on the individual as to their entitlement to health care.

The following are several examples of how cost constraints can directly influence the way medicine is practiced. If there is resource rationing, the delivery of health care services to either individuals or groups could be one of the first to suffer. Another is a policy of euphimization which would affect the health care professional's ability to provide an acceptable standard of care to a patient.[178] Euphimization is defined as a policy of restriction of medical treatment based on such criteria as age, sex or physical parameters and which establishes limits beyond which certain medical procedures are not performed. Next, the use of utilization reviews could prohibit a particular treatment due to the known cost and potential outcome of the procedure. Similarly, practice guidelines, which are a series of statements of appropriate measures to be taken by physicians in the

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[177]Canadian Medical Association, *Core and Comprehensive Health Care Services: The Legal Issues* (Ottawa: Canadian Medical Association, 1994) p. 3.
[178]Peter W. Kryworuk, Brian T. Butler, Allyson L. Otten, "Potential Legal Liability in the Allocation of Scarce Health-Care Resources" *Annals RCPSC* 1995;28(3):154.

diagnosis and treatment of a disease or illness, may affect the ability of a health care team to treat an individual as they deem appropriate. These guidelines are often developed by medical bureaucrats, removed from the reality of practice, who fail to appreciate that many practitioners are faced with a medical environment which is restricted in the sense that they do not have unlimited resources and peer support.[179]

Another consequence of cost containment and rationing is that of informed disclosure to the patient. For the patient to have informed consent they must be told all material information about the care that could affect their ability to make an informed decision about their treatment. Material information entails all treatment alternatives including the possibility of taking no action.[180] This raises concern for the situation in which the physician is aware of an alternative treatment which is unavailable due to a limitation of resources. Must the physician disclose this fact and the fact that it may be available in another jurisdiction, such as the United States where it will have to be paid for?[181]

A final consequence of cost containment is the fact that the supply of physicians and therefore the availability of health care services may be affected . Physicians may leave Canada to practice where their incomes will not be restricted by a salary cap, or they may not enter specialities where there is a greater chance of negligence suits due to practice rationing.

ii) Legal Avenues

a) Charter of Rights and Freedoms [182]

i) Introduction

In general terms, the Charter constrains the actions of governments in the enactment of policy by guaranteeing a set of rights and liberties. If government policy

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[179]*Id.*
[180]*Reibl* v. *Hughes* [1980] 2 S.C.R. 880.
[181]Kryworuk, *supra.*, p. 178.
[182]*Constitution Act, 1982.*

infringes upon these rights and liberties, then the courts will provide protection. This applies to both legislative as well as administrative decisions of the government. In addition, recent Supreme Court of Canada decision, *M.(A.)* v. *Ryan*, held that the Charter did not apply to private litigation, but they went on to state that the court must ensure that the development of common law doctrines (in the *Ryan* case the common law doctrine was that of privilege) must be in accordance with "Charter values". This means that the common law rules and doctrines must be reviewed to ensure that they reflect the values that the Charter enshrines.[183]

As discussed earlier, there are three sections of the Charter that would likely be used in any action involving health care - sections, 7, 15 and 36. Paraphrasing these sections, section 7 provides that everyone has the right to life, liberty and security of the person and the right not to be deprived thereof except in accordance with the principles of fundamental justice. Section 15 states that every person is equal before and under the law and has the right to equal protection and benefit of the law without discrimination. Section 15 also enunciates particular grounds of discrimination including: race, national or ethnic origin, colour, religion, sex, age or mental or physical disability. Section 36 calls for the federal and provincial governments to act together to ensure that all Canadians have equal opportunities for personal well-being and to ensure that public services are of reasonable quality across the country.

The rights prescribed in the Charter are not absolute nor are they given protection in all circumstances. Section 1 of the Charter states that all rights are "subject only to such reasonable limits prescribed by law as can be demonstrably justified in a free and democratic society."[184] The application of section 1 limits would be justified where it is determined that a societal objective is more important than a Charter right. In essence, the court would apply the concept of a balancing process between upholding the rights protected by the Charter and other societal interests where they are conflicting. In

[183] *M.(A.)* v. *Ryan*, [1997] 1 S.C.R. 157.
[184] *Charter*, section 1.

relatively early Charter decisions the Supreme Court of Canada set out a sequence to be considered where section 1 limits are to be applied. First, it must be determined which government objectives are sufficiently important to warrant overriding a Charter right. The objective must relate to concerns which are "pressing and substantial" in a free and democratic society. The next step is to determine if the means chosen to override the Charter right are reasonable; the measures adopted must be carefully designed to achieve the objective in question and must not be arbitrary, unfair or based on irrational considerations. They should also impair the right as little as possible. The final test is one of proportionality between the effects of the measures adopted and the objective sought to be achieved. The more severe the effects of a measure, the more important the objective must be to warrant the overriding of a Charter right.[185] It should also be noted that the courts will take a contextual approach to a section 1 analysis. In other words, they will apply the test to the specific circumstances of the case at issue.

The basic test for a section 15 analysis was set out in the Supreme Court of Canada decision in *Andrews* v. *Law Society of British Columbia*.[186] The court first looks to determine if one of the four enumerated equality rights that are listed in section 15 have been violated through creating a distinction or differentiation among individuals on the basis of one of the grounds listed in section 15. These enumerated grounds are: equality before the law; equality under the law; equal protection of the law; and equal benefit of the law. The court will also look to analogous grounds. However, differential treatment is not enough. The applicant must not only establish the differential treatment, but must also show that this differential treatment results in discrimination in its purpose or effect. The court held for the legislative distinction to be discriminatory it must be one:

> .....which has the effect of imposing burdens, obligations or disadvantages on such individual or group not imposed on others, or which withholds or

[185] *R.* v. *Big M Drug Mart Ltd.*, [1985] 1 S.C.R. 295; *R.* v. *Oakes*, [1986] 1 S.C.R. 103
[186] *Andrews* v. *Law Society of British Columbia*, [1989] 1 S.C.R. 143

> limits access to opportunities, benefits and advantages available to other members of society.[187]

However, the first question that would have to be addressed is the issue of whether the Charter would apply to a legal action or application involving health care.

ii) Charter Application

The Charter only applies to actions involving either the provincial or federal government. Therefore the first question will be whether the alleged action can be tied to a level of government. The Supreme Court of Canada has had before it issues involving the scope of government action and the applicability of the Charter. In *RWDSU* v. *Dolphin Delivery* the court held that the Charter applies to the three branches of government: legislative, executive and administrative.[188] The court again looked at the scope of government action in 1990 when they decided a series of cases, one of which involved a hospital's by-laws. In the case of *Stoffman* v. *Vancouver General Hospital*, the court was required to determine whether the hospital's by-law with respect to mandatory retirement of a physician and the granting of hospital privileges were subject to a Charter review.[189] The court found that the function exercised by the hospital board was one of internal management or of day-to-day operations. Mr. Justice La Forest, with Chief Justice Dickson and Justices Gonthier and Sopinka concurring, discussed the applicability of the Charter to the hospital's decision and by-laws. He found that the hospital was not a part of the administrative branch of the government. Justice La Forest stated that although the provision of health care and hospital services were an important part of the legislative mandate of the provincial government, an entity which provides such care and services was not a part of the government simply because of such provision.[190] Furthermore, the creation of the hospital by virtue of provincial legislation

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[187] *Ibid.*, at p. 174 and as cited in Canadian Bar Association, *supra.*, note 5 at p. 53-54.
[188] *RWDSU* v. *Dolphin Delivery*, [1986] 2 S.C.R. 573
[189] *Stoffman* v. *Vancouver General Hospital*, [1990] 3 S.C.R. 483, 76 D.L.R. (4th) 700.
[190] *Ibid.*, D.L.R. at pp. 735-736.

(*Hospitals Act,* R.S.B.C. 1979, c. 176) did not make the daily or routine aspects of the hospital's operation subject to governmental control. Daily and routine aspects of the hospital's operations were in the hands of its board of trustees.[191] In addition, the ability of the government to appoint members of the board of trustees, or the fact that the board may be required to adopt by-laws suggested by the Minister of Health, did not bring the hospital under section 32 of the Charter. As Justice La Forest stated:

> The provision of a public service, even one as important as health care, is not the kind of function which qualifies as a government function under s. 32.[192]

According to *Stoffman* it would appear that a managerial decision of a hospital is not subject to Charter review. However, when one looks at a broad interpretation of *Stoffman*, *Dolphin Delivery* and the recent decision of *(M.)A.* v. *Ryan*, an argument can be made that a hospital's decision involving allocation or rationing could be subject to a Charter challange. In *Dolphin Delivery*, the court did not close the door on the possibility that the Charter could be used in disputes between private individuals, provided it could be shown that there was some form of governmental action relied upon. In the *Ryan* decision the court held that the court should review matters to ensure that Charter *values* apply. The Charter values are those prinicples that the court has developed over time and which find their place in the enumerated sections of the Charter. In this case it could be found that the *values* as set out in sections 7 and 15 should apply. Therefore medical care delivery decisions affecting a person's life, liberty or security of the person may apply.

iii) How the Charter has been Applied

The Charter has been used in a number of court proceedings in which an aspect of health care is at issue. What follows is a review of some of those proceedings in which the Charter has been applied.

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[191] *Ibid.*, p. 740.
[192] *Ibid.*, p. 741.

In 1988 the Supreme Court of Canada held that section 7 of the Charter can be applied to health. In the decision of *R.* v. *Morgentaler*[193] the court found that personal autonomy and the right to make health care decisions (abortion in this case) outweighed the state's interest in criminalizing abortion. The complex procedure necessary to obtain an abortion and the uneven access to abortion services across the country infringed the rights outlined in section 7. In addition, the majority held that the right to security of the person under section 7 guaranteed a right to access to medically necessary treatment without the threat of criminal sanction. Justice Beetz stated that the right to security of the person conferred by section 7 must include some protection from state interference when a person's life or health is in danger. He then stated:

> If a rule of criminal law precludes a person from obtaining appropriate medical treatment when his or her life or health is in danger, then the state has intervened and this intervention constitutes a violation of that man's or that woman's security of the person. "Security of the person" must include a right of access to medical treatment for a condition representing a danger to life or health without fear of criminal sanction.[194]

The court also discussed the aspect of state imposed psychological stress and its affect as a result of the state's interference with an individual's section 7 rights. In this context it has been postulated in the Canadian Bar's report on health care reform that the Charter can be used to protect an individual from state-imposed psychological stress as a result of the delay or denial of safe and timely medical treatment.[195]

The majority of the cases which have followed *Morgentaler* have involved the Charter and funding of health care. In these cases both section 7 and 15 are used to argue that, in general terms, the plaintiff's or applicant's preceived denial of health care services amounts to a deprivation of the right to life, liberty or security of the person (s. 7) or that they are being treated unequally under the law. (s. 15).

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[193]*R.* v. *Morgentaler*, [1988] 1 S.C.R. 30, 44 D.L.R. (4th) 485.
[194]*Ibid.*, S.C.R. at p. 90.
[195]Canadian Bar Association, *supra.*, note5 at p. 49.

In *Ontario Nursing Home Assn.* v. *Ontario*[196] the issue related to the funding arrangements in place in Ontario with respect to extended care needs for patients in nursing homes as opposed to homes for the aged. Under the government's funding provisions, those patients who were cared for in facilities under the jurisdiction of the *Homes for the Aged and Rest Homes Act*, R.S.O. 1980 c. 203 received more funding, as extended care residents, than those who were in facilities operating under the *Nursing Homes Act*, R.S.O. 1980 c. 320. The applicants sought a variety of declarations the essence of which would order that those residents in facilites under the *Nursing Homes Act* had had their sections 7 and 15(1) Charter rights violated and that the province should increase the funding to those homes. It was calculated that if the court were to order the increase in funding on a *per diem* rate difference between the two levels of care, the cost to the province would be approximately $300,000,000 a year.[197]

In reviewing the evidence of witnesses from the Ministry of Health, the nursing home industry and family members of residents, the court concluded that delivery of long-term care for the elderly is a complex problem. Careful study was required to appreciate the financial limitations in the provision of health care and the relationship to extended care residents. Nursing homes were operated under the *Nursing Homes Act* and administered by the Ministry of Health. Funding had two sources, the Ministry of Health and the resident themselves. These homes are generally operated on a for profit basis.

Homes for the aged were operated under the *Homes for the Aged and Rest Homes Act* which were administered by the Ministry of Community and Social Services. Funding for these homes had a number of sources. The resident paid the same *per diem* rate but the province and the municipality where the home operated also provided funding. The homes were operated on a non-profit basis and there was the ability to apply to recieve part or all of any annual operating deficit.

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[196] *Ontario Nursing Home Association et al.* v. *The Queen in Right of Ontario et al.* (1990), 72 D.L.R. (4th) 166 (Ont. H.C.).
[197] *Ibid.*, pp. 168-169.

The court found that extended care residents in both settings had similar needs and that there were inequities in the funding available for residents in comparative settings. It stated that this was illogical and unfair.[198] As a matter of justice, people with similar needs should receive similar funding. However, despite these statements, the court held that there was no evidence that the individual applicant (Mr. Symons) in the nursing home was not being adequately cared for. The court agreed that if there was greater funding he might receive more care but, as it stood on the facts, he was not being deprived of his section 7 rights to life, liberty or security of the person. The court then applied the reasoning as set out in the Supreme Court of Canada decision of *Whitbread v. Walley*.[199] In this decision the Supreme Court dealt with economic and property rights as they applied to s. 7. Based on the decision in the *Whitbread* case, the Ontario Court held that they could not deal with the issue of whether the entrenchment of property rights in section 7 would have allowed for a consideration of whether additional benefits would have enhanced Mr. Symons' life, libery or security of the person.[200]

As for section 15, the court held that there was no deprivation of equality rights. In addition if there was a deprivation of the right of equal benefit of the law, any discrimination would have been based on the type of residence occupied by Mr. Symons, which is not one of the enumerated grounds under section 15.[201]

In his conclusion Mr. Justice R.E. Holland stated what may be the court's typical view in these types of cases:

> It appears that nursing homes are generally receiving less funding for extended care residents than homes for the aged. It also appears that it would be appropriate to base funding on individual need whether the individual be resident in a nursing home, home for the aged or in a private home. *It is to be hoped that the province will proceed with dispatch to consider the complex problems of financing care for the elderly and for those who require chronic care and will enact appropriate legislation in due course.* (emphasis mine)[202]

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[198] *Ibid.*, pp. 175-176.
[199] *Whitbread v. Walley* (1988), 51 D.L.R. (4th) 509.
[200] *Ontario Nursing., supra.*, note 196 at p. 177
[201] *Ibid.*, p. 178.
[202] *Ibid.*, p. 180.

Mention should be made of two cases involving funding and the request by an individual for specific medical services. In *Brown v. British Columbia (Ministry of Health*[203]and *Re Fernandes and Director of Social Services (Winnipeg Central)*[204] the issues involved the use of the courts and the Charter to obtain individually specific medical services which had been previously denied.

Brown was a 1990 decision of the British Columbia Supreme Court which involved an action to have the court declare that the refusal by the B.C. Ministry of Health to fully fund the cost of the drug AZT was contrary to ss. 15 and 7 of the Charter.

The plaintiff pursued the following points in argument. In June of 1987 the Ministry of Health in British Columbia placed AZT under the provincial Pharmacare Plan which resulted in all HIV/AIDS patients using AZT, except those on social assistance or in long term care facilities, being required to pay a portion of the cost of the drug to a maximum of $2,000.00 a year. In addition, British Columbia was the only province not to fully fund the use of the drug AZT for all who required it. Another argument was that British Columbia discriminated against those who required AZT as full drug funding was provided to those patients who required drugs for cancer treatment and organ transplants.

It was conceded by the defendants that HIV infection is a physical disability and that discrimination based on sexual orientation contravenes the equality provisions of the Charter. In summary, the plaintiff's argument was based on the fact that the government was discriminating against those with HIV/AIDS based on the decision not to fully fund AZT use.

The court rejected this argument stating that under the *Constitution Act, 1867* the province was entitled to disregard the drug funding arrangements in other provinces as health care is the responsibility of each province.[205] Secondly the court made the following comments:

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[203]*Brown v. British Columbia (Ministry of Health)* (1990), 66 D.L.R. (4th) 444.
[204]*Re Fernandes and Director of Social Services (Winnipeg Central)* (1992), 93 D.L.R. (4th) 402.
[205]*Brown, supra.*, note 203 at p. 460.

> The plaintiffs say that the decision to place AZT on the plan discriminates against them, a "discreet and insular minority" on the gounds of physical disability and sexual orientation. But the Pharmacare Plan applies to all residents of this province, including all those who are catastrophically ill: everyone who uses a prescription drug, unless suffering from cancer or undergoing a transplant, must contribute to the cost of the drugs they need.[206]

The court indicated that the distinction in medical treatment between cancer, transplants and HIV/AIDS was acceptable. The court accepted that the treatment therapies for cancer and transplants patients, unlike that for HIV drug therapy, involved complicated and constantly changing medical and drug protocols. The distinction between the drug therapies was an accommodation of the medical difference and was not the sort of inequality addressed by section 15.[207]

In reviewing the law and the application of section 7, the court again reviewed the decision of *Whitbread v. Walley*.[208] The plaintiffs had argued that the decision to place AZT on the plan violated their security because it affected their health, both physically and psychologically, imposing stress, stigma, perception of discrimination and loss of self-esteem. The court found that there was no deprivation of life, liberty or security of the person, but rather, the deprivation lay in the fact that the plaintiffs were infected with a debilitating and incurable disease. Furthermore, any claim under section 7 was based on economic deprivation and a reduction in the standard of living. Reviewing *Whitbread*, the court found that the plaintiffs did not differ from other persons with debilitating diseases who had to pay for their drugs which put these people in similar economic circumstances. While "benefits" of an economic nature might enhance the life, liberty or security of the person, they are not the benefits which section 7 can provide.[209]

In the end the court rejected the plaintiff's action but echoed the sentiments expressed by the court in the *Ontario Nursing Home* case.

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[206] *Ibid.*, p. 463.
[207] *Ibid.*, pp. 462-464.
[208] *Whitbread, supra.*, note 199.
[209] *Brown, supra.*, note 203 at pp. 467-469.

> I have found that the funding policy does not contravene the law. Nevertheless, I recongnize that AIDS is one of the great tragedies of our age. *It behoves those in private life and in government whose actions affect the well-being of those suffering the disease to act decently, fairly, compassionately.*[210] (emphasis mine)

The second case, *Re Fernandes and Director of Social Services (Winnipeg Central)*, involved an appeal from the decision of the Director of Income Security under the *Social Services Act* R.S.M. 1987, c. S160 which refused Mr. Fernandes' request for an additional allowance which would have permitted him to engage the services of an individual to provide health care services for him. The facts were straightforward. Fernandes suffered from Becker's muscular atrophy with progressive respiratory failure. He required a permanent ventalator to control his breathing and achieved mobility with the use of an electric wheelchair. With the aid of attendant care for 16 hours a day he had been able to live on his own. However this attendant care ended in the fall of 1990 when his girlfriend, who had been providing this 16 hours a day care, moved out. When this relationship ended Fenanades was admitted as an in-patient in the Municipal Hospital so that he could continue to receive the care that he required. It was determined that Fernandes did not want, nor did he need, this in-patient treatment. From September 1990 to May 1991 he sought admission to the limited facilities in the City of Winnipeg that would allow him to return to community based living. However there were no vacancies in the community living program so Fernandes was required to remain as an in-patient. He had proposed a plan to the Director of Income Security which would have allowed him to stay in his apartment provided he received an additional allowance to cover the costs of an attendant at his residence 16 hours a day in order to provide him with the care he required. This proposal was rejected by the Director in May 1991. In June of 1991 Fernandes then appealed this decision to the Social Services Advisory Committee. In October of 1991 the Committee ordered that his appeal be dismissed. Fernandes then

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[210] *Ibid.*, p. 469.

sought leave to appeal the decision to the Manitoba Court of Appeal pursuant to the provisions of the *Social Services Act*.[211]

Fernandes challenged the decision of the Director and the Committee on a number of grounds. Principally, he alleged that their decisions infringed his rights under ss. 7 and 15 of the Charter. In dealing with these Charter issues, the court bluntly stated that the applicant's rights, which he alleged were infringed, do not come within the ambit of section 7 of the Charter. To support this position, the court cited Mr. Justice Lamer's reasons in *Reference re: ss. 193 and 195.1(1)(c) of Criminal Code (Man.)* (1990), 56 C.C.C. (3d) 65 at ppl 101-3 and then stated:

> The desire to live in a particular setting does not constitute a right protected under s. 7 of the Charter. Fernandes does not acquire any rights to a particular style of living as a result of his need for an allowance under the Act.
>
> Nor does the fact that Fernandes is required to remain as an in-patient at the Municipal Hospital result in an infringement of his rights under s. 15(1) of the Charter.
>
> In order to establish an infringement under this section of the Charter, Fernandes must demonstrate both that he has received unequal treatment before and under the law and that treatment is discriminatory.
>
> Under the Act, Fernandes is being treated in the same manner as all applicants for an allowance. He is receiving all basic necessities as required by the Act. All his needs are being met. He is not receiving unequal treatment under the law. The fact that he is not being housed in a facility of his choice does not give rise to a determination that he is deprived of equal protection and benefit before and under the law.
>
> Fernandes remains as an in-patient for many reasons. He has a physical handicap which requires an attendant on hand 16 hours per day. He has no independent means to cover the costs of that attendant. He lost his primary caregiver in the fall of 1990 and has no family member or other person who can perform that function on his behalf. There are no other facilities with vacancies that can accommodate his needs. The hospital is available at no additional cost to the program under the Act. It was not his illness that led to his social admission to hospital. It was the loss of his caregiver coupled with the limited resources available in the community to provide the care he requires. The Director's decision denying the request for an additional allowance did not amount to discrimination under the Charter.
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> .....
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> Fernandes is not being disadvantaged because of any personal characteristic or because of his disability. He is unable to remain community-based because he has no caregiver, because he must rely upon

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[211] *Re Fernandes, supra.*, note 204 at pp. 404-406.

> public assistance and because the facilities available to meet his needs are limited.[212]

In the case report no evidence is reported as to the cost of the social admission to hospital nor the anticipated cost of the caregiver for 16 hours. Presumably, the cost for the hospital admission would be essentially fixed costs for the hospital, whereas the caregiver would be additional. On a practical level, the decision may be different today given the devolution of authority and caregiving referred to earlier. Given the trend of government departments to off-load costs or expenses to other departments, a jurisdiction in which the Ministry of Health would incur the cost in one care situation and a Social Services Ministry in another, the decision of both the Director and Committee may have been different to begin with.

Those points aside, this case tells us that the courts are again reluctant to intervene to order a particular type of care be provided. In these cases the courts are not saying that the Charter will not apply to health care decisions, it is just that based on these particular fact situations the Charter does not apply. In what cases would the Charter apply, or would it ever apply? The courts are reluctant to intervene in matters of public policy as they are generally deferential to the legislature. If a government instituted a health care policy that severely restricted access or services to an identifiable group, essentially instituting a policy of euphimization, would the courts apply the Charter? It is difficult to say, for clearly s. 15 would then apply However, it must be remembered that a government can infringe on an individual's Charter rights despite a court's finding of infringement. A government can either justify the infringement under section 1 of the Charter, so long as the decision making process that led to the policy decision was in accordance with the principles of funadatmental justice, or it can ultimately use the 'notwithstanding' clause contained in section 33.

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[212] *Ibid.*, pp. 414-415.

In the cases considered by the courts thus far, and those to be discussed subsequently, the courts have shown deference to a government's health care policy. This deference is based on the fact that the government has demonstrated that it has taken into account the greater good.

While not expressly stating this premise, the following discussion of administrative law decisions implicitly takes this into account.

b) Administrative law review

Government agencies, quasi-judicial bodies, or other such entities granted powers under enabling legislation, when acting in an administrative capacity, are subject to review under the heading of administrative law. This would include such administrative functions as the issuing of regulations or the decision of an administrative board; in other words, the delegated acts of government. The principles of administrative law indicate that the administrative decision-maker must have the statutory authority to make the decision and the decision must be made in accordance with the principles of natural justice. Natural justice includes the issues of procedural fairness - the right to be heard, the right to receive reasons for the decision and, in some cases, the right to be represented and treated reasonably. Administrative law therefore looks at both substance and process.

While constitutional law tends to review the source of the legislative power, administrative law reviews the granting of the power within the enabling legislation. This leads to courts reviewing, not the merits of the decision, but the manner by which the decision was reached. However, in some cases, where the legislation provides for a judicial review of the findings of the decision-maker, the court will review the merits of the decision. In addition, there is the inherent jurisdiction of the courts to review

decisions that cannot be supported on any reasonable interpretation of the law (generally a review of the enabling legislation) and the facts.[213]

Administrative law principles are used in the allocation of medical resources cases. In the Manitoba decision of *Re Fernandes*, the court reviewed whether the discretion given the Director to assess an application for an allowance once the applicant had met the eligibility requirements under the *Social Services Act* had been appropriately exercise. It ruled that the discretion had been appropriately exercised.[214]

Earlier the Ontario government's *Health Services Restructuring Commission* was discussed.[215] The mandate of the *Restructuring Commission* was to restructure Ontario's hospitals with this process involving the closure, or direction to close, a number of hospitals in the province. As a result of these orders there have been a number of court challenges to the *Commission's* orders. These challenges involved a review of administrative law principles.

The first decision which dealt with the merits of the *Commission's* work was the decision of *Pembroke Civic Hosptial v. Ontario (Health Services Restructuring Commission)*[216] This was an application for judicial review of the decision of the*Health Services Restructuring Commission* to the Divisional Court. In the fourth paragraph of the court's reasons Justice Campbell set out the court's role:

> The court's role is very limited in these cases. The court has no power to inquire into the rights and wrongs of hospital restructuring laws or policies, the wisdom or folly of decisions to close particular hospitals, or decisions to direct particular hospital governance structures. It is not for the court to agree or disagree with the decision of the Commission. The law provides no right of appeal from the Commission to the court. The court has no power to review the merits of the Commission's decisions. The only role of the court is to decide whether the Commission acted according to law in arriving at its decision.[217]

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[213]J.M. Evans, H.N. Janish, David J. Mullan, R.C.B. Risk. *Administrative Law 4th Ed.* (Toronto: Emond Montgomery Publications Ltd., 1995) pp 3-33.
[214]*Re Fernandes., supra.* note 204 at p. 408-409.
[215]See *supra.*, pp. 50-52.
[216]*Pembroke Civic Hosptial v. Ontario (Health Services Restructuring Commission* (1997), 36 O.R. (3d) 41.
[217]*Ibid.* p. 44.

In reviewing the enabling legislation Mr. Justice Campbell found that the *Commission* had in law the power to direct the closing or amalgamation of any hosptial when it considered it in the public interest to do so. Two other points emerge from Justice Campbell's reasons. He stated that, although the *Commission* must consider the public interest, its powers were unfettered as it was the surrogate of the Minister of Health. Secondly, on the spectrum between political decision making and judicial decision making, he stated that the *Commission* was close to the extreme political/legislative end of the spectrum.[218] With respect to procedural fairness, the court found that the *Commission* was a policy making and implementation body and not an adversarial forum. As a policy making body, it had no requirement to follow the adversarial process of disclosure and discovery of all the material submitted to it. It only had to afford those who may be affected by its decision an opportunity to appear before it and make submissions.[219]

The *Pembroke* decision, and two which followed and relied upon it, *Doctors Hospital v. Ontario (Health Services Restructuring Commission)*[220] and *Wellesley Central Hospital v. Ontario (Health Services Restructuring Commission)*[221] also looked at the applicability of the Charter with respect to the availability of services and its effect on their patient's sections 7 and 15 rights. The court dismissed these arguments on two points. First, there was no evidence that any individuals would be unable to receive any particular treatment either at the new amalgamated hospital or at another in the catchment area. Secondly, any discussion of a Charter breach was prospective. As such, as a matter of law, there was an onus on the applicant to prove on a high degree of probability that

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[218] *Ibid.* p. 46.
[219] *Ibid.* pp. 48-49.
[220] *Doctors Hospital v. Ontario (Health Services Restructuring Commission)* September 25, 1997, unreported Ontario Divisional Court decision, [1997] O.J. No. 3704.
[221] *Wellesley Central Hospital v. Ontario (Health Services Restructuring Commission)* September 15, 1997, unreported Ontario Divisional Court decision, [1997] O.J. No. 3645.

the alleged Charter infringements would occur. The applicants did not come close to satisfying this onus.[222]

Given the outcomes in these cases the courts also appear to be as reluctant to intervene in macro level decisions as they were in the *Re Fernandes* decision, which could be categorized as a meso/micro level decision. However, there are occasions where the courts will intervene in administrative health care decisions. For there to be intervention, the applicant would have to demonstrate that the decision was made by a body not authorized to make the decision, or that the decision-making body did not exercise their authority pursuant to the statue or enabling legislation (ie; regulations or internal decision-making procedures). An example of decisions outside the enabling legislation which involved resource allocation and insuring of services are the British Columbia Supreme Court decision of *Re British Columbia Civil Liberties Association and Attorney-General for British Columbia*[223] and the Manitoba Court of Appeal decision of *Re Lexogest Inc. et al and Attorney-General of Manitoba et al.*[224] Both these decisions involved the issue of abortion and the restriction of abortion services to hosptials rather than free standing clinics. Both courts found that the enabling legislation did not permit the applicable body to limit medically covered services and thereby ruled that the decisions were invalid.

In the context of managed care and utilization reviews, administrative law procedures could come into consideration. Should the payor's treatment criteria affect the treatment received by a patient, then there could be a review process engaged. In this case the initial decision and the review process would be open to judicial inquiry.[225]

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[222] *Id.*
[223] *Re British Columbia Civil Liberties Association and Attorney-General for British Columbia* (1988), 49 D.L.R. (4th) 493.
[224] *Re Lexogest Inc. et al and Attorney-General of Manitoba et al.* (1993), 101 D.L.R. (4th) 523.
[225] As discussed in *Core and Comprehensive., supra.*, note 177 at p. 23.

c) Civil litigation

If a patient were to suffer harm as a result of decisions involving the funding, delivery and/or allocation of health care services, then the patient or their family could bringing a claim in the civil courts for the damages suffered as a result of the decision.

Negligence suits would be the principle area for this type of litigation. The parties defending the law suit would likely be the health care providers who implemented the treatment or who were unable to provide the treatment due to cost containment, rationing or allocation decisions in addition to the institution where the treatment was provided. For a party to be successful in a civil suit brought in negligence four criteria must be met. These have been called the four "D's" of negligence. There must be a *dereliction* of *duty* which *directly* leads to *damage*. Put another way: the patient must show that a duty of care was owed (*duty*), that this standard of care was breached (*dereliction*), that the injury was suffered (*damage*) and that the conduct complained of was the actual cause of the injury (*directly*).

The key to any negligence action will be the review of the standard of care and the question of causation. How will the courts respond where the health care professional was restricted in the care provided, due to macro or meso level health care policy decisions? Will the court take this into consideration when they are assessing the standard of care?

Historically courts did take into account the situation the health care professional found herself in. In other words, the standard of care imposed upon a rural physician was different than that of an urban physician due to the technical and referral limitations on the rural professional[226]. Over time this 'locality' rule has not been applied, as technology has allowed phyisicans in remote areas to consult with each other. However, the question remains whether the court would take into consideration the cost or resource constraints

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[226]Ellen Picard. *Legal Liability of Doctors and Hospitals in Canada* 2nd ed. (Toronto: The Carswell Company Limited, 1984) p. 175-177.

on a health care professional when these constraints may have been a contributing factor to the plaintiff's alleged injury.

Causation could also be problematic. Causation is that element which requires the plaintiff to prove that "but for" the actions of the defendant the loss would not have occurred. Medical malpractice cases are notoriously difficult on the causation issue. Rules of evidence such as *res ipsa loquitor* have been applied in order for the plaintiff to demonstrate that the the actions of the defendant were one of the causes of the damage. Under the *res ipsa loquitor* doctrine the onus then shifts to the defendant to essentially disprove the alleged negligence. In the context considered here, the plaintiff would have to show that it was the fact there was a restricted or unavailable health care which, on the balance of probabilities, resulted in the damages suffered.

Perhaps the greatest impact any civil action would have would be in the area of publicity and a corresponding political response. Consider that a party brings an action concerning an allocation decision which had resulted in an extended waiting period or a denial of services. The plaintiff may start an action based on the damages suffered, and to be suffered, with a corresponding motion for an interim (also called an interlocutory) injunction or for a *quia timet* injunction. The injunction would ask the court to order that the medical treatment be administered pending the outcome of the action.

An interim injunction's purpose is to balance the plaintiff's need for immediate relief against the defendant's right to a full hearing of the matter. A *quia timet* injunction is only granted where there is a high probablilty that harm or injury will occur (although it has not happend yet), and where its happening is imminent and harm or injury would be irreparable.[227]

For an injunction to be granted the court looks at three factors. The party seeking the injunction must establish that it has a *prima facie* legal right to be enforced or that there is a serious issue to be tried. Secondly, the court examines whether the party

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[227]Allen M. Linden. *Canadian Tort Law 6th Ed.* (Toronto: Butterworths Canada Ltd., 1992) p. 553.

seeking the injunction will suffer irreparable harm that cannot be compensated in damages. In looking at this factor the court must determine whether there would be more harm in granting or not granting the injunction. Following on this consideration, the third factor is a balancing of the interests of the parties.[228]

In the context of the scenario described above, it would be relatively easy to establish the first two factors. As for the third, it may be more problematic to show that the balance of convenience favours the patient. The decision which has led to the law suit is likely one of policy and, as the courts have shown, they are reluctant to intervene in questions involving policy. However, the accompanying publicity with the court action and injunction may result in a political/public response rather than a legal outcome, in which case the desired outcome from the parties (patient's) perspective may have been achieved.

There are no reported Canadian cases involving a civil action resulting from a cost containment or allocation decision. However there is an American decision from California, *Wickline v. State of California*[229], in which at trial a jury awarded damages to a plaintiff as a result of a decision to discharge the patient following surgery pursuant to a prospective utilization review procedure. The Court of Appeal reversed the jury's award and found that the third party payor was not liable for the plaintiff's injuries. However in their decision the court did determine that third party payors can be held legally accountable when medically inappropriate decisions result in damages. The following are the pertinent points from the Court of Appeal's decision:

> As to the principal issue before this court, i.e., who bears responsibility for allowing a patient to be discharged from the hospital, her treating physicians or the health care payor, each side's medical expert witnesses agreed that, in accordance with the standards of medical practice as it existed in January 1977, it was for the patient's treating physician to decide the course of treatment that was medically necessary to treat the

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[228]Injunction criteria have been applied in many cases following from the House of Lords decision of *American Cyanamid v. Ethicon Ltd.*, [1975] 1 All E.R. 504 and the Canadian decision of *Yule Inc.* v. *Atlantic Pizza Delight Franchise (1968) Ltd.* (1977), 17 O.R. (2d) 505, 35 C.P.CR. (2d) 273.

[229]*Wickline* v *State of California* 228 Cal. Rptr. 661 (Cal. App. 2 Dist. 1986)

> ailment. It was also that physician's responsibility to determine whether or not acute care hospitalization was required and for how long. Finally, it was agreed that the patient's physician is in a better position than the Medi-Cal Consultant to determine the number of days medically necessary for any required hospital care. The decision to discharge is therefore, the responsibility of the patient's own treating doctor....
>
> ....However, the physician who complies without protest with the limitations imposed by a third party payor, when his own medical judgment dictates otherwise, cannot avoid his ultimate responsibility for his patient's care. He cannot point to the health care payor as the liability scapegoat when the consequences of his own determinative medical decisions go sour....
>
> ....All the plaintiff's treating physicians concurred and all the doctors who testified at trial, for either plaintiff or defendant, agreed with Dr. Polonsky's medical decision to discharge Wickline met the standard of care applicable at the time. Medi-Cal was not a party to that medical decision and therefore cannot be held to share in the harm resulting if such decision was negligently made.
>
> In addition thereto, while Medi-Cal played a part in the scenario before us in that it was the resource for the funds to pay for the treatment sought, and its input regarding the nature and length of hospital care to be provided was of paramount importance, Medi--Cal did not override the medical judgment of Wickline's treating physicians at the time of her discharge. It was given no opportunity to do so. Therefore, there can be no viable cause of action against it for the consequences of that discharge decision.[230]

Obviously, it follows from this decision, that if the third party payor had insisted upon following a course of treatment contrary to the patient's interests and medical judgment, then their liability would be exposed. The Court notes that the treating physician was in a better position than the medical consultant of Medi-Cal to assess the medical requirements of the patient. If, however, the third party payor had chosen to follow the medical advice of their own consultant then the Court would then be left with having to determine which course of treatment met the standard of care.

iii) Conclusion

The above review of legal challenges demonstrates that the courts will entertain legal actions and have found that health care is a matter of importance. However, they

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[230] *Ibid.*, pp. 670-671.

are reluctant to intervene in matters of public policy. Where an elected government has implemented a policy that affects the delivery of health care to a region or group of people, the courts will defer to the elected representatives and their decisions, so long as the decisions can be justified in a free and democratic society. In this way the court are utilizing the principles of utility for it would appear that they believe that it is preferable that more share in the benefits of a health care system that delivers services broadly as opposed to comprehensively for a select group or individual.

Cases which do go to court will continue to be determined on their own particular facts. Precidents will be argued, but the courts will continue to view each case on its merits and will likely either decline to intervene or rule that the decision reached was within the bounds of the decision maker and appropriate given the facts. In the end the patient may receive the treatment sought, not because of the courts' intervention, but because of publicity and political action. An example of this occurred in Britian in the late 1980s.

The *British Medical Journal* reported in 1987 two cases in which frustrated patients took the National Health Service to court as a result of a denial of treatment and an inordinate wait for surgery.[231] Within a span of several weeks two families took the same health authority to court seeking an order for medical care. One case involved a 6 week old baby with a hole in its heart who had had its operation scheduled and cancelled 5 times. On the day his case was scheduled to be heard by the Court of Appeal he received his operation. Two weeks earlier a blind diabetic with end-stage renal failure, who had been refused dialysis and was publicly preparing to proceed to court, was given the treatment when the Health Minister suddenly made £250,000 available to the renal units in the area. As the article states:

> Publicity combined with the threat of legal action and pressure from members of parliament rather than a court ruling got those paatients the treatment they sought. But does the Court of Appeal's ruling in the Barber

[231]Clare Dyer. "Going to law to get treatment" *British Medical Journal* 1987;295:1554.

> case close this route to other patients who suffer delays in or even denial of treatment?[232]

In the Barber case (the one involving the 6 week old baby) the Court of Appeal stated that could review National Health Service decisions, but emphasized that it would do so only in exceptional circumstances. The court would only intervene where the health care authority's discretion has been exercised unreasonably and even then the court still has a discretion not to become involved.[233] It would be my opinion that the media coverage afforded these two cases, particularly the dialysis refusal, rendered the court's involvment moot.

The conclusion to be drawn from this analysis is that litigants are more likely to achieve results from an effective use of political and public pressure on health care officials and decision-makers than a sometimes lengthy, costly court challenge. The court challenge may eventually be successful, if not for that litigant, then for subsequent parties who built upon the judicial reasoning. But in the interium it affirms the adage that the law does not lead but often follows society's wishes.

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[232] *Id.*
[233] *Id.*

PART V - CONCLUSIONS

Canada's health care system has evolved with time. From the *Hosptial Insurance and Diagnostic Services Act* to the *Canada Health Act*, the system has been required to respond to the demands of its principal component parts: the health care professions, the consumers, and the politicians. In addition, Canadian society and world trends in fields other than medicine and health care have influenced the direction the response has taken. Today the Canadian health care system is again on the precipice of change. The demands of fiscal responsibility and a belief in market economies, in conjunction with a decline in the role of government, has heralded this change.

The *Canada Health Act* has directed the health care system since 1984. Canadian society in the late 1990's is not the same society as it was in 1984. Certain beliefs and principals remain, but the roles of government and the individual have been transformed.

The preamble to the *Canada Health Act* should remain the touchstone of the health care system in providing: "*...that continued access to quality health care without financial or other barriers will be critical to maintaining and improving the health and well-being of Canadians*". Similarly, there should remain essential criteria that will ensure that all Canadians will receive quality health care. The challenge will be to achieve these ends within the current societal paradigm.

As the *National Forum on Health* mused, if the Canadian health care system were being built today they would construct a system that was different than the one currently in place.[234] The difference would not be in philosophy, but in delivery. The fundamental principles would remain, but the system would be less focused on doctors and hospitals and more on community-based services. They would also focus on broader issues of health, in other words, prevention rather than treatment. It is these elements that a modified Canadian health care system should focus upon. This is in keeping with the

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[234]See *supra.*, pp. 61-66.

World Health Organization's definition of health, which states: "*Health is a state of complete physical, mental and social well-being, and not merely the absence of disease or injury*"[235]

The current system's focus is on the absence of disease and the use of health care professionals, principally physicians as the primary players, and infrastructures such as hospitals as the primary means of treating disease. If the focus of the system were to look to ameliorate the underlying socioeconomic factors that influence disease and the disease state, then health care policy would be correspondingly changed. Four factors which were set out in the third section would take on new importance.[236] The four factors were:

i) the number of health care providers which are necessary;
ii) what they should be paid for and how they should be paid;
iii) which infrastructures are necessary and which are not; and,
iv) how their systems can be reorganized to provide the financing delivery and allocation of resources more efficiently and effectively.

By what method would any change in the system be achieved? The section on legal considerations demonstrated that the courts are very reluctant to become involved in health care issues. They appear to understand not only the importance of the issues to the parties, but also the broader social and policy implications of the decisions. Establishing an ethical right to health care only creates a moral obligation which can be used in an argument for a legal right. If a legal right to health care were established, it would impose an obligation to deliver commensurate with the wording of the right. It is relatively easy to argue and justify that there exists a moral/ethical right to health care. The difficulty rests with transforming this to a legal right with all the accompanying implications.

The Canadian Bar Association Task Force on health care reform suggested a pragmatic and principled combination of a recognition of a right to health care together

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[235]See *supra.*, pp. 19 - 21 wherein "Health" is defined.
[236]See *supra.*, p. 41.

with an acknowledgement of the realities of the provision of health care. Their articulation is worth repeating:

> Ideally, the right to health care should be defined not just by a list of services, nor by an idealistic statement of a right, circumscribed by budgetary realities. A more desirable approach might be a pragmatic and principled combination of the two. It would begin with the articulation of a right to health care, including a clear commitment to the important principles underlying this right, such as the right to informed consent, to respect for individual autonomy, to equal access to health care, regardless of region or socioeconomic class. Next, it would set out the criteria to be used in determining which services must be provided by the state. These criteria might combine a consideration of clinical practice standards, assessment of outcomes effectiveness, economic constraints and ethical priority-setting.[237]

Considerations of alternative systems often focus on the delivery and allocation of resources while leaving the third basic component, financing, to be determined. A complete modification will take into account all three: financing, delivery and a use of resources. As indicated earlier in this conclusion, the principles of the *Canada Health Act* have directed Canadian health care policy since 1984. The five cornerstones of the *Act*: public administration, comprehensiveness, universality, portablity, and accessibility, all should remain. The most important element should be the equality of opportunity to access the system. How this will be achieved in a system that is likely to be altered is an important consideration.

The use of managed care and an integrated health delivery system appears to be the trend which the provincial governments are taking. In addition, they are attempting to decentralize the decision-making process. In giving local authorities some say in the decision-making process they are trying to give accountability to the consumers of health care. They should also expand the role the providers of health services have traditionally followed. If the focus should be on an expanded definition of health (the WHO model), then the provision of health care should shift from physicians to other health care providers. Doctors and their associations are extremely reluctant to devolve their

[237]Canadian Bar Association, *supra.*, note 5 at p. 42 and see *supra.* page 38.

authority as the gatekeepers of the system and the provider of traditional medical care. They also would appear to wish to maintain their income levels. How to devolve their power and authority will be a challenge similar to that of altering delivery. However the challenges are intertwined. This is where ethics can be used to ensure that medical services are provided to all in accordance with need.

The financing of any alternative will be the key. If a health care system were essentially expanded to encompass the broader definition of health, then there would be a corresponding increase in the cost of the system. How could a fiscally responsible government justify increasing the scope of health care and its budget? By recognizing that improving the physical, mental and social well-being of the citizens will result in long term benefits for all, these increases can be justified. In addition, it would likely be that much of the expenditures for an expanded health care policy would be shifted from other government agencies or departments.

These are bold statements, but they must be considered if Canadians are to maintain a system that is respected and responsive.

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