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GUIDING DECISION MAKING ON LIMITED RESOURCES IN THE CANADIAN HEALTH CARE SYSTEM: A BIOETHICAL CRITIQUE OF A FEDERAL GOVERNMENT INFLUENCE.

by
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A dissertation submitted to the Faculty of Theology,
Saint Paul University,
in partial fulfillment of the requirements for the Degree of
Master of Arts in Theology.

Ottawa, Canada
July 16, 1993

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ISBN 0-315-95959-2

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INTRODUCTION

Equitable, universal access to comprehensive health care services in an environment of limited resources is generating foundational debate and conflict in our Canadian health care system. Ethical dilemmas have arisen concerning the allocation of these limited resources and the potential for discrimination against the equality and distributive justice of health care among Canadians. From a national perspective, this Canadian health debate has often focused upon the impact of the allocation of resources on the five foundational principles of the Canadian health care system and whether support can continue for each of these principles (universality, accessibility, comprehensiveness, portability, public administration without profit). This thesis will identify and critique one type of ethical influence the federal government has had in decision making concerning limited resources. The type of influence examined is the value choices expressed, explicitly or implicitly, within the texts of prominent federal government documents which have assisted in creating and directing the Canadian health care system.

This examination will attempt to contribute a critique on how the issue of limited resources is understood, approached and addressed in these federal texts and what other factors need to be recognized and discussed if the issue of limited resources is to be adequately addressed in the Canadian health care system. Two focal questions of the examination are: Are the value choices and influences within the federal documents assisting Canadians in addressing and integrating an environment of limited resources or simply creating, perpetuating and escalating its existence? Have the value choices made it necessary to re-evaluate or abandon any or all of the five foundational principles within the Canadian health care system?

Three terms used already in the introduction need further clarification: the Canadian health care system, distributive justice and limited resources. The Canadian health care system is understood broadly in this thesis as the creation over time of the combination of various federal government, provincial government, private and professional organizations, experiences and initiatives which together have formed the different health care services as experienced in Canada. From outside of Canada, these health care services are viewed as uniquely Canadian. It is not understood as simply the federal or national framework. Neither is it understood simply as a current legal and organizational framework such as the Canada Health Act. Distributive justice is understood as a supportive foundation of equality within a nation, through its consideration of the common good of the whole in relation to the individual good and autonomy of its parts. It focuses on the community's distribution of benefits, such as health care resources, and burdens, such as illness or limitation of resources, to individuals and groups.[1] Another potentially arbitrary term is "limited resources" itself. These resources can include the health of individual Canadians, time, personnel, facilities, technology, organs or funding. The term "limited resource" is most commonly thought to pertain to limited finances which enable the funding and availability of resources. The limitedness of finances is often thought to be due to poor

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[1] James F. Childress, John MacQuarrie (eds.), The Westminster Dictionary of Christian Ethics. (Philadelphia: The Westminster Press, 1986): 330-332. A more detailed articulation may be encountered in John Rawls, A Theory of Justice. (Cambridge, Massachusetts: Harvard University Press, 1971)

efficiency, poor cost management, a poor economy or a lack of public and political will. This examination will attempt to discover the underlying causes and approaches, the "why" and the "how", to an environment of limited resources.

The example of Daniel Callahan in What Kind of Life: The Limits of Medical Progress[2] has served as a model of critique in approaching and clarifying this issue of limited resources and its impact on the direction of a nation's health care system. While not dismissing the value of cost containment measures in addressing the problem of limited resources, Callahan advances that these measures alone will never adequately address or resolve the problem of limited resources. He proposes the necessity of a fundamental critique of the values and momentum which have shaped the economically strained American health care system such as: a broad and virtually limitless definition of health; a highly subjective notion of human need; the enshrining of an absolute right to any and all health care, irrespective of the cost to society; the denial of human finitude and the idolatrous belief that unlimited medical progress can meet all human needs and desires; the belief that efficiency and cost containment will solve allocation problems. Callahan's bioethical examination of the foundational choices and directions of the American health care system has proven the necessity and relevance for a similar critique of any national health care system.

I intend to examine the Canadian health care system with a similar foundational value critique, from a bioethical and

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[2] Daniel Callahan, What Kind of Life: The Limits of Medical Progress. (New York: Simon and Schuster, 1990).

theological perspective. As a theologian I am fundamentally interested in the influences and conditions that together either foster or undermine community living. How the federal government addresses the issue of limited resources, within the structure and policy it advocates for the Canadian health care system, will also advocate a perception of how Canadians should live together. Whether the federal government addresses the issue of limited resources in a manner that adequately integrates it rather than perpetuates and accentuates it, in a manner that fosters growth rather than decline, will impact the potential for the growth or decline of community living. As a theologian I am interested in identifying, critiquing and proposing federal government value choices and their structures realizing their potential for fostering or undermining the potential of Canadians to live together.

The first chapter of this thesis continues this theme of theology by exploring in more detail the evolution and the debate questioning whether theological ethics can offer a valuable critique concerning public policy in general or bioethics and medicine in particular. The second chapter then proceeds with the bioethical critique by identifying and presenting the explicitly and implicitly expressed value choices of the federal documents. The third chapter critiques those value choices with respect to their ability to assist society in facing an environment of limited resources and their supportive or undermining influence on the five foundational principles of the Canadian health care system.

CHAPTER ONE

Theological Ethics, Bioethics[3] and Society: Faiths and Values in Conflict.

Introduction

Identifying the pertinent limitations and potential of freedom, reason, and authority in fostering an authentic public dialogue is a complex and elusive quest. It is especially elusive when engaged in the complex bioethical dilemmas which challenge us as a community and a country to articulate how we will live and how we will die. The plurality of faiths and traditions of meaning within our culture and the conflict between individual autonomy and the common good of society seem to foster escalating division in public dialogue. Each of these individual parties seem to perceive "the other" as a threat to the values which constitute their self identity and meaning. It is this threatening perception of conflicting values, escalated by a fear of manipulation and destruction, which shatters the condition of trust necessary for open, constructive dialogue. The possible outcomes include fragmentation, silence, isolation, possible violence and the end of relation. Plurality is truly a celebrated condition of our society but fragmentation is more often the felt experience.

This chapter questions a specific theme in public bioethical dialogue: Can theological ethics, as a discipline, be taken

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[3] There is difficulty with using the concepts "Bioethics" and "Bioethical" today due to the differing interpretations of their meaning. Historically there has been a field "Bioethics" which has reflected from an ethical perspective on health care. [Daniel Callahan, "Religion and the Secularization of Bioethics." in Special Supplement "Theology. Religious Traditions, and Bioethics" Hastings Center Report 20(4) (July/August, 1990): 2-4.]. Yet it is challenged whether "Bioethics" is less a field and more a methodology of interdisciplinarity [Maurice De Wachter, "Interdisciplinary Bioethics: But Where Do We Start?" The Journal of Medicine and Philosophy 7 (1982) 275-287.]; David Roy, "Promesses et Dangers d'un Pouvior Nouveau." in La Bioéthique [Québec: Les Presses de L'Université Laval, 1979]: 93. My use of the concept "bioethics" is as an historically emergent discipline which contributed ethical reflection (as opposed to economic or legal) to the dilemmas arising in health care. The term "bioethics" is also used "to distinguish the field from the type of medical ethics that is oriented exclusively toward problems of physicians". [Leroy Walters, "Religion and the Renaissance of Medical Ethics in the United States: 1965-1975." in Theology and Bioethics. E.E. Shelp (ed.) (D. Reidel Publishing Company, 1985): 14.]

seriously when it offers reflection on public policy in general, or bioethics and medicine in particular?[4] Some propose that it does offer constructive contributions toward the human solutions of our bioethical dilemmas and does not simply provide restrictive, sectarian interests seeking influence or control of public policy. Yet the challenging skepticism and mistrust toward the integrity and credibility of theological reflection on public issues is easily identified in the following;

> I have deliberately not raised the question of the credibility of the whole theological enterprise...But until theologians do this, everything they say will seem to the contemporary unbelieving world to be infected by a fatal arbitrariness. Theologians still owe it to the rest of us to explain why we should not treat their discipline as we do astrology or phrenology. The distinctiveness and importance of what they have to say, if it is true, make this an urgent responsibility.[5]
>
> As we enter neighborhood homes, many of us have been quickened with the peculiar hospitality of a sign that reads: "Beware of dog." There are doubtless many people around who believe that an analogous sign is in place when a theologian is present to discuss the ethical dimensions of biomedicine. Theologians may just bite. Or perhaps worse, they may not. At their best, they are harmless, that is, useless.[6]
>
> Indeed, in response to a query from a friend (who is a distinguished philosopher) about how the term "ethicist" has come about, I responded in a pejorative way, "An ethicist is a former theologian who does not have the professional credentials of a moral philosopher.[7]

A review of the events, trends and challenges shaping the emergence and secularization of bioethics in the United States, will provide insight into this challenging skepticism toward the acceptance and integration of theological reflection with public

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[4] This question of the credible contribution theology can make toward public discourse is being addressed by many theologians today and not just those involved with the discipline of bioethics. Don S. Browning; Francis Schussler Fiorenza (eds). Habermas, Modernity, and Public Theology. (New York: Crossroad, 1992). This dissertation is only one example of this much larger debate.

[5] Alasdair MacIntyre, "Theology, Ethics, and the Ethics of Medicine and Health Care: Comments on Papers by Novak, Mouw, Roach, Cahill and Hartt." Journal of Medicine and Philosophy vol. 4, no.4 (1979): 443.

[6] Richard McCormick, "Theology and Bioethics." Hastings Center Report (March\April, 1989): 5.

[7] James M. Gustafson, "Theology Confronts Technology and the Life Sciences." in On Moral Medicine (eds) Stephen Lammers; Allen Verhey (Grand Rapids, Mich.: Grand Rapids, 1987): 35.

dialogue on bioethical issues. The literature reviewed will primarily be from the United States, since the emergent experience of bioethics in Canada is much less developed and its secularization less documented. One examination of the Canadian bioethical experience that is available is John Williams's Biomedical Ethics in Canada[8]. Although the health care systems of the two countries certainly have their major differences, it is clear that types of medical issues are shared due to the shared experience of the advances of medical technology, the dilemmas of limited resources and the secularization of our societies.

The Emergence and Secularization of Bioethics[9].

The era of the 1960's has continually been described as a time of untidy and unsettling change in moral and social self-understanding, with popular "revolutions" in such areas as social justice and sexuality. It was within that decade of social change that the discipline of bioethics emerged. Two factors which had the greatest influence on this emergence were the advances of medical technology and the recognized plurality of values and traditions of our North American culture.

The advances of medical technology pushed forward our ability to form our world and self identity, raising questions as to how we could practically proceed in health care with integrity. Perhaps no single event provides such a clear and symbolic image of the advancement of medical technology than the first successful

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[8] John Williams, Biomedical Ethics in Canada. (Queenstown, Ontario: Edwin Mellin Press, 1986)

[9] This section is an historical overview of the emergence and secularization of the discipline of bioethics. I am indebted to the following authors whose detailed reviews of this evolution make it possible for me to expand on their work in this dissertation: Leroy Walters, Renee Fox, Daniel Callahan, Robert Morison, Hubert Doucet, Mark Siegler.

heart transplant by Christian Barnard in the late 1960's.[10] The practical medical dilemmas engendered by these types of advances, was felt by some to reintroduce into ethical debate a seriousness, human relevance and concrete focus, felt absent for so long.[11] The central concerns of moral philosophers and theologians had previously been considered as too abstract, analytical and general; out of touch with the concrete, clinical and relevant issues arising in medicine or elsewhere.[12] The practical importance of these new bioethical dilemmas was not engendered by theoretical interest but by medical advancement and the real need for feasible human solutions.

Several events assisted in focusing public attention on what would become bioethical issues. Even before the birth of bioethics in the late 1960's, growing public and professional concern over research involving experimentation with human subjects, particularly in the area of medical research, played a major role in the emergence of bioethics.[13] The world was well aware of the horrific human experimentation and manipulation by physicians during the Second World War. Between 1966-67, two notable, published works authored by medical doctors together recounted over two hundred cases considered as unethical experimentation

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[10] Mark Siegler, "Bioethics: A Critical Consideration." Eglise et Théologie 13 (1982): 297.

[11] Stephen Toulmin, "How Medicine Saved the Life of Ethics.", Perspectives in Biology and Medicine 25,4 (Summer, 1982): 750.

[12] Stephen Toulmin, "How Medicine Saved the Life of Ethics.": 749.

[13] Renee Fox, "The Evolution of American Bioethics: A Sociological Perspective." George Weisz (ed.) in Social Science Perspectives on Medical Ethics (Dordrecht, Boston: Kluwer Academic Publishers, 1990): 202.

involving human subjects.[14] When in the late sixties, with the passage of legislation in both Canada and the United States creating national health care programs (US: Medicare and Medicaid; Can: Medicare), public scrutiny was again focused on the quality, availability, justice and cost of the delivery of medicine.[15]

Challenging developments also occurred in academic or theoretical reflection on medical issues. The majority of literature reflecting on medical ethics in the United States before the mid 1950's was from religious sources, more dominantly Catholic moral theologians.[16] Theology, conventionally understood, demands personal faith in a particular religion in order to understand that religion. The theologian was commonly perceived as an apologist for a particular revelation and tradition, rationally communicating to the physician the "authentic" interpretation of the moral law specific to the theologian's own religious tradition. Most of the medical issues in this theological literature were discussed in a confessional format which related the medical issue or dilemma to a scriptural law or to the sacraments of the Catholic Church.

The arrival of Morals and Medicine in 1954, the pioneering book of protestant theologian Joseph Fletcher, was largely unnoticed and only later appreciated as a formidable challenge to the way theology had traditionally related to medicine and society at large. Fletcher's central premise favored the autonomy of the

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[14] Henry K. Beecher, "Ethics and Clinical Research", New England Journal of Medicine, 247 (1966): 1354-1360.; Maurice Pappworth, Human Guinea Pigs. (London: Routledge & Kegan Paul, 1976). Both cited in Mark Siegler, "Bioethics: A Critical Consideration", Eglise et Théologie 13 (1982): 297-8.

[15] Mark Siegler, "Bioethics: A Critical Consideration.": 298.

[16] Leroy Walters, "Religion and the Renaissance of Medical Ethics in the United States: 1965-1975." Theology and Bioethics (Dordrecht: D. Reidel Publishing, 1985): 5.

individual by maintaining that each person should freely make choices based on their knowledge of the options available to them.[17] Based on universal human rights rather than the revelation or experience of particular religious communities, it proposed more accountable, accessible and seemingly rational foundations for ethical debate on public issues. It challenged the traditional theological approach through its ability to relate practically to the human person within an advancing technological, plural and increasingly secular culture. Most Catholic responses to Joseph Fletcher's proposal were defensive but one interpretive and mediating protestant response by Princeton theologian Paul Ramsey foreshadowed Ramsey's own future formative influence on the discipline of bioethics.[18] Although Fletcher's challenge to secure an ethical foundation accessible to all was not engaged by his theological contemporaries, it prophetically foreshadowed a major theological dilemma of the future while breathing life into a theological ghost of the past.

Fletcher's contribution was part of a long history of theological and public debate and division over accountable and accessible ethical foundations for a pluralist society. It was a search inherited from the Enlightenment age which critiqued whether a moral viewpoint could present itself with authority and accountability to a pluralist culture if it was fashioned from a particular religious tradition or faith. Rationality, because of its universal character, was the Enlightenment principle

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[17] Joseph Fletcher, Morals and Medicine, (CA: Princeton University Press, 1954): 16.

[18] The article entitled "Freedom and Responsibility in Medical and Sex Ethics: A Protestant View," was published in 1956 and attempted to interpret protestant views to Catholic readers. Cited in, Leroy Walters, "Religion and the Renaissance of Medical Ethics," E.E. Shelp (ed.) Theology and Bioethics (Dordrecht: D. Reidel Publishing, 1985): 6.

considered the necessary basis for genuine and credible public discourse. Reason was considered absent and even contrary to the traditional and potential contribution of religious discourse. The use of rationality as a foundation for genuine public dialogue has continually inspired support[19] and critique[20] through persistently inconclusive but insightful debate.[21]

Between the years 1956 and 1966, this debate on the foundations of ethical debate did not continue. Between 1962 and 1965 the energy of Catholic theological ethicists and the interest of the wider professional community involved in ethical debate was engaged by the debate and expected renewal of the Catholic Church through the Second Vatican Council. This Council laid a foundation and expectation for greater diversity within Catholic moral theology, for increased openness to the insights of those outside the Catholic community and for a milieu where ideas enjoyed greater freedom of expression. These foundations included a concern for justice both inside and outside the Church community. They underlined the importance of compassionate reflection on the social, political, and economic concerns of our modern world when offering service. They recognized that the dialogue of Christian Catholic self-understanding was collegial, not only among appointed specialists but that all baptized in the Catholic community were recognized as voices of the Spirit.

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[19] The most well known advocate for using a secular mode of rationality as a foundation for bioethics is H. Tristram Engelhardt Jr. (H.Tristram Engelhardt Jr., The Foundations of Bioethics [New York: Oxford University Press, 1986.]: 3-16.

[20] David Tracy, Blessed Rage for Order. (Minnesota: The Seabury Press, 1975): 11.

[21] Two recent works which speak of this continuing debate are: Don S. Browning; Francis Schussler Fiorenza (eds.). Habermas, Modernity, and Public Theology. (New York: Crossroad, 1992) and Alasdair MacIntyre. Whose Justice? Which Rationality? (Notre Dame, Indiana: University of Notre Dame Press, 1988)

While several events have occurred since Vatican II which have caused many to question the reality of the newly professed openness[22], there was one event often identified as pivotal in shaping the disciplines of theological ethics and bioethics. This event was the creation, dialogue and reports[23] of the Papal Commission for the Study of Population, Family and Birth (more popularly known as the Birth Control Commission) and the resultant Papal encyclical Humanae vitae[24]. A heavy majority on the Commission voted for change to the magisterium's traditional condemnation of birth control, with great expectation and support for change on the part of the wider community both within and outside the Church. The final action by Pope Paul VI in Humanae vitae to not change the Church's traditional stance condemning birth control fostered great skepticism both inside and outside the Church on the teaching integrity and authority of the Roman Catholic magisterium.

> What needs to be emphasized, however, is the enormous influence of this event on subsequent moral theology. Theologians became freshly aware of the inadequacy of a heavily juridical notion of the moral teaching office, and correspondingly they became more sensitive to their occasional duty to dissent in light of their own experience with the faithful and reflection on it.[25]

The larger repercussions from a societal perspective were the loss of trust and the resultant perception of religious reflection

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[22] See, Richard McCormick. "The Shape of Moral Evasion in Catholicism." America 159 (October 1, 1988).

[23] These reports, published in the American Catholic newspaper The National Catholic Reporter, April 15, 1967, were reprinted in Robert G. Hoyt's, The Birth Control Debate. (Kansas City: The National Catholic Reporter Press, 1968). For a detailed examination of the issues and events within and surrounding the Commission, see Robert Blair Kaiser's The Encyclical that Never Was: The Story of the Commission on Population, Family and Birth, 1964-66. (London: Sheed & Ward, 1987).

[24] Paul VI. Encyclical Humanae vitae. (Montreal: Fides, 1968)

[25] Richard McCormick, "Moral Theology 1940-1989: An Overview" Theological Studies 50 (1989): 12.

lacking integrity, insight and understanding when approaching and debating ethical dilemmas in our plural society.

Many theologians, scientists and some philosophers[26] were formative in the emergence of bioethics at this time but two especially embody the pivotal nature of the late 1960's and its secularization; Daniel Callahan and André Hellegers. Daniel Callahan is a philosopher, trained at the universities of Harvard and Georgetown, who in the late 1960's was executive editor of the American Catholic intellectual journal Commonweal. With an excellent position to view both the Second Vatican Council and the release of Humanae vitae, he was deeply disappointed with Paul VI's decision and its ramifications.

> It is impossible to exaggerate the surprise the encyclical caused. It flew in the face of the Pope's own commission, whose conclusions were specifically rejected by the Pope. It flew in the face of an emergent consensus of theologians. It flew in the face of a number of bishops who had asked the Pope not to issue such an encyclical and who had already told their people they should do as their informed consciences dictated. Finally, and most importantly, it flew in the face of a great mass of married lay people. On the basis of their own marital experience and fortified by their knowledge of a change in the thinking of many bishops priests and theologians, they had decided they could morally use contraceptives for the sake of responsible parenthood.[27]

André Hellegers, a Dutch born obstetrician-gynecologist, played a major role on the Papal Commission on Birth Control serving as a member of the executive committee and as secretary to the pastoral section. His comments upon the release of Humanae vitae are as follows,

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[26] Philosophers were not considered to have as great an early formative influence on the emergence of bioethics as theologians and scientists were. Yet as the discipline has become more secularized, philosophers are reported to be more involved academically than their theological colleagues; at least in Canada. See, John Williams, Biomedical Ethics in Canada [Queenstown, Ontario: Edwin Mellin Press, 1986]: 95, 115)

[27] Daniel Callahan (ed), The Catholic Case for Contraception (New York: MacMillan, 1969): ix. cited by Leroy Walters, "Religion and the Renaissance of Medical Ethics in the United States: 1965-1975." Theology and Bioethics (Dordrecht: D. Reidel Publishing, 1985): 10.

> For the scientist the encyclical presents a number of puzzling aspects: in the first place comes the absence of scientific evidence for, or indeed of scientific thought in reaching, the conclusions which the encyclical draws. Secondly, the scientist is struck by the absence of biological considerations in the entire encyclical. It is striking that the first section which deals with "New Aspects", and which alludes to demographic, sociological, and educational problems, nowhere acknowledges that there might have been new biological facts of importance discovered since the encyclical *Casti Connubii*. Thus paragraphs 2 and 3 of the encyclical are written as if no biologist had ever been appointed to the Papal Commission. Equally interesting, but more ominous in this context, is paragraph 6. Here it is made clear that nothing that a present or future scientist could possibly contribute in terms of scientific data could have any pertinence to the subject, if certain criteria of solutions would emerge which departed from the moral teaching of marriage proposed with constant firmness by the teaching authority of the Church. To the scientist it is difficult to see why the Papal Commission should have been called at all.[28]

In both the comments of Callahan and Hellegers, the disappointment and the heightened mistrust over the integrity of the debate and decision in this ecclesial forum are clear. The event fostered the perception that the honest exploration of problems in the dialogue between biology, medicine and moral theology seemed possible only in a non ecclesial forum. While religious issues played a significant role in his early work[29], Callahan was discovering them to be less relevant and perhaps having an impeding influence with bioethics, where both his interest and involvement were growing.[30] Late in 1969 Callahan co-

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[28] Andre E. Hellegers, "A Scientist's Analysis", in Curran, C. E., ed., *Contraception: Authority and Dissent* (New York: Herder and Herder, 1969): 216.

[29] Along with being assistant secretary of the American Conference of Catholic Bishops and executive editor of Commonweal, Callahan's earlier works include; "Authority and the Theologian" *Commonweal* 80, *The Mind of the Catholic Layman* (1963), *Honesty in the Church* (1965), *The New Church* (1966), and (ed.) *The Catholic Case for Contraception*. Later works included *Abortion: Law, Choice and Morality* (1969), *Setting Limits: Medical Goals in an Aging Society* (1987), and *What Kind of Life: The Limits of Medical Progress* (1990).

[30] Leroy Walters, Religion and the Renaissance of Medical Ethics in the United States: 1965-1975.": 13. Also the following quote from Daniel Callahan, "Religion and the Secularization of Bioethics." *Hastings Center Report* (July/August, 1990): 2. "When I first became interested in bioethics in the mid-1960s, the only resources were theological or those drawn from within the tradition of medicine, themselves heavily shaped by religion. In one way, that situation was congenial enough. I was through much of the 1960's a religious person and had no trouble bringing that perspective to bear on the newly emergent issues of bioethics. But that was not to be finally adequate for me. Two personal items were crucial. My religious belief was by then beginning to decline, and by the end of the decade had all

founded with psychiatrist friend Willard Gaylin, the Institute of Society, Ethics, and the Life Sciences, later known as The Hastings Center. Although theologically trained people played a central role on both the staff and the Board of this Institute[31], this non ecclesial forum has become one of the major institutional contributors to the emergence of and perhaps secularization of bioethics.

The year 1967 also saw the creation of the Institute of Religion at the Texas Medical Center. Within the framework of this Institute, protestant theologian Kenneth Vaux organized a conference the following year entitled "Houston Conference on Ethics in Medicine and Theology". This conference attempted to facilitate the diverse dialogue between "several solitudes" and was certainly one of the first of these types of interdisciplinary exercises.[32] During the period between 1967-69 André Hellegers moved from his research engaged at John Hopkins University to Georgetown University. Hellegers invited Paul Ramsey, through funding from the Joseph P. Kennedy, Jr. Foundation, to join him and do research and writing on medical ethics. Paul Ramsey's successful research was published as The Patient as Person; Exploration into Medical Ethics. This published work is considered, more than any other, to have brought the field of medical ethics to the attention of a broader academic and

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but disappeared. My academic training moreover was that of analytic philosophy, and I wanted to bring that work to bear on bioethics. Was it not obvious, I thought, that moral philosophy, with its historical dedication to finding a rational foundation for ethics, was well suited to biomedical ethics, particularly in a pluralistic society? Just as I had found I did not need religion in my personal life, why should biomedicine need it for its collective moral life?"

[31] Leroy Walters, "Religion and the Renaissance of Medical Ethics in the United States: 1965-1975.": 13.

[32] Hubert Doucet, "La Contribution du Théologien en Bioéthique." dans Marie-Hélène Parizeau, Les Fondements de la Bioethique et de la Clarification de son Champ. (Bruxelles, De Boeck Universite, 1992): 55.

professional public.[33] André Hellegers used this success to obtain further funding from the Joseph P. Kennedy, Jr. Foundation to found the Joseph and Rose Kennedy Institute for the Study of Human Reproduction and Bioethics at Georgetown University. Again, those recruited to serve as staff for the Institute were an ecumenical group trained in Christian ethics. By 1975 both the Hastings Center and the Kennedy Institute were providing strong institutional support for the development and study of bioethics.

It is interesting to note that while these Institutes created a non ecclesial, institutional forum for the exploration of bioethical issues, it was apparently important for them to have the contribution of people trained in theological ethics. Obviously, a distinction was made between the integrity of the exploration possible through ecclesial institutions or forums and the integrity of exploration possible through theologians themselves. Therefore, through these institutions, the analytical and critical insights of these theologians were considered pertinent not only for their ecclesial communities but for society at large. What was emerging for the theological ethicist were different forums, each with their own criteria and expectations, requesting their participation.

Characteristics and Critiques Emerging in Bioethics.

What has been remarkable in the emergence of bioethics is the extent that it has pervaded the public domain through the legislative, legal, educational and religious institutions of society. This has occurred perhaps despite, perhaps due to, a definite resistance and a general public suspicion over the

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[33] Leroy Walters, "Religion and the Renaissance of Medical Ethics in the United States: 1965-1975.": 11.

possibility of genuine dialogue on ethical issues in our plural culture. Ethics is often considered expressive of personal taste and cultural relativism since no accepted methodology for public dialogue was present. Concerns arose as to how morality would be worked out in law, public policy and in the actual practice of medicine. This concern and resistance is compounded with the possible participation of theological ethics in these dialogues. Religious perspectives are perceived as a common source of conflict rather than a common resource for the creation of public policy, regardless of what formative and creative role it plays in the life of individuals. As the field of bioethics drew great public attention in the courts, legislatures, media and professional societies, pressure was applied (perhaps more latent than manifest) to frame the issues and to speak in a common secular mode in order to bypass religious struggles.[34] The possibility for the inclusion of religious perspectives in public debate raises the fear that religion will act as a source of deep and unresolvable conflict as well as a single minded, at times irrational, political pressure when aroused. Therefore when questions of a religious nature arise there is a tendency to reduce them, screen them out or fit them into the discipline's language and definition of ethics and ethical.[35] It is the norm that bioethical reports show no trace of religious influence or language and an ethics of universal principles such as autonomy,

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[34] Daniel Callahan, "Religion and the Secularization of Bioethics." Hastings Center Report (July/August 1990): 3. It is important to note that the pressure to speak of issues in a common secular mode and attempt to bypass religious struggles is part of the larger struggle to separate the issues of church and state in the culture and Constitution of the United States.

[35] Renee C. Fox, "The Evolution of American Bioethics: A Sociological Perspective." in George Weisz (ed.) Social Science Perspectives on Medical Ethics (Dordrecht: Klewer Academic Publishers, 1990): 208.

beneficence and justice are given value and priority.[36] While it is thought that these latter universal principles are devoid of religious influence, it is challenged[37] that these particular principles have arisen in a large part due to the advocacy of particular religious traditions. For example, Protestant theologians such as Fletcher and Childress are known advocates of the importance of autonomy; it is in fact the formative principle giving birth to the Protestant tradition. It does not seem so coincidental that autonomy is a central principle in American culture and Protestantism is the mainstream religious tradition of American culture. Principles such as "common good" or "beneficence" are seen as advocated or generated more from the Catholic religious tradition. In this light, these universal principles seem not only influenced by these religious traditions but given birth through them.

From the mid-seventies through to the mid-eighties, bioethics became increasingly involved in the proper definition of life and death, especially surrounding the justifiability of foregoing life-sustaining forms of treatment.[38] These initial bioethical issues and conflicts seemed to have at their root some of the most basic value conflicts of our society. Value conflicts such as autonomy versus the common good, separation of state and religion, and various value choices in attempting to define

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[36] Daniel Callahan, "Religion and the Secularization of Bioethics." Hastings Center Report (July/August, 1990): 3.

[37] Hubert Doucet, "La Liberté dans le Champ Bioéthique: Une Histoire à Suivre pour la Théologie." dans Jean-Claude Petit et Jean-Claude Breton, Questions de Liberté: Actes du 27 Congrès de la Société canadienne de théologie tenu à Montréal du 9 au 11 novembre, 1990. Héritage et Projet, vol. 46 (Quebec: Editions Fides. 1991): 163. Also see Robert M. Veatch, "Medical Ethics: An Introduction." in Medical Ethics. (Boston: Jones and Bartlett Publishers, 1989): 15.

[38] Renee Fox, "The Evolution of American Bioethics: A Sociological Perspective.": 202.

"personhood" and "death" really fueled the public debate making resolution seem impossible. Nevertheless, decisions are made and the resolutions of these dilemmas have been decidedly moving in the direction of the maximization, rather than the restriction, of freedom of choice. A strong support of individualism and a lionization of interest groups has also been witnessed with less consideration being given to the common good of society. The value of autonomy is becoming such a moral obsession in American culture that other values are being dismissed, "particularly those that pertain to social ethical questions."[39]

There are many concerns and critiques[40] on the nature, direction and impact the discipline of bioethics has had and may have on our culture. The interdisciplinary nature of bioethics has fostered a type of participation in health care which has generated a rich dialogue. However, a general suspicion arose on the part of those within medicine about having "outsiders" participate integrally toward the resolution of these issues. The trivialization of the ethical issues debated was the feared outcome, heightened by the later emergence of an "everything is ethics" syndrome. This syndrome only seemed to substantiate the perception that ethical debate by anyone other than clinical, medical specialists would lead to greater obsession, trivialization, and confusion over the issues involved. The opposing concern was that the interdisciplinary approach would be

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[39] Renee Fox, "The Evolution of American Bioethics: A Sociological Perspective.": 211.

[40] Examples of such critiques are: Daniel Callahan, What Kind of Life: The Limits of Medical Progress. (New york: Simon and Schuster, 1990); Daniel Callahan, Setting Limits: Medical Goals in an Aging Society. (New York: Simon and Schuster, 1987); Renee Fox, "The Evolution of American Bioethics: A Sociological Perspective." in George Weisz (ed.), Social Science Perspectives on Medical Ethics. (Dordrecht, Boston: Klewer Academic Publishers, 1990); Mark Siegler, "Bioethics: A Critical Consideration." Eglise et Théologie. 13 (1982); H. Tristram Engelhardt, Jr., The Foundations of Bioethics. (New York: Oxford University Press, 1986.); Richard McCormick, "Bioethics in the Public Forum." Milbank Memorial Fund Quarterly/Health and Society. Vol 61, No. 1, (1983).

inhibited by an emerging trend of professionalism in bioethics through the development of professional bioethicists. The professional involvement and impact thus far in bioethics has also been critiqued: for its identification of ethics with "dilemma ethics" and inadequate fostering of a genuine ethic by not incorporating "a formational dimension and therefore a spirituality of and for the professional person"[41]; for its limited social and cultural breadth since the major intellectual shapers and spokespersons have been professionals, scholars and academics with upper middle class backgrounds.[42]

The nature or direction of the discipline has also been critiqued as shallow in its tendency to seek resolution of dilemmas by turning ethical principles into legal regulations for conduct. The correlation of bioethics with "dilemma ethics" is critiqued for overlooking the foundational conditions necessary for a genuine ethic.[43] Although bioethics has impacted our legal systems through legislation, its impact is considered much less on the daily clinical routine of the practitioners of health care. The teaching of biomedical ethics remains a minor add-on in most medical school criteria with its intellectual influence coming from outside the profession of medicine.[44] A formational dimension or a methodology for ethical deliberation for the professional person has been identified as a great unfulfilled need which would

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[41] Richard McCormick, "Moral Theology 1940-1989: An Overview." Theological Studies. 50 (1989): 14.

[42] Renee Fox, "The Evolution of American Bioethics: A Sociological Perspective." in George Weisz (ed.), Social Science Perspectives on Medical Ethics, (Dordrecht: Klewer Academic Publishers, 1990): 210.

[43] Richard McCormick, "Moral Theology 1940-1989: An Overview." Theological Studies 50 (1989): 14. Also Renee Fox, "The Evolution of American Bioethics: A Sociological Perspective.": 208.

[44] Mark Siegler, "Bioethics: A Critical Consideration.": 304-5.

provide a nourishing and supportive context for decisional or "dilemma ethics".[45]

The experience and impact of the secular character of the discipline of bioethics, has begun to foster critiques of reductionism not only from outside but within the discipline. There is genuine concern that the silencing of this potentially creative contributor, due to a fear of its potentially overbearing influence, may inhibit the comprehensive resolution of dilemmas.

> Society is experiencing great procedural as well as substantive difficulty in resolving, on behalf of its entire citizenry, these more than medical ethical matters that lie at the heart of its moral, religious, and cultural tradition. The problem is complicated, and made more acute by the degree to which such questions have entered the polity. Siphoning off their religious content, and framing them in as secular way as possible provides an institutionally supported, reductionistic way of defining them, compatible with the ethos of bioethics, that makes them more amenable to logical analysis and technical solution. The problem is that, in the end, this masks their essential nature, and because this is true, does not conclusively dispel them.[46]

What has emerged is a secular tradition that attempts to speak to the dilemmas in a neutral common language, stemming from no particular tradition, with a vision of opening dialogue to all rational individuals. The belief and value placed in this neutral common language is critiqued by some as a myth that reduces public discourse. It refuses to recognize that any person who speaks in the discourse speaks from a tradition with a particular "faith", system of beliefs and values. It is felt to promote the compartmentalizing of human lives through inadequate distinctions such as public/private, church/state, and religious/secular. Often, focus on these distinctions inadequately simplifies the social complexities of bioethical dilemmas and the important underlying issues which are the real sources of conflict are not

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[45] Richard McCormick, "Moral Theology 1940-1989: An Overview." Theological Studies 50 (1989): 14.

[46] Renee Fox, "The Evolution of American Bioethics: A Sociological Perspective.": 210.

addressed. One critique gives the example of the,

> attempts to treat the public-private distinction as belonging to the category of problems that ought to be handled by the principles of church/state separation. The church is permitted to speak about private matters, but the separation inhibits theologians from affecting public policy. The aim, to immunize the body politic from the undecidable squabbles that divide theologians is well intended. The effect, to require individuals to avoid speaking theologically if they wish to affect public policy, is paradoxical since all issues relevant to our public life can be discussed theologically.[47]

Obviously there is disenchantment with the "neutral" secular forum of discourse for bioethics and this type of artificial compartmentalization of culture fostered by the exclusion of theological ethics from the dialogue. Two people who have offered consistently insightful critique and direction to the dilemmas thus far surveyed offer visions including theological reflection in public dialogue on bioethical issues.

Daniel Callahan feels the secularization of the discipline of bioethics leaves us bereft of the accumulated wisdom and knowledge that are the fruit of long-established religious traditions. He critiques the establishment of the neutral secular forum of dialogue as forcing us to pretend that we are not creatures of <u>both</u> particular moral communities and the more sprawling, inchoate general community that we celebrate as an expression of our pluralism.[48] He feels the discipline of bioethics and its critiques have become a detached neutrality reluctant, to question the conventional ends and goals of medicine and too heavily dependant on the law as a the working source of morality. The present forum for dialoguing and attempting to resolve bioethical dilemmas has intimidated religion from speaking

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[47] Brendan P. Minogue, "The Exclusion of Theology from Public Policy: The Case of Euthanasia, <u>Second Opinion</u> 14 (1990): 89.

[48] Daniel Callahan, "Religion and the Secularization of Bioethics." <u>Hastings Center Report</u> (July/August, 1990): 4.

in its own rich language and led many to believe that religious reflection can be expressed with integrity only within the confines of particular religious communities.[49] Callahan has surprisingly stated, considering his earlier position,

> If my life had been in a way, relieved by the absence of religion as a guiding force, I cannot say that it has been enriched or that I am a better person for that. Nor can it be said, I think, that biomedical ethics is demonstrably more robust and satisfying as a result of its abandonment of religion. ...whatever the truth status of religious perspectives, they have provided a way of looking at the world and understanding ones own life that has a fecundity and uniqueness not matched by philosophy, law or political theory.[50]

The potential resource that theological reflection could offer as an insightful and imaginative contributor to any public dialogue on societal dilemmas and human meaning has been identified, debated and advocated by many authors.[51] Those who argue for the inclusion of theological reflection in public debate identify that the drive and process toward publicness will purge ideology and sectarianism from the participating traditions, religious or not. One of the strongest advocates of a theology of publicness is Catholic theologian David Tracy[52] who leads us to two types of creative contributions which theology can offer public debate. One is the religious classic itself and the other is the very process of doing public theology.

Tracy claims that a "classic" is any expression of the human spirit on a particular journey in a particular tradition which

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[49] H. Tristram Engelhardt, The Foundations of Bioethics. (New York: Oxford University Press, 1986): 11.

[50] Daniel Callahan, "Religion and the Secularization of Bioethics." Hastings Center Report (July/August, 1990): 2.

[51] "Theology and Bioethics" special issue of The Journal of Medicine and Philosophy 17(3) (June, 1992): 263-365. "Theology, Religious Traditions, and Bioethics." A Special Supplement in Hastings Center Report (July/August, 1990). Earl E. Shelp (ed.), Theology and Bioethics. (Dordrecht: D. Reidel Publishing, 1985)

[52] "Without that demand for publicness - for criteria, evidence, warrants, disciplinary status - serious academic theology is dead." David Tracy, The Analogical Imagination (New York: Crossroad, 1986): 21.

discloses permanent possibilities for human existence, both personal and communal.[53] A "classic" discloses meaning so deeply human that even though it is expressed out of the particularity of one tradition, religious or secular, the meaning it discloses holds relevance for all traditions. A "classic" is therefore always public and never private. Within the process of the secularization of bioethics, the particularity of theology was considered a weakness which inhibited its ability to contribute to genuine public dialogue. Through Tracy's claim, particularity is not the reason to exclude any tradition from participating in public dialogue because out of the particularity of any tradition can come an expression of human meaning pertinent to all traditions.

The religious classic, and any classic for that matter, not only offers reflection and expression on human existence but contributes an opportunity for transformation. Encountering a classic allows a person the opportunity to discover and participate in a world of meaning and possibilities that is related, perhaps similar, but different from that experienced previous to this encounter. The transformative and disclosive power of the classic challenges, provokes and confronts our present horizons, releasing liberating, imaginative and creative perspectives. We recognize that we interpret experience, that our interpretations and horizons are finite, and we demand more. Tracy's analysis proposes that we "respect the public status of all classics, including the religious classics, as cultural

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[53] David Tracy, Analogical Imagination (New York: Crossroad, 1986): 14.

classics bearing a recognizably public meaning"[54].

An encounter with a religious classic or an encounter with a community of authentic, classic, religious discourse,

> will demand of all those caught up in the interpretation of its world that its religious subject matter - its fundamental questions and responses upon my present relationship to the whole - be openly addressed. To allow for the world of the religious classics is in the end to allow for a world of meaning and truth disclosing the truth of the paradigmatic, the classical, the extraordinary. Every religious classic expresses an event of a "limit of" reality that has the full force of a power finally liberating us from ourselves, summoning us to and by a power not our own.[55]

Secondly, while Tracy recognizes the theologians' dilemma of being formed by and addressing a variety of milieus (what Tracy has identified as three publics: society, the academy and the church) this unique type of experience and dialogue between communities of religious discourse fosters linkages[56] which become the sources of the theologian's creativity and imagination.

> ...the very complexity of the contemporary theologian's social reality can also occasion serious and rigorous reflection relevant to the social role of all intellectuals. The theologian's internalization of the demands and plausibility structures of all three publics may, in fact, prove a good test case for studying the genuine dilemmas of any intellectual in modern society.[57]

Through the individual dialogues with each of the three publics and the making explicit of their major claims and counterclaims, theologians foster a process which generates clarity and insight for the wider public.[58] Through the linkages made between these individual dialogues, a broadening of horizons, a creativity and

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[54] David Tracy, The Analogical Imagination: 134.

[55] David Tracy, The Analogical Imagination: 178.

[56] Lonergan would describe the linkages as the shift from description, which is narrow horizon perspectives of a single community of discourse (experiential base), to explanation, or the clarity and insight that dawns through the dialogue between three communities of discourse. See Bernard Lonergan, Insight (New York: Harper & Row, 1978): 332-335.

[57] Tracy, David. The Analogical Imagination. (New York: Crossroad, 1986): 28-9.

[58] Tracy, David. The Analogical Imagination.: 29.

imagination is fostered by this very process of doing theology. It is this accountability to the three publics, and the authenticating drive toward publicness, that justifies, legitimates, and reveals the potential contribution of the theologian.

Conclusion

Callahan, Tracy, and others propose that the potentially creative, transformative and insightful assistance of theological reflection be included in the public debate directed toward the resolution of our societal dilemmas. It is from this point of departure that I continue to offer a theological, ethical critique of the federal government's ethical influence on the environment of limited resources in the Canadian health care system. As a theologian I am interested in how the federal government addresses the issue of limited resources within the structure and policy it advocates for the Canadian health care system. How this issue is addressed will advocate both a perception and a manner that will foster growth or decline in the potential of community living among Canadians.

CHAPTER 2

Discovering Federal Value Choices.

Introduction

The ethical influence of the Canadian federal government on the Canadian health care system is a multifacited and complex influence. The British North America Act of 1867 had given the provinces jurisdiction over most health services. The specific jurisdiction of the federal government involved health services including native peoples, the armed forces, the RCMP, immigrants or refugees at certain stages in the immigration process, those living in the Northwest Territories and the Yukon and a few other small groups. Yet many decisions made by the federal government concerning the economy, agriculture, immigration and environment can directly or indirectly, but dramatically, influence the health of Canadians and the health care system. For example, the 1971 bill legalizing abortion directly affected hospital functions, medical staff organization, hospital board decisions, health care costs and the emotional and physical health of many women.[59] Another example concerns the dilemma over an influx of foreign medical graduates contributing to an oversupply of physicians in Canada in the 1960's and early 1970's. After federal-provincial discussions, the dilemma was dealt with early in 1975 by changing the immigration procedures and the foreign medical graduates entering the country being reduced by 75-80%.[60]

The specific type of ethical influence examined in this presentation will involve identifying and presenting the ethical

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[59] Ralph W. Sutherland; M. Jane Fulton, Health Care in Canada. (Ottawa: The Health Group, 1988): 53.

[60] Ralph W. Sutherland; M. Jane Fulton, Health Care in Canada. (Ottawa: The Health Group, 1988): 70-71.

values and choices expressed within the texts of federal government documents. It is acknowledged that the ethical values and choices expressed and examined in these documents are both the "ideal" and "potential" directions which may or may not have had a practical impact with the Canadian health care system. A presentation of their effectual influence would take more comprehensive examinations of the various social, political and economic elements before, during and after their creation. Also acknowledged, is that the ethical value choices that shape these documents are often not defined or outlined within the documents. These values are not expressed explicitly but implicitly, not consciously but unconsciously. It is therefore necessary at times to review and point to the historical circumstances surrounding the creation of the document which reveal with greater clarity the ethical values and momentum at play.

The federal documents examined in this study have been chosen due to their prominence in creating, detailing and directing the Canadian health care system, between 1957-1991. They consist of three types of documents (legislation, royal commissions and public reports) and will be examined in a consistent manner. First to be examined will be the document's importance, purpose, goal, parameters addressed and its relation to other documents. Second will be the ethical values and choices expressed explicitly or implicitly within the text of the document. Third will be how the content of the document treats the issue of limited resources and how the five foundational principles are impacted. The focal question incorporating these steps is, "What are the value choices, the medical and societal goals within prominent federal documents that have created and shaped the federal approach to the issue of limited resources and their allocation?". The following are the federal documents examined:

1. The Hospital Insurance and Diagnositic Services Act. Statutes of Canada, 1957, chapter 28.

2. Hall, Emmett M. The Royal Commission on Health Services, Summary Report. (Ottawa: Queen's Printer, 1964)

3. The Medical Care Act. Statutes of Canada, 1968, chapter 64.

4. Lalonde, Marc. A New Perspective on the Health of Canadian's: A Working Document. (Ottawa: Queen's Printer, 1974).

5. The Federal - Provincial Fiscal Arrangements and Established Programs Financing Act. Statutes of Canada, 1977, Chapter 10.

6. Hall, Emmett M. Canada's National - Provincial Health Program for the 1980's. (Ottawa: Queen's Printer, 1980).

7. Bégin, Monique. Preserving Universal Medicare: A Government of Canada Working Paper. (Ministry of Supply and Services Canada, 1983).

8. The Canada Health Act. Statutes of Canada, 1984, chapter 6.

9. Epp, Jake. Achieving Health For All: A Framework for Health Promotion. (Ottawa: Queen's Printer, 1986)

10. The Government Expenditures Restraint Act. Statutes of Canada, 1991, Chapter 9.

The Hospital Insurance and Diagnostic Services Act. (1957)

The Hospital Insurance and Diagnostic Services Act, passed in 1957 and in force on July 1, 1958, was the first federal legislation creating a national program specifically attempting to impact health care for the majority of Canadians.[61] Previous attempts had been made by the federal government, with the provincial governments, to generate national programs. The National Liberal party had made a platform promise in 1919 for a

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[61] Ralph W. Sutherland; M. Jane Fulton, Health Care in Canada. (Ottawa: The Health Group, 1988): 51.

national health insurance program. In 1945 a national health insurance proposal made by the federal government to pay 60% of the costs of a broad range of health services failed. The offer was conditional on the provinces accepting transfer of important tax fields to the Federal Government and failed precisely on lack of agreement on these tax transfers between federal and provincial governments.[62] Yet these processes served as important groundwork by revealing to the general public the poor health status of Canadians, the disparity of services in many regions of the country, and the economic barriers which kept needed health services out of reach for many Canadians.

By 1961 all the provinces agreed to participate in the program outlined by the Hospital Insurance and Diagnostic Services Act which authorized conditional contributions from the federal government to universal hospital insurance programs administered by the provincial governments. The Act had two objectives of budgeting individual hospital care costs and providing funds for hospital budgets.[63] It was considered an extraordinary piece of legislation on two counts. First, it was regarded at that time as the largest single program ever undertaken in peace time Canada.[64] Second, considering the history of federal-provincial debate and disagreement over such a program, the federal government surprisingly prescribed every essential requirement for the operation of the program.[65]

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[62] Malcolm G. Taylor, Health Insurance and Canadian Public Policy. (Kingston/Montreal: McGill-Queen's University Press, 1987): 173; 67.

[63] Hall, Canada's National - Provincial Health Program for the 1980's.: 4.

[64] Hall, Canada's National - Provincial Health Program for the 1980's.: 3.

[65] Taylor, Health Insurance and Canadian Public Policy: 230.

The most prominent goals and values within the text of this legislation were shared federal-provincial (Canadian societal) responsibility in the provision and maintenance of equal access[66] to quality[67] hospital resources and services for most if not all Canadians. Several factors had exposed the need and drew support for this type of action: a 1934 Canadian Medical Association report that many Canadians were doing without necessary medical care due to economic barriers[68]; in 1941 the Dominion Bureau of Statistics showed high maternal and infant mortality rates (ranking seventeenth among developed nations), and high mortality rates from communicable diseases[69]; high mortality rates and morbidity rates from preventable diseases and high rejections rates of potential armed forces recruits due to physical and mental reasons had a great impact on public awareness of the health status of Canadians[70]; in 1953, the Dominion Bureau of Statistics released influential analysis revealing the individual and provincial inequities caused by the circular effects of low income and illness[71]. They confirmed the inequity among citizens in the distribution of the burden of both physical and mental illness and the financial impact of their costs. The burden of costs was enormous with the low income group registering almost twice as many disability days as high income groups. Standards of

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[66] Sutherland; Fulton, Health Care in Canada: 183.

[67] Taylor, Health Insurance and Canadian Public Policy: 236.

[68] Taylor, Health Insurance and Canadian Public Policy.: 6.

[69] Taylor, Health Insurance and Canadian Public Policy.: 5.

[70] Taylor, Health Insurance and Canadian Public Policy.: 67.

[71] Taylor, Health Insurance and Canadian Public Policy.: 173.

resources and services varied between provinces as much as two to three times.[72] The revealed inadequacies and inequities mounted public pressure for federal involvement in financing of hospital services, through nationally collected funds, and for provincial cooperation in a national program.

The legislation involved many value choices within its criteria. It attempted to foster equity and non-discrimination of any low income group. This occurred through a criteria of provincially uniform conditions and services, and through a cost sharing formula which allocated the program's financial resources such that wealthier provinces helped financially support the services provided in less wealthy provinces. Accountability was attempted through requiring reporting of provincial expenditures and allowing for audits. By including a compulsory characteristic requiring all citizens of the provinces involved to benefit, federal interests were again shown to be operative. These federal choices at times placed greater value on what the federal government considered the common good of the country, than on the autonomy of provincial or individual interests. These were the value elements proposed as necessary for the creation and maintenance of a reasonable and just national hospital insurance program. Claims of discrimination could be made not only by wealthier provinces and individuals but also according to what services were included in the insurance program. Not included in the definition of "hospital" in the legislation were mental hospitals, tuberculosis sanatoria and institutions for custodial care of the aged. It had been claimed that the legislation was

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[72] Taylor, Health Insurance and Canadian Public Policy: 173-181.

discriminating against mental illness.[73] A rebuttal proposed to this claim was that these services were already being provided for at provincial expense and the intent of the Act was to expand health care access, not to transfer existing provincial expenditures to the federal government.[74]

Although no explicit mention is made in the legislation of "limited resources" as an issue, this legislation was a specific response to problems with types of "limited resources". Functional, physical "health" was seen as a limited resource of the country as a whole but especially among the poor. Good health on the part of its citizens was needed if the country would be able to defend itself, prosper and grow. Second, the infrastructural health resources and services which foster "health" were found to be "limited" in their capacity and competence to address the basic health needs of all Canadians equally.[75] Third, since this was to be the single largest program to be undertaken in peace time Canada, there was concern of the national financial resources it would consume and the limits of the federal budget to support it. A number of elements were included or excluded within the program only in reference to their potential to increase costs and financially sabotage this national social program.[76] The financial formula used to calculate federal

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[73] Taylor, Health Insurance and Canadian Public Policy: 226.

[74] Sutherland, Health Care in Canada: 183.

[75] In order to support the Hospital Insurance and Diagnostic Services Act and to assist in addressing the limited infrastructural resources dilemma, the Health Resources Fund Act became a supporting initiative. Over a seventeen year period (1966-82), the fund provided $427 million to Canada's health professional schools and teaching hospitals, for the planning, acquisition, construction, renovation, and equipping of health training and research facilities. Hencock, R.A. "New Perspectives: The First Ten Years." Annal of the Instituto Superiore di Sanita. vol. 21, n.4 (1985): 557.

[76] Taylor, Health Insurance and Canadian Public Policy: 185, 187, 227-8.

payments to the provinces also provided financial incentive to the provinces to keep their costs below a national average. A sensitivity to limited resources is therefore operative, but understood as "limited" due to other variables such as national economy, the pressure of public opinion or the value given to other competing national interests. Providing the resource of healthy citizens to the country and supporting growth in infrastructural health resources and services seem to be the highly valued national interests producing this initiative.

Although the five foundational principles were not explicitly identified as principles this early in Canadian health care legislation, most were implicitly present. Universal access to a minimum standard of basic, equitable and comprehensive hospital (health) services, under public administration, were implicitly integral in this legislation. Portability would seem to be the only principle not implicitly involved.

The Royal Commission on Health Services. (1964)

The Royal Commission on Health Services, or the "Hall Commission" as it is often referred to, was appointed in March of 1961 by Prime Minister Diefenbaker and charged to,

> ...inquire into and report upon the existing facilities and the future need for health services for the people of Canada, the resources required to provide such services, and to recommend such measures, consistent with the constitutional division of legislative powers in Canada, as the Commissioners believe will ensure that the best possible health care is available to all Canadians.[77]

After three years of dialogue and deliberation, meeting and working with various experts and perspectives, this Commission produced research and recommendations which served as foundational

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[77] Hall, Royal Commission on Health Services, Summary Report.: XIX.

background for the development of the federal legislation known as the Medical Care Act. The essential goal of the Commission, as related in the text, was to resolve the inefficient and ineffective legislative, organizational and financial decisions which had fostered an enormous gap in the Canadian health service field.[78] This "gap" was between the scientific knowledge and skills available, and the insufficient financial and organizational arrangements made to fulfill Canadian health care needs. The gap was to be resolved in order to attain the goal of making, "all the fruits of the health sciences available to all our residents without hindrance of any kind".[79]
Incorporated within this goal, and directing the Commission in its examination, was an "essential" question: "What is society's interest in the health of its individual members?"[80]. This question suggests a balancing of the interests or common good of society with the health needs of its individual citizens. Potentially, the question could be interpreted further in one of two ways. The focus of "society's interest" could be used as a criteria for prioritizing (therefore limiting) the allocation of resources to individual needs. "Society's interest" could also be used as the basis to legitimize an expansion of resources to be made available, in order to meet an expansion of individual needs fulfilled through insured health services.

Originating from this "essential question", the document then moves to expressing the importance of individual

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[78] Hall, Royal Commission on Health Services, Summary Report.: 10.

[79] Hall, Royal Commission on Health Services, Summary Report.: 10.

[80] Hall, Royal Commission on Health Services, Summary Report.: 3.

responsibility in fostering personal health, in the prudent use of health services as a member of society and in contributing to the costs of providing these health services and resources. It continues by expressing the necessity of public interest"[81] in individual health using as an authoritative force the growing Canadian consensus[82] that, "society as a whole must help to bear the costs of accidents and disease that we know will strike the total population in predictable numbers, although we cannot tell which of us will be stricken"[83] The unpredictability of disease becomes the conditional basis for recognizing and advocating an interdependent foundation in society. Whether this foundation is motivated either by utilitarian self-concern or altruistic concern is not specified.

The foundation of interdependence or mutual support is advocated as central for the maintenance of a "good", "free" and prosperous society. The benefits are claimed best exemplified through public health activities such as the creation and maintenance of sewerage systems and pure water supply, the creation and operation of educational institutions for health workers, the provision of hospital facilities, the equal distribution of personnel and other resources across Canada, and prepayment for health services.[84] The harm caused by not

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[81] "The national interest requires that the risk must be spread over the whole productive population to cover everybody and not only those who choose to insure voluntarily. And the device must be used ultimately to finance the whole spectrum of health services, not merely hospital and physicians' services. To make certain that all our citizens have access to the necessary health services is now clearly a matter for the public interest." Royal Commission on Health Services, Summary Report.: 10.

[82] The element of "consensus" is indicated here as an esteemed and authoritative value itself.

[83] Hall, Royal Commission on Health Services, Summary Report.: 5.

[84] Hall, Royal Commission on Health Services, Summary Report.: 5

recognizing this interdependent foundation is exemplified well through the rejection rates of armed services recruits in World War II and the Sickness Survey of 1951. The interdependent nature of society was used not only to demonstrate the necessity of public interest in individual health but also that providing for a healthful environment is a public or societal responsibility.

Within this context of public or societal responsibility in a democratic society, it is indicated that Canada has subscribed to the following value choices as a signing member of the Constitution of the World Health Organization:

> The enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being without the distinction of race, religion, political belief, economic or social condition.
>
> The health of all peoples is fundamental to the attainment of peace and security and is dependent upon the fullest cooperation of individuals and States.[85]

Two statements which imply foundational value choices are also accepted within the document:

> In the first place, the health of every individual is a social concern and responsibility; and secondly, as following from this, medical care in its widest sense for every individual is an essential condition of maximum efficiency and happiness in a civilized community.[86]

A primary concern of the public interest was the unequal distribution of health resources, particularly of personnel.[87] Proposed for adoption within the document is "The Health Charter for Canadians" with the primary goal of national policy being "the achievement of the highest possible health standards for all our people". This goal is considered best achieved through a more

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[85] Preamble to the Constitution of the World Health Organization cited in Royal Commission on Health Services, Summary Report.: 6.

[86] Newsholme, Sir Arthur, Medicine and the State. (London: G. Allen & Unwin Ltd., 1932): 29, cited in Royal Commission on Health Services, Summary Report.: 7.

[87] Hall, Royal Commission on Health Services, Summary Report.: 9.

comprehensive, universal Health Services Program for the Canadian people. "Comprehensive" is defined as including all health services that modern medical and other sciences can provide. "Universal" means that adequate health services shall be available to all Canadians regardless of age or condition, whatever their financial resources may be, and wherever they reside, within the limitations imposed by geographic factors.[88]

Various methods were proposed through the principles of comprehensiveness and universality to attend to national inequalities and injustices. Special funds and subsidies were recommended as incentives to help the distribution of health personnel to rural areas[89] and other northern and isolated regions. Recommended also was that special services be made available to these areas such as air ambulance, two way radio communication and increased nursing stations and medical depots. Accessibility was also fostered through the proposal that the coverage of insured health services be continuous, with portability of benefits assured to individuals moving from province to province. All personal health services were to be universally available on uniform terms and conditions for all residents. Those provinces not yet having one hundred percent coverage of all residents were encouraged that further steps should be taken to see that all are insured. Statistical reporting was proposed on all services so that programs could be evaluated.[90]

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[88] Hall, Royal Commission on Health Services, Summary Report.: 11.

[89] Hall, Royal Commission on Health Services, Summary Report.: 34

[90] Hall, Royal Commission on Health Services, Summary Report.: 20.

The national program was recommended to be based upon: freedom of choice in both patient's right to select a practitioner and practitioner's right to not accept a patient (except in emergency or humanitarian grounds); free and self-governing professions and institutions; financing through prepayment arrangements, accomplished through the full cooperation of the general public, health professions, voluntary agencies, all political parties and levels of government; directed towards the nation's most effective use of health resources in order to attain the highest level of physical and mental well-being."[91]

In being more comprehensive with services than had been offered in the past, this proposed Program is both inclusive and discriminating in its criteria. Due to the shortage of personnel, recommendations for dental and optical services were limited, with priority given to children's programs. In order to provide more comprehensive and universal health services, funds were recommended to be available for: sharing costs for both insured services and building a better infrastructure resource; emphasizing prevention; fostering self-support and independence through prioritizing rehabilitation services[92]; reorganizing and reorientating mental health services through ending the discriminating distinctions and attitudes between physical and mental illness in the organization and provision of services for their treatment; the inclusion of nursing services and tuberculosis sanatoria with the insured administration of personal health services; the recommendation to use a fee-for-service method of payment which would limit the potential of arbitrary

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[91] Hall, Royal Commission on Health Services, Summary Report.: 11.

[92] Hall, Royal Commission on Health Services, Summary Report.: 19

billing methods, allowing greater accountability and cost containment.[93]

> Undoubtedly, the most important conclusion of the Commission was that the objectives of the Canadian people could best be achieved through a universal program administered by public authority with twelve provincial or territorial health insurance funds subsidized from federal general revenues rather than by means testing and subsidizing several millions of individual Canadian's and family heads to enable them to pay voluntary plan or commercial insurance premiums.[94]

Different types of "limited resources" were referred to in this document. Resources were understood as "limited" both in reference to equitable infrastructure and treatment services available between provinces and other geographical areas within the country. Resources were identified as limited concerning dental personnel. There was also a sensitivity to the limitedness of financial resources both for the public to pay for services and in recommending payment structures which emphasized greater potential for accountability and cost containment. In fact all the elements within the charter were directed towards "the most effective use of the nation's health resources". Yet, the impression could also be given that the nation's health resources were in fact limitless, according to the following fundamental goals: "to make all the fruits of the health sciences available to all our residents without hindrance of any kind."; "the achievement of the highest possible health standards for all our people.".

The four principles of comprehensiveness, universality, portability and public administration without profit are each explicitly referred to in the document. The principle of accessibility is implicitly referred to through the principle of

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[93] Hall, Royal Commission on Health Services, Summary Report.: 29.

[94] Hall, Canada's National - Provincial Health Program for the 1980's.: 5.

universality. The principles of accessibility, comprehensiveness and universality are expanded with respect to the scope of services offered. With the broad goals for services offered directing these principles, the foundations were laid for a conflict of competing interests over limited resources.

The Medical Care Act. (1968)

The Medical Care Act of 1968 is, in part, the legislative result of the groundwork and examination of the Royal Commission on Health Services. It articulates the legal, contractual obligations and responsibilities of the federal and provincial governments for the existence and payment of a cost-shared, comprehensive medical insurance program for Canadians. All of the provinces and territories had joined the program by 1972. Section 4 of the _Medical Care Act_ outlines the following criteria of the federal government which must be satisfied if the provincial governments are to receive federal contributions to insured medical services. Each criteria make value choices regarding what is best regarding health care for Canadian society:

> a. The program is to be administered and operated on a _non-profit_ basis by a public authority and subject to audit. This criteria advocates the use of public resources to cover only the cost of services, that the program is not profit oriented but service oriented, that the use of these public resources will be accountable.
>
> b. Insured services are to be provided upon _uniform_ terms and conditions to all insurable residents of a province. The condition of uniformity seems to advocate equal and

universal access and reception of quality services and resources by citizens.

c. "Reasonable compensation" must be provided for insured services rendered by medical practitioners. This "reasonable compensation" is not to impede or preclude, either directly or indirectly, whether by charges made to insured persons or otherwise, reasonable access to insured services by insured persons. This implies that just treatment of all parties, concerning not only financial resources but also in guaranteeing accessibility to these services, is a priority health care.

d. "Insured services" was defined as all services rendered by medical practitioners that are medically required, except any that are already provided for under any federal or provincial act or law. This reveals the expanded comprehensive nature of the program in support of the values of equity and quality of services.

e. The number of insurable residents of the province who are entitled under the plan to insured services is not less than 90% (to be increased to 95%) of the total number of insurable residents of the province. A standard directed toward the universality and accessibility of the program.

f. Three months is the maximum waiting period to become a resident of a province. This is another standard directed toward making the maximum number of Canadian citizens to receive the benefit of this program.

g. The province of residence must pay for insured services rendered to insured persons while temporarily absent from the province. This criteria of portability aids in supporting the principles of accessibility and universality.

h. The calculation of the federal contribution involves a formula sensitive to distributive justice concerning the following provincially unique factors[95]:

1. per capital cost.
2. number of insured persons.
3. cost incurred by province.

The text of this document emphasizes particular medical and societal values. Central is that any Canadian, any provincial resident, should have equal access to increasingly comprehensive quality health care regardless of age, condition, financial resources and, within reason, geographical location. The choice of these health care criteria are presented as collectively best for the "common good" of the country. It was this value of national interests considered serving the "common good" of the country which served to legitimize the use of the compulsory criteria, compromising provincial and personal autonomy, in this voluntary program. "Common good" was also the value used to justify the practice of distributive justice, since the financial formula employed, allocated financial resources from wealthy provinces to assist in funding insured medical services of less wealthy provinces.[96]

The type of limited resources identified in this legislation concern equity of access to health care services. The resources

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[95] "...The Medical Care Act cost sharing formula differed from the formula of The Hospital Insurance and Diagnostic Services Act since the former ignored individual Province's costs. All provincial expenditures on insured medical services for insured persons were totalled and the national average per capita cost calculated. One-half of this amount was paid to each Province in respect of the numbers of insured persons in its population. The effect of this change was to reduce the percentage contribution of high-cost Provinces and in increase it to low cost Provinces." Canada's National - Provincial Health Program for the 1980's.: 7.

[96] The existence and expansion of resources supporting the poorer provinces, "whether imbedded in the basic taxation agreements or incorporated in specific programs, was clearly creating growing resentment, not officially expressed, over the amount of transfer payments flowing through the federal treasury from wealthy to less wealthy provinces". Taylor, Health Insurance and Canadian Public Policy: 355-6.

understood as limited are either financial resources needed to pay for services, by province or individual, infrastructural resources needed if insured medical services are to be made available, and the medical services themselves. Both types seem to simply require financing to make them available, which infers that the resources are not understood as limited in themselves.

The five principles of the Canadian Health Care system are not always explicitly named or definitively defined in the legislation but all are implicitly present. Comprehensiveness is implicitly found in the all inclusive definition of "insured services". Universality and accessibility are found implicitly in the criteria of uniform terms and conditions for the provision of insured services and that insurable residents are not to be less than ninety percent of the total number of insurable residents for the province. Public administration without profit is explicitly named in the first criteria of the plan. The principle of portability is found in the criteria that provinces are to pay for insured services incurred while temporarily absent from the province. None of the five principles are put in conflictual or adversarial positions with each other since they are simply being outlined and not within the context of any type of limited resources.

A New Perspective on the Health of Canadians: A Working Document. (1974)

This internationally known document was a "Working Paper" issued by the minister of Health, the Hon. Marc Lalonde, and based upon the original research of H.L. Laframboise, Director General of the Long Range Health Planning Branch, Health and Welfare Canada. Its intent was to present "a framework for the analysis of the components of, and contributing factors to, all health problems".[97] Its recommendation, some feel its essential message[98], was that potential improvements in the health status of Canadian's were more likely to occur through changes in lifestyle, environment and human biology than allocating consistently increasing resources to the existing health care delivery system.[99] It also inferred an integral and more controversial role for the federal government through identifying "national health problems which know no provincial boundaries and which arise from causes imbedded in the social fabric of the nation as a whole".[100]

This "Working Paper" re-examined the concept of what "health" consisted of and what might be important considerations in attaining "health". It presented the following understanding of "adequate personal health" as basic "gifts" which it sought to ensure for as many Canadians as possible: "Nightly rest and daily bread, the ordinary use of our limbs, and senses, and understandings, are gifts which admit of no comparison with any other"[101]. It further clarifies the type of health it addresses:

> Complete well-being for all may be beyond our grasp, given the human condition, but much more can be done to increase freedom from disease and disability, as well as to promote as state of well-being sufficient to perform at adequate levels of physical, mental and social activity, taking age into account.[102]

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[97] R.A. Heacock, "New Perspectives: The First Ten Years.": 559.

[98] Douglas E. Angus; Pran Manga, "National Health Strategies: Time for a New "New" Perspective." Working Paper 85-34, University of Ottawa: 1.

[99] Lalonde, A New Perspective on the Health of Canadians.: 18.

[100] Lalonde, A New Perspective for the Health of Canadians.: 6.

[101] Lalonde, A New Perspective on the Health of Canadians.: 8. quoted from William Paley in Natural Theology (Famborough, England: Gregg International Publishers, 1970): 498.

[102] Lalonde, A New Perspective on the Health of Canadians.: 8.

The document identified and objected to a traditional view which claimed that the art and science of medicine was the locus where all improvement of health came from. It recognized that individual health care has received the greatest federal government attention and expenditures, oriented around the treatment of existing illness and directed toward improving its quality and accessibility. Upon examining the nature and underlying causes of present illness, mortality and hospital morbidity in Canada, it was proposed that future improvements in the level of health of Canadians would be best served through attention directed toward "improving the environment, moderating self imposed risks in lifestyle and adding to our knowledge of human biology".[103] These improvements were proposed as the responsibility of governments both within how they allocate funds for health and how they impose restrictions on the population whose well being is under their care.[104]

A "health field concept" was then proposed as a conceptual framework tool for the analysis and examination of the health field.[105] It was broken into the segments of human biology, lifestyle, environment and health care organization and aimed at both providing a greater understanding of what contributes to sickness and death and facilitating the identification of courses of action that might be taken to improve health. Individual responsibility was discovered to be a foundational determining

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[103] Lalonde, A New Perspective on the Health of Canadians.: 18.

[104] Lalonde, A New Perspective on the Health of Canadians.: 9.

[105] Some consider this conceptual framework to be the central contribution of the report. Taylor, Health Insurance and Canadian Public Policy.: 478.

factor undermining the traditional federal approach attempting to ensure "health" through providing accessible hospital and medical treatment through insurance programs. This discovery supported arguing against societal responsibility for providing insured health treatment services and protection against the economic consequences of illness.[106]

A related but controversially discriminatory issue arises in the text questioning the extent "society" should limit individual autonomy through the federal government by attempting to modify lifestyle behavior fostering self-imposed health risks. The document proposed the conclusion that "society", through federal and provincial governments, should develop protective marketing techniques to counteract private marketing abuses which promote these lifestyle risks.[107] A more precise explanation of what "protective marketing techniques" of the government were was not given. Potentially, it would seem that individual autonomy could be discriminated against or limited in service of the national interests or common good of Canadian society. Other issues examined concerning conflicting interests, priorities and directions were "science versus health promotion", "care versus cure", and the discriminating and destructive attitudes towards mental illness.

The federal role suggested by the document was not to remain restricted in involving itself with only activities directed towards the improvement of personal health care of Canadians. It was suggested that it should maintain its involvement in these

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[106] Robert Evans, "A Retrospective on the New Perspective." Journal of Health Politics, Policy and Law, Vol. 7 (2) (Summer, 1982): 331.

[107] Lalonde, A New Perspective on the Health of Canadians.: 37.

areas and also direct energy and resources at specific national health problems, aimed at removing or reducing the factors underlying sickness and death. Two broad objectives for the federal government were proposed:

1. To reduce mental and physical health hazards for those parts of the Canadian population whose risks are high.
2. To improve the accessiblity of good mental and physical health care for those whose present access is unsatisfactory.

Five strategies were proposed as vehicles to attain these objectives:

1. A health promotion strategy. Aimed at improving accepted responsibility of individuals and organizations in affecting mental and physical health.
2. A Regulatory Strategy. Using federal regulatory powers in reducing hazards to mental and physical health.
3. A Research Strategy. Directed toward the resolution of mental and physical health problems.
4. A Health Care Efficiency Strategy. Aimed at aiding the provinces in delivery of services such that cost, accessiblity and effectiveness of services are balanced in the interests of Canadians.
5. A Goal Setting Strategy. Aimed at raising the level of mental and physical health and improving efficiency of the health care system.

The document acknowledges the expectation of patient's to receive rapid, quality care with all available resources employed and with little regard for cost; notes that escalating health care costs will soon be beyond the capacity of society to finance them;

realizes the health system lacks a unity of purpose due to competition for limited funds; proposes a health field concept to be used in evaluating effective and efficient health strategies and use of resources directed towards improving the health status of Canadians. Yet the document reports that the intention of the government must be to maintain existing services at a high level with expanded initiatives to be paced with the ability of the economy to absorb them without increasing taxation.[108] While seeming to advocate the health field concept as a criteria for the allocation of limited resources, the document paradoxically advises for implementation of the health field strategies when the economy can absorb them; meaning, when resources are no longer so limited. The text therefore links the condition of limited resources to the condition of the economy in its ability to finance them among other competing interests.

Although the direction taken by this "Working Paper" is non-traditional, the traditional five foundational principles of Canadian health care are certainly implicitly present, if not explicitly present, within it. It is very clear that these five principles can be included in any governmental health strategy that is offered. The comprehensiveness of federal strategy is increased with such an additional health promotion and prevention focus. The strategy could also be easily understood as another service enhancing universality and accessibility of health programs and "good health "to Canadians. Since these health problems are understood to go beyond provincial boundaries, the strategies attending to them could be described as portable.

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[108] Lalonde, A New Perspective on the Health of Canadians.: 65, 73.

Federal - Provincial Fiscal Arrangements and Established Programs Financing Act. (1977)

This legislative Act was very influential in its fundamental restructuring of the underpinnings of the Canadian medical and hospital care system. The essential change concerned the financial formula used to calculate the federal contribution to the provinces, which assisted in financing programs through the Hospital Insurance and Diagnostic Services Act and the Medical Care Act. Prior to 1977, the federal government financed 50% of provincial health expenditures, with control of those expenditures solely in the hands of the provinces. The hospital and medical services that the federal government cost-shared with the provinces had over time become the most expensive health services offered and had the highest rates of increasing costs. With these health expenditures spiraling, the federal government exerted control through this Act by limiting their expenditures. The change limiting the formula for calculating federal contributions under this Act revealed a shift in the role of responsibility "society", through the federal government, was choosing in influencing the health of Canadians.

The new arrangements of the Act were to reduce the direct federal contribution for health care from 50% to 25% of total provincial expenditures. Any subsequent increases in federal payments were tied to the growth of the gross national product, with cost increases in excess of this gross national product growth becoming the responsibility of the provinces. To compensate for this federal reduction, federal income and corporate taxes were decreased in order to create tax room for the provinces, which could increase their tax rates without increasing total taxation levels.[109] The text expressed the explicit objective of financing the programs "in a manner that will increase provincial fiscal flexibility and of maintaining national standards, where appropriate, in the operation of those programs"[110]. Through the arrangements made, the major implicit objectives of both the federal and provincial governments were achieved. The federal government obtained greater predictability in the stabilization of its health expenditures with the provinces and enacted a strategy influencing the provinces to reduce the rates of growth in these cost-shared programs.[111] What it lost was fiscal power to guarantee criteria of national interest within these provincial programs. Fiscal responsibility and therefore a more autonomous power in determining their health care program priorities were gained by the provinces through this transfer of revenues.[112] This autonomous power would also increase if provincial costs increased above the growth of the gross national product. In addition, through the switch to block funding, the provinces were given the "fiscal flexibility" to choose what percentage of the federal block funding would be allocated to the established programs of post-secondary education, the hospital insurance program, the medical care program and others. The provincial government was to maintain the standards (basically the five principles in the Medical Care Act) of health services, but that was more likely to

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[109] The Federal-Provincial Fiscal Arrangements and Established Programs Financing Act, Chapter 10, Section 17, paragraph "a": 318.

[110] Federal-Provincial Fiscal Arrangements and Established Programs Financing Act, Chapter 10, Section 17,: 318.

[111] Hall, Canada's National - Provincial Health Program for the 1980's.: 11.

[112] Taylor, Health Insurance and Canadian Public Policy.: 435.

be accomplished now through provincial resources. Block funding also provided equal per capita payments to provinces, whereas under the formula within the Hospital Insurance and Diagnostic Services Act, low cost provinces received lower per capita payments than high cost provinces.[113]

The very essence of this Act is a strategy of allocating the financial resources of the federal government in face of a perceived condition of limited financial resources. The strategy valued more the limiting of federal expenditures allocated rather than other allocation strategies based on the nature of services financed or the securing of previous program criteria of national interest. The five foundational principles guiding the national interests were not as well protected through this legislation since previously they were guaranteed through these considerable transfer payments. If the provincial governments now decided not to prioritize or support these principles, withholding of federal contributions now became less of an influential penalty.

Canada's National - Provincial Health Program for the 1980's. (1980)

In 1980, Emmett M. Hall, Commissioner of the Royal Commission on Health Services of 1964, was asked by the federal Health and Welfare Minister, the Hon. David Crombie, to head a Commission of inquiry. The central questions to be answered through this inquiry were whether the provinces were diverting federal health funds to non-health purposes and whether extra billing by doctors and hospital user fees violated the principle

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[113] Taylor, Health Insurance and Canadian Public Policy.: 428.

of reasonable access.[114] As with other federal commissions or review reports, its purpose was to research, inform, educate and offer recommendations concerning its following terms of reference[115]:

1. Consider the extent to which the goals of the "Charter of Health for Canadians" have been met.
2. Examine the extent to which the principles of portability, reasonable access, universal coverage, comprehensive coverage, public administration, reasonable compensation and uniform terms and conditions are being achieved.
3. Consider whether there should be other basic principles underlying health insurance delivery.
4. Consider the nature and extent of necessary revisions to the Hospital Insurance and Diagnostic Services Act and the Medical Care Act and related legislation.
5. Consider the other means by which public authorities may best comply with the principles referred to above.

The report of the inquiry begins with commentary, analysis and interpretation of the principles and issues within the previous federal reports and legislation creating and continuing to shape the Canadian hospital and medical insurance programs. <u>The Established Programs and Fiscal Arrangements Act</u> received much attention with the recommendation that provincial governments should have more autonomy in allocating resources to health. This increase of autonomy was proposed with the expectation that the provinces would reduce the rates of growth in the cost-shared

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[114] Taylor, <u>Health Insurance and Canadian Public Policy</u>.: 428.

[115] Taylor, <u>Health Insurance and Canadian Public Policy</u>.: 429.

programs. Also recommended was that the federal government share the costs of the additional insured service programs that the "have-not" provinces wish to begin but are unable to financially support.

Special mention was made of the 1975 document A New Perspective on the Health of Canadians for alerting the public to diverse and innovative approaches to our complex health care issues. It was agreed that curative health services, in past the focus of Canadian health care, were a last resort and the necessity to foster enlightened citizenship and post curative procedures. Additional services being generated to meet health needs, such as rehabilitative medicine, care and housing for those who due to age, disability, poverty or other reason are unable to care for themselves, were recommended to be carried under the insured services category and funded by government. While noting such programs could be valuable, and realizing that funding all would require inappropriate massive expenditures due to limited funds, research in the post-acute hospital stage (rehabilitation) was advocated as a high priority.

The dominant issues of this Review were next confronted. They were:[116]

1. The growing practice of physicians to extra-bill their patients for services rendered.
2. The conflict between the medical profession and the provinces over the scale of fees payable to physicians.

A central allegation which confronted the review committee was that some provinces had diverted federal health care funds to non-health uses with the consequence of some provincial health

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[116] Hall, Canada's National - Provincial Health Program for the 1980's.:

programs being underfunded. This had caused some doctors to "opt out" and extra bill.[117] The review concluded that the alleged diversion of funds could not be established but that the practice of extra billing was a definite threat to both the principles of accessibility and comprehensiveness. It threatened the principle of accessibility since it denied access to many of the poorer elements of society and violates the essential principle of accessibility to all on uniform terms and conditions.[118] It threatened the principle of comprehensiveness since the health insurance program would not be considered as meeting the full costs of the services provided.[119] The inquiry concluded that "physicians are entitled as a right to adequate compensation for services rendered"[120] but that extra billing is not permissible for, if authorized as a right, it would then destroy over time the health insurance program. The inquiry recommended that when negotiations over reasonable physician compensation reached an impasse between physicians and the province, the dispute should be sent to binding arbitration. The arbitration board would consist of nominees named by provincial and federal governments.

The principle of accessibility was found to be threatened not only through extra-billing but also through the imposition of premiums and hospital ward charges, the practice of closure of hospital beds and restricting admissions to hospital emergency services and wards. Also discovered weak was the principle of

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[117] Hall, Canada's National-Provincial Health Program for the 1980's.: 9.

[118] Hall, Canada's National-Provincial Health Program for the 1980's.: 25.

[119] Hall, Canada's National-Provincial Health Program for the 1980's.: 41.

[120] Hall, Canada's National-Provincial Health Program for the 1980's.: 27.

universality because the number of uninsured citizens in some provinces was greater than the 5% tolerance permitted under the Medical Care Act. This situation was recommended to investigated immediately. Recommendations were also made surrounding the principle of portability when it was revealed that the provincial tariffs were not uniform from province to province. Citizens of a province taking hospital or medical services in another province were surprised when they had to pay the provider then and there, that there was no reciprocity between provinces in the matter of insured charges, when returning to their province they experienced either difficulty or great delay in being reimbursed.[121] The review recommended that the provincial ministers and their counterparts in the Territories meet to resolve this issue.

With these various gaps in programs and services, the following role for the federal government was advocated,

> It may be that the introduction of block-funding has created, in both public and governments, the notion that the federal role in health is completed. This is not so. ...without further federal action the gap between levels of service in high and low income provinces will increase, and the goal of a comprehensive health system will never be met.[122]

The issue of limited resources was central throughout the document and the nature of this issue was discussed in terms of the need to deal with rising health care costs and the financing of programs "in a time of limited funds when the emphasis is on cutting costs".[123] Both of the initial questions generating this inquiry concerned strategies for financing services within a context of limited resources. Yet when the inquiry recommended addressing

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[121] Hall, Canada's National-Provincial Health Program for the 1980's.: 39.

[122] Hall, Canada's National - Provincial Health Program for the 1980's.: 47-8.

[123] Hall, Canada's National-Provincial Health Program for the 1980's.: 10. 48, 101.

additional needs through initiating and including more services under the insured services program, it does not include strategies for financing these services within a context of limited resources. One study was recommended to examine the nature of a specific type of perceived limited resource; that of physician undersupply.

Preserving Universal Medicare: A Government of Canada Position Paper. (1983)

This document, published in July of 1983 under the direction of the Hon. Monique Bégin, Minister of Health and Welfare, presented the position and background philosophy of the federal government which was foreshadowed the philosophy creating the Canada Health Act. It commented on the existing Hospital Insurance and Medical Insurance legislation (Medicare), identified the inadequate defining of "reasonable access" in the Medical Care Act (1966) and expressed what it considered to be the destructive effects of direct charges (physician extra-billing and hospital user charges).

The title itself strongly indicates the tone and intent of the document. The text speaks of medicare being "threatened" through these direct charges and identified the focal issue as not whether the services will be paid for, rather "how and when the costs should be paid".[124] The document expresses strongly an

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[124] Bégin, Preserving Universal Medicare.: 7.

expected concern and responsibility of "society":

> The Government of Canada believes that a civilized and wealthy nation, such as ours, should not make the sick bear the financial burden of health care. Everyone benefits from the security and peace of mind that comes with having prepaid insurance. The misfortune of illness which at some time touches each one of us is burden enough: the costs of care should be borne by society as a whole.[125]

An essential principle was feared threatened and desired to be reaffirmed; that "necessary insured hospital and medical services must be accessible to all residents of Canada regardless of their financial circumstances"[126]. The history of the hospital and medical insurance system was reviewed identifying a common thread of Canadian self-understanding as a humane and caring society, a society that has undertaken to care for all its people through a comprehensive health system.[127] Throughout the document, an expectation upon society was expressed to protect and care for powerless and voiceless segments of society such as the sick, the poor, the elderly.

The positive aspects of the system for hospitals, doctors and taxpayers were emphasized but with inconsistent data concerning health care costs. In responding to allegations of underfunding and government cutbacks, the text notes that during the Federal-Provincial Fiscal Arrangements and Established Programs Financing Act negotiations, the Revenue Guarantee Program was introduced to assist the provinces with increasing compensation during the transitional period of adapting to the tax reform measures. It is claimed that there has been no reduction in federal support for health care and there has been no change in

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[125] Bégin, Preserving Universal Medicare.: 7.

[126] Bégin, Preserving Universal Medicare.: 7.

[127] Bégin, Preserving Universal Medicare.: 8.

the federal government's position on the principles of Medicare.[128] Also, hospital expenditures are shown not to have decreased but "increased 400% between 1970-80, well in excess of general inflation rate"[129]. This turns the focus from alleged government underfunding to heavy spending or consumption of resources by the hospitals. Yet later, the document also states that Canada's health care spending is not out of control; "provincial governments and those responsible for managing the system on a day-to-day basis have done a good job of cost management"[130]. Since the document acknowledges that cost management is a daily factor in the management of health, it infers that the issue of limited resources is a condition of health care. But it states that "the current malaise in the health care system is due neither to the overall level of funding nor the size of federal contributions"[131]. The issue of limited resources is not acknowledged as underfunding of services. It is portrayed more as a condition of limited personal finances of Canadian citizens which would deny them access to hospital and medical services if extra-billing and user charges were allowed.
Direct charges were viewed as threatening to the health of Canadians and the Medicare system. Bold assertions were made such as, "Patients should have the security of knowing that they are entitled to needed care"[132]. It was also considered within the

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[128] Bégin, Preserving Universal Medicare.: 29.

[129] Bégin, Preserving Universal Medicare.: 11.

[130] Bégin, Preserving Universal Medicare.: 13.

[131] Bégin, Preserving Universal Medicare.: 30.

[132] Bégin, Preserving Universal Medicare.: 25.

federal government's mandate "to refuse to pass on taxpayers' money to support those aspects of provincial legislation which do not provide reasonable access"[133]. Universality and accessibility were the principles of the Canadian health system that the document focused on and considered threatened. This seemed to be an example where financing expanding comprehensiveness was beginning to compete with principles of universality and accessibility. What is recommended is for the Federal Government to withhold its conditional contributions from those provinces or territorial governments which do not honor the federal conditions of prohibiting direct charges and user fees.

The Canada Health Act. (1984)

The Canada Health Act replaces the Hospital Insurance and Diagnostic Services Act of 1957 and the Medical Care Act of 1966. The focal issue involving this legislation was previously examined within previous federal documents; whether individual provinces could limit or allocate their expenditures such that physicians would be permitted, at will, to extra-bill insured patients and hospitals permitted to charge patients "user fees".[134] The text begins by stating that the intention of the federal government is not to impair or abrogate the powers, rights, privileges and authorities vested in Canada or the provinces through provisions or amendments of the Constitution Act of 1867. It claims that Canadians, through insured health services, have made "outstanding progress in treating sickness and alleviating the consequences of

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[133] Bégin, Preserving Universal Medicare.: 31.

[134] Taylor, Health Insurance and Canadian Public Policy.: 435.

disease and disability among all income groups"[135]. The text then proposes that further improvements can be made in health and well being through fit lifestyles, prevention, health promotion, cooperative partnership and continued access to quality health care without financial or other barriers. The purpose of the Act later defined as "establishing the criteria and conditions that must be met before full payment may be made under the Established Programs Financing Act of 1977 for insured and extended health services provided under provincial law"[136]. The criteria and conditions are then outlined under the five principles of public non-profit administration, comprehensiveness, universality, portability and accessibility.

Public administration is to be non-profit, responsible to the provincial government and subject to audit. Comprehensiveness is defined as the province insuring all health services provided by hospitals, medical practitioners or dentists and where the law permits other health care practitioners. Under the principle of universality, the province must entitle 100% of the insured persons of the province to the health services on uniform terms and conditions. The principle of portability ensures the reception of insured persons from one province to receiving services from any other province or territory, or countries at outlined rates and specified conditions. Accessibility, the focal principle of the Act, outlines that the province must provide insured services on uniform terms and conditions which do not impede accessibility by <u>charges</u> made to insured persons. In connection with this, the province must provide for reasonable compensation of all insured

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[135] <u>The Canada Health Act</u>. Chapter C-6,: 1.

[136] <u>The Canada Health Act</u>. Chapter C-6, paragraph 4,: 5.

services rendered by physicians. Any disputes will be settled between government and medical parties through conciliation or binding arbitration.

If any criteria has not been observed by a province, then the federal government could authorize that province's federal cost-sharing contribution (transfer payment) reduced or withheld until the province again complies with the criteria. If there occurs any extra-billing or user charges, then the federal government will deduct from its contribution to the provinces the amount that the federal government estimates to have been charged, if no information on the amount is provided.

The issue of limited resources is implicitly at play within the text of the document since it is dealing with limiting or allocation strategies (physician extra-billing and hospital user fees) of individual provinces. It is the position of the document that obtaining funds through those proposed additional strategies would undermine the foundational principle of accessibility in the Canadian insured health services system. The point remains that if additional strategies for funds are proposed by provinces, hospitals or medical organizations, a condition of need and therefore limited resources is attempting to be addressed.

Achieving Health for All: A Framework for Health Promotion. (1986)

The "healthy public policy" began by Marc Lalonde with A New Perspective on the Health of Canadians was carried on and incorporated as federal policy within this federal departmental strategy document. The document was released at an international conference on Health Promotion held in Ottawa in November 1986 by the Hon. Jake Epp, then Minister of National Health and Welfare.

It proposes a wider application of health promotion, using the World Health Organization definition of health promotion as, "the process of enabling people to increase control over, and to improve, their health."[137] Health promotion is considered as a multifacited exercise which includes education, training, research, legislation, policy coordination and community development. This proposal for a health promotion framework incorporates a vision of health as "a dimension of the quality of life"[138]

The document outlines three health challenges considered inadequately addressed by current health policies and practices and advocates a "health promotion approach" intended to provide assistance. The first challenge is to reduce the inequities in the health of low versus high income groups in Canada since, the text claims, people's health remains directly related to their economic status. Secondly, various forms of preventable diseases and injuries are reported to continue to undermine the health and quality of life of many Canadians. The document identifies the challenge to find new and more effective ways of preventing the occurrence of injuries and illnesses and their disabilities. Thirdly, many Canadians are described as suffering from chronic disease, disability or various forms of emotional stress and lack adequate community support. The challenge identified is to enhance people's ability to manage and cope with chronic conditions, disabilities and mental health problems.

Having identified the challenges, the document next proposes mechanisms, strategies and processes intrinsic to health promotion

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[137] Epp, Achieving Health for All.: 6.

[138] Epp, Achieving Health for All.: 12.

responses and implicitly emphasizing value choices for equity and accessibility directed toward the common good of the community and/or country. Three mechanisms are submitted as intrinsic to health promotion and could be considered as values within themselves. The first is self care which is an individual's decisions and actions taken in the interest of their own health. Mutual aid is second and understood as the decisions and actions people take to help each other. The third mechanism is the creation of healthy environments. The strategies or processes proposed for implementation in confronting the challenges could also be understood as values within themselves and are: fostering public participation, strengthening community health services and coordinating healthy public policy. All are directed toward the goal of, "achievement of health for all". This proposed federal approach notes that, "adjusting the present health care system in such a way as to assign more responsibility to community-based services means allocating a greater share of resources to such services"[139].

The issue of limited resources and the continuing concern of cost control were raised and interrelated at the end of the document, in relation to the question of "allocating resources during times of scarcity". The health promotion framework was valued due to its potential in the long term to slow the growth of health care costs. In both instances the issue of limited resources is linked inversely to the availability of finances. This would seem to infer that our resources are not limited in themselves, that the issue of limited resources is not to be accepted as a consistent condition to be adapted to and lived

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[139] Epp, Achieving Health for All.: 10.

with.

None of the five foundational principles were mentioned explicitly in the document but all were implicitly present in the document. Comprehensiveness is present in the challenge to find new and more effective ways of prevention and health promotion. In fact the health promotion strategy is a broader and more comprehensive approach to health than traditionally encountered. Universality and accessibility are also involved since the intention of the strategy is to reach those groups of society that have not been inadequately served; the aim being "the achievement of health for all"[140]. Public administration without profit is also incorporated since it includes the allocation of resources from governments. Portability also seems implicated since health promotion is advocated as a national policy reaching beyond the borders of provinces and territories.

Government Expenditures Restraint Act. (1991)

This federal legislation is an amendment to the Federal - Provincial Fiscal Arrangements and Established Programs Financing Act which further decreases the federal cash transfer contributions to the provinces' insured health programs under the Canada Health Act. The terminology of the Act speaks only in terms of the numerical formula used for the calculation of the block funding of the federal to the provincial governments. The ethical parameters of the revision are not revealed within the text as much by the action indicated by the document.

The intent for a decrease in block funding could be to decrease federal costs in transfer payments and also, as with the

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[140] Epp, Achieving Health For All.: 7.

Federal - Provincial Fiscal Arrangements and Established Programs Financing Act, to put pressure on the provinces to decrease their own spending. Yet these transfer payments have acted as a guarantee for provincial support of these national health interests, especially the criteria of the five foundational principles within the Canada Health Act, in provincial health insured services. If the provinces did not honor these criteria of national interest, then the federal government could penalize the provinces by withhold these transfer payments. Decreasing these payments made withholding them less of a penalty. In decreasing block funding payments through this Act, the federal government again gave the provincial governments more autonomy and "fiscal flexibility" in shaping the direction of hospital and medical services within their province.

As with the Federal - Provincial Fiscal Arrangements and Established Programs Financing Act, the essence of this Act concerned setting limits to the financial responsibilities of the federal government in financing hospital and medical insured services. The issue of "limited resources" was identified solely with costs and the resolution employed was to cut costs by contributing less funds. Distributive justice was not an element included since no type of inquiry was initiated concerning prioritizing needs within the provincial programs. If the federal government was to withhold contributions due to inadequate provincial support for the federal criteria of these programs, it would be less of a penalty to the provinces and therefore less authoritative. This type of allocation could potentially allow for increased provincial discrimination against any of the five foundational principles of Canadian health care.

Conclusion

These federal documents have been shown to contain ethical value choices, implicitly or explicitly, consciously or unconsciously, which create, direct and transform our Canadian health system. The central national interest which created the insured hospital and medical services programs and served as foundational to the debate and development of the other federal documents was to eliminate economic inequities and disparities of individuals and provinces. The presence of these inequities and disparities were believed to prevent the equal achievement of provincial and individual health and undermine the prosperity, civility and equality of the country. Both equality and non-discrimination of services were attempted to be fostered in the management and allocation of resources through the five foundational principles of the insured medical services program: comprehensiveness, universality, accessibility, portability and public administration without profit. Most if not all of these principles were consistently present, supported or challenged, either implicitly or explicitly through the documents examined.

The issue of limited resources was also revealed to be consistently present in the documents although understood in different ways. Individual, basic, physical health among many Canadians was judged to be a limited resource of the country which motivated the creation of these national health insurance programs. Infrastructural health resources and services equally accessible to Canadians was another "limited resources" discovered once an examination into the health of Canadians began. There was also the concern and awareness that national financial resources were limited since the proposed programs were large national ventures. Over time, as the standards of health became much broader and limitless, the standards, scope and expense of services, implicating the national principles of comprehensiveness, accessibility and universality, also expanded. National financial resources were experiencing limits in being able to support the increasing costs of broadening services attending more and more needs. The condition of "limited resources" and the inability to support these expanding needs and services was presented through these federal documents as a passing phenomenon; "a time of restraint" due to the shape of the national economy. It was also presented as a sign of inefficient cost management or overconsumption of health finances as opposed to a sign of misdirected needs and understandings in the achievement of health. There were two principal types of federal actions which directly or indirectly addressed the demand for, and allocation of, limited resources. First was the re-evaluation of the focus on the diagnosis and treatment of disease rather than health promotion and the prevention of disease. Second was the limiting of federal financial resources to the provinces in an attempt to gain control of spiraling federal health expenditures. The consistent conflict confronting federal value choices seemed to result from the attempt to support and assist the equal achievement of health by provinces and individuals while dealing with limited health care resources. The debilitating dynamics of the federal approach to this conflict will be explored further in the next chapter.

CHAPTER 3

Facing an Environment of Limited Resources.

Introduction

Before beginning this thesis, I was aware that my reflections as a theologian on the environment of limited resources in the Canadian health care system would be regarded with suspicion. I considered that this suspicion would be related to contemporary divisions such as church/state, private/public, and religious/secular, that arise within dialogues on public issues. I therefore began this thesis by proposing through the work of David Tracy that the particularity of my religious tradition should not exclude the pertinence of my reflections for human experience. It was proposed further that any such reflection contains the potential for contributing an occasion of re-evaluation and transformation of human experience; in this case, the health care experience examined. With this foundation, an analysis within chapter two proceeded to reveal the ethical value choices and goals, advocated explicitly or implicitly, within the federal documents. Special attention was given to whether and how these values and goals appropriated both the issue of limited resources and the five foundational principles of the Canadian health care system. Within chapter three, I am proposing to challenge those values, goals and the nature of the Canadian health care system as it was federally proposed and has developed over time through the documents. This challenge encompasses two focal questions: Are the value choices and influences within the federal documents assisting Canadians in confronting and integrating an environment of limited resources or simply creating, perpetuating and escalating its existence? Have these federal value choices made it necessary to re-evaluate or abandon any or all of the five foundational principles within the Canadian health care system? It is through this challenge of value choices that I seek to offer the occasion for disclosure and the transformation of the Canadian health care system as it was federally proposed.

The Consumption Dynamic: The "Society" and "Health" Pursued.

The challenge to the federal approach, revealed within the federal documents, will occur within the first section of this chapter through the identification and examination of a consistent dynamic escalating the consumption of health resources. Daniel Callahan[141] has illustrated the detrimental effect that broad and limitless goals of "health" have in consuming ever increasing amounts of health care resources in the American health care system. Broad and limitless "health" goals were present in the federal Canadian documents analyzed but they were discovered to be in a dynamic relationship with broad and limitless goals of "society" that were also present. These understandings of Canadian "society" and "health" established and shaped expectations when addressing such issues as: the type "health" we desire to achieve and live in our "society"; the type of "health" Canadian "society" should foster for its citizens; the type of influence "society" should be allowed to use in fostering "health". Together, these goals of "health" and "society" created a dynamic, inciting each other to higher levels of expectation and consumption of health care resources. It is this dynamic relationship and inciting

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[141] Daniel Callahan, What Kind of Life: The Limits of Medical Progress. (New York: Simon and Schuster, 1990).

pattern between the goals and expectations of "health" and "society" that I have named the "consumption dynamic".

Drawing from Kenneth R. Melchin's application[142] of Bernard Lonergan's concept of "schemes of recurrence"[143], I understand the "consumption dynamic" operative in the documents to be what Melchin refers to as a "social recurrence scheme". The consumption dynamic is a recurrent pattern of social living which conditions the goals and outcomes of another social recurrent scheme; in this case, the environment of limited resources within the Canadian health care system. Melchin suggests that from an analysis of the social structures which condition the satisfaction of the desires and interests in a particular sphere of living, moral norms can be derived which will be relevant to that sphere.[144] These moral norms are derived from the ability of the social recurrence schemes to foster either growth or decline. The social recurrence scheme of the "consumption dynamic" fosters increasing consumption of limited health care resources and therefore assists in creating a structure of decline. A moral norm could be suggested such as not advocating broad and limitless goals of health and society, since the consumption dynamic they create fails in assisting to integrate the reality of limited resources within the Canadian health care system. Within each federal document, this debilitating social recurrence scheme of the "consumption dynamic" is either being unknowingly advocated or is the unidentified factor whose effects on limited resources the document is

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[142] Kenneth R. Melchin, "Moral Knowledge and the Structure of Cooperative Living." Theological Studies Vol. 52 (1991): 495-523.

[143] Bernard Lonergan, Insight. (New York: Philosophical Library, 1958): 118-120.

[144] Melchin, "Moral Knowledge and the Structure of Cooperative Living.": 502.

struggling to manage.

To assist in revealing the presence and debilitating momentum of this "consumption dynamic" over time, the federal documents will be classified into four types: foundational strategies addressing health, additional strategies addressing health, strategies limiting health resources, and strategies disregarding limited resources. The challenge and choices that the "consumption dynamic" presents will then be indicated with respect to their impact on the five foundational principles and facing an environment of limited resources.

Foundational Strategies Addressing Health

Three federal documents have provided what I will term "foundational strategies" in attempting to address the health of Canadians. These documents are the Hospital Insurance and Diagnostic Services Act of 1957, the Royal Commission on Health Services Report of 1964, and the Medical Care Act of 1968.

Previous to the creation of The Hospital Insurance and Diagnostic Services Act of 1957, as already mentioned (see p. 20), several statistical analyses of the Dominion Bureau of Statistics and the Canadian Medical Association revealed the poor health status of Canadians.[145] This poor health status was found to have an undermining influence on the security, prosperity, national pride and international reputation of Canada. With this awareness and mounting pressure from public opinion and some provinces, momentum grew in favor of making the health of Canadians a societal responsibility through a national hospital insurance

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[145] Taylor, Health Insurance and Canadian Public Policy.: 4, 6, 67, 73-181.

program.[146]

The understanding of "society" advocated a societal concern and responsibility, through the federal and provincial governments for providing health services to Canadians regardless of an individual's ability to pay for the service. This societal concern and responsibility attempted to remove provincial inequities and individual economic barriers to "health" through the practice of a type of distributive justice directed towards the national interests of Canada. Equality of opportunity to benefit from medical resources was therefore a foundational principle and goal within this document and its understanding of Canadian "society". That the societal value of equality is held with such strength and esteem by Canadians is claimed to arise from a "deep-rooted suspicion of class-based systems of any kind"[147]. Equality was and will be revealed as a consistently esteemed value and goal of "society", forcefully influencing the direction and development of the Canadian health care system.

Although the goals of "society" and "health" within this document were potentially broad and limitless, they were in fact limited by other factors. The societal goals of equality, prosperity, improved Canadian security, national pride and international reputation seemed to offer potential for unlimited pursuit. The only type of "health" goal articulated in the legislation was related to laboratory, radiological and other diagnostic procedures within inpatient services of hospitals. The purpose or goal was articulated as, "to maintain health, prevent

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[146] Taylor, Health Insurance and Canadian Public Policy,: 7-8.

[147] Robert Evans, "We'll Take Care of It for You: Health Care in the Canadian Community." Daedalus 117(4) (1988): 167.

disease and assisting in the diagnosis and treatment of any injury, illness or disability"[148]. Yet the societal and health needs outlined by the Dominion Bureau of Statistics, which this document was attempting to respond to, seemed to define basic needs and limit these societal and health goals. These societal and health needs also indicated a basic economic inequity and not limitless responsibility on the part of "society" for equality. It is also important to note that medicine itself was limited at this time in the basic procedures and technology it had at its disposal to respond to these health needs. At the time of this document, 1957, we are really at the beginning of modern medicine.

With the Royal Commission on Health Services Summary Report, there was a fundamental shift to advocating the pursuit of broad and limitless societal and health goals. An emphasis on valuing societal interests continued to be presented through the essential question within the Royal Commission on Health Services Summary Report: "What is society's interest in the health of its individual members?".[149] The answer proposed, "that the well-being and happiness of society is simply the sum total of the well-being and happiness of its individual members".[150] Society's interests are proposed to be served by attending to the well-being and health of individual citizens, but why and in what manner? It is claimed that the highest attainable standard of health is one of the fundamental rights of every individual and fundamental to the

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[148] Canada, The Hospital Insurance and Diagnostic Services Act, 1958.: Section 2, f (iii).

[149] Hall, Royal Commission on Health Services, Summary Report.: 3.

[150] Hall, Royal Commission on Health Services, Summary Report.: 5.

peace, security, and civility of the nation.[151] Assuring the equality of health care continues to be a priority since the unequal distribution of resources within health care is considered "a primary concern of public interest".[152]

The type of "health" to be pursued is limitlessly defined as: "medical care in its widest sense for every individual" and again "the highest attainable standard of health is one of the fundamental rights of every human being".[153] Within the document, the "Health Charter for Canadians" provides the foundation for potentially limitless individual expectations and demands for "health" by articulating its goal as "the achievement of the highest possible health standards for all our people" based on "free and self governing professions and institutions".[154] This latter value will be seen in later documents to create conflict between health providers seeking and choosing increased resources into the insured services system while governments seek to prevent them for national interests of equality and public economy.[155]

No longer were the federal goals of "society" and "health" limited as they were in the Hospital Insurance and Diagnostic Services Act, responding to more specific although perceived societal and health needs. The Royal Commission on Health Services, Summary Report created a vision for the future including broad and limitless "health" goals to be achieved through a

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[151] Hall, Royal Commission on Health Services, Summary Report.: 6.

[152] Hall, Royal Commission on Health Services, Summary Report.: 9.

[153] Hall, Royal Commission on Health Services, Summary Report.: 6-7.

[154] Hall, Royal Commission on Health Services, Summary Report.: 11.

[155] David J. Roy and John R. Williams, "Canada: Conflict as well as Consensus". Hastings Center Report (June, 1987): 33.

comprehensive national insured services program. There also seemed to be a shift between the two documents concerning the orientation of the "health" they respectively attempted to address. The Hospital Insurance and Diagnostic Services Act seemed to be more disease oriented which limited its vision as compared to the Royal Commission on Health Services which seemed to be oriented toward a broader and more limitless vision of "well-being". A limitless understanding of "health" oriented toward "well-being" was influentially pioneered by the 1947 World Health Organization definition of health: "Health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity."[156] Canada's membership to the Constitution of the World Health Organization was appealed to within the Royal Commission on Health Services, Summary Report to legitimize supporting certain broad and limitless health goals (see p. 23).[157] It would seem plausible that the World Health Organization's definition of health would have been consulted and influential in orienting the Royal Commission's own vision and goals toward a limitless understanding of health as "well-being". This limitless definition of "health" within the Royal Commission of Health Services, Summary Report would be interpreted by other federal documents in a more restrictive or open manner, but the limitless foundation was established.

Within the Royal Commission on Health Services, Summary Report a dynamic became operative whereby the achievement of the broad societal goals of "security" and "civility" were dependent

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[156] Callahan, What Kind of Life: The Limits of Medical Progress.: 34. For a more detailed analysis of the World Health Organization definition of health, see Daniel Callahan, "The WHO Definition of Health." Hastings Center Studies Vol. 1(3) (1973): 77-87.

[157] Hall, Royal Commission on Health Services, Summary Report.: 6.

upon and incited the pursuit of achieving the broad and limitless "health" goals. As health services expand limitlessly, they do so in an attempt to also include and support equally the various health needs of individual citizens. The Medical Care Act of 1968 did not expand federal involvement in as many services as recommended within the Royal Commission on Health Services Report. But the fundamental shift increasing societal responsibility, including its commitment to equality, and advocating broad, limitless health goals gave the Medical Care Act its justification and momentum for the expansion of services it did legislate. So while the Hospital Insurance and Diagnositic Services Act was a foundational strategy with limited goals, both the Royal Commission on Health Services Report and the Medical Care Act were foundational strategies addressing the health of Canadians with limitless goals of "society" and "health" to pursue.

Additional Strategies Addressing Health

A shift in both the goals of "society" and "health" pursued occurred through the analysis proposed within A New Perspective on the Health of Canadians in 1974. First, the goal of "health" was proposed and limited as "a state of well-being sufficient to perform at adequate levels of physical, mental and social activity, taking age into account."[158]. It presented an understanding of "adequate personal health" as basic gifts of nightly rest, daily bread, and ordinary use of limbs, senses, and understandings. The document proposed a new conceptual framework for the analysis of health problems which revealed that "society" had greater potential for influencing the underlying foundations

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[158] Lalonde, A New Perspective on the Health of Canadians.: 8.

of "health" through improving the environment, moderating self-imposed risks and adding to the knowledge of human biology. This potential for influencing health was considered greater than that offered through the traditional treatment-oriented insured services programs. Part of the uniqueness and shift within this document was this defining and limiting of the type of "health" it was attempting to address and desiring to achieve.

This new strategy still relied upon the concern and responsibility of "society" and still addressed the achievement of goals of "society" such as civility, security, and equality. The shift occurred in questioning where the concern and responsibility of "society" could best be focused, could best support equality and receive the best return for resources contributed in addressing "health". Individual responsibility was found to be an important determining factor undermining the traditional federal approach attempting to ensure "health" through providing accessible hospital and medical treatment through insurance programs. The problem concerned individual lifestyle behavior such as excess consumption of alcohol or cigarette smoking which fostered self-imposed health risks.[159] This finding concerning individual responsibility supported arguing against societal responsibility for providing insured health treatment services and protection against economic consequences of illness.[160] A controversial but related issue arose questioning to what extent "society" should limit individual autonomy through the federal government by attempting to modify lifestyle behavior fostering

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[159] Lalonde, A New Perspective on the Health of Canadians.: 24.

[160] Robert Evans, "A Retrospective on the New Perspective." Journal of Health Politics, Policy and Law Vol. 7 (2) (Summer, 1982): 331.

self-imposed health risks. The document proposed the conclusion that "society", through federal and provincial governments, should develop protective marketing techniques to counteract private marketing abuses which promote these lifestyle risks.[161]

Although the insights of the document's conceptual framework revealed implications surrounding the allocation of resources and justification for limiting the expansion, these insights and implications were not explored or applied to the traditional, treatment-oriented, insured services programs. No foundational revaluation occurred on how the goals of "society" or "health" would change, or how resources might be reallocated, in the traditional federal strategy. Because these insights and implications were not explored, the data and framework presented were capable of bearing a very wide range of interpretations.[162] The document could have been interpreted as supporting not only a limitation on health care expansion but a shift limiting the cost sharing responsibilities of the federal government with the provinces in insured health services.[163] Limiting the resources they would contribute to the Canadian health care system is in fact what the federal government proceeded to do three years later through the Federal - Provincial Fiscal Arrangements and Established Programs Financing Act. This latter federal action raises the question of whether the intent of A New Perspective on the Health of Canadians was to present a new conceptual framework for addressing health through prevention or to address the issue

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[161] Lalonde, A New Perspective on the Health of Canadians.: 37.

[162] Robert G. Evans, "A Retrospective on the "New Perspective"." Journal of Health Politics, Policy and Law Vol 7 (2) (Summer, 1982): 329.

[163] Robert G. Evans, "A Retrospective on the "New Perspective".": 330.

of limited resources and justify the limiting of federal health resources.

The document therefore seemed to support two different strategies with differing understandings and goals of "society" and "health". The traditional strategy concerned medical treatments within insured services while the new strategy concerned prevention and promotion of health within the environment, lifestyle and human biology. Rather than integrating the insights of this new strategy, the document seemed to propose supporting it <u>in addition</u> to the existing insured health services programs.

> Accordingly, it is the intention of the government of Canada, first, to maintain at a high level the services and support provided through its present activities in health protection, research and the financing of personal health care. To these will be added measures directed at specific national health care problems, chosen in consultation with provinces, consumers, professions and associations according to their gravity and incidence, and aimed at removing or reducing the factors underlying sickness and death.[164]

<u>Achieving Health for All</u> attempted to continue the "healthy public policy" of <u>A New Perspective on the Health of Canadians</u>, through a wider application of health promotion. The definition of health promotion given is "the process of enabling people to increase control over, and to improve, their health"[165]. Such a broad and limitless "health" goal increases the expected breadth of responsibility and equality from "society", through the federal government, and the expected breadth of entitlement to "health". The challenges to be met within this strategy of health promotion include addressing disadvantaged groups, various forms of preventable diseases and injury, and those Canadians who suffer

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[164] Lalonde, <u>A New Perspective on the Health of Canadians</u>.: 65.

[165] Epp, <u>Achieving Health for All</u>.: 6.

from chronic disease, disability, or various forms of emotional stress.[166] This health promotion approach is valued and legitimized precisely for its expected potential over the long term to slow the growth of health care costs.[167]

Achieving Health for All is similar to that of A New Perspective on the Health of Canadians since it is a strategy advocating insights of foundational change to how the goals of "health" and "society" have been addressed. While its understanding of "health" addressed is broad and limitless, unlike A New Perspective on the Health of Canadians, both of these strategies are considered additional as opposed to alternative strategies. Even though these newer strategies attempt to address what is overlooked, inefficient or ineffectual in the older, more foundational strategies, there is no attempt to restructure the older strategies. These newer strategies were to function in addition to the older strategies already in operation.

Strategies Limiting Health Resources

Through the Federal - Provincial Fiscal and Established Programs Financing Act of 1977 and the Government Expenditures Restraint Act of 1991 a shift was expressed. This shift in the federal-provincial cost sharing formula lessened the future contributions the federal government would make, therefore the degree of financial responsibility society should have through the federal government, in pursuing increasing standards of individual health. The momentum of the traditionally broad and limitless goals of "health" and "society" within its insured health services

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[166] Epp, Achieving Health For All.: 2.

[167] Epp. Achieving Health for All.: 12-13.

programs continued to be operative and fostering expansion (the "consumption dynamic"). Yet the limiting strategies within these pieces of legislation were advocating goals of "society" and "health" fostering limitation. The structure of the insured health services programs were caught in the middle and subjected to an increasing amount of pressure over resources due to the dynamic of these conflicting strategies with opposing goals of "health" and "society". What is also ironic is that none of the examined federal documents appearing after the Royal Commission on Health Services, Summary Report, identified and admitted it was addressing the issue and dynamics of limited resources as a foundationally consistent reality impacting the Canadian health care system. It would seem that if limited resources were admitted as a reality, it was feared that the achievement of the societal goals of equality, civility and prosperity would be severely threatened. Admitting to the reality of limited resources would seem to be analogous to admitting some sort of societal defeat.

Strategies Disregarding Limited Resources

Opposing strategies over the broad and limitless goals of "health" and "society" are revealed again to create competitive pressure over resources within Canada's National - Provincial Health Program for the 1980's, Preserving Universal Medicare, and the resultant legislation of The Canada Health Act. The two focal issues causing conflict in these three documents were the charges that "health" was underfunded and the attempt to initiate direct charges through user fees and extra billing as methods to supplement financial resources. The dilemma concerned whether the practice of user fees and extra billing by hospitals and physicians threatened the goals of universally equal access to insured health services, and also the goals of "society" and "health" pursued through that health strategy. The concern of this "threat" is most forcefully expressed within Preserving Universal Medicare,

> The government of Canada believes that a civilized and wealthy nation such as ours should not make the sick bear the financial burden of health care. Everyone benefits from the security and peace of mind that comes with having prepaid insurance. The misfortune of illness which at some time touches each one of us is burden enough: the costs of care should be borne by society as whole.[168]

The dilemma also concerned whether denying user fees and extra billing would undermine another "health" goal of the "Health Charter of Canadians" articulated within the Royal Commission on Health Services, Summary Report: free and self-governing professions and institutions. These broad and limitless goals and values of "society" and "health" within the Royal Commission on Health Services, Summary Report and the Medical Care Act continue to provide uninterrupted momentum for increasing expansion and consumption of resources through insured health services. Their existence continues within the Canada Health Act, the federal government supports equality of access to health care among all income levels of Canadian citizens. "Health" itself is not defined but used in conjunction with the word "well-being". Supported are improvements in treating sickness, preventing and alleviating the consequences of disease and disability among all income groups, individual lifestyles that emphasize fitness, promotion of physical and mental health.[169] Within all three of these documents there is no expression of when the progress and improvement which

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[168] Bégin, Preserving Universal Medicare.: 7.

[169] Canada Health Act, Statutes of Canada, 1984, chapter 6, Preamble.

fosters health and the equality of well-being has reached an adequate standard. The limitless goals of "health" and "society" which provide the increasing momentum for the consumption of resources are not identified or challenged in any of these three documents.

User fees and extra billing (direct charges) seemed to be strategies attempted in order to continue expansion by supplementing the limited availability of resources. The Canada Health Act denied the practice of direct charges as an acceptable method to finance the increasing consumption of resources. The increasing limitedness of resources therefore continues with the broad and limitless goals of "society" and "health" providing the momentum for consumption remaining unidentified, unexamined and unchanged.

Operative throughout these four types of federal documents is the momentum of the "consumption dynamic" created through the advocated broad, limitless and interrelated goals of "society" and "health". The examination suggests that each document following the Royal Commission on Health Services, Summary Report and the Medical Care Act is a document created due to the difficulty of implementing, maintaining and surviving the broad and limitless goals advocated within those two foundational strategies addressing health. This suggestion seems supported further through these three documents addressing user fees, which disregard the forces escalating the environment of limited resources and creating pressure for the employment of user fees.

The Impact of the Consumption Dynamic.

The critique will continue in this section through focusing on two central elements of this examination: the five foundational principles and the issue of limited resources. The aim is to discover how the "consumption dynamic" impacts these two elements and how this impact reveals implications for the nature of the environment of limited resources and for resource allocation solutions advocating structural revisions of the five foundational principles of Canadian health care.

Five Foundational Principles

The five foundational principles of comprehensiveness, accessibility, universality, portability and public administration without profit shape an environment for the insured services programs to operate within. Through the *Medical Care Act* they foster a type of equality and distributive justice in that environment by attempting to ensure that the economic burdens of medical care and "health" do not exclude lower income groups. The five principles and the distributive justice they foster were affirmed again in the *Health Care Act*. Yet these five federal principles and their distributive justice have been in turn shaped, determined and driven by value choices concerning "society" and "health". The foundational, unlimited goals and values of "society" and "health", within the *Royal Commission on Health Services, Summary Report* and the *Medical Care Act*, provide an unlimited character to the five foundational principles and their distributive justice. Their unlimited character accentuates the consumption of resources through an unlimited demand for services.

If the federal financial resources are limited, as they were under The Federal - Provincial Fiscal Arrangements and Established Programs Financing Act and The Government Expenditures Restraint Act, this action does not stop the momentum for consumption, improvement, or expansion services legitimized through the five foundational principles. The degree and variety of health needs embraced through health services expand through the principle of comprehensiveness due to the momentum fostered by the goals of unlimited improvement of "health". The people addressed and the methods employed to make these services available, through the principles of accessibility and universality, also expand due to the expected responsibility of "society" to ensure equality. The scope of comprehensiveness, universality and accessiblity each expand until some type of limit to resources is reached. If the forces of consumption are not addressed in accordance with the limits of available resources then the principles of comprehensiveness, accessibility and universality are forced to compete among, perhaps cannibalize each other for resources. It is the realization of this thesis that the momentum will stop when the broad and unlimited values and goals of "society" and "health" are defined and limited through specific and adequate standards of what is to be achieved through the five principles and their distributive justice.

This legislation of the Federal - Provincial Fiscal Arrangements and Established Programs Financing Act and The Government Expenditures Restraint Act fails to recognize the momentum causing it to restrict its expenditures. Distributive justice is not exercised by the indiscriminate cut through these legislative Acts to increasing expenditures. By not consciously addressing this "consumption dynamic" and decisions concerning the allocation of limited resources, distributive justice is denied and the five foundational principles continue to be undermined.

Re-evaluating Limited Resources

As identified in Chapter 2, the federal documents examined implicitly or explicitly recognized a variety of types of limited resources: functional, physical health; infrastructural resources such as facilities, trained personnel, and technology; individual income levels; provincial budget resources; federal budget resources. What were never adequately identified or addressed were the causes of an environment of limited resources in health care.

The impact fostered by the consumption dynamic on the environment of limited resources is a continual expansion of services and increasing consumption of resources. Consumption was indirectly examined in A New Perspective on the Health of Canadians but was only attempted to be contained through The Federal - Provincial Fiscal Arrangements and Established Programs Financing Act and The Government Expenditures Restraint Act. Also the federal government had assisted in protecting its citizens from concretely experiencing the impact of consumption and the rising cost of care on the concrete issue of limited resources. It insulated them and allowed high expectations to continue on the type of health care to be delivered.[170] There has never been, either within the documents or proposed through the documents, a situation where individuals on a broad scale have been given an opportunity to experience or understand the responsibility they

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[170] Iglehart, "Canada's Health Care System Faces its Problems.", The New England Journal of Medicine (February 22, 1990): 564.

have on influencing the consumption of limited resources in health care. Since the social concern and responsibility of "society" is understood to be unlimited, principles such as comprehensiveness, universality, and accessibility also become open to unlimited expansion.

The issue of limited resources is tremendously impacted in the same way by broad and limitless goals of "health" to be attained. Regardless of whether the "health" pursued occurs through high standards or broad standards, continuous expansion has occurred consuming more resources. From the early beginnings of the Royal Commission on Health Services Report, unlimited definitions of the standard of "health" to be achieved have fostered a public expectation for the ability to receive rapid quality care using all needed resources with little regard for cost and availability.[171] What has also changed in the understanding of "health" over time is the way the common good of society was to be realized. Making the individual's equal access to "health" a priority of "society" in the Royal Commission on Health Services Report, since this was believed to realize the common good of society, created endless possibilities for pursuing "health".

These federal documents have been critiqued concerning the creation and inadequate use of limited resources by inefficient balancing of costs and benefits through cost management.[172] Beginning with the Hospital Insurance and Diagnostic Services Act, the most expensive means of delivery had been entrenched with the

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[171] Lalonde, A New Perspective on the Health of Canadians.: 8.

[172] See Pran Manga; Geoffrey Weller, "The Canada Health Act of 1984 and the Future of the Canadian Health Care System.", Working Paper 85-25, University of Ottawa.

federal government consistently avoiding issues of reorganization, management and control of the system as a whole.[173] That efficient rationing and cost containment strategies need to be employed by the federal government is a valid critique that is not questioned. What the revealed structure of the consumption dynamic does bring into question, is whether the approach of cost containment strategies understand and address sufficiently the nature of the environment of limited resources which has created some of our most poignant dilemmas in health care.

The technological imperative which consumes an increasing share of resources for the use and development of expensive service infrastructure and medical equipment has also been identified as having a major influence in creating and perpetuating an environment of limited resources.[174] The proposed solution to use the "success" of technology as an assessment criteria to increase efficiency has proven inadequate since the greatest long term costs for health care have come with the successes, not the failures, of medical technology.[175] It is also ironic that in a study of three developed countries, the differences in levels, and therefore costs, "of major technology, in themselves, indicate little about the overall effectiveness, achievements, and weaknesses of the health care systems".[176] This

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[173] Eugene, Vayda; Raisa B. Deber, "The Canadian Health Care System: An Overview." Social Science and Medicine. 18(3) (1984): 192-3, 196.

[174] M. Janet Barger-Lux; Robert P. Heaney, "For Better an Worse: The Technological Imperative in Health Care." Social Science and Medicine (Oxford) Vol 22 (12) (1986): 1313-1320. Also Daniel Callahan, What Kind of Life.: 89-97.

[175] Daniel Callahan, What Kind of Life.: 94.

[176] John Iglehart, "Canada's Health Care System Faces Its Problems." The New England Journal of Medicine (February 22, 1990): 565.

examination proposes that the goals and values concerning "society" and "health", the "consumption dynamic", also generate the momentum behind the technological imperative. This examination proposes that the identified and consistently foundational problem of the "consumption dynamic" must be addressed if our environment of limited resources is to be adequately integrated and the pressure threatening the five foundational principles of Canadian health care system is to be diffused.

Conclusion

What is clear from this examination is that the value choices and influences within these federal government documents are escalating and accentuating our environment of limited resources. This is due to a foundational shift through the Royal Commission on Health Services, Summary Report from limited to broad and unlimited goals of "health" and "society". Strongly held values of "society" such as equality were present as they had been in the past but their character changed from being limited to having unlimited potential for pursuit. The interdependent and inciting relationship between the broad and limitless goals of health and society created a consumption dynamic which fostered the increasing consumption of limited care resources. This consumption dynamic created a structure of decline within the Canadian health care system. Such were the forces set up unknowingly by the Royal Commission on Health Services, Summary Report and the resultant Medical Care Act. Each of the federal document examined which followed those foundational documents were attempting to deal with the unmanageable forces and problems those foundational documents inadvertently created.

It is also clear that it is necessary to re-evaluate but not necessarily abandon any of the five foundational principles of the Canadian health care system. Because the equality being advocated through these principles was an unlimited equality, the services advocated and being provided through these principles were open to unlimited expansion. It is not so much the principles themselves that need to be re-evaluated as much as the type or standard of equality that is adequate to achieve through these principles. A strong federal role in the health care of Canadians has been advocated in such documents as Canada's National - Provincial Health Program for the 1980's.[177] Strong federal leadership certainly seems a responsibility since the federal government has instilled the "consumption dynamic" through the goals and values it has advocated. The challenge will be to define a realistic limit to the type of goals and expectations of "society", such as equality, and the specific type or standard of "health" that will be pursued.

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[177] Hall, Canada's National - Provincial Health Program for the 1980's.: 47-48.

CONCLUSION

The broad theme of this examination has been the guidance given by the federal government's ethical influence, to decision-making concerning limited resources in the Canadian health care system. The environment of limited resources and their allocation has confronted Canadians with ethical dilemmas over the potential to deliver equitable, universal access to comprehensive health care services. The examination attempted to discover how the issue of limited resources was understood, approached and addressed in the federal documents. It also attempted to discover if other factors needed to be recognized and discussed if the issue of limited resources is to be adequately addressed within the Canadian health care system. Had the value choices and influences within the federal documents assisted Canadians in addressing and integrating the environment of limited resources or assisted Canadians in creating, perpetuating and escalating its existence? Have the federal value choices made it necessary to re-evaluate or abandon any or all of the five foundational principles (comprehensiveness, universality, accessibility, portability and public administration without profit) within the Canadian health care system? As a theologian I was fundamentally interested in whether these federal value choices within the structures or policies federally advocated for the Canadian health care system, fostered growth or decline in the potential for community living among Canadians.

Discovered within the prominent federal documents were broad and limitless goals or value choices between the interrelated understandings of "society" and "health". The societal goals of equality, civility and security were pursued through the Canadian health care system which pursued the "health" goal of achieving the highest health standards possible for all Canadians. The greater the achievement of health standards, the greater the civility attained by "society" but also the greater equality that had to be ensured among all Canadians. Each incited the other to greater pursuit of its goals and since the foundational goals of "health" and "society" were broad and limitless, the pursuit of these goals became potentially limitless. The limitless pursuit of these goals together escalated the limitless expansion of services and consumption of resources. Clearly, a type of consumption dynamic was operative in the relationship between the goals of "health" and "society". This dynamic is a structure within the Canadian health care system which assists in perpetuating and escalating the existence of limited resources and fosters decline in the potential for community living among Canadians.

The federal value choices examined and the consumption dynamic identified do not necessitate abandoning any of the five foundational principles of the Canadian health care system but only a re-evaluation of how these principles are used. It is not the five foundational principles that are unmanageable but the limitless goals and the services that are continually included under their umbrella in the name of pursuing unlimited standards of "health" and equality. The federal endeavor to indiscriminantly limit available resources for health expenditures, without identifying and limiting these limitless goals of "health" and "society", does not stop the momentum of the "consumption dynamic". Such action places increasing pressure on the five foundational principles to acquire resources through competition among each other. For example, increases in services through comprehensiveness occur at the expense of a loss to the accessiblity or universality offered. Abandoning one of the principles will not stop the momentum of consumption but only satisfy it for the present time. The limitless goals of "health" and "society" within the federal documents have been revealed over time to serve their own dynamic demand for expansion and undermine the potential for community living among Canadians.

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INTERVIEWS

An interview in Ottawa with Bruce W. Harber, Executive Director, Mount Saint Joseph Hospital, Vancouver, British Colombia - Wednesday, November 28, 2:30 P.M., 1990.

An interview in Ottawa with John McKenna, Assistant Vice President of Information Services, Saint Boniface General Hospital, Winnipeg, Manitoba, - Wednesday, November 28, 2:30 P.M., 1990.

An interview in Ottawa with Doug McDermid, Assistant Administrator, Saint Martha's Regional Hospital, Antigonish, Nova Scotia. - Wednesday, November 28, 1:00 P.M., 1990.

An interview in Ottawa with Hon. Monique Bégin, former Minister of Health and Welfare (1977-1979; 1980-1984). Present Dean of Health Sciences, University of Ottawa, Ottawa, - Friday, December 21, 10:00 A.M., 1990.