An Ethical Approach to Health Care Reform in Canada: A Comparative Analysis

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I. INTRODUCTION

WHILE HEALTH CARE is perhaps imbued with more ethical principles than any other professional activity, ethics as an analytical approach is rarely used in health care reform.[1] As can be discerned by examining the debates on reform of the Canadian health care system, discussion instead tends to focus on various cost-benefit analyses and the appropriate balance of provincial-federal power. As a result of this economic and political focus, initiatives that appear too narrow to have real impact are scrutinised in great detail. Specific economic costs and policy options are presented with little perspective on what is really wanted out of health care systems.[2] It is no wonder that, to date, no underlying ethical philosophy has emerged as the foundation for cost-cutting and reorganisation initiatives, and, to a significant extent, the various initiatives conflict with one another from an ethical perspective.

In considering options for health care reform, note that while Canada and the United States have two of the most expensive health care systems in the world, and have interdependent and complementary economies, cultures, and geographies, the countries have historically had fundamentally different ethical philosophies underlying their health care systems. The American approach, to a large extent, has been driven by libertarian conceptions of distributive justice; Canada's approach rests largely on egalitarian principles. An analysis of the two systems, including recent U.S. reform efforts, in relation to their differing ethical foundations is revealing, and suggests an underlying ethical framework from which to make the difficult choices required as Canada's health care system undergoes fundamental change.

This article will begin with a general description of the way in which the United States and Canadian health care systems function (Part I). The ethical

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1 T.A. Brennan, "An Ethical Perspective on Health Care Insurance Reform" (1993) 19:1 Am. J.L. & Med. 37.

2 *Ibid.* at 38.

foundations of the systems will then be explored (Part II), the comparative effect of each foundation on health care distribution analysed (Part III), and a conclusion reached about the comparative appropriateness of the foundations (Part IV). The comparative costs of the systems will then be explored (Part V). Finally, the author will conclude that Canadian legislators and policy-makers should insure that the nation's health care reform initiatives are consistent with their historical philosophical approach to distributive justice in health care, and the practical implications of such an approach are discussed (Part VI).

II: THE AMERICAN AND CANADIAN HEALTH CARE SYSTEMS

TO COMPARE THE UNITED STATES and Canadian health care systems with respect to their underlying ethical foundations, an understanding of the two systems is necessary. This section of the article will describe how the respective health care systems function. First, the American system will be described, specifically private health insurance, Medicare, and Medicaid (government programs). This will be followed by a description of the functioning of universal health insurance in Canada, including its aspects of provincial flexibility and funding.

A. The American Health Care System

The United States spends far more on health per capita than any other country.[3] While the care is often superb,[4] the United States is the only advanced in-

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[3] A. Birenbaum, *Putting Health Care on the National Agenda* (Westport, CT: Praeger, 1993) at ix; J. Holahan *et al.*, "An American Approach to Health System Reform" (1991) 265 J.A.M.A. 2537, contrasting the expenditure of funds to the reality that over 32 million Americans lack health insurance coverage. The author further states that the United States has "one of the highest rates of increase [in health care spending]—over 4 percent per year after adjusting for inflation."; E. Eckholm, "Rescuing Health Care: Minefield of Hurdles and Competing Cures Poses a Herculean Task for Congress in 90's" *The New York Times* (2 May 1991) A1; see P. Caper, "Solving the Medical Care Dilemma" (1988) 318 N. Eng. J. Med. 1535, stating that "[t]he United States spends more on medical care-both in absolute terms and as a percentage of its gross national product-than any other industrialized nation."

[4] D.A. Rublee, "DataWatch: Medical Technology in Canada, Germany, and the United States" (Fall 1989) Health Affairs 178 at 180, reporting on findings which compare the availability of selected medical technologies and commenting that "American physicians, with a universe of modern technology at their fingertips, are the envy of the world's physicians. German and Canadian physicians are well-equipped technologically, but do not, on the basis of these data, have as much major technology with which to work as Americans do."; Eckholm, *supra* note 3 at A1; see also J.S. Todd, "Sounding Board: It is Time for Universal Access, Not Universal Coverage" (1989) 321 N. Eng. J. Med. 46 stating that "[t]he American health care system at its best is universally acknowledged to be the best in the world."

dustrial nation that fails to insure care for all of its citizens.[5] The fact that the United States is the only nation that leaves families vulnerable to medically-induced financial disaster has challenged the appropriateness of the current system.[6] Due to the urgent need for a solution to this problem, health care became a major issue in the 1992 Presidential campaign. In fact, President Clinton's successful election campaign platform promised extensive health care reform which would provide universal access.[7]

The United States is unique in that voluntary employment-based private health care plans are the primary source of health insurance coverage for most of the population. Sixty-six percent of the non-elderly population are covered by employer-based insurance,, ten percent by non-employment based private health insurance, and 12 percent by public health insurance.[8] Medicare and Medicaid, the popular names given to two programs enacted by Congress in 1965, were intended to help the aged and certain low-income individuals pay for the costs of medical care. Medicare is a nationwide health insurance program for the aged and disabled, while Medicaid is a federally-aided, state-operated and administered program for certain categories of low-income persons.[9]

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5 Birenbaum, *supra* note 3 at ix, stating that "[a]side from South Africa, [America is] the only advanced industrial society without a universal national health-care program." The author further states that "... 37 million Americans lack insurance while health-care costs comprise a remarkable and unrivaled 14 percent of the gross domestic product."; Eckholm, *supra* note 3 at A1, A12; see also J. Holahan *et al.*, *supra* note 3 at 2537 stating that "the problem of being uninsured is faced by a large percentage of the [American] population."

6 D. Callahan, "Allocating Health Resources" (April/May 1988) 18 Hastings Ctr. Rep. 14 at 15, discussing findings of two careful studies of public opinion—one by Louis Harris and Associates for the Loran Commission, and the other by the Public Agenda Foundation, the author reports "... widespread recognition that catastrophic illness could bankrupt a family, and that it was a danger for all families and not just poor ones. There was a corresponding belief that it is the duty of government, not families, to bear the cost of such illness."; Eckholm, *supra* note 3 at A1, A12.

7 Birenbaum, *supra* note 3 at xv, commenting that "[w]hat ... is of increasing importance is the voting public's concern with the financing of quality health care for all."; P.G. Gosselin & E. Neuffer, "Clinton Sounds Call: Care Coverage For All, Links Health Reform to National Destiny" *Boston Globe* (23 September 1993) A1, A14, reporting that "[a]lthough Clinton has staked substantial political capital on health care, it was not one of his initial issues during last year's campaign. But after the subject dominated the New Hampshire primary, he seized it and made it his own."; R. Toner, "The Politics of Anxiety" *The New York Times* (23 September 1993) A1, stating that "[t]he idea of a health care overhaul has gained force on the campaign trail over the last five years, breaking through in the 1991 Pennsylvania Senate race and driving much of the 1992 Presidential campaign."

8 G.F. Aukerman, "Access to Health Care for the Uninsured, The Perspective of the American Academy of Family Physicians" (1991) 265 J.A.M.A. 2856, citing data from 1988.

9 Cong. Res. Serv., Lib. of Cong., *Medicare and Medicaid, Info Pack 67M* (Cong. Ref. Div. Nov. 1990).

1. Private Health Insurance

In the private sector, the most pervasive source of funds for medical care is private insurance. Employers provide and, to a great extent, finance private health insurance plans.[10] Since employment-based programs are provided voluntarily, Americans have no guarantee that their employers will not decide to reduce the breadth of their insurance benefits when the benefits may be most needed.[11] The major incentive for employers to provide health insurance, in addition to increased employee goodwill and productivity, is the fact that health insurance premiums are tax deductible.[12]

Both state and federal governments have supported an increase in private employment-based health insurance to reduce the number of people who are uninsured.[13] For example, states have imposed obligations on health insurers that increase opportunities for individuals to obtain or retain insurance. The most traditional of these are conversion and continuation requirements.[14] Moreover, the United States Congress has required employers of 20 or more persons to offer health insurance continuation for 18 months to terminated employees and 36 months to their widows, divorced or separated spouses, and children.[15]

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10 P.A. Butler, *Too Poor To Be Sick* (Washington, D.C.: Am. Public Health Assoc., 1988) at 63; see generally, L. Uchitelle, "Insurance Linked to Jobs: System Showing Its Age" *The New York Times* (1 May 1991) A1, describing the origins of how health insurance coverage came to be linked to jobs. She explains that during the first few months of World War II, the War Labor Board put a ceiling on wages to prevent inflation. As a result, the trade unions negotiated in collective bargaining and won support by the War Labor Board for money that had been targeted for raises to be used to pay for employee health insurance.

11 R.J. Blendon *et al.*, "DataWatch: Satisfaction With Health Systems in Ten Nations"(Summer 1990) Health Affairs 185 at 191; see also Birenbaum, *supra* note 3 at 72–74, 85, discussing cost-shifting moves by employers who try to reduce their costs of providing health benefits to their employees and the effect on employees; stating that the American people largely rely upon employers to provide health benefits.

12 Butler, *supra* note 10 at 63, explaining that the Federal Government supports the employer subsidy with more than $30 billion in general revenues.

13 *Ibid.* at 63–66, discussing Hawaii's state mandates for employers, Massachusetts' attempt to circumvent the federal Employee's Retirement Income Security Act [ERISA] through its 1988 "pay or play" program, states' programs for affordable insurance for small employers [Arizona, Wisconsin, Denver, Michigan], projects in Utah and Maine combining insurance plans with case management by physicians paid on a fee-for-service basis.

14 *Ibid.* at 67, stating that "[i]n thirty-four states insurers must allow group subscribers to convert to individual coverage and [usually higher] rates when leaving the group. In thirty-one states insurers must allow people leaving an employer group to retain their group coverage for some period of time, usually six to eighteen months."

15 Butler, *supra* note 10, recounting that Congress mandated in PL 99–272 "that employers of twenty or more persons offer continuation for eighteen months to terminated employees and thirty-six months to their widows, divorced or separated spouses, and children."

Insurance continuation and conversion are important protections, given the constant threat of personal financial disaster imposed by the occurrence of an unexpected health care expense.[16] However, there are some significant problems with state and Congressional efforts to date. First, to benefit from continuation, subscribers must be able to afford the premiums, which may be too expensive for laid-off employees or their spouses.[17] Second, continuation requirements provide short-term protection—the longer-term unemployed would have to seek more costly individual policy coverage— and have no effect on employees not offered insurance through their workplaces.[18]

Other approaches to assist the uninsured include risk pools for medically uninsurable people with chronic conditions or serious illness,[19] hospital rate setting,[20] and an insurance regulation approach that prohibits insurers (other than self-insured firms) from refusing to cover part-time employees.[21]

During World War II, and for a subsequent period, the employment-linked insurance system functioned adequately for most companies and employees; however, since it was voluntary many small companies did not participate.[22] Those that did participate were forced to pay higher health insurance premiums. Today, corporate America is inundated with the explosion of employee-related health care costs.[23] Such costs have put American companies at a competitive disadvantage; as a result, even large corporations have suggested the adoption of a national health insurance system in an effort to reduce costs.[24]

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16 *Supra* note 10.

17 *Ibid.*

18 *Ibid.*

19 *Ibid.* at 67–68. The proportion of the American population in the category of medically uninsurable is estimated to be between 0.5 percent and 1 percent, not yet including those with AIDS who will surely be added to this group. The author states that "[f]ifteen states have adopted risk pool requirements ... [and] ... Wisconsin and Maine are the only states to subsidize their pools with state funds." The author states that risk pools "can be useful" for people who can afford to pay high premiums to be in a risk pool; however, "... risk pools address a very small part of the problem of the uninsured," the majority of which are not medically uninsurable and are so poor that they cannot afford pool premiums. The author also discusses briefly "a difficult dilemma because of ERISA."

20 *Ibid.* at 68–69 The author states that as of 1987 nine states had mandatory rate-setting systems.

21 *Ibid.* at 69. The author defines part-time employees as those who work fifteen to thirty-five hours per week. New Hampshire adopted this approach.

22 Uchitelle, *supra* note 10 at A1.

23 *Ibid.* at A14.

24 *Ibid.* at A1, naming Chrysler Corporation and Caterpillar, Inc. as two such companies.

Many economists assert that if the United States were now initiating a health insurance program, they would not recommend tying health insurance to employment.[25] They contend that the job-linked insurance system has fueled health cost inflation by offering open-ended coverage. Employers, insurance companies, and government are currently examining various methods of slowing the rate of increase of health care costs: in effect attempting to place ceilings on what Americans spend for health care.[26]

2. Medicare

Medicare, a Federal insurance program created by title XVIII of the *Social Security Act* of 1965, was originally designed to protect people aged 65 and over from the high cost of health care.[27] In 1972, the program was expanded to cover permanently disabled workers eligible for old age, survivors, and disability insurance benefits and their dependents, as well as people with end stage renal disease.[28]

Medicare provides health insurance protection for 33 million aged and disabled individuals.[29] The program covers hospital services, physician services, and other medical services for those eligible, regardless of income. Medicare includes two parts: Hospital Insurance (Part A) and Supplementary Medical Insurance (Part B). The Federal Administration estimated net Medicare outlays of $116.7 billion for fiscal year 1992.[30]

Part A, the Hospital Insurance (HI) program, of Medicare covers inpatient hospital care. In some cases, it also covers short-term skilled nursing facility care after a hospital stay, home health agency visits, and hospice care. Patients are responsible for a deductible each time a hospital admission begins a new benefit period ($628 in 1991).[31] Part A is financed primarily from Hospital Insurance

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25 *Supra* note 10

26 *Ibid.*

27 K.R. Levitt *et al.*, "National Health Expenditures, 1990" (Fall 1991) 13 Health Care Fin. Rev. 29 at 39.

28 *Ibid.*

29 Cong. Res. Serv., Lib. of Cong., *CRS Issue Brief, Medicare: FY1992 Budget* (Celinda M. Franco & Kathleen M. King Dec. 13, 1991) at CRS-1, CRS-2. Another publication reported that "[m]ore than thirty–four million aged and disabled people were enrolled in Medicare on July 1, 1990." Levitt *et al.*, *supra* note 27 at 39.

30 Cong. Res. Serv., Lib. of Cong., *CRS Issue Brief, Medicare: FY1992 Budget*, *supra* note 29 at CRS-2.

31 *Supra* note 30. A benefit period is the period beginning when a patient enters a hospital and ending when he or she has not been in a hospital or skilled nursing facility for sixty days.

payroll taxes.[32] A small number of persons over age 65 are not entitled to Medicare because they are ineligible for Social Security or railroad retirement benefits; these persons may enroll under Part A by paying a monthly premium ($177 in 1991).[33]

Part B, the Supplementary Medical Insurance (SMI) program, is a voluntary program; individuals must enroll and pay a premium to receive benefits. All persons entitled to Part A and all persons over 65 are eligible to enroll. The program covers the services of physicians, outpatient hospital care, laboratory and x-ray services, and other related medical services and supplies.[34] The program is financed by beneficiary premiums and general revenues. The monthly premium ($29.90 in 1991)[35] accounts for about 25 percent of program costs. Medicare generally pays 80 percent of the reasonable charges or approved amounts for covered services, after the beneficiary has met the annual deductible of $100. The beneficiary is liable for the remaining 20 percent, an amount known as co-insurance.[36]

3. Medicaid

Medicaid, authorized by Title XIX of the *Social Security Act*, is a federal-state matching program providing medical assistance to approximately 27 million low-income persons who are aged, blind, disabled, or members of families with children.[37] Each state[38] designs and administers its own Medicaid program, setting eligibility and coverage standards within broad federal guidelines. The federal share of Medicaid expenditures is appropriated from general revenues and

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[32] *Supra* note 30. See Levitt *et al.*, *supra* note 27 at 39 stating that "[u]nlike other federal health programs, Medicare is not financed solely by general revenue [appropriations from general tax receipts]. In 1990, 89 percent of the income for [Part A] came from a 1.45 percent payroll tax levied on employers and on employees for the first $51,300 of wages."

[33] Cong. Res. Serv., Lib. of Cong., *CRS Issue Brief, Medicare: FY1992 Budget*, *supra* note 30 at CRS-2.

[34] *Ibid.*

[35] *Ibid.* The monthly premium payments were $28.60 per enrollee in 1990. Levitt *et al.*, *supra* note 27 at 39.

[36] Cong. Res. Serv., Lib. of Cong., *CRS Issue Brief, Medicare: FY1992 Budget*, *supra* note 29 at CRS-2, CRS-3.

[37] Cong. Res. Serv., Lib. of Cong., *CRS Issue Brief, Medicaid: FY1992 Budget* (Melvina Ford May 29, 1991) at CRS-1.

[38] *Supra* note 37, in May 29, 1991, the Congressional Research Service of the Library of Congress reported that "[e]very [s]tate except Arizona participates in the Medicaid program, as do the District of Columbia, American Samoa, Guam, Puerto Rico, the Virgin Islands, and the Northern Mariana Islands. Arizona currently provides federally funded medical assistance through a demonstration program that has received waivers of certain Medicaid requirements."

is approximately 57 percent of total program spending. Federal matching for state program administration is generally at 50 percent.[39]

Traditionally, eligibility for Medicaid benefits has been linked to actual or potential receipt of cash assistance under either of two programs: Aid to Families with Dependent Children (AFDC) and Supplemental Security Income (SSI) for the aged, blind, and disabled. Recently, states have been given the option to extend Medicaid to other low-income groups. By federal law, many of the options for pregnant women, children, and the low-income elderly have been converted to mandates.[40]

All states must cover the categorically needy. These persons include all AFDC recipients and, in most states, persons receiving SSI and groups not receiving AFDC or SSI but which are mandated by federal law.[41] States must cover a minimum set of services under Medicaid and may at their option offer additional services. They are generally free to develop their own reimbursement methodologies and levels for covered services.[42]

Thirty-nine states and other jurisdictions also provide Medicaid to the medically needy. These are persons whose income or resources exceed the standards for the cash assistance programs, but who meet a separate medically needy financial standard established by the state and also meet the non-financial standards for categorical eligibility (such as age, disability, or being a member of a family with dependent children).[43]

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39 *Supra* note 37 at CRS-2.

40 *Ibid.* at CRS-3.

41 *Ibid.* The following are among these groups:

> *(i)* Pregnant women, infants, and children up to age six, with family incomes up to 133 percent of the poverty level.
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> *(ii)* Children aged six to nineteen and born after 30 September1983, with family incomes up to 100 percent of the poverty level.
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> *(iii)* Certain persons whose family income and resources are below AFDC standards but who fail to qualify for AFDC for other reasons, such as family structure.
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> *(iv)* Families losing AFDC benefits as a result of increased employment income or working hours or increased child or spousal support payments.
>
> *(v)* Persons who have been receiving both social security and SSI benefits and who become ineligible for SSI because of increases in their Social Security payments.
>
> *(vi)* Certain disabled people who lose SSI after returning to work but who remain disabled and who could not continue working if their Medicaid benefits were terminated.

42 *Supra* note 37 at CRS-3, CRS-5.

43 *Supra* note 37 at CR3-3, CR3-4.

B. The Canadian Health Care System[44]

Generally speaking, Canada has a taxpayer-financed, comprehensive health care system that covers hospital and medical services for all residents, regardless of ability to pay.[45] In theory, all Canadians have access to well-trained doctors and well equipped hospitals.[46]

Because the provinces have constitutional authority for health care delivery, the system is made up of interlocking provincial health plans. The federal government sets basic standards[47] and contributes financially to the operation of the provincial plans. It also provides health services directly to aboriginal peoples, the military, and other special groups.[48]

In terms of program delivery, when Canadians need medical care, they go to the doctor, clinic, or hospital of their choice and present their medical insurance card, issued to all residents of a province who have immigration status.[49] Doctors bill the province; patients do not pay directly for medical services and are not required to fill out forms. Unlike most insurance plans in the U.S., there are no deductibles or co-payments.[50]

Most doctors are in private practice and are compensated on a fee-for-service basis under a fee schedule negotiated between the provincial medical association and the provincial government.[51] Approximately 95 percent of the hospitals in Canada are non-profit and are operated by voluntary organizations, municipalities, or other agencies. Hospital administrators are accountable to local boards of trustees, not to the provincial or federal bureaucracy.[52]

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44 Canada's national health insurance program is known as Medicare. T.R. Marmor & J. Godfrey, "Canada's Medical System Is A Model. That's A Fact." *The New York Times* (23 July 1992) Op-Ed.

45 R.W. Sutherland & M.J. Fulton, *Health Care in Canada* (Ottawa: Health Group, 1988).

46 *Ibid.*

47 *Ibid.*

48 Sutherland, *supra* note 45 at 1.

49 Sutherland, *supra* note 45 at 1; see Cong. Res. Service, Lib. of Cong., *CRS Report for Congress, The Canadian Health Care System* CRS-1 (Beth C. Fuchs & Joan Sokolovsky 20 February 1990) at CRS-8 noting that while patients are free to choose their physicians, physicians have the option of accepting or refusing any patient.

50 Sutherland, *supra* note 45 at 1.

51 Sutherland, *supra* note 45 at 1; see Cong. Res. Serv., Lib. of Cong., *CRS Report for Congress, The Canadian Health Care System*, *supra* note 49 at CRS-8 explaining that while "the majority of practicing physicians are private practitioners reimbursed according to a provincial-wide negotiated fee schedule" and note 4 at CRS-8 explaining that all "[p]hysicians have the option of practicing completely outside the national health insurance scheme but they cannot take some patients covered by the plan and others as private pay patients."

52 Sutherland, *supra* note 45 at 1.

1. *Provincial Flexibility*

As long as a province meets the criteria specified in the *Canada Health Act*, it has considerable flexibility in the organisation and delivery of its health services.[53] Provincial plans offer a range of supplementary benefits, such as prescription drugs for the elderly and dental care for children, which vary from province to province. Employee benefit plans cover additional services, such as optometry and physical therapy.[54]

Although user fees have been eliminated for acute hospital care under the *Canada Health Act*, provinces are permitted to charge patients for meals and accommodations in chronic care facilities. As the provincial health plans provide for ward-level care only, charges may also be made for upgrades to semi-private or private rooms.[55]

2. *Funding*

In 1989, health care spending in Canada totalled an estimated $47.4 billion U.S.[56] Spending varies from approximately one-fifth to one-third of provincial budgets.[57] Funds for the provincial plans may be supplemented by sales taxes, taxes levied on employers, or premiums paid by individuals. Only Alberta and British Columbia collect premiums. The premiums are not rated by risk in either province and prior payment of a premium is not a condition of eligibility for treatment.[58]

Until 1977, the federal contribution was linked to the cost of health services and roughly matched provincial expenditures.[59] Since 1977, the federal contribution has taken the form of block grants and tax transfers to the provinces.[60] It is based on a three-year moving average of the GNP and is calculated independently of provincial costs. A separate annual federal grant is made to each

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53 *Supra* note 45 at 2.

54 *Ibid.*

55 *Ibid.*

56 *Ibid.* Recall that Medicare payments alone were estimated to cost $116.7 billion in American funds for fiscal year 1992. See *supra* text accompanying note 31.

57 Sutherland, *supra* note 45 at 2.

58 Sutherland, *supra* note 45 at 2.

59 *Ibid.* This means that the Canadian federal government reimbursed the individual provincial authorities for 50 percent of the incurred cost of health care services. See Cong. Res. Serv., Lib. of Cong., *CRS Report for Congress, The Canadian Health Care System*, *supra* note 49 at CRS-3.

60 Sutherland, *supra* note 45 at 2. In 1977, the Federal-Provincial Fiscal Arrangements and Established Program Financing Act was passed and instituted the block grant approach to the federal fiscal contributions. Cong. Res. Serv., Lib. of Cong., *CRS Report for Congress, The Canadian Health Care System*, *supra* note 49 at CRS-3.

province toward the costs of extended care provided outside hospitals. The federal contribution is financed through consolidated revenues (including personal and corporate income taxes, excise taxes, and import duties).[61]

II: ETHICAL FOUNDATIONS OF THE AMERICAN AND CANADIAN HEALTH CARE SYSTEMS

TRADITIONAL ANALYSES of the effectiveness of health care systems have focussed on such issues as access to health care and cost of the system as though they exist in isolation. A health care system does not operate in a vacuum, but in a world of people. Theoretically, a democratic political system must have support in order to be effective; if there is no popular support, the people will force the system to change. Even a health care system which provides the highest levels of access at the lowest possible cost cannot survive in a democratic society without the support of the citizenry. Consequently, a system viewed as just by those affected will tend to work better than a system seen as unjust.[62]

The concepts of "fairness" and "desert" are the foundation of a person's intuitive sense of justice.[63] Philosophers have asserted that justice is best explained in terms of fairness and desert, or "giving to each his right or due."[64] The expression "distributive justice" refers to the just distribution of benefits and burdens in society.[65] Theoretical conceptions of distributive justice require persons to be treated alike unless there are relevant differences among them.[66]

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61 Sutherland, *supra* note 46 at 2; see Cong. Res. Serv., Lib. of Cong., *CRS Report for Congress, The Canadian Health Care System*, *supra* note 50 at CRS-3, CRS-4 explaining that provinces have great latitude in determining how they will finance their share of health care costs. They cannot impose user fees or extra-billing without losing Federal financial support, but they may institute insurance premiums, sales taxes, use general revenues or utilize a combination of approaches. The author explains that "[a]ll provinces and territories use general tax revenues to support most of the costs of their insurance programs. In addition, Ontario, British Columbia, and Alberta impose a small payroll tax premium to raise a portion of the required sums."

62 T.L. Beauchamp & J.F. Childress, *Principles of Biomedical Ethics*, 2d ed. (New York: Oxford Univ. Press, 1983) at 184.

63 *Ibid.* at 184; see R. Branson, "Health Care: Theories of Justice and Health Care" in W.T. Reich, ed., *The Encyclopedia of Bioethics* (New York: The Free Press, 1978) 630 at 630–31.

64 Beauchamp & Childress, *supra* note 62 at 184; see M. Golding, "Justice and Rights: A Study in Relationship" in E.E. Shelp ed., *Justice and Health Care* (Boston: D. Reidel Pub., 1981); see also Branson, *supra* note 63 at 630.

65 Beauchamp & Childress, *supra* note 63 at 184; Branson, *supra* note 64 at 631.

66 Branson, *supra* note 62 at 631–32. J. Feinberg, "The Concept of Justice" in W.T. Reich, ed., *The Encyclopedia of Bioethics* (New York: The Free Press, 1978) 802 at 803.

This distribution is a cooperative enterprise among the members of society, and is structured by various moral, legal, and cultural principles.[67]

While most democratised nations adopt distributive justice as a fundamental principle, proclaiming the equal worth of all persons and backing that proclamation with various legal guarantees of equal justice and rights, varying notions of distributive justice compete for acceptance in each nation, and several theories of distributive justice have been used to justify the societal distribution of health care.[68] This article will isolate and examine the libertarian and egalitarian theories of justice, theories that resemble the ethical foundations of the American and Canadian health care systems.

A. The American Health Care System: A Libertarian Approach to Distributive Justice

Libertarian theories of justice concentrate on the individual rights of persons to enter and withdraw freely from arrangements in accordance with their perceptions of their interests;[69] that is, persons are at "liberty" to do what they want. Because arrangements are freely chosen, such arrangements can be considered morally relevant bases on which to discriminate among individuals in distributing economic burdens and benefits.[70] Government action, on the other hand, can be justified only where it protects the fundamental rights or entitlements of such citizens.[71]

It is clear that the United States' health care system has historically, though not exclusively, been driven by such libertarian conceptualisation of distributive justice; that is, the system has operated on the principle that the distribution of health care services and goods is best left to the marketplace, where the implicit distributive principle, or relevant distinction among people, is the ability to pay.[72] In large part, Americans are responsible for generating their own ability to

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67 Beauchamp & Childress, *supra* note 62 at 184; see generally Branson, *supra* note 63 at 631–32.

68 Beauchamp & Childress, *supra* note 62 at 184, 190; see generally O.W. Anderson, "Health Policy: Health Policy in International Perspective" in W.T. Reich, ed., *The Encyclopedia of Bioethics* (New York: The Free Press, 1978) 651; see Branson, *supra* note 63 discussing theories he refers to as "Utility of health care," "Entitlement to health care," "Decent minimum of health care," "Maximum level of health care," and "Equal access to equal levels of health."

69 Beauchamp & Childress, *supra* note 62 at 190.

70 *Ibid.*

71 *Ibid.* This libertarian theory of justice has been developed in considerable detail through the work of Robert Nozick. Nozick emphasizes that rights should not be coerced, and that there should be redistribution of economic benefits and burdens. Branson, *supra* note 63 at 631–33.

72 Beauchamp & Childress, *supra* note 62 at 190; see generally Branson, *supra* note 63 at 633.

pay, either through voluntary employment-based private health care plans, non-employment based private health insurance, or from directly-held financial resources. The U.S. has deviated from a strict libertarian approach, to some extent, in that public health insurance is provided for some 12 percent of its population, based on those persons' age or extreme lack of ability to pay as determined by federal and state regulations.[73] For the most part, however, the U.S. has used the principal tools of libertarian justice, competition, and the marketplace, as the foundation for its health care system.

B. The Canadian Health Care System: An Egalitarian Approach to Distributive Justice

Egalitarian theories of justice challenge the libertarian approach to the distribution of health care in that they emphasise equal access to care instead of rights to social and economic liberty.[74] For example, moral philosophers such as John Rawls contend that all vital economic goods and services should be distributed equally, unless an unequal distribution would work to everyone's advantage. Rawls's theory is presented through a hypothetical social contract strongly indebted to a Kantian conception of equality. In such an account, the valid principles of justice are those principles to which all would agree if each person could freely consider the social situation from the "original position." Equality is built into that hypothetical position in the form of a free and equal bargain among all parties where, unlike libertarian theory, there is equal ignorance of all individual characteristics and advantages that persons have or will have in their daily lives.[75] Rawls's approach has been interpreted as supplementing the libertarian marketplace system of distribution, in that persons considering the social situation from the original position choose principles of justice that maximize the minimal level of "primary goods" in order to protect the vital interests of society's members in uncertain, but perhaps disastrous, contexts.[76]

The implications of Rawls's theory are egalitarian when applied to a system of national health care: under Rawls's conceptualisation of justice, each member of society, irrespective of wealth or position, is provided with equal access to an adequate, though not maximal, level of health care for all available types of services.[77] The distribution would proceed on the basis of need (the relevant

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[73] Aukerman, *supra* note 8 at 2856 (citing data from 1988).

[74] Beauchamp & Childress, *supra* note 62 at 190 citing N. Daniels, "Health Care Needs and Distributive Justice" (1981) 10 Phil. & Pub. Pol'y. 146–79; see Branson, *supra* note 63.

[75] Beauchamp & Childress, *supra* note 62 at 191 citing R.M. Green, "Health Care and Justice in Contract Perspective" in R.M. Veatch & R. Branson, eds., *Ethics and Health Policy* (Cambridge, Mass.: Balinger Pub. Co., 1976) 111–26.

[76] Beauchamp & Childress, *supra* note 62 at 191.

[77] *Ibid.*

distinction among people), and needs are met by equal access to services. Each person's health needs are to be met at a level which has been described as a "decent minimum."[78] By providing equal access to an adequate level of health care, but distributing health care resources on the basis of need, everyone's health needs are protected, including those who have need in contexts that could be described as disastrous.

The egalitarian theory presented by Rawls's model of distributive justice has served as the foundation of the Canadian health care system in the last quarter-century.[79] In theory, each Canadian, irrespective of wealth or position, receives equal access to an adequate level of health care for all available types of services.[80] Distribution proceeds on the basis of medical need—needs met by theoretically equal access to services. Canadian legislators, as agents for the people, have determined that health care providers shall decide which persons, medically, need. The policy underlying such an egalitarian theory achieves neither equality in *levels* of health care nor in health, but recognizes the moral intuition that society should not entirely neglect any of its citizens' basic needs or allow disruption of the political and economic system of society.[81] In accordance with the theory,[82] Canadian legislators have determined that "better," non-essential services, such as luxury hospital rooms, dental work, and elective plastic surgery, be made available for purchase at personal expense by those who are able to and wish to do so.

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78 *Supra* note 62 Compare C. Fried, "Equality and Rights in Medical Care" (Feb. 1976) 6 Hastings Ctr. Rep. 29–34.

79 See Rublee, *supra* note 4 at 181 referring to the "egalitarian principles underlying Canada's health care system."

80 See *supra* note 46 and accompanying text; see *infra* notes 85, 86, 90 and accompanying text; see generally Branson, *supra* note 63 at 634; but see *infra* notes 94–96 and accompanying text.

81 Branson, *supra* note 63 at 634.

82 Beauchamp & Childress, *supra* note 62 at 191.

III: THE EFFECT OF DISTRIBUTIVE JUSTICE ON HEALTH CARE

THE TERM ACCESS HAS BEEN DEFINED as the ability to obtain medical services.[83] The fundamental difference between the libertarian approach to health care justice and the egalitarian approach as propounded by Rawls, is embodied by the concept of universal coverage.

Universal coverage of the population is the particular aspect of the Canadian health care system that is overwhelmingly described as superior to the U.S. system.[84] Because all Canadians have universal access to health insurance, all have the ability to pay for stated levels of medical intervention.

Unlike Canadians, all Americans do not have health insurance.[85] Uninsured citizens may receive emergency care,[86] paying for the care they can afford out of personal funds. Hospitals, municipal and state governments, charities, and other agencies absorb the cost of services above and beyond what uninsured citizens can afford.[87] Therefore, the absence of health insurance, while not resulting in the denial of required medical services, comes at a profound price. The uninsured recipient of health care must spend the totality of her personal funds, becoming indigent before these services are provided at no charge through one of the agencies described above.[88] In Canada, it is a fundamental tenet of the *Canada Health Act* that all residents are covered by the various provincial health plans even for preventive, curative, and emergency care.[89]

The absence of insurance has a profound impact in the United States. While the American public itself mistakenly believes that all of the poor are covered by Medicaid,[90] in fact, the program covers only about 40 percent of the

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[83] See Butler, *supra* note 11 at xiii-xvi; P.R. Lee & C. Emmott, "Health Care: Health-Care System" in W.T. Reich, ed., *The Encyclopedia of Bioethics* (New York: The Free Press, 1978) 610 at 617.

[84] J. Krasny & I.R. Ferrier, "Peer Review: A Closer Look at Health Care in Canada" (Summer 1991) Health Affairs 152 at 154.

[85] See *supra* notes 5, 158, 209–10 and accompanying text.

[86] See Krasny & Ferrier, *supra* note 84 at 154 stating that "[m]any in the United States receive needed care ... ."

[87] *Ibid.*

[88] *Ibid.* at 155.

[89] See Krasny & Ferrier, *supra* note 84 at 155; compare J. Greene, "Looking North for a Model in Health Care, Canada's Medical System is Object of Praise, Criticism" *Cleveland Plain Dealer* (23 February 1992) 4-E, stating that "[u]ninsured Americans who need emergency treatment usually get it, but preventive and long-term care are elusive. Without question, Canadians have complete access regardless of money or insurance ... ."

[90] Aukerman, *supra* note 8 at 2856.

population with income below the federal poverty level.[91] As a consequence, most poor individuals and their families do not have adequate access to health care. Without coverage, there is a decreased use of health services, and a resulting tendency to postpone seeking care until a condition has become severe.[92]

While health insurance is universally provided in Canada, access to care is limited in some respects, and to that extent, the country has departed from Rawlsian principles of egalitarianism.[93] Although there is theoretical access for all, some experience lengthy delays in receiving care.[94] Queuing, meaning "to form or wait in line," has become a frequent criticism of the national health programs in Canada.[95] Where a patient dies or his medical condition significantly deteriorates while waiting for an essential service, the patient has neither been supplied health care to meet his or her "basic needs," nor obtained a "decent minimum"; thus, the distribution of care has not followed egalitarian theory.

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91 Aukerman, *supra* note 8 at 2856.

92 *Ibid.* See *supra* text accompanying note 86. See also C.L. Marshall & C.P. Marshall, "Poverty and Health in the United States" in W.T. Reich, ed., *The Encyclopedia of Bioethics* (New York: The Free Press, 1978) 1316 at 1317, where the authors state:

> Although the health problems of the poor indicate an obvious need for medical services, utilization of physicians is less than that of any other socioeconomic group. Members of low-income groups are more likely to ... seek the physician only when seriously ill. Partly as a result of such delays, hospital stays are longer. Unfortunately, fewer poor people have health insurance, and for those who do[,] less of the bill is covered. This disadvantaged population endures more days of restricted activity, more bed-disability days, and more days lost from work per person. When considered together, these patterns indicate that, while the health needs of the poor are great, their utilization of health services is meager.

93 Greene, *supra* note 89 at 4-E stating that Canadian access for non-emergency procedures "is generally not unfettered or immediate." See also *supra* note 89 and accompanying text; but see *infra* note 191 and accompanying text.

94 S.J. Katz *et al.*, "Special Communication, British Columbia Sends Patients to Seattle for Coronary Artery Surgery" (1991) 266 J.A.M.A. 1108; Greene, *supra* note 89 at 4-E reporting that "[m]edical practices tend to be very high volume in Canada. Patients may spend several hours in a waiting room, only to see a physician for 15 minutes," according to two doctors (Drs. Boutry and Brunengraber) who moved to the United States (Cleveland, Ohio) from Canada (Montreal, Quebec) in 1990; but see *infra* text accompanying note 100.

95 Katz *et al.*, *supra* note 94 at 1108; see also Greene, *supra* note 89 at 4-E reporting that "[w]hen [then] President Bush unveiled his health reform package in Cleveland [in February, 1992], he criticized the Canadian system, saying patients in British Columbia wait six months for coronary bypass surgery."; Marmor & Godfrey, *supra* note 44 at Op-Ed asserting that "critics in conservative American think-tanks such as the Heritage Foundation propagandistically tell stories of endless waiting in Canadian medicine".

The medical organisations of both the United States and Canada have been among the loudest critics of this aspect of Canadian-style health care.[96] Stressing the detrimental effects of queuing for cardiovascular services on patients in Canada,[97] the American Medical Association recently initiated a high-profile publicity campaign, which included a mailing to physicians, against proposals for a Canadian-style (egalitarianism-based) system in the U.S.[98] Canadian medical organisations have characterised queuing as "rationing" caused by inadequate government funding.[99] Both these groups, however, have vested interests in reducing delays in treatment. In reality, 96 percent of Canadians over the age of 15 obtain their care within seven days of requesting it.[100] In Canada, the goal of provincial program funding is to control costs while ensuring that access to expensive medical procedures is provided without compromising access to other hospital services.[101] The response by both American and Canadian medical associations to queuing for certain high-profile procedures manifest the tensions that exist between physicians, who seek to expand services, and the government, which seeks to control utilisation.[102]

While medical associations imply that health suffers from the queuing system, Canadians believe that quality is not lower because of their system.[103] Moreover, those who decry the adoption of Rawlsian egalitarianism as the basis for distribution of health care in the U.S.—because of the potential for queuing—ignore the realities of the U.S. hospital setting for those without adequate insurance. Such individuals wait longer for care and may be transferred to other

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96 See Katz *et al.*, *supra* note 94 at 1108.

97 *Ibid.* at 1108; see also Andrew Pollock, "Medical Technology 'Arms Race' Add Billions to the Nation's Bills: Concern Over Costs Prompts Limits on Scanners" *The New York Times* (29 April 1991) A12 reporting that a cardiologist, Dr. Wigle, "has a patient who had a major heart attack while waiting for bypass surgery. Although he survived, his heart muscle was so damaged that he is now on another waiting list, this one for a heart transplant"; but see Greene, *supra* note 89 at 4-E stating that "Canadian health care officials ... [say] that queues exist but quality does not suffer. And[,] patients that need immediate care[,] get it."

98 Katz *et al.*, *supra* note 94 at 1108.

99 *Ibid.*

100 Marmot & Godfrey, *supra* note 44 at Op-Ed.

101 Katz *et al.*, *supra* note 94 at 1109; see generally R.G. Evans *et al.*, "Special Article: Controlling Health Expenditures—The Canadian Reality" (1989) 320 N. Eng. J. Med. 571 at 574.

102 See Katz *et al.*, *supra* note 94 at 1109 stating that "there's a tension between physicians and those who pay them ... [T]he government places high value on fiscal restraint and perceives the queue as a manifestation of the tendency for physicians to expand services and push against any budgetary constraint."; Evans *et al.*, *supra* note 101 at 573–76 discussing the effect of the Canadian-style centralized health care system on hospitals and on doctors.

103 See Birenbaum, *supra* note 3 at 162–63.

hospitals for treatment.[104] Furthermore, though the United States is praised for immediate access to health care, there still exists a scarcity of certain resources, among them hospital Intensive Care Unit (ICU) beds.[105] Canadian-style rationing and queuing take place in the U.S. every day in that regard. Additionally, it has been argued that queuing for non-emergency treatment promotes much-needed efficiency and priority setting in health care.[106] Those who need immediate care usually receive it in Canada; those who can wait for treatment stand in line.[107] Priority of access is determined by need for health care rather than ability to pay.[108]

The Canadian health care system has been praised for its universal access to needed health care services; it has been asserted, however, that universal access does not apply with respect to new treatment regimens and technologies.[109] In fact, one currently unmeasured use of health care technology in the United States is the direct use of services by Canadian citizens who do not want to wait in the queue for access to new technology.[110] The problem of resource constraint in Canada can be illustrated by comparing access to higher technologies between the United States and Canada. The per capita ratio of accessible higher (or newer) technology resources between the United States and Canada ranges from 200 to 800 percent.[111] Some have suggested that this comparison supports the inference that people have greater access to new technology in the United States than in Canada.[112]

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[104] See Butler, *supra* note 10 at xiii stating that "[d]espite a federal law protecting emergency room patients from precipitous transfers, scandalous examples of such patient dumping persist", 26 stating that many of the uninsured poor "postpone or delay care until their conditions become urgent or emergent, when they know that the local hospital emergency room is unlikely to refuse to treat them." See generally P. Stark, "Perspectives: United States, Fixing an Inefficient System" (Winter 1988) Health Affairs 35 at 36.

[105] Brookings Institution, Brookings Dialogues on Public Policy, *Rationing of Medical Care for the Critically Ill* 3 (M.A. Strosberg *et al.* ed., Report of Conference held in Wash., D.C., May 27, 1986); see generally C. Elliott, "Where Ethics Comes from and What to Do about It" (July-Aug. 1992) 22 Hastings Ctr. Rep. 28.

[106] See Greene, *supra* note 89 at 4-E.

[107] See Katz *et al.*, *supra* note 94 at 1111 stating that the debate about queues is a debate about need; but see *supra* note 97 and accompanying text.

[108] See Greene, *supra* note 89 at 4-E.

[109] See Pollock, *supra* note 97 at A12.

[110] See, for example, Katz *et al.*, *supra* note 94 at 1110 mentioning that on 8 January 1990, George Yetman, a thirty-five-year-old worker from British Columbia, underwent quadruple bypass surgery in Detroit, Mich., at his own expense after waiting ten months (in Canada) for surgery. He was later reimbursed for his operation by the Canadian Ministry of Health.

[111] Krasny & Ferrier, *supra* note 84 at 156.

[112] *Ibid.*

Another interpretation of this data shows that while *some* people have greater ease of access, others do not. Access to newer technology in the U.S. is distributed in accordance with libertarian principles: the range of choices depends on insurance coverage. Rawlsian egalitarianism does not attempt to stifle medical advance; in theory, advances in technology serve society as a whole, becoming primary goods available to work for everyone's advantage. Accordingly, available data shows that although Canada does not have as much high technology as the U.S., it ranks second in the world in the supply of ICU and diagnostic machinery.[113] Additionally, the Canadian system, which promotes preventive measures and provides access to social benefit programs, works to prevent the greater need for the primary good of high technology.[114]

That access to higher technologies is perceived as a more valuable asset in the U.S. than in Canada reflects the American tradition of libertarianism in health care.[115] The idea of setting limits on medical care horrifies many Americans.[116] Some analysts, in accordance with libertarian principles, perceive technological advancement and the right to select it as imperative, and they strongly advise against resource constraint.[117] They admit that Americans need to address the enormous problems that exist in American health care, but warn against any plan that seeks to completely revamp the system. They argue that abandoning the current system will "kill the can-do spirit that has fostered the best parts of American medicine—the breakthrough research, technological advances, and widespread availability of life-enhancing procedures."[118]

While difficult to argue against the monumental benefits of breakthrough research resulting in the discovery of new treatment methods,[119] technological advancement must be put in context of the historical time and needs of the

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[113] See Marmor & Godfrey, *supra* note 44 at Op-Ed.

[114] See Pollock, *supra* note 97 at A12 reporting that in an effort to promote access to basic care for its citizens, the Canadian Government maintains a ratio of general doctors to specialists of about four to one, as opposed to the one-to-one ratio in the United States; and reporting that "some experts say that technical plenty in the United States does not always lead to better care, just to more care, while basic needs go wanting."

[115] Todd, *supra* note 3 at 47; see generally Rublee, *supra* note 4.

[116] Caper, *supra* note 3 at 1535; Todd, *supra* note 4 at 47 asserting the pluralistic tradition of the American culture.

[117] Todd, *supra* note 4 at 47 asserting that the American citizens greatly value their right to free choice.

[118] *Ibid.*

[119] Pollock, *supra* note 97 at A12 reporting that "experts agree that society should not try to stifle new technology because of the better health care and lower costs it can provide" for example, laparoscopy for removing gall bladders. Pollock continues to say "the case of medical imaging is an example of how technology can spread virtually unchecked by considerations of cost."

people. Before all research in the name of scientific advancement is encouraged and funded, the resulting benefits should and must be rationalized. The strong tradition in the United States of favouring the interests of the individual over those of society means that the medical establishment condones, even insists upon, heroic measures to extend and improve the quality of life of specific individuals, even where the improvement is slight and the long-term prognosis poor.[120] American doctors tend to fight disease, disability, and the prospect of death aggressively with every tool modern technology makes available.[121] The "treat the problem at all costs" approach produces an occasional miracle, but it is very expensive, and the incremental improvement in health status often slight.[122] Access to the occasional miracle by a few rich individuals comes at the expense of the death and indigence of the collective lower to middle-class.[123]

Canadian physicians work with less advanced technology than American physicians.[124] In Canada, for example, major technologies such as Magnetic Resonance Imaging (MRI) are prohibited outside of hospitals.[125] Because fewer machines are available, persons who have no immediate need for the technology have to wait in line.[126] Because of the ability of rich Americans to "jump the line" regarding access to new technology,[127] uninsured Americans cannot get in line at all.[128]

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120 S.A. Mitchell, "Perspectives: United States, Defending The U.S. Approach To Health Spending" (Winter 1988) Health Affairs 31 at 32; see generally Rublee, *supra* note 4 at 178–79 commenting that most countries in the West do not plan for the long-run use of medical technology so as to reap any benefits of quality enhancement and cost saving.

121 Mitchell, *supra* note 120 at 32; see also Pollock, *supra* note 97 at A12.

122 Mitchell, *supra* note 120 at 32; see generally Pollock, *supra* note 97 at A12.

123 See A. Enthoven & R. Kronick, "Special Articles, A Consumer-Choice Health Plan For The 1990s: Universal Health Insurance in a System Designed to Promote Quality and Economy (Second of Two Parts)" (1990) 320 N. Eng. J. Med. 94 at 100 forecasting the opposition to a Canadian-style health system by "[m]illions of relatively well-to-do Americans [who] would fear that 'socialized medicine' would deprive them of access to high-quality care and advanced technology." See generally T. Lewin, "High Medical Costs Hurt Growing Numbers in U.S." *The New York Times* (28 April 1991) at A1.

124 Rublee, *supra* note 4 at 180.

125 *Ibid.* at 180.

126 See Greene, *supra* note 89 at 4-E reporting that "Canadian provincial governments tend to buy fewer high-cost, high-tech. equipment than U.S. hospitals because such machines as MRIs can cost $1.7 million or more. Scheduling an appointment can sometimes be a problem ... By comparison, three hospitals in Cleveland's University Circle area-Mt. Sinai, University and the Cleveland Clinic-have seven MRIs among them." By further comparison, according to a report published on 29 April 1991, "there are fifteen MRI scanners in all of Canada, and 2000 in the United States." Pollock, *supra* note 97 at A12.

127 Compare Pollock, *supra* note 97 at A12. The cardiologist Dr. Wigle says that in Canada, the long lines sometimes lead to charges of favouritism. "Those with 'influence and afflu-

Differences in access to major technology which result from the adoption of libertarianism versus egalitarianism as a distributive principle suggest either over-provision in the U.S., under-provision in Canada, or both.[129] In fact, U.S. insurance companies indicate that technology, such as MRI, often gets used unnecessarily—an indication of over-provision.[130] Queuing in the Canadian health care system with respect to new technologies such as MRI, on the other hand, suggests under-provision. Such under-provision, however, may result in the more effective use of the health care dollar, as the effectiveness of new technologies is reviewed over time.[131] Indeed, critics who allege that Canada has insufficient technology often fail to recognize inherent differences in the Canadian and American approaches to health care. For example, a widely cited study purported to demonstrate insufficient technology in Canada when compared with that of the U.S. by contrasting the number of units available for certain procedures, rather than by examining the number of actual procedures performed.[132] It has been shown, however, that while the Canadian egalitarian system tends to restrict the number of available units, Canadian units operate at

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ence' frequently jump to the top of waiting lists." Dr. Walter Kucharczyk, a radiologist who runs the MRI scanner at Toronto Hospitals is reported as having said, "People who have influence at the ministry or friends at the hospital get different treatment."

128 Eckholm, *supra* note 3 at A12 reporting the sentiments of Dr. Uwe E. Reinhardt, a health economist at Princeton University that "first, the country must do something about another kind of rationing, already here and more shameful [than suggesting hospitals and their staffs not provide access to high technology resources to patients in intensive care units], that expense and indignities prevent the poor from getting decent medical treatment." See generally A.S. Relman, "Is Rationing Inevitable?" (1990) 322 N. Eng. J. Med. 1809 at 1810 stating that "[l]imited access to medical care has always been with us. Over five years ago Fuchs pointed out in the *New England Journal of Medicine* that patients' income and the geographic location of physicians and facilities have historically restricted the availability of medical services to many Americans. And Grumet has also reminded us that reimbursement regulations imposed by third-party payors [a part of what is euphemistically called 'managed care']can similarly result in a kind of rationing."

129 Eckholm, *supra* note 3 at A12; Pollock, *supra* note 98 at A12; see *supra* notes 113, 126 and accompanying text; see also Greene, *supra* note 89 at 4-E; Marmor & Godfrey, *supra* note 44 at Op-Ed.

130 See Pollock, *supra* note 97 at A12 citing comments by John L. Cova, Director of Medical Technology Assessment for the Health Insurance Association of America.

131 For example, a review article identified 54 articles comparing MRI versus CAT scan. None of the articles provided scientifically acceptable data to support the use of the more expensive MRI technology (Can Fam Phys, March 1989). Similarly, a survey providing approximately 400 references concluded that while MRI may eventually be found to lead to more optimal outcomes in particular circumstances, such has not be proven to date. D.L. Kent and E.B. Larson, (1988) 108 Ann. Intern. Med. at 402–424).

132 See Rublee, *supra* note 4 at 178.

far higher volumes than in the U.S.[133] In fact, the procedure rates do not vary greatly between the countries.[134] Moreover, some experts believe that restricting certain procedures to "centers of excellence" not only secures better health care outcomes,[135] but helps avoid over-utilisation of services that occurs in the United States.[136]

IV. LIBERTARIANISM VERSUS EGALITARIANISM IN THE DISTRIBUTION OF HEALTH CARE

PEOPLE NEED JUSTICE, and, as mentioned above, concepts of fairness and desert form the foundation of a person's sense of justice. Yet, since ideas vary as to what constitutes justice, or fairness and desert, objectively determining which model of distributive justice ought serve as the foundation for a health care system poses enormous difficulties.

Since the concept of what constitutes justice is personal in nature—each person has her own sense of what is fair and deserving—the appropriateness of the ethical foundation of a health care system can be seen in people's attitudes toward their system. Where people are pleased with a particular system, we infer, to some extent, that they believe the system is just, and that outcomes are distributed in accordance with their personal views of fairness and desert. Where the fundamental need for justice is not met, people will not be satisfied with the system.

Polls have shown that the overwhelming majority of Canadians (some 95 percent) prefer their system to the U.S. system[137] In fact, of ten nations surveyed, Canadians were most satisfied with their current health care system.[138] On the other hand, more than 60 percent of U.S. citizens indicate that they would prefer the Canadian system to their own.[139] This statistic is of particular interest because one would expect that those Americans who are covered for health insurance would have a tendency to be satisfied with their system, and

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133 R. Deber, "Canadian Medicare: Can it Work in the United States? Will it Survive in Canada?" (1993) 19 Am. J.L. & Med. 75 at 82.

134 *Ibid.*

135 See, for example, R. Hughes *et al.*, "Hospital Volume and Patient Outcomes" (1988) 267 Med. Care 1057 at 1067.

136 T. Marmor, "Commentary on Canadian Health Insurance: Lessons for the United States" (1993) 23 Int'l J. Health Serv. 45 at 57.

137 Krasny & Ferrier, *supra* note 84 at 157 citing R.J. Blendon & H. Taylor, "Views on Health Care: Public Opinion in Three Nations" (Spring 1989) Health Affairs 149–57.

138 Blendon *et al.*, *supra* note 11 at 188.

139 Krasny & Ferrier, *supra* note 84 at 157; Blendon *et al.*, *supra* note 11 at 185, 187 stating the percentage was 61 percent in 1988 and rose to 66 percent in 1990.

would be more likely tend to see it as fair and just. This is not the case: although the American public consistently reports general satisfaction with its personal health care arrangements, almost one-third agree health care requires fundamental change,[140] and three out of five indicate a preference for a Canadian-style system.

Perhaps the cause of any dissatisfaction the American public has with its health care system is rooted in the libertarian model of distributive justice chosen as its foundation. Libertarian theories of health care entitle those who possess certain natural assets.[141] They do not base this entitlement on any measure of personal merit, effort, or achievement possessed by the persons claiming the entitlement. Such a theory hints that one person deserves the advantage one enjoys from his or her natural assets.[142] Most Americans recognise this principle to be false. As Rawls stated, "No person deserves his place in the distribution of native endowments any more than he deserves his initial starting place in society ... ."[143] Under the libertarian theory, people are also entitled to (and deserving of) their natural liabilities, including physical handicaps and congenital diseases.[144] Such a theory is not in accordance with most Americans' belief systems, because it is generally recognised that at least to some extent, natural abilities as well as liabilities are randomly and arbitrarily distributed.[145] That health care distribution in the U.S. is based on the arbitrary or random distribution of assets or liabilities is dissonant with many Americans' concepts of fairness, desert, and justice.

Another reason libertarian theory may be perceived as inadequately reflecting Americans' perceptions of fairness and desert is due to the unique nature of health care.[146] Libertarian theory requires that the distribution of health care goods and services in the U.S. be left to the marketplace. However, it is generally recognised that health care is not desired in the way consumers desire other goods.[147] While the free market is premised on the principle of informed consumers free to make rational decisions, a consumer seeking health care is often not in this position. For example, consider a woman who suddenly devel-

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[140] See Blendon *et al.*, *supra* note 11.

[141] The libertarian theory has also been called the entitlement position. Branson, *supra* note 63 at 631–32.

[142] *Ibid.* at 632.

[143] *Ibid.* (quoting John Rawls); N. Daniels, *Just Health Care* (Cambridge: Cambridge Univ. Press, 1985) at 46.

[144] Branson, *supra* note 63 at 632.

[145] *Ibid.*

[146] *Supra* note 144 at 632–33.

[147] *Ibid.* at 633.

ops brain cancer. The decisions regarding the price she will pay for health care are not based on rational decision-making; she will pay anything to save her life. Moreover, the decision not to buy health insurance to cover this contingency may not have been a free choice if she had few assets, or if her employer did not offer health care benefits. Since a health care consumer is not in the position of the theoretical consumers necessary to maintain the libertarian free market, health care should be viewed as a unique commodity.[148] Even some proponents of the free market system in other goods acknowledge that the specific characteristics of medical care dictate unique methods of distribution.[149] Since Americans likely realise, on some level, that many people do not have any real bargaining power under the U.S. health care system, they would be unsatisfied with an ethical foundation premised on such bargaining power and a truly free marketplace, is not surprising.

If Americans really view the underlying philosophy of their health care as unjust, democratic theory suggests that the people will force the system to change. The results of the 1992 Presidential election support the proposition that Americans would like to implement a health care system more in accordance with egalitarian principles. President Clinton promised universal health insurance coverage as fundamental part of his presidential agenda during the 1992 campaign.[150] Despite the fact that many perceived the introduction of universal health care as expensive, Clinton was voted into office. While it is obvious that factors other than health care reform played a role in Clinton's victory, as a centerpiece of the election debate, most Americans who voted for him were likely aware that the implementation of universal health care could possibly result from a Clinton presidency.

The health care reform plan ultimately introduced by President Clinton was an unequivocal move away from libertarianism and toward a system based on egalitarianism. The Final Draft Report of the President's Health Security Plan stated:[151]

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[148] See generally M. Slade, "Billable Hour, a Centerpiece of American Law, Is Fading" *The New York Times* (22 October 1993) A1 at B7 quoting Robert C. Buenger, marketing director of a St-Louis-based law firm, as saying that "[e]veryone wants managed health care to contain costs, until they get sick. Then they want the best care, regardless of costs."

[149] See Bransom, *supra* note 63 at 633.

[150] See generally *supra* note 7 and accompanying text.

[151] White House Domestic Policy Council, "The President's Health Security Plan: The Draft Report, September 7, 1993" at 11 in *The President's Health Security Plan* (New York: Times Books, 1993).

Ethical Foundations of Health Reform

(i) The values and principles that shape the new health care system reflect fundamental national beliefs about community, equality, justice and liberty. These convictions anchor health reform in shared moral traditions.

(ii) Universal Access: Every American citizen and legal resident should have access to health care without financial or other barriers.

(iii) Comprehensive Benefits: Guaranteed benefits should meet the full range of health needs, including primary, preventative and specialized care.

(iv) Equality of Care: The system should avoid the creation of a tiered system providing care based only on differences of need, not individual or group characteristics.

The embodiment of such moral principles in the reform package can only be viewed as a momentous shift toward egalitarianism as the ethical foundation for the U.S. health care system. While Clinton's health reform initiative was ultimately defeated, largely as the result of heavy spending by special interest groups such as the insurance company lobby and the American Medical Association, the debate leading to its downfall did not directly focus on ethical issues.

Since the defeat of the Health Security Plan, the Clinton administration has continued its move toward increased egalitarianism in health care, albeit through smaller initiatives which do not significantly overhaul the system's libertarian foundation. The *Health Insurance Portability and Accountability Act* of 1996,[152] for example, which was recently passed by Congress and signed by the President, is intended to improve access to health insurance and other health care plans. Under the legislation, increased access will be achieved primarily through limiting pre-existing condition restrictions and mandating portability of insurance upon employment termination.

V: Comparative Costs and Effectiveness

FOR A HEALTH CARE SYSTEM to be strong, it must be cost efficient: a system that is not cost efficient cannot maximize positive health care outcomes.[153] Where a system can minimize cost while maximizing health outcomes, the fact that the ethical foundation for the system may not be as suitable as the foundation for another more costly system can be justified. It becomes more difficult to justify the system based on a less appropriate ethical system where it does not provide better health outcomes at a lesser cost.

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[152] Pub. L. No. 104–191, 110 Stat. 1936 (1996).

[153] See generally Eckholm, *supra* note 3.

Despite the fact that a significant number of citizens do not have health care coverage,[154] the U.S. spends more on health care, per capita and as a percentage of gross national product (GNP), than any other country. Moreover, the U.S. has one of the highest annual rates of increase in health care spending.[155] In 1986, the United States spent 10.9 percent of its GNP on health care;[156] by 1993, the health care budget exceeded 14 percent of GNP.[157] Health care expenditures are projected to reach 19 percent of GDP by the end of the decade if effective controls are not implemented,[158]with total health care spending in excess of 1.5 trillion dollars.[159] The money invested in American health care was not the result of some overall, well-developed health-care policy, but the cumulative effect of decisions made by individuals, employers, hospitals, insurance companies, and local, state, and federal governments operating under libertarian principles.[160]

In Canada, on the other hand, health care expenditures grew from 8.8 percent of GNP in 1986 to 10.2 percent by 1992.[161] By 1991, all provinces had begun serious cost control, and by 1993–1994, total Canadian spending on health care was projected to increase by only 0.15 percent.[162]

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154 Birenbaum, *supra* note 3 at 85 stating the total population of the United States in March, 1991 to be 245 million, according to Census Bureau data which had been combined with information from the Employee Benefits Research Institute and explaining that of those 245 million Americans, 35.7 million Americans, or 14.6 percent were without health insurance.

155 Holahan *et al.*, *supra* note 3 at 2537; see generally D.J. Besharov & J.D. Silver, "Rationing Access to Advanced Medical Techniques"(1987) 8 J. Legal Med. 507 at 510.

156 T.A. Mappes & J.S. Zembaty, eds., *Biomedical Ethics*, 3d ed. (New York: McGraw-Hill, 1991) at 545.

157 U.E. Reinhardt, "A Billion Here, a Billion There" *The New York Times* (18 October 1993) at A17, commenting that "[t]he Congressional Budget Office forecast last spring that, at current trends, the United States will spend 19 percent of its gross national product on health care in the year 2000, up from 14 percent today." See *supra* note 6; see also M.J. Garland, "Light On The Black Box of Basic Health Care: Oregon's Contribution To The National Movement Toward Universal Health Insurance" (1992) 10 Yale L. & Pol'y Rev. 409 at 409 stating that the 1992 health care budget exceeded the GNP by approximately 13 percent.

158 White House Domestic Policy Council, "Health Security: The President's Report to the American People, October 27, 1993" at 9 in *The President's Health Security Plan* (New York: Times Books, 1993).

159 L.O. Gostin, "Foreword: Health Care Reform in the United States—The Presidential Task Force" (1993) 19 Am. J. L. & Med. 1 at 2.

160 Mappes & Zembaty, *supra* note 156 at 545.

161 R.W. Sutherland & M.J. Fulton, Spending Smarter and Spending Less: Policies and Partnerships for Health Care in Canada (Ottawa: The Health Group, 1994) at 35.

162 *Ibid.*

Given the magnitude and rate of growth of American health care expenditures, one would expect positive effects on aggregate health. Instead, researchers have found that the United States has spent at least three times as much per person on health care as other Western countries, without producing demonstrably better overall health.[163] Furthermore, when mortality is used as an indicator, the United States consistently exhibits one of the highest degrees of inequality in health among 32 industrialized nations.[164]

On a microeconomic level, Americans pay 26 percent of their health care bills "out of pocket," and one in six report paying more than 40 percent of these costs directly.[165] In Canada, by way of contrast, the patient pays no deductibles or co-payments.[166]

In 1987, Americans spent $2051 per capita on health care,[167] while each Canadian spent $1483.[168] Since that time, the gap between the two countries' per capita spending has continued to widen. Furthermore, for those Americans with insurance coverage, the personal cost is greater and coverage not as comprehensive as for their Canadian counterparts.[169]

On a macroeconomic level, the American health care system is a high cost system.[170] The United States' system costs more than Canada's for several reasons, including differences in administrative costs,[171] demographics,[172] malprac-

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163 R.L. Dickman *et al.*, "Sounding Board: An End to Patchwork Reform of Health Care" (1987) 317 N. Eng. J. Med. 1086 at 1087.

164 *Ibid.*

165 Blendon *et al.*, *supra* note 11 at 191.

166 See *supra* text accompanying notes 49–50.

167 Blendon *et al.*, *supra* note 11 at 188. The authors noted that the United States and Italy were the two countries of the ten-nation survey reported in *International Health Care Expenditure Trends: 1987* that had the highest level of "public disenchantment" with their systems, but a marked difference in health care arrangements and amount spent in 1987 per person for health care. "In 1987, Americans spent $2051 per person for health care; Italians spent $841 [American dollars]." *Ibid.* This demonstrates that the increased spending has not produced a more favored health care system.

168 Blendon *et al.*, *supra* note 11 at 188.

169 Blendon *et al.*, *supra* note 11 at 190 reporting on inadequate insurance protection and high out-of-pocket spending and citing these as major reasons for the American public's dissatisfaction with medical care.

170 Marmor & Godfrey, *supra* note 44 at Op-Ed stating that "[i]n 1991, Canada spent about 9.2 percent of its national income for medical care while the U.S. spent 12.3 percent; the proportions for 1971, the year Canadian Medicare became universal, were 7.3 percent and 7.4 percent, respectively. So, over two decades Canada learned how to insure everyone while spending less."

171 See *supra* notes 179–80 accompanying text.

172 See *supra* notes 185–91 accompanying text.

tice insurance costs,[173] research and development expenditures,[174] and hospital expenditures.[175]

Some claim that one of the major cost problems with the American health care system is the complex administrative aspect of the system.[176] Administrative overhead exceeds 20 percent of total health care costs.[177] Canadians spend much less per capita to *administer* universal comprehensive coverage than Americans spend to administer Medicare and Medicaid alone. For example, one study showed that Canadians spent $21 per citizen on universal health care, while Americans paid $26 per citizen for Medicare and Medicaid.[178]

What accounts for this difference in administrative cost? Due to the egalitarian nature of the Canadian system, all the costs of determining coverage and eligibility are avoided because all citizens are eligible for the same benefits. Patients are not involved in the payment system because reimbursement takes place between the public insurer and the health care provider. There are few marketing expenses and no costs of estimating risk status to set differential premiums or decide whom to cover.[179] Moreover, the process of claims payment is greatly simplified and much cheaper.[180]

In addition to administrative costs, the comparatively high cost of the U.S. health care system has been attributed to demographic considerations.[181] There is a disproportionate share of health care consumption by the elderly in the two nations. While the elderly make up just over 12 percent of the U.S. population, they account for well over 50 percent of health care consumption.[182] In the United States, the group aged 65 and over is 1.2 percent larger than in Canada (as percentage of the population), with a resulting net impact on U.S. health

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173 See *supra* notes 192–95 accompanying text.

174 See *supra* notes 196–97 accompanying text.

175 See *supra* notes 198–200 accompanying text.

176 See R.G. Evans, "Perspectives: Canada, Split Vision: Interpreting Cross-Border Differences In Health Spending" (Winter 1988) Health Affairs 17 at 18; see also Marmor & Godfrey, *supra* note 44 at Op-Ed stating that "[n]o financial or administrative barriers prevent patients from seeking the services of any family doctor."

177 Caper, *supra* note 3 at 1535.

178 Evans, *supra* note 101 at 573.

179 Sutherland, *supra* note 45 at 3.

180 *Ibid.*

181 See Krasny & Ferrier, *supra* note 84 at 153–54.

182 *Ibid.* at 153.

care costs of 5.3 percent.[183] Moreover, as the population of the elderly rises, the impact on U.S. health care costs may also reasonably be expected to rise.[184]

Other demographic considerations also make the United States a more expensive population to serve.[185] The impact of past military actions—particularly the Vietnam and Korea experiences—greatly increased demand for medical care. No directly comparable experience exists in Canada.[186] Moreover, inner-city phenomena such as crimes of violence, substance abuse, sexually transmitted disease, and teen pregnancy also have greater impact on health costs in the U.S. than in Canada.[187]

In addition to higher administrative costs and demographic considerations, the substantially greater cost of malpractice insurance in the United States[188]

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183 *Supra* note 184.

184 See Birenbaum, *supra* note 3 at 27 stating that fewer children are being born resulting in an increased proportion of elderly citizens. The author further states that "[c]learly, older people have more health problems per individual than younger ones." See also Todd, *supra* note 4 at 47 stating in 1989 that "it is unrealistic to expect health care expenditures to level off, much less to decrease, in the absence of economic rationing. Instead, the level of health care activity will continue to grow as a result of various factors, including an aging population ... ."

185 Krasny & Ferrier, *supra* note 84 at 154; see Birenbaum, *supra* note 3 at 27–28 mentioning that an increasing elderly population for whom to provide health care services has increased the number of doctors and expenditures on health care in the past ten years; compare D.R. Waldo & S.T. Sonnefeld, "Peer Review, U.S./Canadian Health Spending: Methods and Assumptions"(Summer 1991) Health Affairs 159 at 160–61 claiming that "the demographic effect on differences in health spending between Canada and the United States is in the process of reversing sign," and that in forty years the United States' spending per capita will be 8.4 percent lower than in Canada based on age and sex alone.

186 Krasny & Ferrier, *supra* note 84 at 154. The Department of Veterans Affairs (VA) designates about 20 percent of its patients as veterans of the Vietnam-era. *Ibid.* note 5 at 158. A recent study by the Centers for Disease Control (CDC) concluded that "Vietnam veterans were substantially prone to problems of alcohol abuse or dependence, clinical depression, and general anxiety." *Ibid.*

187 Krasny & Ferrier, *supra* note 84 at 154; See generally J.R. Missett & C.E. Taylor, "Health International" in W.T. Reich, ed., *The Encyclopedia of Bioethics* (New York: The Free Press, 1978) 643 at 643. The authors state that "[h]ealth care embraces [medical care] ... but entails in addition the identification and eradication of all factors, social as well as personal, that contribute to ill health. President Clinton's health care plan which mentions the violence and crime as contributing to the crisis in the U.S. health care system is consistent with this definition. See Greene, *supra* note 89 at 4-E stating that "Canadians are statistically, far less violent, far less likely to use drugs and far less likely to become pregnant as teenagers than Americans, all of which severely tax the U.S. health care system."

188 J.A. Califano, Jr., "Rationing Health Care: The Unnecessary Solution"(1992) 140 U. Pa. L. Rev. 1525 at 1531 estimating that $7 billion is paid by doctors and hospitals in annual medical malpractice insurance premiums; see J.P. Newhouse *et al.*, "Hospital Spending in the United States and Canada: A Comparison" (Winter 1988) Health Affairs 6 at 14.

leads to higher medical (or treatment) costs than occur in the Canadian system. In Canada, because patients are not directly paying health care costs, they are less likely to sue health care providers to recover these expenses in the event of malpractice.[189] Moreover, the quantum of damages awarded to the plaintiff in a medical malpractice action tends to be lower in Canada than in the United States. As a consequence, the cost of insuring health care providers is lower than the cost in the U.S.

The high cost of malpractice insurance leads to high health care costs in two ways. First, high malpractice premiums are passed on to the consumer through higher prices for services.[190] Second, health care providers tend to order an exhaustive battery of tests in most situations. Many of these tests are not ordered because they are necessary or useful, but rather to protect the health care provider in the case of future litigation. The health care consumer is spending money not to improve diagnosis but merely to protect the health care provider.[191]

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189 See generally Califano, Jr., *supra* note 188 at 1531–32 stating that as a result of the most comprehensive study of medical malpractice conducted in the United States at the time, Harvard School of Public Health researchers estimated that less than 2 percent of injuries due to negligence led to malpractice claims. "The vast majority of patients injured in hospitals never receive any compensation."; but see Krasny & Ferrier, *supra* note 85 at 157 stating that "cultural differences [between the U.S. and Canada] affect the consumption of health care" with Canada "creating limitations on individual rights." To illustrate their point, the authors state:

> Canadians wronged by a medical practitioner do not have access to punitive damages since, for all intents, none are awarded by Canadian courts. There are no contingent legal fees in Canada; consequently, those wishing to pursue legal remedy must have the necessary financial resources at hand. With minor exceptions, there are no class-action suits. Consequently, there is no mechanism for pursuing legal remedy in situations in which large numbers of people have been wronged. There is no right to sue government officials, or ministries of health, for medical negligence. Indeed, there is no right to sue the Canadian government without first obtaining permission from the government to do so.

190 See Califano, *supra* note 188 at 1530 stating that "how doctors are paid is a factor contributing to rising health care costs." Privately insured patients tend to receive more services and/or more sophisticated services than do uninsured patients.

191 See Califano, *supra* note 188 at 1529–30, 1531 asserting that medical malpractice generates unnecessary tests and procedures. Califano quotes a former editor of the *Journal of American Medical Association* as saying that half of the forty million medical tests performed each day "do not really contribute to a patient's diagnosis." Califano further states that "Doctors order many procedures and tests to protect themselves from potential medical malpractice liability." See also Greene, *supra* note 89 at 4-E reporting Dr. Colin McMillan, a cardiologist in Prince Edward Island, as saying that "the Canadian system also tends to cut down unnecessary use of high-tech equipment, which doctors sometimes order to defend against malpractice claims or simply to pad their bills."

Also accounting for the higher cost of American health care is the greater expenditure on Research and Development (R&D). If Canada were to spend the same amount as a proportion of GNP on health care R&D, it would face a 2.4 percent increase in health expenditures.[192] Instead, Canada "rides the coat tails" of higher United States R&D expenditures by licensing U.S. technology once it has been developed.[193]

A final difference in health care costs between the two countries relates to hospital expenditures, which are much higher in the United States.[194] In Canada, global budgets are negotiated between ministries and individual hospitals. Although political pressures have sometimes forced governments to assume the deficits of hospitals that were unable or unwilling to stay within these budgets, the process has resulted in a significantly slower rise in hospital expenditures than in the United States.[195] Notwithstanding that Canada has higher rates of hospitalisation and greater average lengths of stay than the United States, it has lower per capita hospital expenditures.[196]

The above discussion indicates that the U.S. spends more on health care than Canada.[197] This in itself does not indicate that the U.S. system is less efficient. The U.S. system can be condoned if it leads to better health for the population. However, it appears that this is not the case. For example, one measure of the health of a population is its mean life expectancy.[198] The mean life expectancy of a Canadian exceeds that of an American by a full year and a half.[199] Moreover, when recent mortality data was standardized to account for

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192 Krasny & Ferrier, *supra* note 84 at 154.

193 See *ibid.*, suggesting that "if Canada were to spend proportionally as much on health R&D as the United States spends, it would face a 2.4 percent increase in health expenditures." But see Waldo & Sonnefeld, *supra* note 185 at 159–60.

194 See Evans *et al.*, *supra* note 101 at 574.

195 Evans *et al.*, *supra* note 101 at 574.

196 *Ibid.*

197 See *supra* notes 165–96 and accompanying text; see also Waldo & Sonnefeld, *supra* note 186 at 162 stating that "Canadian health expenditures per capita have grown more rapidly than have U.S. expenditures ... in both nominal terms and opportunity cost. Yet Canadian GDP (Gross Domestic Product) has grown much more rapidly than has U.S. GDP, which accounts for the finding that the share of GDP consumed by health has risen more slowly in Canada than in the United States."

198 See generally D.U. Himmelstein & S. Woolhandler, "Sounding Board: Cost Without Benefit, Administrative Waste in U.S. Health Care" (1986) 314 N. Eng. J. Med. 441.

199 *Ibid.*

the age of the respective populations, it was found that substantially more Americans died annually per capita than Canadians.[200]

Another indicator of the health of a population is premature mortality.[201] A recent study which examined a measure of premature mortality (the years of potential life lost before the age of 65) indicated that the U.S. had substantially greater premature mortality per capita than Canada.[202] Therefore, mortality and premature mortality statistics suggest that the Canadian population has better health than its neighbour to the south.

It has been suggested that the ethical foundation of Canada's health care system as it presently exists is a more appropriate model of distributive justice than that underlying the U.S. system. The use of a libertarian model could be justified if it led to better health at a lower cost. It has been demonstrated, however, that the United States' health care system costs more than its Canadian counterpart. The additional expense is not correlated with better health as measured by such indicators as mortality and premature mortality statistics. Because the Canadian system provides better health to more people at a lower cost than the U.S. system, the comparative cost-benefit analysis does not suggest that Canada should abandon its egalitarian ethical foundation in pursuing reform initiatives.

VI CONCLUSION

THE CANADIAN HEALTH CARE SYSTEM is under increasing strain. Problems include increasing costs and an economy that may no longer be able to bear them; the uncertain relationship between increased spending for medical services and improvements in health status; the efficiency and effectiveness of existing delivery systems; and responsiveness to consumers needs and demands.[203]

To deal with such problems, a number of reform alternatives have and are being tested throughout the country. One is an effort by some provinces to exploit government power through tough fee and budget negotiations. Another is an increased emphasis on quality assurance and appropriateness. Some provinces have attempted to get more "bang for the buck" through restructuring in-

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200 See Himmelstein & Woolhandler, *supra* note 198 at 444 stating that "[b]efore the introduction of universal access to care in Canada [and Great Britain], both countries had age-adjusted mortality rates that were higher than those in the Unites States. Within a decade of the introduction of free access, a sharp decline in mortality occurred, so that the current levels in both Canada and Great Britain are slightly lower than those in the United States."

201 See generally Califano, *supra* note 188 at 1535 stating that "[t]wo-thirds of all disease and premature death is preventable ... ."

202 See Himmelstein & Woolhandler, *supra* note 198; see also Greene, *supra* note 89 at 4-E stating that infant mortality is higher in the U.S. than in Canada.

203 See R. Deber, *supra* note 133 at 76.

stitutions and encouraging increased rationalization of services. To date, no underlying ethical philosophy has emerged as the basis for these and other reform initiatives and, to some extent such proposals have conflicted with one another from an ethical perspective.

Canadians and Americans are concerned about the cost and effectiveness of their health care systems: Canadians are generally pleased with their system, while Americans are unsatisfied. In fact, most Americans have indicated that they would prefer a Canadian-style system, and President Clinton's 1994 reform initiative was an attempt, in large part, to move from a system based on libertarianism to one based on egalitarianism. This paper has argued, through a comparison of both health care systems that the egalitarian approach to distributive justice is a more appropriate model for health care (and its reform) than the libertarian model.

What does this imply for Canadian health care reform? First, it is suggested that Canadian policy-makers re-examine the issue of justice in health care, and determine the fundamental beliefs Canadians have about community, equality, justice, and liberty. Do Canadians continue to believe that a health care system should be grounded in a Rawlsian conception of egalitarian distributive justice? Does such a system adequately address Canadian's intuitive sense of fairness and desert? By comparing the U.S. experience in libertarianism with Canada's experience in egalitarianism, the conclusion can be drawn that egalitarianism should continue as the ethical basis of Canada's health care system.

Furthermore, an ethical analysis should apply to all present and future Canadian reform initiatives. It makes little sense to consider or implement a series of reform initiatives that conflict with or undermine the basic principles underlying the Canadian health care system; such initiatives will act to erode public support for the system. If policy-makers, legislators and the public agree that Rawlsian egalitarianism should continue as the ethical basis for health care distribution in Canada, cost-cutting and organisational initiatives that do not detract from Canadian egalitarianism should be pursued; initiatives that undermine or conflict with that philosophy should be discarded.

How would such an analysis work? Each initiative would be examined as to its expected concordance with or divergence from the ethical philosophy of the Canadian health care system. Based on this ethical analysis, the initiative would be approved, modified, or discarded.

Consider a hypothetical initiative for the introduction of a $10 user fee or co-payment, which would be payable by the patient upon each visit to a doctor. The use of such a disincentive is based on the idea that "need" for a service is user-determined; when services are free and convenient, people will use them even when the need is quite small.[204] Such fees are routinely used in the U.S. to discourage the frivolous use of health care services.

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[204] See R.W. Sutherland & M.J. Fulton, *supra* note 161 at 160.

After Canadian policy makers and legislators have determined the favourability of introducing fees, from a cost-cutting perspective, an ethical analysis would take place. In this case, the ethical analysis would initially find that the user fee was unjust—such fees would not adversely affect wealthy Canadians, who would continue to have uninhibited access, while poorer Canadians would be less likely to use needed health care services because the $10 fee would be significant to them. This result would not be permissible under egalitarian theory and, therefore, the initiative could not be pursued "as is."

Having failed the first step in the ethical analysis, the initiative would be examined to see if it could be modified to become consistent with the Canadian philosophy of justice in health care. With respect to user fees, the fee amount could be graduated, making the initiative comply with egalitarian principles. For example, a scale could be implemented so that persons in the lowest tax bracket would pay a $1 fee per doctor visit, or request exemption from the fee (available upon a written declaration that payment of such a fee would create a hardship). The fee maintains the desired effect, requiring the recipient incur some sort of liability for using the service, and discouraging use when his or her perceived need is small. Middle income earners could be required to pay a $10 fee; persons in the highest tax bracket a $25 fee. The initiative would now conform with the Canadian philosophy of health care distribution. Access remains available to all, but due to budgetary constraints and scarce resources, one must show that the level of need exceeds a minimal amount (that the person had a "basic" need under Rawlsian theory); paying user fees confirm such a need. A graduated scale of user fees would, in a financially equitable manner, help ensure that patients do not abuse the system.

By requiring health care reform initiatives to endure a standardised ethical analysis, and to comply with the ethical foundation of Canada's health care system, Canadians can ensure that the health care system that eventually results from the implementation of reform initiatives accords with Canadian perceptions of justice in health care, and reflects shared Canadian beliefs about liberty, community, and equality.