

The Sustainability of Canada's Health Care System: Some Ethical Challenges

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For the annual CCBI lecture on Friday November 18, 2007, the topic chosen was a discussion about whether or not a two-tier system for health care would be desirable in Canada. John Kyle who has a Ph. D. in Economics, and Claudette Chase, a family physician and member of Canadian Doctors for Medicare, took on the challenge of discussing the pros and cons of this issue.

Dr. Chase was emphatic that she does not claim that the present system is perfect; there are many problems to be fixed. Despite that, she believes the continuation of universality is the best way to ensure that people receive the treatment they need. Dr. Chase pointed out that under the present system we do receive care, although perhaps not as quickly as we would like. She suggested that attitudes towards wait times perhaps simply reflect societal pressures, which may have little to do with the actual care that we receive. She felt that compared with two-tier systems, the Canadian way is more just and more equitable. To illustrate her point, she showed statistics relating to the two-tier system in the UK, showing that, in practice, the private sector is not completely separate from the public sector. This means that the private sector partly functions by using some publicly financed resources. In effect, people who are willing to pay for procedures pre-empt others in the system, yet the public system funds at least some part of the procedures. In countries where the two systems are completely separate, ethical questions may remain, but they will be different.

Dr. Kyle's discussion let us see that sometimes we fail to ask enough questions about the present Canadian health care system. We recognize that there are problems, but are reluctant to move away from the universality model. If that

reluctance is based on evidence, that would be one thing, but too often it is a reluctance based on fear, or perhaps bias, that a two-tier system would automatically mean that there would be two-tiers of citizens. The latter is unacceptable, and Dr. Kyle was also careful to point out that the American model is not what he proposes. Rather, he recommended that we take a look at some factual issues, based on the experience of other countries. The aim is to see whether a different economic model could improve our system.

Dr. Kyle referred to a position embraced by Janice McKinnon, finance minister of a former NDP government in Saskatchewan that holds the opinion that the rising costs of health care cannot be met without jeopardizing other areas such as education and housing, which are also fundamental to health itself. She is open to user fees and to examining other ways to subsidize health care budgets, which would in turn make more money available for use in the public realm. These arguments are supported by many physicians, not least by the President-elect of the Canadian Medical Association, and by those who feel that, since cost containment is important, we should be at least open to thinking of other ways to increase money available for health care. One way of doing this is to move away from our current system where we expect everything will be paid for in full.

But this is the crux of the matter for Canadians. The health care system was devised on the universality principle, and many insist that principle should be preserved, no matter what demands are put on health care budgets. Dr. Kyle advocated a re-examination of the principle: if there are problems, financial and otherwise, should we not look for alternatives? How can we decide in advance that some of these new ideas are nonviable? In answer to Dr. Chase's point that Canadians do get the health care that we need, but perhaps not as fast as we want it, he replied that this is inadequate, since in fact many people may become more ill while they wait.

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There are some cases where waiting is dangerous, and on what basis should these be arranged in priority? This is, of course, acknowledged by Dr. Chase, and the Canadian government is trying to reduce waiting times, in some cases giving guarantees, especially for cancer treatments.

An article in the *Globe and Mail*, November 22, 2007, highlighted the waiting time for treatment of prostate cancer patients. Canada's health ministers have set a goal of four weeks, but 70% of the hospitals surveyed do not meet that goal. The problem is that while the wait will not harm some patients, it will harm those whose cancers are fast growing. Compounding this problem is the fact that radiation oncologists recommended a two-week wait, but the standard was set at four, leaving those with prostate and other forms of cancer more concerned than ever. The public is under the impression that breast cancer patients receive faster care, perhaps because they are seen to have a higher profile. This is not the case: according to another article in the *Globe and Mail*, only 53% of hospitals meet their wait time standards for breast cancer patients. The Conservatives had said that they would work with the provinces to bring in guaranteed wait-times, but without extra money for the initiatives the provinces find it difficult to comply.

There are countless other examples of severe problems, including the fact that Ontario, for example, because of expense, does not provide certain drugs for some forms of cancer, available in other provinces. Not only do these patients receive second-class treatment, but the province is unable to participate in important clinical trials, vital for improved treatment of patients.

These few facts are but the tip of the iceberg. As a society, we are aware of the problems. The challenge is to find a solution. Is more money in the system the best approach? The Romanow Report thought that better management would be the answer. Many hospitals have already improved management, and have cut back as far

as possible in many situations: more money is poured in, but there never seems to be enough. We must take into account Janice McKinnon's point that we increase the amount allocated to the health care system to the detriment of other essential social services such as education and housing. Those areas have their own tales of woe. The major question that arises is: is it time for another overhaul of the system, or is it time for a new system? What is the evidence from other countries similar to Canada? What problems, if any, have surfaced because of their two-tier systems? How have some of these problems been resolved, if at all? Is there a truly universal system in place in any country similar to Canada, without private or user-fee components? What have the results been?

A future "Bioethics Matters" will continue this discussion, initiated by John Kyle and Claudette Chase at our annual lecture. We will try to provide some answers to the questions raised there. We realize that this can be an emotional area, with strong feelings on each side, and that dimension must also be recognized. This debate cannot be just about economic possibilities, since fundamentally any health care system must aim at what is best for us as individuals with responsibilities to the rest of society. As Catholics we are always aware that we have the responsibility to look after our neighbours as ourselves. That is demanding, but for us that is always part of the picture. However we proceed, there is no doubt that the most important focus must be health CARE. Our emphasis will always be on care of the whole person, and any system that achieves that will be reasonable and just.