

**Health Care:
A Right, Not a Commodity**

By Senator Douglas Roche O.C.

An Address to the Senate of Canada

June 6, 2002

Honourable Senators,

As I enter the current health care debate in the Senate, I want to state at the outset that health care is a right, not a commodity. The values of Canadian society that built the medicare system must be protected from, not subsumed into, the new marketplace conditions. As we go forward in meeting the new challenges to health care, let us immediately reaffirm that governments have an obligation to use sufficient resources to implement health policy for the common good of all. The debate about health care reform involves the renegotiation of the social covenant defining social obligations and commitments between government and society.

This debate is taking place in a period of phenomenal growth in medical science and technology, which offers a range and level of health care that Canadians of previous generations could only dream of. But the promise of better care does not come without a price tag. The amount of the bill, when it must be paid, how and by whom, has been the subject of intense debate across the political spectrum and has been studied by the Social Affairs, Science and Technology Committee for two years.

With the tabling of Volume Five, the Committee provided a guide to moving forward on these questions. I was heartened yesterday to learn that the Canadian Healthcare Association, which represents a broad range of

health system managers and trustees, supports 18 or the 20 Principles elaborated in Volume Five. In offering some thoughts on Volume Five, I want also to make some suggestions for Volume Six, which will present recommendations on the financing and restructuring of health care. First, let me commend the Committee members and staff on the work they have done and also thank the Chairman for bringing before us such highly qualified experts. I would also like to praise the Commission on the Future of Health Care in Canada, which I attended when the Commission held hearings in Edmonton. I was very impressed with Roy Romanow's work and look forward to his main report.

The health care debate thus far has been essentially one about money. The list of what we expect from our health care system, and hence its cost, is growing and can only continue to grow as new technologies and treatments become available, our population ages and Canadians become better informed and thus more demanding of better quality and timely access to their health care system.

But funding has not grown at the same rate as our expectations. It is certainly true, when considering tax transfers, that the Federal Government has largely restored health care funding to the level it was at before the cuts in the mid-1990s to reduce the deficit. The Government increased its cash

contribution to health care to \$12.5 billion in 1998, invested an extra \$11.5 billion in 1999, injected \$2.3 billion into the Provinces to help bring health care technology up-to-date in 2000 and is increasing the total “Canada Health and Social Transfer” by \$21 billion between 2000 and 2005.

Although very welcome, in the face of rising cost pressures, even this increase is inadequate to maintain the health care system as we know it. It is a fact that waiting lists continue to grow. Our health care system is at an important juncture and tough choices must be made.

However, agreement typically ends here. At one end of the spectrum are those who say the system is in a “crisis” and that costs are spiralling out of control. At the other end are those who claim that the system is fine where it is and, with a few inefficiencies ironed out, it is perfectly sustainable. I believe the answer is somewhere in the middle. The health care system is definitely under stress, but it is not in “crisis” and no dismantling is required.

Many terms are used interchangeably in the media and in discussions about what our options are: public, private, payer, insurer, for-profit, not-for-profit, etc. This confusion hints at the complexity of the subject. However, there has been an oversimplification in terms of the options being placed

before Canadians. The choice has been boiled down to one between injecting more money into the system or accepting a parallel private one.

The Volume Five report puts it this way: if the government decides not to fully implement all the principles, especially Principle Number 20—the “care guarantee”—then we are effectively choosing the continued rationing of services and continued lengthening of waiting lines that characterize the status quo. But we are entitled to step back and ask why we are hinging all we are saying about health care on this one guarantee. Surely, guaranteeing a national home care system would produce a better result. Could it not be that we are setting ourselves up by saying “all or nothing?” Considering that some experts “fundamentally disagree” with some of the 20 Principles outlined in Volume Five, this could very well be the case. In other words, there are elements that lie outside this clean distinction, and by simplifying our challenge as an either/or issue we are doing little to reduce the complexity of the decisions facing us.

The reason why our task is so complex is that the question of health care reform is essentially one of values. The health care debate has so far been largely limited to one of private versus public funding. It is not, as some incorrectly claim, an exercise in choosing one over the other—we already have both. This is a fact often lost in the discussion. More

precisely, and as Volume Five correctly states, where best to draw the line between public and private involvement in the health care system is *one* of the issues that must be addressed in the overall debate about health care reform. To do so in a way that benefits all Canadians and ensures the best quality care demands a close look at what we value as a society and what those values say about reform.

Although Volume Five states that it wishes to avoid this “uniquely Canadian” debate over ideology, it nonetheless touches upon it—as it should. The fact that Volume Five does not recommend user-fees or private insurance is an expression of Canadian values.

Honourable Senators, values are a necessary component of public policy-making, since we are tasked with making decisions for others. In this case, we are charged with ensuring the health of all Canadians and are thus involved with an emotionally charged issue that necessarily invokes a discussion of Canadian values. This is a good thing. We have to understand the values which have brought us to where we are, and we must refer back to them as we move forward with recommendations for the future.

A constant challenge from witnesses who commented on Volume Four was to change the focus of the discussion from the marketplace toward a discussion of the core Canadian values that underpin the health care

system. It was rightly said that an understanding of these values and a critical analysis of new and emerging values can clarify our objectives and thus provide a map to guide us through the funding options for health care reform.

So what do Canadians value when it comes to funding health care?

Dr. Nuala Kenny, Chair of the Department of Bioethics at Dalhousie University and former Deputy Minister of Health for Nova Scotia, summed them up for the Committee. The first value is one of “collective responsibility” or “solidarity.” There is a sense that we are all in the same boat, and when we are talking about health care, we are in fact talking about *all* Canadians.

A second key value is “fairness,” which is understood as *equity* – a belief that we should treat people the same while taking into account individual differences.

Third, we value “compassion.” This is the human dimension of health care – the recognition that the health care encounter touches on fundamental experiences related to illness, dependence and mortality. It is this human dimension that we risk losing in an increasingly commercialized view of health care.

The fourth Canadian value is one of “efficiency” in how the system manages its resources. The Canada Health Act makes an important point about efficiency: it expresses the conviction that delivering this kind of a good is done better by the state than by the market.

Of course, it is the myriad of issues surrounding this last value that grab the headlines and around which the Committee has focussed its energies. But what are we aiming for in health care reform? Is it more efficiency? More caring, more accountability, more choice? Or is it something else?

The Volume Five report does an important job in examining the single-insurer concept and in trying to come up with a better mix of public-private health care delivery. But we must also focus on other core values and use them to define our objectives before we get into any implementation exercise that would serve to undermine them.

I am specifically worried that a drift to what Dr. Arnold Relman, Professor Emeritus of Medicine and Social Medicine at Harvard Medical School and Emeritus Editor-in-Chief of the *New England Journal of Medicine*, referred to as the “commercialization” of medicine and of health care systems. I was surprised that the testimony of such a distinguished witness did not find its way into the report.

I share Dr. Relman's concern that "commercialization" would compromise other values that do not necessarily involve a price tag. Zeroing in on these values is an essential exercise in ensuring that any recommendations have relevance in the Canadian context. In other words, we have to address the troubling disconnect between talk of values and talk of reform if reform is to be effective. On this point, I would like to commend the Ecumenical Health Care Network for its work on a covenant of Canadian values that underpin the health care system. The Romanow Commission is taking the idea seriously as a way to help underpin the values that need to be affirmed in organizing reform.

To date, the dominant language of reform has in fact been the language of the market. The notion is that we can simply transplant the logic of the marketplace into the health care system and thus introduce a degree of competition that would theoretically lead to greater efficiency. Let Adam Smith's "invisible hand" do the work. Although it seems to work well for fast-food chains, cars and coffee, I would suggest—and I think most Canadians would agree—that health care represents a unique social challenge that is not readily adaptable to market logic.

It is no surprise that market values are often embraced when talking about health care reform. They are widely embraced in our society and

provide the fuel for liberal democracies throughout the world. But health care represents an entirely different challenge. With health care, we are talking about a “public good” provided to all without exclusion. But the market, by its very nature, *is* exclusive—goods go to those who can afford to pay for them. In other words, we cannot simply impose market mechanisms on health care, as we do with other sectors of the economy, and expect the creases to be ironed out by the laws of supply and demand. Regulations may promise some degree of confidence to market advocates, but the fact remains that governments are best-suited to providing social goods, whether education, security, or health.

Of course, in practice, there are aspects of our health care system that are “for-profit.” Hospitals, for instance, have to make up some 30 percent of their own budgets by turning a profit at the cafeteria, or by renting television sets and private rooms. But the difference is that this profit is re-invested into the hospital and thus the bottom-line remains the care of patients and not dividends paid to shareholders. The key then, is to ensure that market values do not interfere with other important values.

Take the market value of “choice” for instance. Who could argue against increased choice, unless of course we consider that choice is often congruent with privilege? User fees, privatized services, medical savings

accounts: these can all increase choice—for those who can afford it. Where does this leave the value of “fairness?” To quote the editorial in the May 28, 2002 issue of the *Canadian Medical Association Journal*:

The trouble is that health care is such a complex and fatally *human* institution that any attempt to “rationalize” any part of it has unintended consequences.

The recent study by Dr. Philip Devereux of McMaster University and published in the same issue of the *Canadian Medical Association Journal*, suggests a higher death rate in for-profit hospitals. This finding should serve as a warning to those would implement reforms without first understanding their consequences.

This view was reinforced for the Committee yesterday when it heard from Sharon Sholzberg-Gray, President and CEO of the Canadian Healthcare Association. Her organization is very much opposed to Volume Five’s Principle Number 13, which—if implemented—would create “internal markets.” I certainly do not want “internal markets” to be an invite to private corporations to flood the system.

The Association urged the Committee to consider the inherent problems with internal markets and the United Kingdom’s failure in trying to implement them. All the evidence suggests that, by creating this extra market layer in the health care system, we would be driving up costs. With

regard to the Association's concern with Principle Number 8—service-based funding—it appears as if the Committee and the Association are closer than originally thought in light of yesterday's meeting.

I come back to my essential point: we must let our values guide us if we are to clarify our objectives and thus provide sound recommendations in Volume Six as to how the system should be financed. In recommending solutions that only address economic efficiency without first studying their potential impact on other core Canadian values, we will have made little progress. We must strike a balance between the efficiency needed for economic sustainability and the moral and ethical demands of health care.

Framed this way, the financing debate can lead to only one conclusion. Since we value health care as a public good, and since the government most efficiently provides them, it is government that must lead the reinvestment in health care system. Along with restructuring and better efficiency, Canadians want the medicare system widened. The provision of home care for those who cannot take care of themselves but who do not need the services of high-tech hospitals should be publicly funded in an appropriate manner. This would meet a growing need and reduce hospital costs. The May 27, 2002 Pollara survey that found some 70 percent of

Canadians willing to pay more to improve health care is a reassuring sign that the Government would have public support.

The Federal Government certainly has it in its capacity to properly finance health care—all it needs is the political will to implement it. A dedicated tax that is equitable should be instituted.

We are currently hearing calls for more government spending on the military. This must not be done at the expense of meeting the health care needs of Canadians. As the Prime Minister correctly stated, the military must compete with other spending priorities. In giving priority to the health of Canadians, the government would be sending a clear signal that it intends to remain the guarantor of a health care system for all Canadians.

The nature and humaneness of the society in which current and future generations will live will depend on such decisions.