Healthcare Reform in Canada: The Romanow Report

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The recent history of the Canadian healthcare system has been increasingly one of shortages. There are delays for services that impose risk and hardship, disparities between the accessibility of healthcare for rural versus urban populations, and a lack of adequate coverage for or access to prescription drugs, diagnostic services, and homecare. Add to these problems shortages of healthcare providers—in particular, physicians and nurses—and state-of-the-art equipment, and we can understand the universal agreement that the Canadian healthcare system must change. The only question is how. Some argue for modifications within the basic framework of a one-tier single-payer system; others for more radical reform that will allow for infusions of money by expedients such as user fees, extra billing, or a full-blooded second tier where one can buy any healthcare one wants.

The Romanow Report, *Building on Values*,[1] which appeared in the fall of 2002, is the result of a Royal Commission on the Future of Health Care in Canada and constitutes the latest, most extensive and distinguished of a series of studies made of the Canadian healthcare system. Supporters of Medicare breathed a collective sigh of relief when the report was released, as it came down firmly on the side of preserving the main contours of the system, while recommending transformative changes to the details to make it more efficient, expansive, and sustainable. The report makes 47 recommendations. Of these, four deserve special mention.

First, the report recommends that a Canadian Health Covenant be written, expressing Canadians' collective vision for healthcare and outlining the responsibilities and entitlements of individual citizens, health providers, and governments in regard to the system. This is not proposed as a legal document, akin to a Bill of Rights. Rather, it is intended to secure the agreement of citizens and (especially) premiers of provinces that the Canadian healthcare system should follow the basic principles of the Canada Health Act.

Second, there is a proposal to modernize the Canada Health Act. This act, which came into being in 1984, consists of five principles that define the Canadian healthcare system:

1. Public administration: All medically necessary services are insured by a single payer.
2. Universality: Everyone who is covered by the healthcare system is covered in the same manner and under the same terms.

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3. Accessibility: There are no financial barriers (e.g., user fees, extra billing) to accessing healthcare services.

These three principles constitute the heart of the act. Articles 2 and 3 express a commitment to equity, and amount to the assertion that essential healthcare services are available on the basis of need and need alone; article 1 is advanced as the most efficient means to give that commitment practical effect. Romanow does not tinker with these principles but recommends changes to the remaining two principles and the addition of a sixth.

4. Portability: This principle guarantees mobility rights. Under the existing act, those insured by the healthcare system are covered (at their home province rate) for healthcare wherever they may be inside or outside of Canada. Romanow recommends enhanced portability within Canada to remove the inconvenience Canadians sometimes meet in provinces by having to pay out of pocket and subsequently seek reimbursement, as well as eliminating out-of-country coverage.
5. Comprehensiveness: The act covers all "medically necessary services." What falls under this description is a matter of contention, and importance. If services are medically necessary, Canadian nationals are entitled to them but cannot purchase them; if they are not medically necessary, Canadian nationals are not entitled to them but can purchase them. Historically, Medicare was brought in to cover physician and hospital costs. But the realities of modern medicine require an expansion of these costs, and Romanow recommends that "medically necessary services" be immediately expanded to cover diagnostic services and homecare, and later to include prescription drugs and improved access to healthcare for those living in rural and remote parts of Canada.
6. Accountability: Under this proposed principle, Canadians will be provided with a transparent account of how the system is administered, financed, and delivered and of who has responsibility for what. In a democracy, the people are the rulers and hence entitled to decide how their money is to be spent on their health. They must therefore have full information about the workings of their healthcare system. It is unacceptable, albeit common, to have decisions about the delivery of healthcare made by unidentified individuals, in secret, without consultation, on invisible principles.

The third principal recommendation of the Romanow Report is that the federal government commit to funding a minimum of 25% of the cost of insured health services under the Canada Health Act by 2005/2006, with a built-in escalator to ensure more stable and predictable funding. This money comes with strings attached. Provinces will get the money only if they agree to funnel it into initiatives in five key areas: access to care in rural and remote areas, decrease in wait times for diagnostic services, primary healthcare delivery, a national homecare strategy, and assistance for patients facing catastrophic drug bills. The increase in federal funding also increases the only real control—the threat of withholding funds—that Ottawa has over wayward provinces tempted to cut corners on the Canada Health Act.

Fourth, and finally, Romanow recommends the creation of a Health Council of Canada. Its function would be to monitor and report on the quality of healthcare in Canada, make recommendations regarding improvements, assess technology, and serve as a conflict-resolution mechanism for disputes among governments, providers, and citizens.

Romanow recommends that the Canadian healthcare system continue to be funded by progressive taxation. He considers a number of suggestions about alternative ways of paying for healthcare services: user fees, extra billing, medical savings accounts (where individuals are allotted a yearly healthcare allowance from which they can "purchase" healthcare services), and tax-based copayments, tax credits, and deductibles (where the cost of the health services individuals receive in a year would be added to their taxable income). But he rejects all of these on the grounds that they will deter individuals from seeking healthcare and make access dependent on ability to pay rather than on need alone.

Romanow stops short of recommending increased taxation. He anticipates some cost containment by elimination of waste (e.g., duplication of services, purchase of cost-effective technology), an increased emphasis on preventative healthcare (e.g., discouraging smoking and obesity, encouraging active lifestyles), and enhanced primary care that will keep patients out of emergency rooms and hospitals. But Romanow also sets the stage for increased taxation when he says that Canadians told the Commission that they are prepared to pay more for healthcare to ensure the system's sustainability, provided the system changes to meet their needs and expectations.

That is the essence of the Romanow Report. What should we think of it? A full evaluation would require expert opinion about health economics, epidemiology, constitutional law, and more space than is available here, but we can take a brief look at it from the point of view of justice.

Daniels has argued that society has a general social obligation to ensure that its members have fair equality of opportunity.[2] Given that disease and disability prevent one from functioning in a way that is normal for human beings, and thus deprive individuals of equality of opportunity, society has the specific obligation to provide healthcare to all its members. Judged by this standard of justice, the Romanow recommendations do very well. They provide for a system that guarantees all Canadian nationals all medically necessary treatments in a hassle-free way that does not tie them to their jobs or location in Canada.

But judged by other standards of justice, the recommendations do not do well at all. A libertarian such as Nozick,[3] for example, will argue that, because individuals are not allowed to spend their money on medically necessary healthcare when the public system does not deliver what they want, the Canadian healthcare system is unjust. On this view of justice, individuals have the right to possess anything they justly acquire, and the right to enter into voluntary agreements with others to exchange what they rightly possess for anything others rightly possess and are willing to give in return. No state can properly infringe these rights. Given that a one-tier system with finite resources will necessarily violate the second of these rights, justice requires two-tier healthcare. Such a system will lead to unequal access to healthcare, but it does not follow that this is unjust. For any result arrived at by just steps must be just. Thus, if one justly acquires property and justly exchanges it with another

for that person's services, any inequality that may result must be just. Indeed, any attempt to impose some pattern of distribution will violate one or the other of these rights, and so be unjust.

Nor does Romanow's recommendation for a one-tier healthcare system automatically follow from an egalitarian theory of justice. The argument is often made that opening a second tier that allows individuals to buy the healthcare they want will shorten waiting lists and improve services to those in the public tier, and thus everyone will benefit. Some will benefit more than others, but it is unattractive to argue that, because everyone will not benefit equally, no one should benefit at all. Thus if egalitarians allow, as does Rawls,[4] for deviations from equality if that will be to everyone's advantage, an egalitarian can support two-tier healthcare.

Finally, Romanow's recommendation for a one-tier healthcare system will be opposed by those like Engelhardt[5] who argue that two-tier healthcare is the most just compromise between irreconcilable principles, even if not everyone benefits from the inequality. Egalitarians are concerned to maximize equality; libertarians, to maximize liberty. But because the goal of providing equal care for all is inconsistent with the goal of providing unimpeded freedom of choice on the part of healthcare providers and consumers, and given that there is no decisive way of saying which goal should take priority over the other, the only just thing to do is split the difference. This (the argument goes) leads to a two-tier healthcare system that will provide basic healthcare for all, as good as communal resources will allow, and at the same time not interfere with individuals' freedom of association and use of private resources.

Reasonable people of good will may be attracted to these alternatives, and Romanow does not provide detailed arguments against them. He saw his central mandate as making recommendations "to ensure the long-term sustainability of a universally accessible, publicly funded health system," not to choose between alternative ways of delivering healthcare. But the outline of his objections is clear. Two-tier healthcare is unacceptable because it is inefficient, thereby increasing administrative costs and hassles for consumers and providers alike, and Canadians do not want one kind of healthcare for the wealthy and another for the poor.

This mixture of pragmatism and moral vision does not make for a philosophically satisfying basis of a healthcare system. Efficiency is not everything, as Americans show when they continue to have an inefficient healthcare system rather than restrict individual choice.[6] And wants, which are quite changeable in any case, do not determine what is just. It may nonetheless have been the course of wisdom for Romanow not to have tried to provide a deeper basis. Not only would that have been difficult to do, but, given that Canadians are happy with the egalitarian underpinning of Medicare, why should he do anything more than show that Medicare can be improved and sustained in practice? And why should Canadians move to any other healthcare system if those things can be done, when no other system promises to be more agreeable to them, and all have the potential for being less so?

Still, hard questions remain. The Canadian healthcare system is not designed to deliver high-end Mayo Clinic medicine. As long as it does not, some Canadians will hanker after two-tier healthcare and ask why, as a matter of justice, they cannot spend their money to buy better healthcare when they can do so in any other matter, including the determinants of health. What is special

about healthcare that Canadians should be so egalitarian about that and nothing else? To answer these questions, a deeper analysis of justice is needed, and until it is provided, the debate about healthcare in Canada will not be over. But Romanow does not have to settle that debate once and for all to give Canadians sufficient reason to sign onto the Canadian Health Covenant that is supposed to kick off the new era of healthcare in Canada and to politically seal the fate of the Canadian healthcare system for the foreseeable future.

Notes

1. Romanow R. *Building on Values: The Future of Health Care in Canada—Final Report*. Ottawa: Commission on the Future of Health Care in Canada; 2002.
2. Daniels N. National health care reform. In: Veatch R, ed. *Medical Ethics*, 2nd ed. Sudbury, MA: Jones and Bartlett; 1997:chap. 14, 421.
3. Nozick R. *Anarchy, State, and Utopia*. New York: Basic Books; 1974.
4. Rawls J. *A Theory of Justice*. Cambridge, MA: Harvard University Press; 1971.
5. Engelhardt T. *The Foundations of Bioethics*. New York: Oxford University Press; 1986:chap. 8.
6. For an account of efficiency as a virtue, and argument that it is the chief characteristic of Canadian society that makes Canada as close to utopia as is achievable on Earth, see: Heath J. *The Efficient Society*. Toronto: Penguin; 2001.