Ethical Consistency, the Canada Health Act and Resource Allocation: Arguments for a Rights-Based Approach to Decision-Making

by

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ABSTRACT

The purpose of this work is to show the importance of ethical consistency and its application in the decision-making process when allocating health care resources with respect to the Canada Health Act. Based on the specific decisions in its history and the development of its principles, I suggest that the Act can be interpreted as indicating a particular moral basis and that this could have an influence on how resources are allocated. I will focus on three claims supporting the argument that services can be delivered in a consistent and methodical manner that respects this particular moral foundation. First, the outcomes of decisions justified by simultaneous use of logically incompatible and distinct moral theories are problematic. I suggest that an approach to reasoning that uses one type of moral theory throughout the decision-making process results in less ambiguous outcomes. Second, based on key points in the history of the Canada Health Act, I believe there is a moral theory, deontological in nature, and that it captures the spirit behind the Act's development and current formulation. Third, decision-makers in Canada should follow one deontological theory when allocating health care resources to avoid inconsistencies, and to work within the moral framework of the Act as I have interpreted it. A delivery system that consistently follows this procedure may have different outcomes than the current methods of macro-allocation, and these differences may have effects on the amount and availability of health care services.

Examiners:

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Acknowledgments

This work is for Adam, Adam, and Mike; Zach and Tom; Courtney, Eddie, and Dave, without whom it would never have been finished. I would also like to thank Patrick McGoohan, number six, for offering hope and inspiration. But most importantly, it is dedicated to my mother—she is the turtle on whose back my world rests.

Introduction

Health care service delivery in Canada is an important ministration that is currently the focus of public scrutiny. The purpose of this work is to show the importance of ethical consistency and its application in the decision-making process when allocating health care resources with respect to the Canada Health Act.[1] Based on the specific decisions in its history and the development of its principles, I suggest that the Act can be interpreted as indicating a particular moral basis and that this could have an influence on how resources are allocated. I will focus on three claims supporting the argument that services can be delivered in a consistent and methodical manner that respects this particular moral foundation. First, the outcomes of decisions justified by simultaneous use of logically incompatible and distinct moral theories are problematic. I suggest that an approach to reasoning that uses one type of moral theory throughout the decision-making process results in less ambiguous outcomes. Second, based on key points in the history of the Canada Health Act, I believe there is a moral theory, deontological in nature, which captures the spirit behind the Act's development and current formulation. Third, decision-makers in Canada should follow one deontological theory when allocating health care resources to avoid inconsistencies, and to work within the moral framework of the Act as I have interpreted it. A delivery system that consistently follows this procedure may have different outcomes than the current methods of macro-allocation, and these differences may have affects on the amount and

[1] The Canada Health Act may be shortened to either the CHA or referenced as the Act for the remainder of this work.

availability of health care services. I suspect that the current procedures are *ad hoc* and politically influenced; thus may not be ideal methods for service delivery.

I will discuss the three claims in the following manner. The first claim examines the importance of structure and consistency in the decision-making processes. There are two main reasons why this is important: the practical use of resources and the ethical implications in decision-making processes. When making allocation decisions, limited health care resources must be used judiciously as wasting limited funds can lead to serious consequences. I suggest that an approach based on one theory is more consistent and creates less conflict in the decision-making procedure. This in turn has implications on the direction and availability of resources. A streamlined and ethically consistent decision-making process produces fewer discrepancies and a more valid allocation of funds. To support this claim I will examine two different approaches to ethical analysis, a single-theory and a mixed-theoretical approach. I will examine the differences between the two methods and argue that the former is a more consistent guide for resource allocation decisions.

I have chosen two particular types of moral theory, deontological and utilitarian ethics, because these are the two theories that frequently come into conflict in health care resource allocation. Often these theories have opposite criteria for what constitutes the morally correct action/non-action. I will create a template detailing particular features of utilitarian and deontological theories to assist in understanding indicators of each theory. Using separate deontological and utilitarian approaches, I will analyse the five principles of the CHA (portability, universality, public administration, comprehensiveness, accessibility) in order to demonstrate logically distinct definitions

of the two moral theories. The difference in these definitions will be an example supporting the claim that consistency in the decision-making process is best served using one theory only.

While working on a HEALNet research project, I gathered empirical data in the form of interviews with chief executive officers (CEOs) of different health care regions. I have selected one as a case study for an ethical analysis to see how possible inconsistencies can occur.[2] I will apply the template to the CEO's responses and then list examples that suggest deontological or utilitarian influences, as well as instances that are indicative of combining distinct moral theories (should they occur).

My second major claim is based on the Canada Health Act. I will give a brief discussion of its history, concentrating on key points from amendments to the 1934 Rural Municipality Act in Saskatchewan to its current form passed in 1984. I will highlight these points and note the possibilities of ethical considerations in their development. If there are such indications, then the template created in the earlier section will suggest their correspondence to a deontological or utilitarian theory.

I will discuss the possible effects of inconsistency on the amount and availability of health care resources to support the third claim. I will argue for a single theory approach, deontological in nature, as the best guide for decision-makers to use when allocating resources. I will review information from the interview and discuss how both the CEO's and the board's reasoning lead to particular results and how these may differ

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[2] Due to the structure and limits of this thesis work I have chosen to include one case study and not to cross-reference all six interviews. The purpose of this thesis is to have an opportunity to examine a real life situation. It is not to assess the six interviews, as that would be a separate project in itself. For an examination of all six interviews see Kluge and Tomasson. "Health Care Resource Allocation: Complicating Ethical Factors at the Macro-Allocation Level."

from the suggested method. I will then discuss why this difference is important in the delivery of health care services.

The thesis will take the following structure: the Introduction will continue with a brief mention of the Canadian literature on resource allocation in health care. It is useful to present the research of health care decision-making in Canada. For the purpose of this work, it is important to see how the Canada Health Act relates to these processes. I will begin the first chapter with a general discussion of deontological and utilitarian ethics and their application to resource allocation in health care. In the second chapter, I will discuss the particular type of deontological and utilitarian indicators I will use in creating the template. This will then be used to analyse the history of the CHA and the CEO interview. I will conclude the chapter by discussing the different approaches of ethical analysis and the merits of the single-theory procedure. In the third chapter, I will present key points in the history of the Canada Health Act from 1934 to 1984, with indications of ethical considerations in the Act's creation. I will end the chapter with the application of the template as evidence of whether a deontological or utilitarian theory best fits the spirit of the CHA. My focus in the fourth chapter will be on the case study of the CEO and allocation decisions made by the CEO and the regional health board. In the fifth chapter, I suggest that health care decision-makers ought to use a process based on a deontological interpretation of the Canada Health Act. Although the Canada Health Act may be interpreted from different moral perspectives, I will argue that the single-theory deontological approach is most compatible with my interpretation of the Act's development. I will advocate for this approach as the best method, even though a mixed-theoretical approach may support identical processes for allocating resources

within the Act's framework. I will conclude the chapter with a discussion of the effects of consistency in the decision-making process with respect to service delivery and resource allocation. In the last chapter, I will re-examine the three claims in support of the main thesis. I will summarise the discussion and findings to see whether the three claims have been substantiated. I will also suggest directions for future research.

General Discussion of Allocation in the Canadian Health Care Setting

Little research examines whether there is an ethical theory underlying the Canada Health Act. Discussions of the Act occur primarily in contexts outside of philosophy, although, the Act is mentioned in texts meant for Canadian courses in bioethics. One such text is the second edition of Kluge's Readings in Biomedical Ethics: A Canadian Focus, and the other is Baylis et al.'s Health Care Ethics in Canada. The former includes parts of the Canada Health Act pertaining to the five principles. The latter mentions the Act in the introduction to Chapter Three, "Health Care in Canada":

> The core values in the Canada Health Act comprise a moral vision of health and health care. In Canada, health care is regarded as a common good to which all of us, as moral equals, are entitled. The public system of health care displays our shared concern and responsibility for one another and differentiates Canada from the United States, where health care is regarded more as a commodity. (Baylis et al. 75)

This is an important citation because most of the work on resource allocation has been done in reference to the American system, different from the Canadian one, as noted by Roy, Williams, and Dickens, who claimed; "... the Canadian system has founded upon a principle of public ethics to which the Canadian people fiercely adhere" (95). They

introduce the five principles as "[t]he principle features of Canadian Medicare, as originally included in the Hospital Insurance Act and reaffirmed in the *Canada Health Act*, derive from the health care system's fundamental principle of equality" (Ibid.). Trish Reay also mentioned the Act in her work, "Allocating Scarce Resources in a Publicly Funded Health System: Ethical Considerations of a Canadian Managed Care Proposal", where she explored an alternative to fee-for-service payment. The moral interpretation of the Canada Health Act is not the focus of these pieces, and there is no mention of whether there is an ethical basis to the Act.

Findings commissioned by the province of Quebec examined allocation issues. Pran Magna, in 1987, wrote a paper for this commission entitled The Allocation of Health Care Resources: Ethical and Economic Choices, Conflicts, and Compromise. This work examined allocation issues and discussed rights to health care at a theoretical level. The Canada Health Act is mentioned, but is not the focus of the discussion. This work is interesting as the time of this commission is just after 1984 when the Act was passed. At the same time, the Canadian Medical Association requested that a task force examine resource allocation and present their findings in Health: A Need for Redirection. The recent release in 2002 of a Royal Commission titled Building on Values: The Future of Health Care in Canada (Final Report), (the Romanow report), added to the discussion. It concentrated on the future of health care and suggested the addition of a sixth principle in the Canada Health Act: accountability.

I found that most work in this area was performed outside of philosophy. Despite the use of a moral theory in the title, "Utilitarian Theories Reconsidered: Common Misconceptions, More Recent Developments, and Health Policy Implications" (from

Germany) this work by Gandjour and Lauterbach did not present a philosophical analysis. Other studies that mention utilitarian reasoning processes are "Ethical Issues in the Economic Assessment of Health Care Technologies" (Moatti), and "Evidence-Based Medicine: Excessive Attraction to Efficiency and Certainty?" (Nord). However, these articles do not present in depth analyses regarding utilitarian moral theory.

There have been two studies in the context of Canadian resource allocation that should be noted. One led to two publications by Mitton and Donaldson; "Setting Priorities in Canadian Regional Health Authorities: A Survey of Key Decision Makers" in Health Policy, and "Resource Allocation in Health Care: Health Economics and Beyond" in Health Care Analysis. In the second article the investigators proposed to "develop an explicit, evidence based approach to priority setting to aid decision-makers in the process of resource allocation across major service areas at the level of the entire health authority" (246). The work focused on how allocation decisions were made in the Calgary setting, not their ethical validity. In the first article the authors pointed out the lack of priority setting skills at the regional level, and the lack of work conducted (40). It is important to note that for this work the Canada Health Act is not mentioned as a factor in the priority setting process.

The most interesting and appropriate study found is a pilot project on Prince Edward Island where an ethical framework to help guide the region was created and implemented. The study, "Incorporating Ethics in Priority Setting: A Case Study of a Regional Health Board in Canada" by Michael Yeo, John R. Williams, and Wayne Hooper found that despite the best of intentions, political factors and other priorities

hindered the program's full acceptance. The Canada Health Act was not mentioned when choosing the region's guiding principles.

Another work, although not yet published, promotes a model of decision-making directed at government employees whereby principles can be inserted into a specific area in a flow chart layout of the decision process. Ted Shrecker and Margaret A. Sommerville prepared work for the Department Executive Sub-Committee on Policy Analysis for Health Canada: "Ethical Analysis of Health Issues: A Proposed Model." Their work took a case of climate change and human health and ran it through their multi-state model for analysis. One theory that could be explored by the government is Benjamin Freedman and Francoise Baylis' work, "Purpose and Function in Government-Funded Health Coverage" included in both Readings in Biomedical Ethics: A Canadian Focus and Health Care Ethics in Canada. It was concerned with allocation in the Canadian health care system and the claim that the "functional approach" would help in the difficult task of demarking service limits. Again, this work examined resource allocation in the Canadian context but it failed to incorporate the Canada Health Act. One article that examined resource allocation within the Canadian context is "Macro Allocation in Health: An Ethically Based Model" where the authors submit an allocative mechanism that works with their interpretation of the Canada Health Act. It is an appropriate device that could function to allocate resources within the framework that my thesis is supporting – a deontological one. The Canada Health Act was discussed in conjunction with other considered principles in the area of macro-allocation making the article relevant to this work. With the focus of the current political climate

on possible challenges to the Act, it is important to isolate and identify exactly what is being challenged.

This introduction has presented an outline of my thesis and provided an account of how I intend to defend it. My main claim is that Canadian health care service delivery may be impacted by conflict in the decision-making process caused by inconsistent methods of macro-resource allocation, and that a better method is one that is both consistent and respects the moral framework of the Canada Health Act. As mentioned, I will present my argument in three parts. One, if decision-makers use more than one moral theory in the decision-making process, then the process is inconsistent leading to a problematic outcome. Two, based on the development of the Canada Health Act there are indications of moral considerations. These are best interpreted with a deontological theory. Three, a single-theory approach that is deontological is the best guideline for decision-makers in Canada to follow. The amount and availability of resources may differ from those of current methods if a decision-maker followed this type of procedure. This difference is important. The process may produce more health care resources and a better ethical defence of their allocation. I will begin the next chapter with the discussion of deontological and utilitarian theories.

Chapter One
Deontological and Utilitarian Theories and Their Impact on Resource Allocation

I will begin this chapter with a description of the basic features of deontological and utilitarian theories and their relevance to health care resource allocation.[3] I will give brief descriptions of particular deontological or utilitarian perspectives and then discuss how they differ in their approaches. The purpose of this discussion is to demonstrate that deontological and utilitarian theories can be defined in a number of different ways and refer to a number of different approaches. To avoid confusion I will create my template by choosing certain indicators from each theory. The philosophers who work in the deontological tradition that I will discuss are James Childress, Norm Daniels, and H. Tristram Engelhardt Jr. In Chapter Ten from Practical Reasoning in Bioethics, Childress wrote that human dignity is the element that limits considerations of social utility and asserts that a lottery or a queue is the best means to promote fairness and respect individuals' dignity when allocating scarce resources.[4] Daniels outlined a theory based on equality of opportunity based on the need to restore human species functioning in his book Just Health Care. There he suggested that there are rights to access a certain amount of health care so that people can fairly enjoy what he called the "normal opportunity range" (33). Engelhardt Jr. based his deontological theory on the ability to enter into mutually respectful agreements. In a secular society where different groups have ideas of what is good, he believes that the best way to treat

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[3] Discussions in philosophy can take up volumes of work, where the slightest distinction is analysed and critiqued. I am limiting myself for clarity and brevity, and do not want to infer that the philosophers mentioned are by any means an exhaustive list, nor are the points mentioned meant to suggest that these are the only relevant issues.

[4] Future references will be from this chapter, unless specified.

people with respect is to come to a peaceful resolution in areas of conflict and, if necessary, to attempt to do the good for that group. He extended this belief and applied it to the government's power to redistribute taxes and allow a certain level of access to services. He is fundamentally opposed to the Canadian system, interpreting the loss of the freedom to choose where one can enter into a contract (insurance policy) as immoral.

The utilitarian philosophers who I will focus on are John Harris, Allan Gibbard, James Fletcher, and Richard Brandt. Harris suggested that equality of opportunity is best served by a needs-based account grounded on the desire to survive, rather than on the capacity to benefit from a particular treatment ("Micro-allocation: deciding between patients"). Gibbard discussed a type of Pareto Principle in support of the idea that access to resources that are not the best available is morally justified. Fletcher wrote that artificial intelligence might be necessary to quantify the myriad of moral values and medical utility. He argued that using computers to calculate social preferences and medical utility might enhance more traditional methods of choosing how resources are allocated. Brandt discussed how to decide whether to provide a defective newborn with the health care resources necessary to survive.

The purpose of discussing these approaches to health care resource allocation is to show how, within particular types of moral theories, there are different views on what defines the morally correct action/non-action. My discussion will briefly touch on some of the issues in resource allocation in health care. I will highlight specific areas: the idea of need, its function in a claim to societal resources, and some of the difficulties associated with deciding how services can be delivered. I claim that inconsistency in the

decision-making process affects the direction of services and is validated by highlighting different opinions on service delivery. The different opinions can suggest different directions for how to allocate funds.

Deontological theories

Although deontological theories can be defined in various ways, the factor common to all is that correct moral action is not dependent on the consequences produced by the action/non-action. As Frankena stated, "... a deontologist contends that it is possible for an action or rule of action to be the morally right or obligatory one even if it does not promote the greatest possible balance of good over evil for self, society or universe. It may be right or obligatory simply because of some other fact about it or because of its own nature" (15). Davis elaborated on this definition in her explanation of deontological theory:

> Many people profess to believe that acting morally, or as we ought to act, involves the self-conscious acceptance of some (quite unspecific) constraints or rules that place limits both on the pursuit of our own interests and on our pursuit of the general good. Though these people do not regard the furtherance of our own interests or the pursuit of the general good as ignoble ends, or ones that we are morally required to eschew, they believe that neither can be regarded as providing us with morally sufficient reason to take action. Those who hold such a view believe that there are certain sorts of acts that are wrong in themselves, and thus morally unacceptable means to the pursuit of any ends, even ends that are morally admirable, or morally obligatory...Philosophers call such ethical views 'deontological'... (205)

Davis, in formal language, wrote that the good of specific actions, although desired, cannot be the reason for action. The constraints on action can often be described as a conflict of rights and there may be different ways for establishing which right

trumps another. The purpose of her statement is to articulate the predominant claim for defining deontological theories.

Rawls, in A Theory of Justice, described a deontological theory as "one that either does not specify the good independently from the right, or does not interpret the right as maximizing the good. (It should be noted that deontological theories are defined as non-teleological ones, not as views that characterize the rightness of institutions and acts independently from their consequences)" (26). Here Rawls points out that although consequences may be influential in deciding the morally proper action, they cannot be the deciding factor.[5] When a person does not have the consequences to direct his or her decision, the notion of duty can describe the reason for taking action. However, different deontological theories offer different definitions of when someone should act out of duty.

An example would be a doctor's dilemma of whether or not to inform the wife of an HIV positive patient of her husband's condition. The doctor has a duty to respect confidentiality concerning his patient (the husband), yet also has a duty to inform the wife who, due to the intimate nature of marital relations, needs the information as she may be in a potentially life threatening situation. Consequently, there are two conflicting rights in this situation: the right to confidentiality and the right not to be harmed. This example also illustrates how the deontological approach tempers considerations of consequences as ethically determining. Thus, the consequences of breaking confidentiality, specifically with regard to the wife's health, are certainly important;

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[5] John Rawls is an important figure in distributive justice and many contemporary works concerning rights and the creation of fair institutions are written in reply to his book, A Theory of Justice. However, he does not mention health or health care as a primary good. The most prominent philosopher who builds on his work in the area of health care is Norm Daniels. Therefore, for this thesis I will concentrate on Daniels' work, but recognise that Rawls is an important foundation of Daniels' ideas.

however, whether this breach can be justified in and of itself would have to be explained in terms of the conflicting rights possessed by the respective individuals.

In health care, deontological theories may employ different approaches to establish claims to health care services, as well as to how conflicts between those claims are resolved. Childress suggested that other considerations cannot override human dignity and presented the case of *U.S. v Holmes* to discuss how society ought to distribute scarce life-saving medical resources. The case involved survivors of a sunken ship who were forced to throw off fourteen men from an overloaded lifeboat in order to ensure the survival of the remainder. The criteria used to choose those sacrificed being that married couples and women would not be harmed. After the rescue the crew disappeared, save for crewman Holmes, who was tried and found guilty of unlawful homicide. The judge declared, "lots should have been cast, for in such conflict situations, there is no other procedure so consonant both to humanity and to justice" (Childress 171). Childress agreed with the judge and suggested that when allocating scarce medical resources a lottery, or natural selection, such as a first-come-first-served system, is the best method for respecting human dignity.[6] Childress identified two stages in allocating scarce medical resources, such as bone marrow for a transplant. First, whether the population pool needing treatment x is medically acceptable would be determined. There would be no point in donating bone marrow if it was known with

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[6] In the book Triage and Justice, Winslow discussed different egalitarian principles, one being "none should be saved if not all can be saved." He wrote about Cahn's ideas regarding the Holmes case and Cahn's opinion that to treat people truly as equals would mean that none should have been sacrificed. Cahn suggested that human dignity is respected if no one innocent person dies. Although Cahn's criterion is similar to Childress', and therefore interesting, it is not a position I accept. There will always be times when the needs of a particular group of people will not be met. I do not believe we should stop transplanting all organs because there is a shortage. Childress himself rejected Cahn's idea as a notion of "heroic or saintly morality" (171).

certainty that there is no compatibility between donor and patient. Second, the natural selection process (lottery or queue) would take place and then from this second group. The process rejects the social value of individuals and is based on a method that respects people as individuals independent of their contribution to, or position within, society. This mechanism, a queue or lottery, is based on random selection only. For this reason, Childress proposed a deontological method of resource allocation because the determining factor is a respect for human dignity and the allocation mechanism is based on chance.

Daniels argued for a right to access to certain health care resources determined by a deviation from normal species functioning, thus preventing people from participating in the normal opportunity range. Daniels began with a principle based on species functioning in which "impairments of normal species functioning reduce the range of opportunity open to the individual in which he may construct his 'plan of life' or 'conception of the good'" (Just Health Care 27). He clarified further; "[t]he *normal opportunity range* for a given society is the array of life plans reasonable persons in it are likely to construct for themselves" (Just Health Care 33, italics in original). Daniels suggested that health care is instrumental in establishing fair equality of opportunity. Disease and disability, especially stemming from bad luck (accident or nature) and not due to irresponsibility, hinder this opportunity. Allowing access to health services to return people, within reason, to normal functioning would be classified as treating people fairly and respecting them as persons. Daniels did not suggest unlimited access to health care, but emphasised that the important feature here is that health care needs form the basis for a claim to some resources at the societal level.

Engelhardt Jr. promoted a different deontological approach. He described two principles, the principle of permission and beneficence. The former was based on the liberty to peacefully enter into mutually respectful relationships (communities) in a secular society. The latter was expressed by the maxim of 'do to others their good,' which is meant to respect individual (or community) decisions as to what is their own ranking of goods. He described these principles in The Foundations of Bioethics:

> Neither the principle of permission nor that of beneficence is justified in terms of its consequences. They rather disclose unavoidable areas of personal conduct. They are in this sense deontological principles: their rightness is not defined in terms of, or justified in terms of, their consequences. However, concrete rules of beneficence are likely to be teleological in being justified in terms of their consequences. Concrete applications of the principle of permission, in contrast, bind, even if they have negative consequences for liberty. The principle of permission, which is justified in terms of the morality of mutual respect, does not focus on freedom as a value, but on persons as the source of general secular moral authority. (119)

Engelhardt Jr. focused on the ability to resolve conflict between persons (communities) without resorting to force or coercion: "[it] is this perspective that justifies the morality of mutual respect" (127). Engelhardt Jr. is a libertarian; he values the freedom to purchase health care and views government taxation as coercion. The government has not entered into a mutually respectful contract that follows the principle of permission. Nor does this respect the individual's idea of the 'good' as there is no freedom to choose services such as insurance plans. The application of this theory of resource allocation is framed in terms of rights to health care services. Engelhardt Jr.

discussed the effects of the natural lottery (natural disease and disability) on claims to such services:

> [W]hen no one is to blame, no one may be charged with the responsibility of making whole those who lose the natural lottery on the ground of accountability for the harm. One will need an argument dependent on the particular sense of fairness to show that the readers of this volume should submit to the forcible redistribution of their resources to provide health care for those injured by nature...The natural lottery creates inequalities and places individuals at disadvantage without creating a straightforward secular moral obligation on the part of others to aid those in need. (380)

Engelhardt Jr.'s theory is deontological in nature and very different from Daniels' interpretation of how to allocate resources. The brief mention of these philosophers demonstrates how a deontological theory can be constructed using different criteria that surpass other considerations.

Utilitarian Theories

In contrast to deontological theories, utilitarian theories base morally right action on the consequences of actions/non-actions to increase the 'good' or at least to decrease the 'bad', for lack of a better term. The 'good' can be pleasure, happiness, health status, preference, or desire satisfaction. Kymlicka stated that, "[u]tilitarianism, in its simplest formulation, claims that the morally right act or policy is that which produces the greatest happiness for members of society" (9). Brandt described why utilitarianism is attractive, "[t]he utilitarian principle provides a clear and definite procedure for determining which acts are right or wrong (praiseworthy or blameworthy), by observation and the methods of science alone and without the use of any supplementary

intuitions (assuming that empirical procedures can determine when something maximizes utility)..." (113). In medical utility the effect of a particular treatment on health status to increase health or decrease health would be calculated. For example, if I gave a flu shot to a population, and the effect was a decrease in flu episodes that winter, then despite the pain of the shot, the overall medical utility would be positive leading to an increased health status for that population.

Brandt differentiated between act and rule-utilitarianism in the following description: "[a]ct-utilitarianism is hence a rather atomistic theory: The rightness of a single act is fixed by its effects on the world. Rule-utilitarianism, in contrast, is the view that the rightness of an act is fixed, not by its relative utility, but by the utility of having a relevant moral rule, or of most or all members of a certain class of acts being performed" (114). The difference can be seen in the following example: A physician is asked by her patient whether her annual test results have come back. The patient has a tendency to worry over small details and as one result was slightly off, the physician assumes that the patient will become unnecessarily distressed. Should the doctor tell a white lie saying that everything is fine, knowing that the patient will accept this and be satisfied? Act-utilitarianism would say that this is the best method for increasing utility. However, there may be a rule against lying and the fiduciary bond between physician and patient would override the act of telling a white lie in this situation. The physician should tell her patient the truth, despite the consequences in this particular situation.

Another distinction in utilitarianism is Kymlicka's description of direct and indirect utilitarianism. He addressed the question of how to act using the principles of utilitarianism:

> On one view, this means that the agent should decide how to act by consciously making utilitarian calculations, by trying to assess how different actions would affect the satisfaction of informed preferences (direct utilitarianism); on the other view, the idea of maximizing utility enters only indirectly (if at all) into the agent's decision-making. Morally right actions are those that maximize utility, but agents are more likely to maximize utility by following non-utilitarian rules or habits than by following utilitarian reasoning (indirect utilitarianism).[7] (20)

Hare defined three elements of utilitarianism: consequentialism, welfarism, and aggregationism. Welfarism considers how consequences either increase or decrease people's welfare. Welfare is "the obtaining to a high or at least reasonable degree of a quality of life which the whole a person wants, or prefers to have" (81). There are problems with what preferences would be described as (rational preferences or desires), as well as deciding which ones would count in utilitarian calculations (preferences in the past, present, or future). Although the discussion surrounding preferences is beyond the scope of this paper, it is important to acknowledge them briefly in order to show how utilitarianism, as a moral theory, is too complicated to be defined simply. Particularly relevant to my work is Hare's description of utilitarianism as aggregationism because of its relation to population health outcomes:

> Aggregationism implies that we should ignore the *distribution* of the welfare that we are bringing about and simply maximize its total sum in aggregate. That is, if one outcome will produce more welfare, but distribute it very unequally, but another will produce less, but distribute it more equally, it is, according to aggregationism, the first outcome that we ought to choose. (82)

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[7] This is an interesting distinction because Kymlicka is saying that even if someone follows a deontological reasoning process and it increases utility as a side effect, the action is still captured by a utilitarian moral theory. I will discuss his perspective later in the thesis when I argue for a single-theory approach as the best guideline for allocating resources.

When one is examining overall population health, it is the general medical utility and health status that is quantified and the goal is to increase these total outcomes.

Harris examined the idea of needs and the problems involved in allocating resources based on different definitions of needs. He proposed an interpretation of equality of opportunity based on utilitarianism:

> The principle that each individual is entitled to an equal opportunity to benefit from any public health care system, and that this entitlement is proportionate neither to the size of their chance of benefiting, nor to the quality of the benefit, nor to the length of lifetime remaining in which that benefit may be enjoyed, runs counter to most current thinking about the allocation of resources for health care. It is my contention that any system of prioritisation of the resources available for healthcare or for rationing such resources must be governed by this principle. ("Justice and Equal Opportunities in Health Care" 392)

His thesis asserted that for each person the value of survival is equally rational and valuable:

> It surely must always be *rational* for someone who wants to live to choose a chance of continued survival over earlier death, even where the survival period will be relatively short or where the chances of survival are slim, so long as the life to be continued will likely be of acceptable quality. The *strength* of the agent's reason will be relative to the desire to live or to the fear of death, not to the chances of survival. ("Justice and Equal Opportunities in Health Care" 394 – 5)

This looks at the aggregate health outcomes and is the point traditionally ignored by policy. Essentially, one has this 'need' for survival equally and the traditional methods for calculating utility are, for Harris, flawed because they are usually based on how an individual (or population) has the capacity for increased health status. In his

chapter in A Companion to Bioethics, Harris wrote; "[a] common way of prioritising patients is in terms of their need for treatment. Need is all to often defined either in terms of one conception of the degree of benefit to be obtained from health care, or in terms of the capacity of the patient to benefit, with the implication that the greater the capacity to benefit the greater the need" (293). He continued to suggest that there are at least three dimensions to need; one, "urgency, intensity or importance of the need"; two, "amount of whatever it is that is needed"; and three, "capacity of the individual to benefit from what she needs" ("Micro-Allocation: Deciding Between Patients" 294).

Gibbard discussed a utilitarian-based theory in his article "The Prospective Pareto Principle and Equity of Access to Health Care" where he suggested that using the Ex Ante Pareto Principle can help decide policy ethically. The first principle he explained was the Simple Pareto Principle:

> [A] given person may be benefited by a given policy in some ways and harmed by it in other ways. We may speak, though, of how he is affected *on balance* by some policy- of whether, on balance, he is benefited or harmed. If some people benefit on balance from a policy and some, on balance, are harmed by it that may raise difficult questions of welfare and equity. Suppose, though, that no one is harmed on balance and at least some are benefited. Then assessment of the policy is unproblematical. If ethical questions are to be addressed in terms of benefits and harms, then it would seem that a policy that benefits someone on balance and that harms no one on balance is a good policy, from an ethical point of view. That, in rough form is the Simple Pareto Principle. (156-7)

This principle can influence decisions concerning population health cost/effective measures. For example, having decided to provide pre-natal nutrition for teenage girls, policy makers could implement a method that would optimise the delivery of this care. Gibbard also used the principle to examine the value of the statement, "If it is

economically feasible for all to receive the best care known to medical science, then equity demands that such care be provided to all" (166).[8] He rejected this idea and discusses limits, claiming "[t]here must be a limit, then to what we ought, from an ethical point of view, to be willing to pay for life-saving treatment" (168). Gibbard continued to use an insurance scheme based on rational risks as an heuristic device and determined that it would be rational for someone not to insure for extraordinarily expensive treatment and to use their income for something else. He developed this argument and reached the conclusion that needs determine utility more than desire, but these alone are not determinate in demanding resources. Gibbard further asserted that "[t]he medical care that has promise of immensely contributing to intrinsic reward in life is care that is reasonably likely to make a difference between a long life well worth living, and early death or a life ill worth living" (174). However, he also suggested that when treatment is neither increasing medical utility, nor extending one's life, resources should be directed to "enhancing the lives of the healthy" (Ibid.). The purpose of his work was to provide a method, in certain conditions, that discusses prospects. In this situation, the Ex Ante Pareto Principle can help to provide "a complete ordering of institutional arrangements that a society must have, by the desirability in prospect of being anybody in the society subject to those arrangements. To order alternative social

[8] Gibbard was making reference to a problem with health care resource allocation. The 'black hole' issue is that if everyone were entitled to optimal health services without limits, these demands would be impossible to meet. Thus, there must be limits placed on peoples' access to resources. Although there is much discussion about American health care and the concept of a right to a decent minimum, I will not address this particular issue in my work as the Canadian health care system currently offers its citizens access to health care services at a level that is superior to the American system. The focus of this thesis is the consistency of single-theories, the possible underlying moral theory that best fits the Canada Health act, and the claim that decision-makers should use a particular deontological theory to ground their decision process. The level of discussion that would be necessary to examine the issue concerning a right to a decent minimum thoroughly could be a topic for future work. For further discussion see: Gibbard; Buchanan, "The Right to a Decent Minimum of Health Care,"; Daniels, "Fair Equality of Opportunity and Decent Minimums: A Reply to Buchanan,"; Beauchamp and Childress, Principles of Biomedical Ethics pp. 348 – 361; Childress, Practical Reasoning in Bioethics, pp. 252 – 254.

arrangements in that way is simply to order them by average desirability of prospects – by average expected utility- and that is a form of utilitarianism" (175). Gibbard's work does differentiate between act-utilitarianism as he suggested that rule-utilitarian reasoning might override proposals grounded on the principle. He focused on the ability to examine the limits of claims to expensive resources. This is useful because he was offering a mechanism for allocating resources related to maximising utility.

Fletcher promoted an idea of "ethical arithmetic" in the difficult task of quantifying values (99). In "Computers and Distributive Justice" he offered the term "ethometrics" to denote "ethical analysis seeking distributive justice" (108). According to Fletcher, this "is a good label for applying statistical terms of amount and probability to macromoral problems, even down to the level of allocating funds as between developing an acceptable artificial heart and meeting the needs for patients in renal failure" (Ibid.). Cost-benefit analysis, triage, and selection committees for transplant organs are examples where he suggested that the use of artificial intelligence could help calculate outcomes. He also gave a statistical example from a New York hospital to highlight specific areas of consideration when allocating funds:

> [The hospital's] hyperbaric chamber cost $750,000 to install, $600,000 per year to operate. In five years the total cost was $3,700,000 – and only 900 patients were treated at a cost of $4111.11 each. For the same amount of funds 20,000 outpatients could have been treated per year, or 100,000 altogether. Or a screening program could have been set up in East Harlem to detect lead poisoning and anaemia in a million children, to keep their brains from being ruined. If you want to think about ethics and health care delivery, here is a good case, posing all the factors at stake – both numbers and competing values. (105)

Fletcher's example identified theoretical discussions with a real situation to illustrate the difficulty of allocating resources. His purpose was not to question the philosophical nuances in utilitarianism, but to suggest a means to use it as a tool to deliver services. I have included it in this work as a reminder of the particulars of resource allocation for, as Fletcher said, "[t]he point is this: To sacrifice the one for the many is to sacrifice the one for the many *ones*. The 'greatest number' is not an abstraction; it is the sum of real, particular, and personal individuals" (107). His desire to include computers as a tool for useful quantification is, therefore, applicable in health care policy. It becomes more relevant as other questions such as how society defines values and distributes services arise.[9]

Discussion

I have chosen to focus my discussion on the above philosophers because their various arguments demonstrate both the differences and similarities between particular classifications of deontological and utilitarian theories. For example, both Childress and Harris would support a lottery or queue to allocate scarce medical resources, but for different reasons. This point reinforces the argument for the use of a single theory in decision-making processes because it maintains consistency. A policy stating that organs would be allocated based on a lottery or queue could not be, on this factor alone, described as deontological or utilitarian and would need contextual information to help with the analysis. Alternatively, Daniels and Englehardt Jr. had different interpretations of what resources society has a duty to provide its members; Daniels supported

[9] For a discussion on establishing limits in the Canadian context that would be an interesting link with Fletcher's paper, see Kluge, "Social Values, Socioeconomic Resources, and Effectiveness Coefficients."

governmental redistribution of funds to provide access to a certain amount of funds, whereas Engelhardt Jr. saw government taxation as an immoral affront against the principle of permission, yet they are both considered deontologists. Again, this reinforces the idea that a particular version of a theory should be chosen for consistency.

Needs as a determining factor in justifying a claim to resources is primarily addressed by Daniels and Harris. Although both use the phrase 'equality of opportunity,' their individual interpretations are different. Needs, from Daniels' perspective, would be the capacity to return to normal species functioning (Just Health Care). The further away one is from the achievement of this, the greater the claim one could have (although he restricts unlimited claims). Harris rejected this capacity to benefit, and instead claimed that equality of opportunity supports the desire to survive and is therefore important ("Micro-allocation: deciding between patients"). During resource allocation, Daniels also gave priority of access to greater resources to those who can participate in the normal opportunity range with their normal specifies functioning restored (Just Health Care). However, he did not suggest a method to deal with two people who have an equal claim. Harris stated that in determining public policy, decision-makers should "not know or enquire into the detailed reasons why even a small chance of life or a short period of remission is wanted and needed" ("Justice and Equal Opportunities" 404). Instead, he argued "such a distributor of public resources should be 'blind' to these individual differences, for to evaluate them violates the equality principle. This is why a distributor of public resources must afford equal opportunities for healthcare and not formalise principles that may accord different values to the lives of equals" (Ibid.). Harris thus rejected utilitarian considerations of social utility.

Fletcher cited Boulding when he described a method for ranking preferences based on moral propositions as "...a statement about a rank order of preferences among alternatives, which is intended to apply to more than one person" (105). Fletcher stated that "... somehow we must learn to program computers with preference questions" (Ibid.). A rule-utilitarian approach could justify a principle that would allocate resources to those who maximise medical utility. However, two interpretations of what constitutes maximising utility are possible. Those who have a greater capacity (medical need) could obtain the desired resources to calculate the utility gained. In Fletcher's example, those who use the other interpretation would incorporate population outcomes to increase the overall health status. For example, the treatment of lead poisoning and anaemia in children would increase the final medical utility and therefore the funds should be given to that program.

Childress wrote that, "[a]n obvious advantage of the utilitarian approach is that occasionally circumstances arise that make it necessary to say that one man is practically indispensable for a society in view of a particular set of problems it faces..." (179). However, the burden of proof society must provide to use this type of calculation to override the personal dignity of another would be based on the negative consequences of losing this person, rather than the positive potential the person could contribute. He continued to say that the right to equal treatment is based on:

> The individual's personal and transcendent dignity, on which the utilitarian approach can be protected and witnessed to by a recognition of his equal right to be saved. Such a right is best preserved by procedures which establish equality of opportunity. Thus selection by chance more closely approximates the requirements established by human dignity than does utilitarian calculation. (176)

Harris would challenge Childress on the point of this presentation of utilitarian calculations. Harris rejected the approach that resources should go to those who have the capacity to benefit more than others and would support a lottery style allocation procedure if each person wanted to live equally ("Micro-allocation: deciding between patients"). For example, if there is a medication that can save one person, Bob, but Jim also needs it. Let's say that Bob has had the disease for a longer time and is sicker. Although Bob has a greater medical need and would have the greater capacity to become well, if Jim has an equal desire to live this would make them equal. The decision to give the medication to one over the other would need to have a basis on something else. Here Harris would probably agree with Childress on the drawing of lots.

Childress attempted to support the validity of the random selection process by arguing for the fiduciary bond between physician and patient. First, he linked trust with dignity in his claim:

> Trust, which is inextricably bound to respect for human dignity, is an attitude of expectation about another. It is not simply the expectation that another will perform a particular act, but more specifically that another will act toward him in certain ways – which will respect him as a person...This trust cannot be preserved in life-and-death situations where a person expects decisions about him to be made in terms of his social worth, for such decisions violate his status as a person. (177)

As mentioned earlier, Childress believed that equality of opportunity is a strong enough position that it cannot be violated unless there are extreme circumstances, such as choosing to save the President above others when there is an emergency. In this case,

the negative social utility from losing the President would override concerns of equality of opportunity to live based on human dignity.

Brandt examined whether a defective newborn ought to be given resources to live. The focus on social utility is important, and is the reason why Childress made a concession to allow the President to live. Social utility, in the newborn's case, is entirely speculative concerning how much he or she would bring to society, but irrelevant when viewed from an aggregate utility perspective. Thus for the purpose of aggregate utility, medical need would decide whether the resources would be given. Brandt also broached the issue of whether the mentally disabled have the capacity to benefit, especially when the societal resources needed to compensate for their natural deficiencies may outweigh what the newborn could contribute as an adult. One pertinent question is whether the dignity of the newborn is enough to validate a claim on scarce resources. First, Brandt made it clear that he would "affirm that a policy is justified from a moral point of view if and only if it is one that is factually informed, rational, and otherwise what normal persons would want for a society in which they expected to live a lifetime" (354). He then discussed the value of life with a handicap, both the value to the child itself and to the family. Societal role is important because society will be impacted by the decision, whether the child becomes a ward of the state, or by the extra demand for resources made by the family. Societal welfare would not increase because of the extra resources needed to raise the child, despite the possibility of a very happy family life. Gibbard's discussion of the Ex Ante Pareto Principle is important in that he would advocate providing the resources to another child who may have a better quality of life. The overall social welfare that results from the application of a rule where severely defective

children are not offered scarce resources may be the morally correct rule that rational people would prefer. All told, he concluded "[i]n our case, the test is the maximal net benefit for the infant, although in most cases a policy mandating the maximal net benefit for the infant will not diverge from one aiming at the maximal net benefit of society" (366). The utilitarian policy offered by Brandt would produce a different conclusion to Childress in which the dignity of the child would be enough to provide the opportunity to access scarce resources via the natural selection process.

Daniels would agree that the normal opportunity range for a newborn would be different, but there would be a claim based on the right to equality of opportunity for a certain amount of resources (Just Health Care). Engelhardt Jr. would disagree, saying instead that society would not have a duty to provide medical care in the case of the newborn. Daniels' concern in Just Health Care was not with micro-allocation (bedside ethical decisions), but rather at the societal level, so this particular example was explicitly avoided. He was concerned with macro-allocation decisions and instead considered the policy dealing with equal access for disabled people. Disease interferes with the quality of opportunities for life plans, so the eradication of a disease optimises an individual's opportunities. Daniels discussed two points relating to disease and the normal opportunity range (Just Health Care). One considers how the impact of different diseases may be relative to different societies and uses dyslexia in a non-literate society as an explanatory example. Daniels termed the second point "effective opportunity," subsequently explaining this as "[f]rom the perspective of an individual who has a particular plan of life and who has developed certain skills accordingly, the effective opportunity range will be only a part of his fair share of the normal range" (Just Health

Care 34). The objective is to prevent those who have (medical) desires beyond their natural ability from demanding social resources beyond their fair share. For example, the newborn because of its congenital limitations may have a restricted claim to societal resources.

When allocating resources and incorporating Gibbard's Pareto Principle, the policy in which more people benefit and no one would be worse off is ethically preferred. What makes this interesting is that Gibbard did not accept equality of opportunity to resources, unless society has a broad right to economic equality, he wrote that "except under special circumstances, there is no moral right to equal availability of health care, unless there is a moral right to full economic equality in general (158)." Therefore, "if a treatment is sufficiently expensive, it should be withheld even if it is the most effective treatment for a grave ailment" (Ibid.). Following Gibbard's perspective, the newborn may have claims to some resources, but if the treatment is incredibly expensive and does not significantly increase health or life expectancy as mentioned earlier, the resources should be given to healthier children. Needs, determined as the capacity to benefit, is the measurement that dictates the redirection of funds. Gibbard questioned whether equity should determine demand for access to the best medical care. He claimed that, if everyone demanded the best care, "the resources of that society, or indeed of the world, are insufficient for the treatment to be provided for all...[e]quity cannot require the impossible, and if the demands of equity are governmental policy alone, then they cannot require what is economically infeasible" (166). He suggested that there "must be a limit, then, to what we ought, from an ethical point of view, to be willing to pay for life-saving treatment" (168). Further, Gibbard stated, "equitable

access to health care will not be unlimited access" because new technology can be costly (169). The Ex Ante Pareto Principle can be applied as a method for establishing the limits for funding when very expensive treatment is desired, because, Gibbard claimed, it "transforms some questions of equity into questions of prudence under conditions of risk" (166). Would it be prudent to purchase hypothetical insurance for expensive care if there was a slight chance of needing it? Gibbard's answer to this was no, because the opportunity to use resources for other necessities verses the hypothetical premium's cost may not be worth the risk. Thus, the newborn may not have a claim to resources.

I have briefly discussed some of the similarities and differences between specific positions in resource allocation. There are differences in how claims are established and how these claims are subsequently addressed by society. A rights-based claim to resources may not be necessary, as in utilitarian theories; however, the question concerning how resources are allocated remains. The purpose of this chapter is to clarify some of the basic differences between two major theories in philosophy and then illustrate how they function within the scope of health care resource allocation. I have chosen different philosophers for their unique conceptions of how claims to health care services are established and their proposed methods of dealing with such claims through the allocation of resources. The discussion briefly touches on some points in the area of resource allocation. For the purposes of this project it is necessary to highlight some of the differences to support the idea that for consistency, a single-theory is necessary. The disagreement that occurs between philosophers regarding ethical theories can be tempered from affecting resource allocation in health care by restricting the decision-making process to a single-theory based approach.

Chapter Two
Creation of the Template and Arguments to Support a Single-Theory Approach to Ethical Analysis

In this chapter, I will create the template that I will later use to analyse key elements in the history of the Canada Health Act and the interview with the CEO of a health care region in Canada. I will present key features of a needs-based deontological framework that functions to provide equal opportunity to access health services, and a rule-utilitarian framework based on increasing aggregate health status. I will analyse the five principles of the Canada Health Act (public-accountability, universality, comprehensiveness, portability, and accessibility) to demonstrate how different theories create logically distinct interpretations. I will conclude the chapter with an outline of different approaches to bioethics. Discussions of principalism, casuistry, and a single-theory will show how the latter is the best method for achieving consistency.

The deontological features for the template are similar to Daniels' position concerning normal species functioning and its relationship to health care needs, and a perspective on the equality of opportunity position (Just Health Care). Defining equality of opportunity, Veatch wrote "justice is seen as requiring that people have opportunities for equality of well-being" (The Basics of Bioethics, 125). He went on to say that "[i]n health care, this is often interpreted as leading to distributing health services on the basis of need" (Ibid.). He clarified that "[w]hile need could be determined in terms of relative overall well-being, health care is often allocated in the basis of *medical need*" (Ibid.). My earlier discussion identified differences in opinion regarding the definition of needs. Veatch discussed two different interpretations regarding "who is in the greatest need" (Ibid.). He referenced needs as defined by "a moment-in-time" or over a person's

lifetime (Ibid.). For the purpose of this thesis, I will define needs as the difference between current health status and normal health status at a moment in time.[10] My reason for choosing this interpretation derives from decision-makers' perceptions that an important focus of the current Canadian system is to treat people at the point of entry.[11]

Daniels grounded his theory in a right to equal opportunity, asserting, "my fair equality of opportunity account is intended to explain the importance or urgency of meeting health-care needs, as opposed to satisfying other preferences, such as desires to use certain health-care services that do not meet health-care needs" (Just Health Care 107). The concept that people are to be treated as having equal opportunity, relative to their normal functioning, to access services and have their needs met is the foundation for the template. Population group outcomes would identify overall population health, and could be divided based on health status. The outcomes can be used to establish whether these rights to access services were met.[12]

Essentially, the function of the equality of opportunity theory would stem from medical needs to allow access to services that would promote the return to the level of normal range for the group; equality is grounded on the opportunity to enter the system, not on a guarantee of access to services. For example, paraplegics function with a normal range of abilities for those limited by the use of a wheelchair. A person who was injured and lost the use of his or her legs would be redefined and regrouped with other

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[10] The constraints of normal must be within reason. No one ever functions with perfect health and perfection as a standard is unreasonable. However a medical opinion can suggest the desired level for a healthy person.

[11] I arrive at this conclusion based on the interviews collected for the HEALNet project.

[12] Population health outcomes used in this context is different from the use of population health outcomes in a utility maximising process. For most of this thesis I use population health outcomes as indicative of utilitarian reasoning. This is because the goal of increasing population health uses outcomes to define service delivery direction. The purpose of using population health outcomes is different in each case.

paraplegics. Thus, the system would not need to expend resources exclusively on this group in order to restore their ability to walk. A cure may be desirable, but to expect a person, or group, to use the societal resources exclusively to that end would not be respecting the rights of others and their claims to resources. However, when the injury occurred, his or her immediate health care needs to stop the pain and address the injury would be met, despite the fact that normal species functioning would determine that the newfound health status would be less than the original.[13]

It is important to remember that an individual right does not mean a right to everything, and that one can have a right to *x* and not receive *x*.[14] Buchanan briefly outlined some issues surrounding rights:

> Positions on the right to health care range from the denial that there is a moral right to health care to the claim that there is a strong egalitarian right, a right of each to an equal share of health resources. Another view holds that the right to health care is derivative, based exclusively on considerations of utility-maximization. The opposing thesis is that the right to health care is independent of and 'trumps' (that is, overrides) all appeals to utility-maximization. ("Health-Care Delivery and Resource Allocation" 307)

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[13] This statement needs clarification. In cases that are not as extreme, society could be satisfied with the decrease in health status. I used this example because currently there is no cure for spinal cord injuries. I do not want to suggest that there are no claims for societal resources, or the purpose of the health care system would be to alleviate pain and suffering exclusively. I am indicating that there need to be limits placed on demands to the system and I claim a deontological theory would be the best theory to establish such claims.

[14] The purpose of the template is to identify when a deontological indicator is active. Although an important feature of resource allocation is to show how particular deontological theories would manage rights-based claims to resources, that subject is beyond the scope of this work. My thesis examines how inconsistency in the decision-making process can impact the amount and availability of resources. I advocate for a deontological egalitarian needs-based approach to be used in the decision-making process, but I am not claiming that this theory would address all the concerns, nor is it the only deontological theory that could be used. The types of theories that would be candidates for the decision-making process could be the direction of future research.

He then offered a brief outline of what he interprets as a right claim. One, that if someone has a right to *x* then there is a valid claim, regardless of whether that person benefits or whether *x* is desirable for either that person or others (Ibid.). Two, if that right is violated, a wrong has occurred and the person holding the right is the "appropriate recipient of compensation or restitution" (Ibid.). Three, if the person has a right to *x*, then someone, or a collective agency, has an obligation to provide *x* to that person. Four, the existence of this right, *x*, "provides a strong prima facie justification for enforcing these obligations if necessary" (Ibid.).[15] This brief description outlines how a right can be defined.

Utilitarian theories do have "derivative rights" based on rule-utilitarian precepts, as defined by Buchanan; "[r]ights founded ultimately on considerations of utility may be called derivative, to distinguish them from rights in the strict or fundamental sense" ("Health-Care Delivery and Resource Allocation," 309). He gave an example:

> ...it may be that a judicial system which maximizes utility will do so by including rules which prohibit judges from deciding a case according to their estimates of what would maximize utility in that particular case. Thus the utilitarian justification of a particular action or decision may not be that it maximizes utility, but rather that it falls under some rule of an institution or set of institutions which maximize utility. (308)

Because these 'rights' can function as an expression of utilitarian rules, it would be suitable to acknowledge that policy can be seen as acting within a rule-utilitarian construct. An aggregational utilitarian theory that looks at the overall health status of a

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[15] Buchanan presented a fifth claim (although he found fault with it); "a valid right-claim overrides appeal to utility maximization; in other words, the mere fact that failing to respect the right would maximize utility is not itself a sufficient reason for doing so" (307). He referenced utilitarian derivative rights: that a rule-utilitarian perspective would work as a *de facto* rights-based approach. This is a valid point, and I will address it in the fifth chapter where I argue in support of a deontologically based decision-process.

population would also be appropriate because maximising health outcomes is a reasonable 'good' for regional health boards. The effectiveness of a treatment in a particular population can be ascertained using medical utility; for example, the flu shot to increase a population's health status is effective. Needs would be defined in relation to what would increase health status for the population.

Template

The key identifiers of the deontological theory will be the following:

1) There is a right and a corresponding duty that is independent of the benefits produced.

The discussion in the preceding chapter promoted the notion of duty as one of the key identifiers of a deontological theory. This is consistent with information identifying the use of a deontological theory in a particular decision or decision process. The meaning of independent is that the outcome does not determine the correct action, but may suggest what right is activated given particulars of the situation.

2) The specific criteria used to justify particular decisions are related to health care needs.

The context would determine that needs were being discussed in an egalitarian fashion, specifically that the presenting of needs was sufficient to be given equal opportunity to access services.

3) There is particular reference to a decision as necessary despite the adverse affect on the health of others.

Importance is given to a claim, which cannot be overridden for other concerns, such as efficiency.

The key identifiers of the utilitarian theory will be:

1) The measure for successful delivery of health care services will be the benefits for the population as a whole.

The population benefits are not predicated on an egalitarian presentation for access to services. There can be groups that are not granted access to resources justified by maximising utility, rather than a mechanism that examines conflicting rights claims.

2) Cost-benefit analysis will be used to justify particular decisions.[16]

3) Rights are identified as the best rules or principles to follow to maximise utility.

[16] There are different opinions on cost/benefit analysis and its foundation. For simplicity I will use the basic utilitarian calculation, which is one that maximises utility (health outcomes) as an indication of utilitarian reasoning. For a good basic discussion of cost/benefit analysis see Buchanan "Health-Care Delivery and Resource Allocation." 298 – 302.

The context would dictate whether the term right would be identified as a rule-utilitarian principle. The right would develop from the rule that promoted maximised utility, or would be thought to maximise utility.

These identifiers can be applied to decisions, principles, and justifications to examine whether a deontologically or utilitarian-based theory is being used. The parameters are specific, which is not to suggest that they are exhaustive. I have chosen these criteria because I found that, in the project interviews, the current climate of health care decision-making discusses these features.

To illustrate how such a simplified template can create logical discrepancies, I will present the five principles from the Canada Health Act using both theories. The point of this exercise is to show how the principles can be justified with different moral criteria. Some of the interpretations will not fit easily into one theory or the other. This only strengthens the claim that there is a natural fit between one particular theory and particular principles. At this point, my focus is not to offer an argument for one theory or another, but rather to illustrate how one principle can be justified with two distinctly different theories.

Interpretations

I will now interpret the five principles of the Canada Health Act using the template. I will first cite the formal definition of each principle and then follow with the different interpretations. The Canada Health Act stated that in order to receive federal transfer payments, provincial and territorial governments must meet the following

conditions: public administration, comprehensiveness, universality, portability, and accessibility (CHA Section 7). In the Canada Health Act Annual Report 2001 – 2002 the question "What is the Canada Health Act?" was addressed:

> The *Canada Health Act* is Canada's federal health insurance legislation.
>
> The Act sets out the primary objective of Canadian health care policy: 'to protect, promote and restore the physical and mental well-being of residents and to facilitate reasonable access to health services without or other barriers.'
>
> The *Canada Health Act* establishes criteria and conditions related to insured health services and extended health care services that the provinces and territories must meet in order to receive the full federal cash contribution under the Canada Health and Social Transfer (CHST).
>
> The aim of the *Canada Health Act* is to ensure that all eligible residents of Canada have reasonable access to medically necessary insured services on a prepaid basis, without direct charges at the point of service for such services. (CHA sec. 7)

The Honourable Jake Epp, the Minister of Health and Welfare when the Act was first implemented, sent a letter to all provincial and territorial Ministers with brief explanations of each principle (Canada Health Act Report 2002). Quotations from the letter will be included to supplement the legal language quoted from the Act itself.

Public administration

Section Eight of the CHA outlined the requirements of public administration. Two relevant subsections stated:

> [the] insurance plan of a province must be administered and operated on a non-profit basis by a public authority appointed or designated by the government of a province; (b) the public authority must be responsible to the provincial government for that administration and operation; [and] (c) the public authority must be subjected to an audit of its accounts and financial transactions by such authority as is charged by law and the audits of the accounts of the province. (CHA sec. 8)

The next subsection stated that outside agencies are allowed to run accounts and not be in breach of the principle if they follow the authority of the Canadian government's mandate of public administration (CHA sec. 8.2). Epp stated "the intent is that the provincial health insurance plans be administered by a public authority, accountable to the provincial government for decision-making on benefit levels and services, and whose records and accounts are publicly audited" (316).

Interpretations

The decision to have publicly administered services aims to prevent for-profit health care. A deontological definition would frame the principle by asserting that something provides a check and balance on service delivery. In this situation, the principle reflects a commitment to social responsibility, not profit. The principles that drive commercial enterprise would most likely come into conflict with the mandate to meet health care needs. Moreover, the need for profit would most likely prevail over an alternative decision, yet a deficit is allowed in a government where the purpose is to meet a social requirement, or duty. The principle of public administration interpreted by a deontological theory would specify that the private sector be kept at arms length due to the potential conflicts in the delivery of services.

The utilitarian theory would promote a non-profit system so long as the overall population outcomes were maximised. If a case could be made that a for-profit system would produce greater health status, then the principle, or rule, would need to be changed to whichever rule would promote maximised utility.

Comprehensiveness

Comprehensiveness was defined in the ninth section of the Canada Health Act where it stated that, "[i]n order to satisfy the criterion respecting comprehensiveness, the health care insurance plan of a province must insure all insured health services provided by hospitals, medical practitioners or dentists, and where the law of the province so permits, similar or additional services rendered by other health care practitioners."

The principle of comprehensiveness in the Canada Health Act permitted the creation of boundaries of service delivery, similar to a conventional insurance program.[17] The language structure allowed provincial medical service plans to choose which services would be covered. Notice that it stated the province must ensure all "insured services"; it does not say the province must ensure "all services." I will discuss this distinction later in more detail, but its function is to regulate the availability of resources. Epp, however, made a specific claim that this principle was not meant for the demarcation of services at the federal level, but left that task to the provinces. He wrote;

> The intent of the Canada Health Act is neither to expand or contract the range of insured services covered under the previous federal legislation. The range of insured services encompasses medically necessary hospital care, physician

[17] Importantly though, the purpose of a conventional commercial insurance program is to maximise profit. I am only indicating that both situations need boundaries for service delivery.

> services and surgical-dental services, which require a hospital for their proper performance. Hospital plans are expected to cover in-patient and out-patient hospital services associated with the provision of acute, rehabilitative and chronic care. As regards physician services, the range of insured services generally encompasses medically required services rendered by licensed medical practitioners as well as surgical-dental procedures that require a hospital for proper performance. Services rendered by other health care practitioners, except those required to provide necessary hospital services, are not subject to the Act's criteria.
>
> Within these broad parameters, provinces, along with medical professionals, have the prerogative and responsibility for interpreting what physician services are medically necessary. As well, provinces determine which hospitals and hospital services are required to provide acute, rehabilitative or chronic care. (316)

Interpretations

The principle of comprehensiveness was based on the word "all"; as noted, it stated that the insurance plan must "insure all insured health services" (CHA sec. 8). This appears redundant, but logically it permits each province to have variations of funded services so long as they provide *all* of the chosen services to their population. The point is that the principle of comprehensiveness was used to control service delivery by defining what is "comprehensive," albeit at the provincial level.

Deontological justifications for funding would be based on medically necessary health needs. The concept of "insured services" would be determined by an egalitarian approach to access services, and not on services that would exclusively promote increased health status. An example is when someone has a rare or incurable disease. The services needed would have the opportunity to maintain their insured status despite the patient's outcome, which did not maximise his or her health status. Most importantly, if the health status would not improve the status of the overall population health, there would still be a reason for listing them. However, as noted earlier,

comprehensive does not mean unlimited services. The process that incorporates a balancing of needs is different from the utilitarian method. In both situations the term "comprehensive" does not logically mean "all."[18] As noted, the demarcation of services would follow the recognition of a process grounded in rights based on equality of access. Programs that do not increase health status would not be automatically removed from the group of insured services.

A utilitarian would want the insured services that produce the highest aggregate utility in population health outcomes. Theoretically, health care specialists examining disease incidence and prevalence would determine the current health situation. Health care professionals would decide what treatment has been or will be effective in reducing "unhealthy" numbers; services that fall outside of these proposed strategies would lose their funding. Cost-benefit analysis would examine the dollar outcomes for various programs and those that provided the best value would be listed.[19] Decision-makers would follow a rule (policy) to maximise population outcomes; programs or services that did not achieve this outcome would not be funded. Services addressing the health care needs of population groups that demanded more expensive treatments would not be listed.

Universality

The principle of universality identified the population group covered by the Canada Health Act. It stated that "[i]n order to satisfy the criterion respecting

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[18] For a deontologically based approach to how the limits are drawn see Kluge, "Social Values, Socioeconomic Resources, and Effectiveness Coefficients."

[19] Once a service is listed both deontological and utilitarian theories could incorporate a cost-effective analysis to maximise efficiency.

universality, the health care insurance plan of a province must entitle one hundred per cent of the insured persons of the province to the insured health services provided for by the plan on uniform terms and conditions" (CHA sec. 10). Essentially, the purpose of this principle is to ensure that insured services are not denied to those who are qualified. The use of the term "qualified" limits access to services by extended visitors, tourists, and others who are not residents of a province. Epp wrote of Universality: "The intent of the Canada Health Act is to ensure all bona-fide residents of all provinces be entitled to coverage and to the benefits under one of the twelve provincial/territorial health care insurance plans. However, eligible residents do have the option not to participate under a provincial plan should they elect to do so" (316). He also noted that "[a]dministrative arrangements should be such that residents are not precluded from or do not forego coverage by reason of an inability to pay premiums" (Ibid.).

Interpretations

A deontological position would guarantee coverage based on being a qualified resident in a Canadian province or territory. Universal coverage would be a duty, and consequences, such as high cost for service delivery for the entire population, would not be justification to limit coverage. Although the overall budget constraints may be important, the social duty to fund universal health care would have to override those who cannot afford premiums. Those who did not want to participate have the option of opting out of the plan.[20] A right to health care coverage would be guaranteed despite the health of the individual based on their needs. If a population group had a pre-existing

[20] An interesting point here is that a libertarian deontologist, Engelhardt Jr., would see universal coverage as fundamentally immoral. The discussion regarding a deontological argument to support a two-tier system in Canada, although interesting, is beyond the scope of this thesis.

condition that would guarantee the need for access to services to restore, within reason, normal species functioning, they would still be insured. Population health outcomes based on insuring healthy people, compared to insuring the entire population, would favour an insurance program for the healthy. A deontological interpretation would not take these outcomes as a consideration. A cost-effective program could function to deliver services efficiently, but the right to insurance would be based on qualified residential status and not on current or predicted health status.

The utilitarian approach calculates the overall maximised health status that comes from the insurance of every eligible member of the Canadian population. The consequences for a society in which there is a large uninsured population may not promote the greatest aggregate utility. A cost-benefit approach may state that it is less expensive for the society as a whole to have universal insurance than to pay for the consequences of those who do not have insurance. The financial consequences may be indirectly higher health care costs that would be borne by the population. Those without insurance may not go to a doctor at the first sign of illness and when they must receive care to meet their needs, those needs are greater

Portability

The fourth principle, portability, was described in three sections. The first stated that there might be movement between provinces and that if residency changes, a province might not wait for more than three months before granting insured status (CHA sec. 11). It provided details concerning payments between persons and the home province when a qualified Canadian resident travels between provinces or has services

provided outside Canada. The second subsection discussed elective services for persons who are temporarily absent from their home province (CHA sec. 11). The third section defined "elective insured health services" (CHA sec. 11). The Canada Health Act Annual Report stated:

> Residents who are temporarily absent from their home province or territory or from Canada, must continue to be covered for insured health services during their absence. This allows individuals to travel or be absent from their home province or territory, within a prescribed duration, while retaining their health coverage. The portability criterion does not entitle a person to seek services in another province, territory or country, but is intended to permit one to receive necessary services in relation to an urgent or emergent need when absent on a temporary basis, such as on business or vacation.[21] (4)

Epp also expressed the flexibility of travelling within Canada. He claimed:

> ...I detected a desire to achieve these portability objectives and to minimize the difficulties that Canadians may encounter when moving or travelling about in Canada. In order that Canadians may maintain their health insurance coverage and obtain benefits or services without undue impediment, I believe that all provincial/territorial Health Ministers are interested in seeing these services provided more efficiently and economically. (317)

Interpretations

The principle of portability allowed Canadians to move between provinces and travel outside the country with the confidence that they will not lose their entitlement to health care insurance. A deontological interpretation based on an egalitarian needs-based right to access health care is not limited to geography. A person may travel or take up residency in another province or territory, and the rights afforded to him or her

[21] To receive elective services in another province the individual must have prior consent from the home province's public authority.

would be linked to that individual. The decision of where to reside would not be constrained by a concern that one would lose access to care. The access to care would be based on health care needs establishing a right to access services.

A utilitarian framework would advocate that aggregate utility be maximised by allowing movement between provincial borders as well as outside the country. The ability to access services maintains healthier outcomes for the whole of Canada, and thus keeping the overall health level of the population higher. A rule-utilitarian policy would state that the Canadian population is free to pursue economic advantage, relationships, or any other desire. This 'right' would continue until the population health outcomes were adversely affected.

Accessibility

Accessibility was the fifth principle consisting of two subsections. The first one dictated what a province must provide to its citizens. A province "must provide for insured health services on uniform terms and conditions and on a basis that does not impede or preclude, either directly or indirectly whether by charges made to insured persons or otherwise, reasonable access to those services by insured persons" (CHA sec. 12). There were three other sections within this first subsection, but these concerned the payment process. For this work, the pertinent part of the principle is the section that I have already quoted, and this will be the focus of my analysis. The report clarified what constitutes "reasonable access":

> Reasonable access in terms of physical availability of medically necessary services has been interpreted under the *Canada Health Act* using the 'where and as available' rule. Thus, residents of a province or territory are entitled to have

> access on uniform terms and conditions to insured health care services at the setting 'where' the services are provided and 'as' the services are available at that setting. (The Canada Health Act Annual Report 2002, 5)

In his letter to the Ministers of Health, Epp offered the following details:

> The Act is fairly clear with respect to certain aspects of accessibility. The Act seeks to discourage all point-of-service charges for insured services provided to insured persons and to prevent adverse discrimination against any population group with respect to charges for, or necessary use of, insured services...I want to assure [the Ministers] that the reasonable access provision will not be used to interfere directly in matters such as the physical and geographic availability of services or provincial governance of the institutions and professions that provide insured services. (317)

Interpretations

The term 'accessibility' is particularly ambiguous. The term "reasonable access" from the report's previous quotation is a requirement for meeting the standards set out by the principle; however, this is open to a number of interpretations (5). 'Access' may be temporal; the framework that delivers services strives to have equal access measured in time. Another meaning incorporates geography, as mentioned in Epp's letter to the Ministers of Health; delivery is available within a specific geographic range for eligible residents. The rural/urban distinction is very apparent in these definitions as noted by the "where and as" reference regarding reasonable access. Ideally, someone in a remote town would be able to have access to a physician within the same approximate time frame as someone in an urban environment. The recent emergence of telemedicine would be one method to achieve reasonable access when the rural/urban issue arises. This specific problem was outlined in the Romanow Report;

> Canadians in rural communities often have difficulty accessing primary health care and keeping health care providers in their communities, let alone accessing diagnostic services and other more advanced treatments... [a]s a result, some services were centralized into larger centres. Partly because of these changes, provincial and territorial ministries of health and regional health authorities have used a number of different approaches to improve access through outreach programs, financial assistance for people who need to travel to access care, and new delivery approaches like telehealth. (Building on Values 162)

Despite increased cost of providing care in remote or rural locations, there would be a duty to achieve the best reasonable access to services. The right to have reasonable access to services in order to address health care needs could trump cost considerations in implementing these services.

Using the utilitarian theory, 'reasonable access' would be defined in the following way: aggregate utility would be maximised by having equipment and technicians in each region guaranteeing citizens uniformity in geography and reasonable time to access services. However, the method for achieving this system, if it were possible, would be impractical, leaving little in budgets for society's infrastructure. The resources necessary to achieve this goal would leave the population with little funding for any services outside of health care, similar to the black hole issue. Thus, within the parameter of health care service delivery, this definition would be functional; however, overall it would not maximise utility for society. However, the "where and as" clause could function as a constraint when a population crosses the 'positive utility' line (essentially a population count). Once the population is large enough to support a hospital or clinic, the aggregate utility would be higher than the disutility of travelling to larger centres. The "reasonable access" would then be an appropriate rule to follow.

Both Epp and Marleau discussed an interpretation of 'reasonable access' in letters to the provincial and territorial Ministers of Health (Canada Health Annual Report 2002). The ability to receive care without restrictions, such as service fees, is equal; meaning that anyone showing up at a point of service delivery, such as a hospital or a clinic, would have direct access to services. The equality of opportunity based on needs is expressed when one arrives at a clinic and does not have to pay a fee to see a physician. For example, a person deciding to go to a late night clinic, or see a remote area physician would not incur user-fees. The deontological position would define uniform accessibility as a guarantee to equal access, regardless of socio-economic status. These definitions are respected when financial barriers would not stand between a patient and the services they need. This action protects members of society who cannot afford to pay service fees. Thus, access to services is guaranteed to all, regardless of socio-economic status, although perhaps limited if the services they need are not listed.

Using a utilitarian theory, 'reasonable access' would be defined as the ability to see a physician without impediment and thus maximise aggregate utility. Medical need for extensive resources would be pre-empted because the patient did not hesitate to seek attention early. On first glance, this is reasonable. However, the principle is challenged if population outcomes are maximised by restricting reasonable access. Perhaps physicians would treat patients with better care only if they were allowed to extra-bill certain patients; those with high medical needs. The system could grant access to particular patients who would receive extensive care with the result being an increase in aggregate utility.

I have interpreted the principles of the Canada Health Act to show how different interpretations stem from deontological and utilitarian perspectives. I have cited the criteria suggesting either deontological or utilitarian identifiers, and I will use these again when examining both the history of the Canada Health Act and the case study. One reason for this exercise is to support the idea that a single-theory that frames decision-making processes is the best method for achieving consistency. As noted by the different interpretations of the principles of the CHA, different theories can justify a specific principle within their approach. However, there are problems with consistency when one does not use a single-theory approach.

I have suggested one difficulty inherent in moral dilemmas, namely clarity and consistency in the use of common moral terms. In Volume 2 of Securing Access to Health Care, Wikler wrote that the philosophers presented have "sought to provide intellectual clarification – resolving ambiguities and exposing unnoticed premises and assumptions that occur in public debates over moral issues. A more ambitious goal has been to provide moral arguments that meet certain standards of coherence, consistency, and logic" (111). He continued to address criticism that methodology in philosophy is not the same as science where terms like "proof" and "demonstration" are the norm and the scope of philosophy is limited to subjective beliefs (112). The criticism here is directed towards the objectivity and testability of moral 'facts'. His response, which I agree with, was "[i]f moral philosophy is stuck in its social context, so is all moralizing; and if one rejects moral philosophy for want of objectivity, one must, to remain consistent, refuse to make moral judgments at all" (Ibid.). There are inherent problems

within any form of theorising in moral philosophy, however, the difficulties can be minimised, and this goal is acceptable.

There are different methods for ethically examining cases in bioethics, the most common are casuistry, principalism, and using a single-theory approach. Casuistry is the comparison between similar cases with the aim of finding a resolution to the dilemma. "Paradigm cases" are used to appease the intuition that "in matters of ethics, similar cases should be treated similarly" (Veatch, The Basics of Bioethics 2). The new case is presented and, if there are similar aspects, then the correct procedure is to follow what occurred in the past. I agree with Engelhardt Jr., who found fault with this process; "for casuistry [is] not simply to involve an appeal to intuitions...the guiding cases must be understood within both a dogmatic framework that offered authoritative content and confessors who were in authority to interpret cases and guide penitents" (43-44). He stated that this method needs a framework or method beyond the particular cases, and used the light-hearted example of asking friends for advice in solving moral dilemmas to illustrate its difficulties.[22]

Principalism looks at basic principles familiar with health care professionals. This is helpful when, "[t]he discussion of ethics at a purely theoretical or philosophical level might not provide the understandable guidance needed by professionals who must make decisions despite dilemmas" (Anderson and Glesnes-Anderson xii). Beauchamp and Childress wrote Principles of Biomedical Ethics to help with decision-making in health care with the benefit of blending different styles of moral thinking at the level of middle-principles. The authors did not find the need to ground such principles on a

[22] The work here involves policy decisions and not case-by-case situations, thus the benefits and shortcomings of casuistry will not be discussed. I mentioned it because it is a popular current method in health care settings.

single-theory. As such, the principled approach offers a popular method for health care professionals because the principles offered are intuitively acceptable; respect for autonomy, nonmaleficence, beneficence, and justice.

The principles suggested by Beauchamp and Childress were founded on different theories, suggesting that a mixed-theoretical approach can reconcile conflict of moral dilemmas at the level of middle-principles. For example, they discussed the principle of autonomy by offering the theories of both Immanuel Kant (deontologist) and John Stuart Mill (utilitarian) and their support for the principle. As evidence for a deontological acceptance, they stated, "Kant argued that respect for autonomy flows from the recognition that all persons have conditional worth, each having the capacity to determine his or her own destiny" (125). As proof that a utilitarian justification could also support the principle, they then referenced Mill, claiming "[he] was more concerned about the autonomy – or as he preferred to say, the individuality – of persons in shaping their lives" (Ibid.). They concluded that "[i]n the final analysis, however, these two profoundly different philosophers both provide support for the principle of respect for autonomy" (Ibid.). Principalism as a guideline for decision-making has problems associated with its use.

One problem, related to decision-making, is that if different principles can be justified with different theories, there is no specific method for carrying out the action the principle demands. For example, regarding the interpretation of the principle of accessibility in the CHA there was a different framework for when the accessibility could accept user-fees. In the utilitarian approach, once the population health outcomes could be maximised by allowing user-fees, the principle would need to be changed.

Thus, the decision-maker would be directed to allow user-fees, whereas in the deontological interpretation, the principle would hold and user-fees would not be permitted, despite the increased health status reflected in population health outcomes.

Engelhardt Jr. discussed another problem with the approach presented by Beauchamp and Childress, claiming "[they] contend that middle-level principles can be used by individuals with different theoretical and moral perspectives, thus allowing both consequentialists and deontologists to employ the middle-level principles in order to resolve bioethical controversies" (56). He continued, suggesting that if the consequentialists and deontologists come from the same community then, "[i]t is not remarkable that they are able to come to similar practical choices using middle-level principles, since they began with similar moral commitments or prejudices" (57). Engelhardt Jr.'s point was that, when there is no common community, such as within secular or multi-cultural societies, the appeal to middle-level principles "will not resolve controversies, but instead highlight their depth" (Ibid.). The fault he found with principalism highlights a potential problem with the decision-making process. The ambiguity of particular principles means that, even if a certain principle can be justified by different theories, it will falter just when moral principles should offer guidance, when there are differences that cannot be resolved by appeal to that principle alone. In such situations a group of principles that are grounded on a single-theory can offer guidance at greater depth.

In his article, "Can Applied Ethics Be Effective in Health Care and Should It Strive to Be?", Caplan presented a model that strives to follow a scientific approach. He summarised the format as follows:

> ... there is a body of knowledge concerning ethics that persons can be more or less knowledgeable about; (2) this knowledge becomes "applied" in medical settings by (a) deducing conclusions from theories in light of relevant empirical facts and descriptions of circumstances and (b) properly the process of deduction (i.e., watching for logical fallacies, ambiguities in the meaning of key terms, improper classifications of entities, misdescriptions, etc.); and (3) the process of applying ethical knowledge to moral problems in medicine can be carried out in an impartial, disinterested, value-free manner. (314)

Caplan continued to find the limited success of applying ethics in medicine, but his criticisms were not entirely in accord with the structure of the model. He was concerned with the tendency for abstract theorizing and the difficulty involved in linking theories with application (applied ethics). The response addressed this particular issue articulated by Wikler in Securing Access to Health Care:

> Philosophical writing on moral issues aims to improve, in certain respects, on day-to-day ethical reasoning. The chief difference is that we ordinarily take no special pains to ensure that our moral judgments are systematic. On occasion we back up our moral views by reference to moral rules, such as the doctors' 'First, do no harm.' Rarely do we try to defend these rules, or to resolve a conflict among rules, by referring to higher-order principles. This is ordinarily just as well, for most of us would quickly find that our moral outlook is not organized according to any consistent principle or set of principles. The assumption underlying much philosophical work on current moral issues, however, is that a reasoned, comprehensive theory of social morality may be achievable; or at least, that this ideal may be approached must more closely than is usually assumed. To the extent that this goal is pursued, the scope of intuition and ad hoc rationalization is reduced, and at the same time the debate is focused upon the most basic issues underlying the public debate. (113)

Here Wikler was discussing the general problem with applied ethics, which can be directed at all attempts to reconcile theory with reality. However, the point noted by

both philosophers was the need for a tighter analysis and a greater consistency if the gulf between theoretical ethics and applied ethics can be breeched. One method that Wikler pointed to was one based on using a single theory to ground principles.

Engelhardt Jr. discussed two problems with theory construction, or appeals to principles; the first often produces the fallacy of begging-the-question, whereas the second is susceptible to infinite regress. The first problem suggests that, in appealing to principles in order to reach a moral conclusion, the notion of a moral dilemma has already been inferred. For example, when one considers whether the physician is morally wrong to lie to the patient regarding her test results, and one appeals to the principle of autonomy for an answer, the problem is already seen as a "moral problem" with content. Engelhardt Jr. asserted, "[t]o have moral content, one must endorse particular moral premises or rules of moral evidence as a point of departure, thus endorsing one from among the class of available moralities" (59). To avoid this problem, the qualities that create a "moral dilemma" and what constitutes a "moral fact" would need to be agreed upon prior to questioning the answer to a moral dilemma. In the second situation, the appeal to foundation can continue to the point where one is consistently searching for another higher-order principle to justify etc. Of these two problems, the single-theory approach will minimise the effects of the fallacy compared to a multi-theory approach, but will be vulnerable to the infinite regress problem. However, I suggest that infinite regress is the lesser of two problems. Any theory can be susceptible to that particular criticism, whereas to minimise the affects of the fallacy will support the claim that consistency is necessary for the decision-making process.

I began the chapter with the key identifiers for the deontological and utilitarian aspects of the template. I applied these to the principles of the Canada Health Act to illustrate how different theories can logically define a similar principle in unique ways. This supports my claim that an ethical approach founded on one theory would be more consistent. Consistency is valued in the decision-making process because inconsistency can affect the direction and availability of health care resources. I concluded the chapter with a brief outline of three approaches to bioethical analysis, with emphasis on principalism and a single-theory approach. I offered reasons for choosing a single-theory approach; the fact that it offers greater guidance in decision-making and it minimises fallacious problems.

Chapter Three
History of the Canada Health Act and its Ethical Analysis

I will begin this chapter by highlighting certain aspects in the history of health insurance in Canada that led to the passing of the Canada Health Act in 1984. I will analyse historical research using my template to see if ethical considerations can be identified, and if so, which theory best expresses them.[23] The history of the Canada Health Act does not have a definite starting point. For practical reasons I will start my account approximately fifty years before the Act was passed, with the understanding that important pieces prior to this date will be mentioned in passing. This period corresponded with a particular event that is a good marker for the beginning of the national insurance program, the 1934 amendment to the Rural Municipalities Act in Saskatchewan. This particular development stands out because it was the first time that personal income tax could be collected for health care. In Taylor's work, Health Insurance and Canadian Public Policy, he suggested seven important decisions that shaped the development of health insurance. Taylor's book was well researched and detailed, making it an ideal guide for the historical section of this chapter.[24] The purpose of this section is to present a portion of the Act's history and to search for the possibility of ethical considerations.

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[23] This topic is one where the breadth and depth necessary to address the history adequately is not possible in this work. The focus here is to analyse key developments to see if there are indications of ethical reasoning. I hope to find enough to support further research in this area.

[24] Other sources that I will reference are Naylor's book Private Practice, Public Payment, work found in Perspectives on Canadian Health and Social Services Policy: History and Emerging Trends, and the 1964 Royal Commission on Health Services' Report. However, the majority of the work will come from Taylor's classic text.

History

Prior to 1934, interest in a prepaid health insurance scheme was sparked by three identifiable factors, an understanding of which provides context for the historical development of the Act. Naylor suggested that Canada's involvement in World War I and World War II altered the population's view concerning the role of government. An interest in social services, including health insurance, acknowledged that Canadians could accept a larger amount of government involvement in their lives. Naylor remarked on one particular event that brought the health status of Canadians to light. When men presented themselves for the physical examination needed to enter military service in the First World War, many were rejected due to poor health. Both Flood and Taylor referenced the Second World War and its rejection rates. Taylor mentioned the results from the Dominion Bureau of Statistics, which showed Canada as ranking seventeenth among developed nations for infant mortality rates in 1937. In 1951, results of the Sickness Survey showed "the information at hand reinforced what everyone knew, that Canadians were not a healthy people" (Taylor 5). The concern for Canadian's health and the need for health services for returning military men and women fostered an environment receptive towards social programs. This was noted by Morgan, who claimed "[t]he effect of the First World War was to be seen in the provision of allowances for the families of service men and in the establishment of pensions and medical services for the returning veterans as a federal responsibility" (88). This was one of the factors important in laying the foundation for the acceptance of a national health insurance scheme.

The second and third factors were linked together as cause and effect. The Great Depression of 1929-1941 resulted in doctors not being paid for their services. The Depression had a terrible effect on the Canadian economy. The municipalities were particularly hard hit because they were responsible for the poor due to the Elizabethan Poor Law tradition.[25] Taylor described the cause and effect in the following manner: first, due to the Depression, "[m]edical care, except in the direst emergency conditions, was a luxury that only few individuals or municipalities could afford" (4); the effect of this was that "[t]he medical profession thus bore the brunt of providing medical care to the indigent and their stacks of unpaid bills would be empty legacies for their heirs" (Ibid.). The financial uncertainties of both patients and physicians resulted in a general desire for a government policy that would guarantee payment for physicians and ease the financial burden of illness for the communities. Naylor mentioned the Canadian Medical Association's Committee on Economics that produced a report in June 1934. It reviewed the financial realities for physicians in the Depression and suggested a national health insurance plan as a possible solution to these financial difficulties. These three factors helped to create a social environment amenable to such a program.

I choose to begin the detailed history of the Canada Health Act with the amendment to the Saskatchewan Rural Municipalities Act in 1934 because this amendment allowed personal tax to be collected and used for health services.[26] I want

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[25] Cassidy described the function of the poor law methods as placing responsibility for the destitute on the municipalities, which became a problem in the 1930's when the municipalities were overwhelmed with requests. He wrote that the provision of relief was not mandatory, but that the municipalities, for example those in British Columbia, had "to 'make suitable provision for its poor and destitute'" (55). This consisted of offering "general relief and medical care for the needy" (Ibid.).

[26] For the purpose of clarity I will give the origins of this Act as it relates to this thesis. The original Rural Municipality Act, passed in 1909, began the process whereby municipalities formally acknowledged the importance of addressing health care needs within the community. Taylor stated, "one of the duties of the municipal council was to pass bylaws for the purpose of granting 'aid or relief to any needy person who is

to emphasize the importance of the change from property tax to personal tax. This change expanded the tax base and began the process of collective funding in support of health care services. The step from collective funding for services to a collective claim to receive services would be possible. Accessing such services would then not be limited to the destitute. Taylor observed the development as, "appear[ing] to be the first instance in which statutory authority was granted for the levying of a personal tax for health services in Saskatchewan and, indeed, in Canada" (72). Taylor noted the number of municipalities who "provided their residents hospital services at municipal expense" had grown to eighty-eight by 1942 (Ibid.). Referring to the initiative by local municipalities to invest in prepayment of medical and hospital insurance with the construction and maintenance of hospitals as an "understanding of the importance of health services" (Ibid.), Taylor observed that it was "a remarkable development not duplicated elsewhere in Canada" (Ibid.).

An important development in articulating the constitutional arrangements regarding financial responsibilities for health insurance was the appointment in 1937 of a Royal Commission on Dominion-Provincial Relations, also known as the Rowell-Sirois Report (Taylor). The creation of the Royal Commission was in reaction to the federal government's Employment and Social Insurance Act of 1935 where the federal government had structured its administrative and financial involvement in extensive social programs. Gelber noted that, "it was hoped, the federal government itself would

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a resident of the municipality'" (71). Many municipalities had provided hospital care for the indigent by collecting funds through general land tax. In 1916, the Rural Municipality Act was amended to allow physicians to be paid a retainer for their services and for the municipality to levy taxes to pay for the retainer. This amendment suggests the communities' desire to keep health care services available to the community by providing the salary for physicians to serve their health care needs.

directly administer a health and welfare program to be financed by premium payments" (159). The commission examined which form of government, provincial or federal, would have financial jurisdiction over health insurance and found that, "although the [British North America] Act did not expressly allocate jurisdiction in public health, ...the power over generally all matters of a merely local or private nature assigned to the provinces was probably, as the commission observed, 'deemed to cover health matters'"(Taylor 10). In 1940, the commission concluded that, of the federal and provincial governments, there would be "provincial jurisdiction over health insurance" (Gelber 160). This is significant because the commission's observations are realised in the division of political powers in the Canada Health Act.

Another important development in the history of health insurance occurred in 1940. Ian Mackenzie, newly appointed federal Minister of Pensions and National Health, had particular ideas for a post-war Canada. He made a request to Prime Minister King that unemployment and health insurance be incorporated into war measures policies to provide structure for the future demands of Canadians. Taylor quoted Mackenzie as saying, "a demand for health insurance is inevitable" (16). King rejected Mackenzie's suggestions on grounds that the government had to contend with other issues, prompting Mackenzie to take initiative on his own. J. J. Heagerty was the director of Public Health Services when Mackenzie requested that he incorporate the study of health insurance into his responsibilities. Heagerty would work with insurance committees made up of health professionals and other organisations gathering information on potential problems in creating an insurance program. Particularly important would be the involvement of the Dominion Bureau of Statistics because of the

huge amount of statistical information needed for such a task. In 1942, Mackenzie received approval from the Cabinet to continue Heagerty's work and to provide the necessary tools by including the Dominion Bureau of Statistics. This became the Inter-Departmental Advisory Committee on Health Insurance. It was "an internal 'task force' which, in the short space of a year, was to create the first blueprint ever drawn for a national health insurance plan for Canada" (Taylor 17). The Canadian Medical Association sent a 'Committee of Seven' to represent the physicians as stakeholders in such a scheme. They clearly stated their rejection of salaried or state controlled payment, but were supportive of "any fair insurance plan that would make curative and preventative services available to all Canadians regardless of income" (Naylor 99).[27]

The Heagerty Report, the product of the Inter-Departmental Advisory Committee, suggested six principles that a federal program should follow. They are listed here:

> 1. That no scheme of health insurance can be successful without a comprehensive public health program of a preventative nature;
> 2. That a real health program as distinguished from a policy of cash benefits can be effective only if it embraces the entire population;
> 3. That the principle of compulsory contributions should be embodied in any plan of health insurance to the greatest possible extent;
> 4. That public opinion and efficiency demand to the greatest possible extent a national plan;
> 5. That the Constitution, as at present understood and interpreted, prevents the Dominion Parliament from adopting a single comprehensive national Health Insurance Act;
> 6. That, for practical reasons, a constitutional amendment is not desirable. (Taylor 18)

[27] The political reasons behind the dispute between physicians and politicians are important, but not the focus of this work. For further reading, see Taylor and especially Naylor's, work.

These are important because they are the first example of an extensive, multi-disciplinary survey of health insurance and instrumental in the development of the Green Book proposals that presented a post-war vision for Canada, including health care.[28]

In the preface of his text, Taylor classifies six decisions that created health insurance as "determinative," meaning, "they launched the system and created the program design" (xiii).[29] Three were federal: the Green Book Proposals (1945), hospital insurance (1956), and medical insurance (1966), and three were provincial; Saskatchewan hospital insurance (1946), Ontario hospital insurance (1955), and Saskatchewan medical care insurance (1959). I will take the six dates that Taylor has deemed determinative as a guide to the key aspects in the history of the Act. I will examine these decisions and later use the template to look for the possibility of ethical considerations.

The Green Book proposals specifically addressed health concerns in a fashion that was, according to Taylor, "bold, imaginative, and comprehensive" (3). The four areas where the federal government would provide financial assistance to the provinces were; "Grants for Planning and Organization"; "Health insurance grants for a wide range of benefits"; "Health Grants"; and "Financial Assistance in the Construction of

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[28] The Green Book proposals refer to sweeping changes in tax reform to support new social welfare programs presented at the 1945 Dominion-Provincial Conference on Post-War Reconstruction. The proposals were to address the burgeoning concern for protection from destitution and disease. Government involvement in social insurance schemes could help protect Canadians from the effects felt in the depression and during the war. The name refers to the colour of the document's cover.

[29] I have chosen to leave out Taylor's chapter on Quebec's decision on medicare. I believe it does not add any additional information to this topic. It primarily discusses the health of the population, the social status of physicians, and the effect of the specialist strike within Quebec. The physicians did abandon their sliding scale fee for patients and adopted fee-for-service payments. This did allow the population to access health services, but these achievements had already occurred in other areas of Canada. For further interest, see Taylor's Chapter Eight, pages 380 – 413.

Hospitals" (Taylor 3). The first provided funds for staff and their training in preparation for administering this type of health insurance. The second provided financial assistance for provincial governments "to develop and administer a comprehensive health insurance program" (Taylor 51). The Health Grants provided for those situations where "the government had removed the condition that they would be available only if the province introduced health insurance" (Taylor 53). The federal government could offer these grants so that provinces could begin to receive funding without a proper insurance scheme in place. The fourth allowed loans for the creation of hospitals. A new ambitious goal was in place to create a national health insurance program and its first federal steps had been proposed, but not adopted. Taylor offered his insight into an outcome of these proposals. He ended his chapter on the Green Book proposals by writing, "[m]ost important of all, there had been developed, and enunciated for all to ponder, a national initiative that might be postponed, but not be permanently ignored, to act in behalf of the average citizen who daily faced the potentially catastrophic physical and financial consequences of unpredictable illness, accident, and disability" (68).

The second decision was when Saskatchewan created a provincial hospital insurance program and pioneered the implementation of universal insurance, in this limited form. Taking direction from the Heagerty Report, Saskatchewan's Liberal government introduced "A Bill Respecting Health Insurance" on March 31, 1944, and "gave it first and second reading on the same day" (Taylor 77). However, due to the provincial elections in the province the launching of "the first universal hospital services plan in North America" was delayed for two and a half years (Taylor 78). The majority win by the Cooperative Commonwealth Federation allowed Tommy Douglas to become

Premier and hold the position of Health Minister. The impact of his vision on Canadian health care is undeniable. The following quotation from Douglas in Health Insurance and Canadian Public Policy summarises his personal agenda:

> I made a pledge with myself long before I ever sat in this House, in the years when I knew something about what it meant to get health services when you didn't have money to pay for it. I made a pledge with myself that someday if I ever had anything to do with it, people would be able to get health services just as they are able to get educational services, as an inalienable right of being a citizen of a Christian country. (80)

These words clearly express the importance Douglas placed on access to health care services.

Taylor stated particular areas where government involvement had been proven possible. Taxes could be collected by municipalities and used to fund "essential health services" (82). These taxes would be used to build and maintain hospitals as well as to pay for physicians' services. The municipalities "could combine on a province-wide basis to insure against catastrophic costs to any one of them," and "in the case of a specific disease (cancer), provincial government action could mobilize expensive resources to pay for services provided to individuals" (Ibid.). There was a possibility to implement the type of system that Douglas had envisioned

In 1944, the Saskatchewan government had set out to provide a "comprehensive health services plan for all individuals receiving regular social assistance payments" (Taylor 87). Approximately 28,000 people would be covered and "each beneficiary should be insured for the costs of the authorized health services" (Ibid). The importance of providing health services for the poor would be the first step to providing insurance

for everyone. The goal of the health commission would be just that; "to provide complete medical services to all people of the province, irrespective of their economic status or of whether they lived in town or country" (Taylor 88). However, the need for hospitals was seen as a priority. The care received in the new (and established) hospitals would be the focus of universal coverage and a stepping-stone for the future acceptance of medical insurance.

The Saskatchewan Hospitals Services Plan, which "established a universal, compulsory hospital care insurance system" was introduced on March 12, 1946 and received Royal Assent on April 4, 1946 (Taylor 104). The taxing of a population is never popular, but the lack of public outcry over the taxes for compulsory hospital insurance made this legislation "the most widely endorsed program the government introduced in its first twenty years of office" (Ibid.). The residents of Saskatchewan were the first in Canada to receive health care services based on compulsory prepayment of insurance and they seemed to accept and pay for these services willingly.

Saskatchewan's decision pioneered the route for other provinces to continue pushing for a national insurance program. The next province to adopt hospital insurance was Ontario. The major difference between Saskatchewan and Ontario was that many people in Ontario were voluntarily buying insurance provided by private companies or the Blue Cross. In contrast to Ontario, as noted, Saskatchewan had collective municipalities working together and a socialist government supporting the implementation of a universal insurance scheme. Ontario had a Conservative government and a leader who "was not committed to health insurance" (Taylor 125). There was also a large and established commercial insurance industry in the province.

Those in the industry would not want a provincial insurance scheme to interfere with their business. Ontario's population was voluntarily purchasing commercial insurance and may not have been comfortable with compulsory taxation that supported a provincial plan. These factors made the environment in Ontario more challenging for the acceptance of a provincial health insurance scheme.

Ontario's Premier Frost was hesitant to invoke sweeping change in Ontario. However, according to George Gathercole, a close former advisor, Frost was a reformer, "albeit a moderate reformer" (qtd. in Taylor 124). Frost would need a higher political authority to provide funding and administrative guidance to facilitate a transition towards public health insurance in his province. To this end Ontario's Premier Frost orchestrated the push for the federal government to take such steps towards universal health insurance. In the spring of 1955, Prime Minister St. Laurent addressed the Premiers at a conference where he spoke about the federal agenda. Taylor referenced St. Laurent's insistence that there was no federal interest in changing constitutional arrangements regarding healthcare, arrangements that the federal government considered as falling under provincial jurisdiction. Provinces would be 'responsible' for health care, but dependent on federal money if the universal standards were to be realised. Another important factor was St. Laurent's mention of needs and their function in accessing health care services via a national health insurance scheme. St. Laurent stated:

> For a number of years, through the national health grants program, we have provided assistance in the development of a full network of basic health facilities and services fitted to the needs of the Canadian people. We recognise that the building up of these facilities through the national health program constitutes, in the words of my predecessor, Mr. King, 'a fundamental prerequisite of a nationwide system of health insurance.' (qtd. in Taylor 211)

That next autumn, at the re-convened conference, Premier Frost reminded the attendees "of the length of time that health insurance had been proposed" (Taylor 131). He then presented "four elements in a comprehensive plan" that would include home care; in-patient care for tuberculosis and mental hospitals; in-patient care for chronic care, convalescent, and general hospitals; and most importantly, in-patient and outpatient diagnostic services (Ibid.). The needs of the Canadian people were addressed with this inclusive proposal. St. Laurent then proposed a committee to investigate health insurance, the Federal-Provincial Health Insurance Committee.

The federal government later countered Ontario's proposal with one of its own, outlined by Taylor. Important for my thesis topic was the inclusion in the federal proposals of government assistance for any province interested in implementing hospital insurance. Diagnostic services and hospitals would be a priority, but there would not be federal assistance for mental hospitals or tuberculosis. Taylor listed the three features of another important policy regarding provincial hospital plans. One, coverage would be available to all residents of the province (universally). Two, laboratory and radiological diagnostic services to in-patients would be provided and outpatient services would begin within a period of time agreed upon between the federal and provincial governments. Three, charges that would interfere with patients receiving services at the point of entry would be limited to make sure residents would not feel financial hardship in accessing services. The principles that would eventually establish the Canada Health Act were taking form.

Before the Hospital Insurance and Diagnosis Services Act of 1957 (HIDS) was passed, there were questions about its structure. Taylor enquired, "[w]hat construct of values should underlie the program?" to which he added, "should the health insurance formula contain an element of equalization or was that a principle to be ignored by any specific program and negotiated separately within the framework of tax agreements?" (201). The federal government did provide funding for "the inauguration of a phased health insurance program" (Gelber 162). The provinces had to provide the traditional services performed in hospitals, but funding outpatient services was optional. Gelber wrote, "a primary principle of the program was that insured services must be made available to all residents on uniform terms and conditions" (163). One question that Taylor raised was; "what degree of uniformity and what standards of quality should be nationally determined, and what degree and kinds of federal control would be necessary to achieve those standards?" (202). The HIDS Act did aim to offer universal coverage for a certain part of health services; those inside the hospitals (although not for the mentally ill nor tuberculoses patients). I suggest that it was an important step in addressing service delivery for the Canadian population in a universal fashion.

Despite the political dance between the Conservative Premier Frost and the Liberal Prime Minister St. Laurent, the amendments to the Ontario Hospital Services Commission Act were passed on March 28, 1957, and the Ontario Hospital Services Plan took effect on January 1, 1958. Shortly after the amendments were passed in Ontario, the federal Hospital Insurance and Diagnostic Services Act passed on April 12, 1957 and became law on May 1. The Hospital Insurance and Diagnostic Services Act began to take effect on July 1, 1958 with the participation of "the first five provinces to

participate – British Columbia, Alberta, Saskatchewan, Manitoba, and Newfoundland" (Gelber 163). When Quebec started their program by January 1, 1961 "virtually all residents of all the provinces and territories were covered for hospital insurance and diagnostic services" (Ibid.).

The next step towards universal health care was to include outpatient services. Saskatchewan, again, led the country by passing the Medical Care Insurance Act to provide universal medical insurance for its population. Premier Douglas presented five principles in a radio broadcast on December 16, 1959, which he believed could be the foundation for such a scheme. They were; "the prepayment principle"; "universal coverage"; "high quality of service"; "[a] government-sponsored program administered by a public body responsible to the legislature and, through it, to the entire population"; and delivery that occurred in "a form that is acceptable both to those providing the service and those receiving it" (qtd. in Taylor 278). These principles were articulated by the Saskatchewan government and can be seen as a blueprint for the principles in the Canada Health Act.

The strike action taken by physicians did prompt the provincial government to clarify their position. The Royal Commission on Health Services (The Hall Commission) came to Regina and on January 22, 1962 the provincial government "outlined its philosophy with respect to health services as a basic right, asserting that 'Health services must be viewed as public services which can be best planned, organized, administered, and financed by governments'" (Taylor 289). The movement from universal coverage and access to comprehensive hospital and diagnostic services had now taken on the requirement for public administration.

The Hall Commission was released in 1964 and was considered "a body blow for the medical profession and the insurance industry" (Naylor 221). The force was in its Health Charter, which contained eight standards supporting a comprehensive and universal "Health Services Programme for the Canadian people" (The Royal Commission on Health Services 11). In its opening chapter, the commission addressed individual responsibility and public interest. The commission reflected a change in philosophy regarding public health from "community measures to prevent and control communicable diseases" (4). The new interpretation for public health is described in the following quotation from the Hall Commission's report:

> The first is a deepening of our humanitarian concern for our fellows. We recognize that the well-being and happiness of the society is simply the sum total of the well-being and happiness of its individual members. It is clear that the well-being of a proportion of the population at any given time is seriously curtailed because of mental or physical disease or impairment that, strictly by the laws of chance, could strike any one of us. (5)

The commission recommended a conference that would address federal and provincial governments within six months. The first chapter from the report ends with the succinct suggestion:

> We do not suggest that the various provincial programmes be required to conform to any rigid pattern, but to qualify for federal support they need to provide, in whatever manner may be chosen, universal coverage in the province regardless of age or condition, or ability to pay, upon uniform terms and conditions, and to adhere to the basic inclusive features of each of the programmes recommended. (15)

This quotation indicates the basic underlying philosophy of the Hall Commission's recommendations. Whether the government would accept them would be the next hurdle to overcome in the path to universal national health insurance for all services, both within and outside of the hospitals.

The Federal-Provincial conference began on July 19, 1965 and the Federal government presented four principles that would form a foundation for a national proposal. They were:

> 1) The scope should include all services provided by general practitioners and specialists.
> 2) The plan should cover all residents in a province on uniform terms and conditions.
> 3) The plan should be publicly administered by the government or by a non-profit agency.
> 4) The plan should provide full transferability of benefits to recognize that Canadians can be either absent from their home province or move (Taylor).

The criteria that would eventually become principles in the Canada Health Act were presented to the Premiers and the public. The debate between the provinces and the federal government continued however, and the result was that on December 8, 1966 Bill C-227 was read for the third time and ultimately passed on December16, 1966. Royal Assent was given to the Medical Care Insurance Act on December 21, 1966 with only Saskatchewan and British Columbia qualifying when it took effect on July 1, 1968. When the Yukon territories joined on April 1, 1972, all of Canada was covered under this Act. The Medical Care Act provided 50% of the cost for physician services, regardless of where they were performed, provided that the provinces "had a health

insurance plan that was universal, comprehensive, portable, and financed through a publicly administered non-profit body" (Flood 17).

The next important piece for my thesis is the 1980 health services review, headed again by Emmett Hall, which investigated charges of extra-billing, user-fees, and redirected funding into non-health areas.[30] Two considerations of the five are directly applicable to my thesis topic. One is "the extent to which the principles of portability, reasonable access, universal coverage, comprehensive coverage, reasonable compensation, and uniform terms and conditions are being achieved" (Taylor 429). The other is "whether there should be other basic principles underlying health insurance delivery" (Ibid.). Hall, when discussing whether user-fees infringed on the principle of reasonable access, replied, "[h]ealth services were no longer items to be bought off the shelf and paid for at the checkout stand. They were a fundamental need, like education, which Canadians could meet collectively and pay for through taxes" (Taylor 430).

Another task force was commissioned by the Liberal government in 1980 to investigate user fees and extra-billing, and their impact on the idea of reasonable access.[31] This was an *ad hoc*, federal government appointed, all-party House of Commons task force set to examine fiscal relationships between federal and provincial

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[30] A major development in the funding mechanism was the change in 1977 to the Federal-Provincial Fiscal Arrangements and Established Programs Financing Act (EPFA). It tied the transfer payments to the provinces, previously based on 50/50 funding arrangements, to the Gross National Product. However, for this work, I will only mention the change in the funding mechanism in passing. One effect of the EPFA is that the federal government has provided less money over time than would have been provided by the former 50/50 arrangement. However, this information is not necessary for this ethical analysis. The development of the principles of the Canada Health Act is the focus for this chapter. It is another question for society to decide which part of the overall budget should be allocated to health care. This could be an area for future research.

[31] Flood distinguishes between user-fees and extra-billing. User-fees are when the patient pays out of pocket for a service, for example $10 for a doctor's visit. Extra-billing is when the physician bills both the national health insurance and the private health company. For example, a patient who has extended health benefits from their employer sees a physician and receives services. The physician could bill both the private insurance agency and the provincial insurance scheme.

governments. This task force concluded that user-fees were not a barrier to reasonable access. However, it also "endorsed the view of the Health Services Review that the 'user pay' concept is contrary to the principles and spirit of the National Health Program" (Taylor 432). Political consensus among the task force members on the subject of extra-billing was elusive. The Conservative members on the task force recommended that if a physician decided to charge extra fees he or she would have to opt out of the insurance fee-for-service payments entirely for all patients. The discussion of reasonable access had reached the above conclusions; user-fees were not a barrier for reasonable access, but not in the spirit of the program and no consensus on extra-billing. The task force also addressed the subject of whether Canadians "were committing a sufficient proportion of national resources to meet their essential health care needs" (Taylor 433). It compared Canada to eight other western nations, including the United States, and discovered that only the United Kingdom and New Zealand spent less money on their health care system (Taylor). The task force also commented on the difference between Canada and the United States regarding their funding of the health care system. Its conclusion was that the difference in these two countries' spending was "irrelevant" and based on different philosophies: "Canadians are endeavouring to develop a health care system directed to health needs – not a competitive system to serve an illness market" (Taylor 433). The release of this task force report would be the last important step and paved the way for the Canada Health Act.

The Canada Health Act was the product of merging the Hospital Insurance and Diagnostic Services Act of 1957 and the Medical Care Act of 1966. Bill C-3 was passed unanimously on April 17, 1984 and Royal Assent was granted the same day. The final

product of years of debate and hard work was seen in this important document. I have mentioned the principles contained in the Canada Health Act in the previous chapter, but they deserve mentioning again now that there is a context to their development. The principles of accessibility, universality, comprehensiveness, public administration, and portability had now been articulated and would become the backbone for the Canadian health care system.

The focus of the historical section was to mark particular developments in the history of the Canada Health Act. I chose Taylor's work because of its in-depth analysis of the path to national health insurance. I have chosen pieces that lead from 1934 to 1984 to illustrate how the principles developed. The next section of the chapter will look for ethical considerations in the Act's development.

Analysis

My analysis examines key points in the Act's history to see whether ethical considerations are present, with significant pieces referencing 'needs'. Health care needs can be defined with utilitarian and deontological theories. The context can suggest which interpretation is probable. I will start the analysis in chronological order and finish the chapter by noting particular trends, if any, throughout the process.

The poor health status of the Canadian population was a catalyst for action. The solution(s) and method(s) for addressing the health concerns is where the analysis can search for signs of ethical considerations. The 1909 Rural Municipalities Act's mention of the need for health services as enough for the council to grant aid suggests the second

indicator of the deontological template.[32] There is no stipulation that the first indicator of the utilitarian template is active, whereby aggregate utility is a consideration. For this reason, I claim that a deontological consideration was present when this Act was passed. When the 1934 amendment was passed the tax base expanded from property tax to personal tax. I suggest that this promotes an idea of inclusion (of those of working age) in the Canadian community, not based on property ownership, which is limited. The term 'rights' is not stated, as per the first indicator in the deontological template, but the movement from property to personal tax suggests a claim to health services based on majority age.[33]

The Heagerty Report promoted six principles that would be guidelines for a federal program; four are useful for the analysis, the other two address constitutional arrangements.[34] The first one is "[t]hat no scheme can be successful without a comprehensive public health program of a preventative nature" (Taylor 18). The notion of comprehensive public health indicates the second deontological indicator where general health care needs, not simply acute care needs of the indigent, are adequate for access to services; it is egalitarian in nature. Preventative health would promote healthier overall population outcomes, as per the first indicator from the utilitarian template, showing a utilitarian consideration. This appears to be a mixing of theories. The second principle is "[t]hat a real health program as distinguished from a policy of cash benefits can be effective only if it embraces the entire population" (Ibid.). The

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[32] I feel it is important for clarity to address the origin of the Rural Municipalities Act because it specifically mentions health care needs.

[33] I suggest that prior to individual income tax, dependents are included with their parent's taxes, and are effectively 'paying' into the system.

[34] The other two principles stated that the Constitution prevented a national health insurance act and that constitutional changes would not be practical (Taylor).

notion of the entire population suggests an egalitarian equality of opportunity that does not focus on utility maximisation. Although the population is mentioned, the utilitarian calculations would need to be based on maximising population health outcomes. Mentioning a policy of cash benefits as not 'real' suggests that cost/benefit considerations may be what the commission is attempting to avoid. The third principle is "[t]hat the principle of compulsory contributions should be embodied in any plan of health insurance to the greatest possible extent" (Ibid.). A rule-utilitarian principle of compulsory contributions could be functioning and would be in affect until the aggregate utility would decrease. The fourth principle is "[t]hat public opinion and efficiency demand to the greatest possible extent a national plan" (Ibid.). The mention of public opinion and efficiency suggest utilitarian considerations via majority rule. Cost/efficiency can be incorporated into both deontological and utilitarian theories once the decision for a particular program has been made. However, if efficiency alone is mentioned, it is suggestive that it overrides other considerations. Nothing here is mentioned for a particular goal, save for a national plan. For this reason I suggest that efficiency and working with public opinion point to utilitarian considerations for this principle. Thus, the principles in total appear split between the two theories, indicating that mixed-theories (and an inconsistency) underlie the Heagerty Report.

The Green Book proposals incorporated recommendations from the report, however, I detect a deontological framework in these proposals. The second proposal that funded provincial governments in the establishing of a comprehensive program would address the needs of the population in an egalitarian fashion. The last paragraph

from Taylor is ambiguous.[35] To shelter the average citizen via prepayment of health insurance can be justified by utilitarian considerations, especially since the municipalities were responsible for the direst of its members. Taking steps to minimise financial risks can be a utilitarian calculation. It can also be interpreted as a duty related to the first indicator from the deontological template. I believe the tone, however, is deontological; an egalitarian basis for a comprehensive health care program indicates that the nation had a duty to protect its citizens from the unpredictability of disease or accident by addressing their health care needs.

The Saskatchewan initiative prepared by Tommy Douglas' government suggests a definite deontological tone. His personal vision saw health care as a right although his personal opinion and governmental procedures could differ. The first indicator from the deontological template may be active, but also the third from the utilitarian template. More analysis is necessary. The government's ability to address particularly expensive health care needs suggests deontological considerations where cost is seen as secondary to meeting needs (the second criterion from the deontological template). This reflects the movement to insure the poor first and then provide "complete medical services to all people of the province, irrespective of their economic status or of whether they lived in town or country" (Taylor 88). This suggests an egalitarian approach based on provincial status as a resident. Population indicators to limit services are not 'complete' nor 'to all people', indicating a rejection of utilitarian considerations. Health care needs are

[35] The paragraph referred to states "[m]ost important of all, there had been developed, and enunciated for all to ponder, a national initiative that might be postponed, but not be permanently ignored, to act in behalf of the average citizen who daily faced the potentially catastrophic physical and financial consequences of unpredictable illness, accident, and disability" (68).

necessary for access to services, not the ability to pay, which indicates an egalitarian approach.

Prime Minister St. Laurent directly mentioned needs in 1955 when he stated "we have provided assistance in the development of a full network of basic health facilities fitted to the needs of the Canadian people" (qtd. in Taylor 211). Here he was not mentioning programs that maximise utility, but simply stating needs. As noted, the context would offer clues to whether the term is utilitarian or deontological. I suggest that St. Laurent meant a deontological egalitarian interpretation. The national insurance program does not have the weakness of traditional insurance programs that exclude those who are most needy, and he was not suggesting a national insurance program that follows this traditional route. The maximisation of population health was not suggested, but rather services that are fitted to health care needs. For this reason I suggest that the use of needs in this context is deontological in nature. St. Laurent also mentioned the majority rule when discussing whether to tax the population to support the national insurance program. This indicates a utilitarian consideration, particularly the rule-utilitarian feature of the template. St. Laurent's rule to "embark upon provincially administered health insurance schemes" would change once the overall utility decreased (qtd. in Taylor 212).

The Hospital Insurance and Diagnostic Services Act of 1957 began a process of providing hospital services for all of Canada. I suggest that this indicates an extension of Saskatchewan's initiative where inclusion in the population is enough for a rights claim to access services. The provision of these services can be interpreted using the deontological template (the first indicator) where the benefits do not play into whether

the government should provide such services. Yet, the overriding criteria could be St. Laurent's majority rule criteria, meaning that considerations of utility would be the deciding reason for implementing insurance.

The next move was towards accessing services outside the hospital environment. Premier Douglas passed the Medical Care Insurance Act. Universal coverage for its population for medical services indicates a deontological egalitarian consideration; as does the quote from the Saskatchewan government's address to the Hall Commission. The provincial brief stated, "[h]ealth services must be viewed as public services which can be best planned, organized, administered, and financed by governments" (Taylor 289). The idea that health would be included in services, such as education, infers a right by citizens to that service. The idea that health needs would be enough to have access suggests the first indicator from the deontological template. However, the third indicator from the utilitarian template might be active if the best method for maximising utility would be to provide services. The important piece is that needs are sufficient to access services.

The Hall Commission also presented indications of deontological reasoning. When the Commission rejected traditional health insurance schemes and supported a national health insurance "regardless of age or condition, or ability to pay", the first deontological indicator is suggested (15). Considerations of utility are not active, but rather an egalitarian approach based on being included in Canadian society is present. The egalitarian approach is indicated as a theme throughout the history of the Canadian Health Act. When the Hall Commission addressed individual responsibility and public interests, the reasoning, taken in isolation, can be utilitarian. The quote regarding "the

well-being and happiness of society is simply the sum total of the well-being and happiness of its individual members" is aggregate utilitarian reasoning (5). Yet, because the commission was advocating for comprehensive, universal coverage as a method for respecting the innate concern for the human condition, I suggest the motivation is egalitarian and a deontological philosophy. If the commission was advocating respect for the population via each individual member, then this achievement can be met via an egalitarian needs-based approach; a deontological approach. When making a policy for its citizens that must include all concerns for well-being, not just those that would promote aggregate utility, the process suggests a deontological duty towards others (the first indicator). However, the rule-utilitarian approach could support this same policy until aggregate utility was insufficient to maintain it. That physical disease or impairment can distract from the pursuit of well-being indicates the second criterion in the deontological template in which health needs alone can justify access to care. Finally, as mentioned earlier, the statement that suggests coverage regardless of ability to pay, age, or condition, and the achieving of services on uniform terms and conditions, indicates an egalitarian deontological philosophy. I believe, when taken in total, these excerpts from the Hall Commission indicate a tone that is deontological in nature.

The Medical Care Insurance Act of 1966 provided coverage that was "universal, comprehensive, portable, and financed through a publicly-administered non-profit body" (Flood 17). The universal principle suggested by the federal government in 1965 suggests the first indictor from the deontological template as a right to coverage corresponding to residency. The use of uniform terms and conditions suggests an egalitarian approach rather than a utilitarian approach, where utility may be maximised

by not providing coverage on such terms, such as a conventional insurance methods. The comprehensive principle that includes services from both general practitioners and specialists also suggests the second deontological indicator where needs, even those that are beyond basic care, are necessary to access services. There is no mention of services that maximise utility or whether cost/benefits would be used to limit services; indicators from the utilitarian template. Public administration can be interpreted with the first deontological indicator as a right to these public services, such as education, and the obligation by society (government) to provide them. The role of government had expanded after World War I and World War II with social programs to help individuals from destitution. Public administration can also be linked to the first and third indicators from the utilitarian template where the population as a whole benefits and this rule should be followed to maximise utility. However, I would suggest that the public administration is necessary to guarantee certain services to the public on an egalitarian fashion and this is inferred by the historical development of the social programs, including health care. The principle of portability can be interpreted as an extension of universality in its transferability between provinces. This can suggest the first and second indicators from the deontological template where a right would be based on the egalitarian interpretation. Regardless of movement within Canada, society would have a duty to provide coverage and access to services would remain. Needs for services would also be necessary to access the system, regardless of which province the person was in at the time. The first indicator from the utilitarian template could be active because the portability principle could suggest that the benefits of the population are best served by allowing access to services. However, a problem would be apparent if

another province did not allow 'full transferability of benefits.' This indicates that population health calculations would not function within a program that wanted full transferability of benefits. For this reason, I suggest that the deontological interpretation fits. The Medical Care Insurance Act of 1966 appears to have an overall tone that is egalitarian deontological in nature.

The health services review by Hall in 1980 examined user-fees and extra-billing, as did the *ad hoc* all-party House of Commons task force. Hall found that user-fees interfered with his interpretation of reasonable access because he saw health services as a fundamental need, and used education as an example. This is indicative of the second deontological indicator where needs justify access. The task force found that user-fees, although not a barrier, were not in the spirit of the program. The point here is that financial barriers should not obstruct the access of services. The task force also mentioned the philosophy of the Canadian health care system is directed to needs, not profit. This is indicative of deontological reasoning.

Summary

The tone of the historical analysis seems to be deontological in nature based on particular developments in the brief historical evidence.[36] I will briefly summarise the analysis indicating where utilitarian reasoning seemed apparent through the developments. Then I will review the deontological indications in this history of the Act. Based on these developments, I claim that there is evidence of ethical

[36] The purpose here is to indicate whether there are ethical considerations and which type of theory fits with these considerations. A larger project that would allow a larger historical analysis could be the direction for future research.

considerations and that a deontological interpretation would best fit the spirit of these considerations.

It is important to mention that the deontological analysis where I advocate for an egalitarian needs-based interpretation could also be understood, in its entirety, as a function of the third indicator of the template; a rule-utilitarian derived rights that maximises utility. This criticism would be based on the following point. The purpose for developing a health care system in Canada was to address the needs of the population to increase health status, thereby maximising utility. This is an important consideration and will be addressed in more detail in the fifth chapter when I advocate the use of a deontological theory when allocating resources. This observation should not distract from the purpose of the analysis in this chapter, but it is important to mention it as a possible criticism of my conclusion.[37] To continue, the utilitarian considerations were apparent in the following areas. The Heagerty Report suggested preventative health, which would function to maximise population health indicators. Compulsory contributions could possibly be utilitarian, but public opinion and efficiency were a better indication that the majority-rule would prevail. The next possible indications were apparent in one element of the Green Book proposals; preventing financial and physical hardships by compulsory pre-payment of health insurance. Calculating risks can be interpreted as considerations of maximising utility. The next development is St. Laurent's mention of majority-rule to move forward to create a national insurance program based on compulsory taxation. The Hall

[37] The conclusion is that a deontological interpretation best captures the development of the principles in the Canada Health Act. As noted, I will address this properly in Chapter Five. The third indicator from the utilitarian template that indicates a right will not be mentioned in the summary as I have outlined why these deontological rules could be interpreted as a function of a utilitarian consideration. I will only mention other utilitarian considerations for the summary

Commission report's quotation, "the well-being and happiness of society is simply the sum total of the well-being and happiness of its individual members" on its own does indicate utility considerations, however, I suggested the context in which it occurs is more indicative of deontological reasoning (5). The Medical Care Insurance Act of 1966 suggested possible utilitarian considerations. The principles of portability and public administration may be indicative of the first indicator from the utilitarian template where maximised aggregate population health outcomes measure success. These were the indications of utilitarian reasoning in the historical analysis.

The developments in the historical research that point towards a deontological interpretation were the following. The need to address health services as a social duty is apparent in the earliest form of the Saskatchewan Rural Municipality Act of 1909. The 1934 amendment where the tax base changes to include personal income tax was pointed out as possible beginnings for a rights-claim to services. Next, certain recommendations by the Heagerty Report, particularly the desire for a comprehensive program, suggested the second indicator whereby egalitarian concerns were apparent. Egalitarian concerns were also evident when the Report recommended a program that would need to be available to the whole population. The Green Book proposals were seen as primarily deontological in nature based on a duty to address health care needs in a comprehensive program, therefore suggesting egalitarian needs-based concerns. Addressing health care needs were again the overriding concern for the Saskatchewan government under Douglas and the initiative to provide care via the Hospital Services Plan of 1946. The plan did not suggest only those needs that would maximise the population outcomes. St. Laurent mentioned health care needs and the best method to

address them, not simply the needs that would promote overall healthy outcomes. The best method to address health care needs would be a national insurance program. As mentioned, a program was developing that would fit the needs of the population. The Hospital and Diagnostic Services Act of 1957 would begin to capture that philosophy because the services provided inside the hospitals were inclusive and did not simply maximise the population's health.

So far in the analysis an egalitarian needs-based approach that is deontological in nature is the theme throughout the historical information. The next move in addressing needs outside the parameters of hospital services was the Saskatchewan Medical Care Insurance Act of 1959. The Saskatchewan initiative was based on a rights-based approach as mentioned by its brief to the Hall Commission. The Hall Commission itself was interpreted as primarily deontological in its recommendations. There were ambiguities in the federal Medical Care Insurance Act of 1966. If the deontological trend that has developed so far is correct, then the basis for this Act would probably lean towards deontological reasoning. Again, health care need is the basis for accessing services. The final pieces examined were Hall's review and the House of Commons' task force that both examined user-fees and extra-billing. The discussion indicated deontological indications in the judgements from Hall that user-fees restricted access. The task force was not in agreement regarding extra-billing, but found user-fees to contradict the spirit of the health care program. Considering their further comments regarding the philosophical basis for the health care system as one that determines needs, and needs alone, as necessary for access to services, I suggest that the deontological interpretation is the one that best fits this philosophy.

In total, when these pieces of the history of the Canada Health Act are considered, I suggest that the tone of the process is one that reflects a deontological interpretation. This interpretation is based on an egalitarian rights-based approach founded on health care needs that would override concerns of population health outcomes for access to services. The principles in the Canada Health Act were analysed with both a utilitarian and a deontological framework in Chapter Two. Based on the historical evidence, albeit at this cursory level, the tone is deontological, indicating that the best method for interpreting the principles of the Canada Health Act would be deontological. The next chapter will examine whether decision-makers use a single-theory or mixed-theories in a health care region in Canada. The information from this chapter will be used in Chapter Five where I advocate a single-theory approach that is deontological in nature when decision-makers allocate resources.

Chapter Four
Case Study of the CEO Interview and its Ethical Analysis

I will begin the chapter with a brief overview of the HEALNet project to explain the background of the case study in which I interviewed a CEO of a health care region in Canada.[38] I have selected only some questions to represent this one interview; overall the HEALNet interviews were semi-structured and designed to allow the identification of logical inconsistencies concerning allocation decisions.[39] Therefore, the specific questions I have selected, and by extension the ones I have omitted, do not impact the overall value of the case study as an opportunity to observe a real life situation. I will present benefits and limitations of using one case to acknowledge why its inclusion is appropriate. Then I will apply the template to show how an ethical analysis functions and its results. The chapter will conclude with a summary of the results from the analysis and possible implications for service delivery in health care.

The Case Study

The HEALNet project, of which the interview for the present study was a part, was exploratory and qualitative rather than statistical in nature.[40] Six interviews were conducted in three regions of Canada: Western, Central, and Atlantic Canada.

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[38] The project was supported by a grant from Health Evidence and Application Linkage Network (HEALNet). HEALNet was one of 18 federal Networks of Centres of Excellence funded through the Natural Sciences and Engineering Research Council, the Canadian Institutes of Health Research, and the Social Sciences and Humanities Research Council. Its focus was on evidence-based knowledge and technologies and their application to decision-making in the health care sector.

[39] The full set of questions will be added as an appendix.

[40] See Kluge and Tomasson. "Health Care Resource Allocation: Complicating Ethical Factors at the Macro-Allocation Level."

Seventeen invitations to participate in the study were extended, resulting in ten affirmative responses; from these, six were chosen, representing each region equitably.

Prior to the interview, each chief executive officer, or equivalent, received a consent form stating the possibility that information collected during the interview may be used in the interviewer's thesis, should it be chosen for the case study. The particulars of the agreement stated that confidentiality would be maintained to allow for candid responses. Names and any other identifying factors in the responses were omitted; thus, answers may not be identical to the transcript.[41] The interviewees did not receive a copy of the questions prior to being interviewed, but one was provided during the interview process. The decision to withhold the questions prior to the meeting ensured that the responses were intuitive and unrehearsed, resulting in accurate responses for the analysis.

There were seven groups of questions, each consisting of two to seven individual questions. The first section asked whether the subject faced allocation decisions where competing claims had to be addressed. An affirmative response was required in order for the interview to proceed. The CEO was then asked to cite examples in order to demonstrate that he fully understood the question before continuing.[42] The second section consisted of seven questions determining allocation considerations, values, and the corporate mission statement (if one existed).[43] This section offered the greatest insight into the CEO's reasoning processes, and to whether the CEO or the board steered

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[41] Only responses where the details would identify the CEO or their region were altered in this way.

[42] Further references to the CEO shall be in the masculine form for simplicity. It does not infer that the CEO in question is actually male.

[43] For reasons of confidentiality I cannot supply the exact mission statement. It is mentioned here to show that one exists and its essence.

the decision-process. The third set of questions established whether the board had different wants than the CEO, and, if so, where the divergences occurred. The fourth section searched for justifications for particular decisions offered to stake holders and other members of the community that were political in nature. The fifth section examined the CEO's views on the role of health care in Canada; these responses were crucial as they grounded the CEO's personal philosophical view, and they were compared to those given in the second section. This allowed me to assess who controlled the decision-process. The sixth section examined the regional board or council's decision-making process, and its power structure. The last section asked for the training and educational background of all board members, to establish whether some of the conflicts stemmed from differences in areas of expertise.

All six interviews in their entirety were required for the HEALNet project, but as previously noted, this analysis is limited to one randomly selected interview.[44] The format is as follows: the question; the selection from the CEO's response that I wish to highlight; an examination of specific words that point to a deontological or a utilitarian theory; and lastly, reasons to support my decision to classify the piece as either deontological or utilitarian in nature. As only sections of the interview are necessary, only certain segments will be investigated in the analysis. These omissions, however, will not detract from the validity of the exercise. The purpose is to pursue an opportunity to learn whether conflicting moral theories affect the consistency of the decision process.

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[44] As noted earlier, it would have been interesting and helpful to incorporate all six interviews in this work. However, due to the limited space and the broad scope of this thesis I chose to include only one. The work that would be necessary to adequately address all six interviews would have been a project itself and the purpose here is to have a real life case study to examine how decisions are actually made. The limits of this decision are addressed in this work.

The main drawback in using one case study is the inability to make general conclusions based on the analysis. If this particular CEO and regional health board justified their decisions with different theories it does not follow that this behaviour extends beyond this one region. The study from which the interview was drawn was also qualitative and exploratory, being based on only six interviews. Considering the limits of this study, it is understandable that one case would be even more limited. However, that does not mean that the case is not helpful as a real situation to illustrate how an analysis proceeds.[45]

I claim that inconsistency in the decision-making process has effects on the availability and direction of resources. Inconsistency can cause unnecessary time spent on clarifying misunderstandings and rectifying misguided funding decisions. If there is not a clear guide to addressing health needs, then the process may be confused and funding directions may become *ad hoc*. I claim that the nature of these allocations would not be ethically defensible; even beyond this claim they would not be generally defensible either because an established check for their validity is missing. If board members are unclear of the board's mandate, then they may spend valuable time debating what its goal is, and whether it had been achieved. The examination of this case study can offer insight into how those decisions actually occur in one region in Canada. The benefit of including this case is to use real responses rather than to create hypothetical examples. The interview gives unrehearsed information. Any hypothetical situation I could create may be subconsciously biased, leaving the exercise vulnerable to criticism. I can avoid criticism of creating an example with a foregone conclusion by

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[45] If there are indications in this region of conflicting theories affecting the decision-process it is possible the problem is more widespread, indicating a need for further research.

using the real responses from a CEO. For these reasons I am choosing to include the case study, despite its failure to support generalised results.[46]

The Analysis

The first question establishes the interviewee as an appropriate subject, specifically, one who has made allocation decisions.

> **Question 1a:** Do you ever have to make allocation decisions where you have to balance competing claims for limited resources?
>
> **Response:** Yes, the [regional] health council does do that.

The question was answered in the affirmative, allowing the interview to continue and the responses to be recorded. It is important to note that the CEO is, in effect, speaking for the board.

The responses from the second section established any differences between the interviewee's personal values and "corporate" values. The presence of any discrepancy is significant because the dominant value system will reveal whether the CEO allowed his own values to justify allocation decisions.

> **Question 2a:** People sometimes try to work out a process they can use when they have to balance competing claims. Do you do this, and if so, what types of considerations are typically at work?
>
> **Response:** ...the only structure that we would bring into that would be our [board] representation, their process for making largely a *consensus-based decisions*, and possibly a tool for evaluating the proposals. The ministry wouldn't likely provide us with a tool for evaluating the proposals, but they

[46] The study mentions that it was exploratory and further research could be directed in this area.

would have the guidelines for what the care, the new care service was supposed to address.

The phrase "consensus-based decisions" suggests a democratic framework, as method noted earlier, suggesting the *ad hoc* nature of the process. A consensus-based decision process proves ambiguous because the majority of board members may espouse deontological, utilitarian, contractarian, or other theories. In this fashion, the pursuit of ethical decision-making appears to have taken a back seat to the need to come to an agreement. This phrase illustrates the ambiguity present in such a process. It shows the process itself is unclear as to its moral framework. A utilitarian framework would support consensus-based decisions because aggregate utility is maximised by pleasing the majority. Egalitarian democratic systems also support majority rule decision-making because each person has one vote.

One problem with consensus-based decision-making is its potential inconsistency. One group may agree to different criteria for allocating resources than another, even within the same region. A method based on specific guidelines for the allocation process would cut across regional groups helping the process be consistent between boards. It would also help limit the inconsistency of one board over time. The clear structure would facilitate internal consistency first, and then help this internal consistency continue. For example, a decision may be reached to fund the first initiation stage of a particular program, but then the second stage to implement it is cut. The resources that were used to first choose the program, decide how it should be implemented, and then begin with the implementation process would be wasted. The resources could have been used in another area with better results. The decision to cut the program could also be based on *ad hoc* procedures, meaning the program could

begin again with the authorisation of another board.[47] The duplication would have opportunity costs that impact the opportunity for others' needs to be addressed.

> **Response:** Another example that's a bit different would be when, for instance, we were providing, we were meant to provide, advice around hospital restructuring. The objectives were clearly to constrain hospital expenditures, or to deal with eventual constraints on hospital expenditures in the most collective and coordinated fashion....[I]t was more about the agency as a whole as opposed to specific needs-based services. It included *population-based, needs-based care issues*. It included fiscal constraints. It included best-practice considerations and critical-mass considerations around specialized programs.

The two phrases highlighted here give interesting evidence.[48] The use of the term "population-based" is the first indicator from the utilitarian template. When one examines population-based issues, one is looking at what types of health issues are most prevalent in a specific population. Addressing rare diseases does not give the same aggregate utility as providing resources for needs that are common across the population. When allocating resources, a decision-maker following a population-based health model would want the outcome of a plan to be favourable; the population would have less disease and/or higher health status. This would be carried out at the expense of those in the minority.

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[47] There are many possibilities that would cause a program to lose the resources it needs to continue. My point here is specifically addressing consistency and that the decision may be a function of a democratic procedure without a clear justification for stopping a program.

[48] It is unclear whether the CEO was describing the process for one hospital or a group of regional hospitals. However, for the analysis I will interpret the response for group of hospital because the CEO knew the project topic concerned regional justifications. I will assume he was incorporating this knowledge into his response.

The use of the term "needs-based" could be interpreted as either utilitarian or deontological. If "needs-based" were in the context of the population as a whole, then the phrase is utilitarian in nature; whereas should the CEO have meant addressing individual health care needs, having been given equal priority in an egalitarian-needs based allocative process, then there is evidence for the second indicator from the deontological interpretation. This would reflect ethical conflict within one sentence, and evidence of mixing theories. However, I suggest that the CEO meant population needs as utilitarian in nature and was clarifying the population-needs based approach. Therefore, there is consistency in his response.

> **Response:** What [the board] would typically do is seek input from presentations, written information, etc., about any or all of these areas. We don't necessarily have a tool to *weigh* which ones are most important. What we have is a broad base of community representation on the [board], which is supposed to bring in a broad perspective about the interests of our community. And it's a bringing together of those expressed opinions, *building a consensus* among those opinions that would lead to a decision. So *we try to find those solutions that meet the participants' interests; the common interests that they have.*

There are different methods for weighing the value of one proposal over another; it would depend on how one interprets 'weigh'. So far the CEO has offered indications of utilitarian reasoning by maximising aggregate utility in his population-health approach. When the common interests are promoted the aggregate utility can be maximised. A process that balances conflicting rights that can occur in a deontological process may also be functioning. As noted earlier, achieving consensus as a moral exercise on its own, is ambiguous. However, there was earlier evidence to support a

utilitarian reasoning process when building consensus. This continues in the following response.

> **Response:** And the way we create some structure around that is the [board] is to be made up of a certain percentage of consumers, of health care providers, and of municipal government representatives. Because we try to seek consensus *it's appropriate for everyone to raise their unique issues,* but everyone has to make a commitment to find *where the common ground is amongst those different issues.*

The CEO stated that it is appropriate to raise specific issues, but quickly negated those that are not part of the majority. I suggest that this is following from the earlier response when the CEO was explaining the hospital restructuring priorities. There he identified population needs, which support the first indicator from the utilitarian template. Despite the possibility that an individual egalitarian approach is requested, the tone suggests common ground as maximising aggregate utility. There has been some ambiguity in specific terms, and nothing concrete to suggest definite conflicts. However, based on the population needs response, I suggest that a utilitarian framework is functioning behind the decision-process.

> **Question 2b:** Do the types of considerations that you focus on when making decisions change from case to case? Are there any particularly important ones which come into play regularly? Please explain.
>
> **Response:** I think the core we always want to focus on is a population-needs–based approach to planning, providing our advice around the planning of health services. That is about where the *population as a whole is going*, that is about *not addressing solely those individuals who are presenting with illness.* And that's the common theme that we always come down to. So health services within the context of *meeting the needs of the population as a whole.*

The statement "where the population as a whole is going" indicates the first part of the utilitarian template, but it is not fully clear. When the CEO stated that the process is "not addressing solely those individuals who are presenting with illness," the statement is referring to the needs other than health care needs. He is identifying other considerations that the board must include within their recommendations to the ministry. With this being said, however, how the board addresses the health care needs remains unclear. There have been indications that population health outcomes are guiding the allocative process. As mentioned earlier, when replying to question 2a the CEO mentioned hospital restructuring. Health care needs, along with fiscal constraints, and best-practice considerations, were mentioned. When the needs were identified these considerations were most likely population-based concerns. I claim that the CEO is in fact discussing needs related to population health outcomes, and this is in line with first indicator from the utilitarian template. The context of meeting the population's needs would support a population-health based model maximising aggregate utility, the first indicator from the utilitarian template.

The response to the following question is significant in reporting beliefs about moral theories. The talk of values permeates the discussion of the health care service delivery.[49] Values are rarely clarified, and so this particular part of the analysis is important.

Question 2e: What sorts of values would you consider relevant?

Response: A value that has evolved out of the last few years has been to ensure that the sustainability of services by seeking out affordable approaches to delivering that care. The assumption that health care resources is not going to

[49] The release of the Romanow Report is noted.

> increase as substantively as it has over the last couple of decades, that we need to seek *equity of service, of resource and service delivery across the population*, in the context of a constrained budget, as opposed to constantly added...but presuming that the historical allocations are completely appropriate, and that every new *population need requires new resources*, you have to ask yourself, "Yes, it is a recognized population need, but what resources already exist that can be reinvested in that?"

In this section the CEO used the philosophically ambiguous term "equity", particularly to define resource and service delivery across the population. If he had been alluding to the first part of the deontological framework, then the services would be delivered following a rights-based egalitarian approach. However, speculation is not certainty. I believe that when he used the word "across" in reference to the population, he was offering context. In the previous sections, there was a strong possibility that the utilitarian reasoning process is in effect. Sub-groups of the population have been overlooked to promote aggregate utility. In order to achieve this end, access to certain services would have to be constrained in order to promote others. A deontologically based framework would support restricting access to services, but the process, as mentioned earlier, would be based on balancing competing rights-claims, not on the maximising of overall population utility.

Considerations of utility apply when the decision-making process reflects a cost/benefit analysis. Certain types of services would not promote increased health outcomes, and services that were used by only a few people would be costly. In this case, equity of access to services would not be achieved. People whose health status would not contribute to population health outcomes would not be recognised in the allocative process. The deontological approach to allocate service delivery would not

have been followed; if it had it would have considered minority groups in the process. Rather, the population groups who would not pass the cost/benefit analysis would be pre-emptively weeded out. When the CEO wanted equity of service delivery across the population it would seem that the best method for achieving this is the deontologically grounded egalitarian needs-based approach. So far the analysis is not showing one theory definitely conflicting with another, but rather there is the possibility. The CEO could be indicating a concern that within the population an individual cannot demand services beyond their individual claim.[50] This interpretation would support restricting claims of specific individuals. If there is support for a population health based mechanism for allocating resources, and now the deontological approach is a guiding concern, then and the CEO and the board have inconsistencies. They could not support both allocative decision processes.

Inconsistencies appear when the CEO proposed limiting the distribution of new resources based on population health–based need. The mandate for funding new health care needs suggests the utilitarian approach; the individual need is unimportant when it fails to maximise population health outcomes. This would lead to inconsistency in service delivery directions.

> **Response:** I guess what that speaks to, though, is that, as a population value, *equity* is really important.

Here the meaning of "equity" is suggestive of another type of interpretation. The response to the above question stated that the board wanted to provide service delivery

[50] This concern suggests the black hole problem that has been mentioned in Chapter One.

across the population in an equitable manner. This would need another mechanism than one that incorporated maximising population health outcomes. The board appears to interpret equity as a value that can be best addressed by egalitarian-needs based concerns. Following a process that maximises population health outcomes is not a method for meeting these concerns. So far in this analysis population needs have been mentioned, and a utilitarian interpretation for addressing these health care needs seems appropriate, but not proven. If true, then this portion of the transcripts suggests a switch from one theory to another. There is verification of two moral theories active within the process. Further responses will be examined to strengthen my claim that the CEO and the board have used distinctly different moral theories to justify decisions.

> **Question 2g:** What would you say is the main point of that mission statement?
>
> **Response:** I think the main point is to refocus decisions back on a *common interest*. Well, when we reflect back upon our visions and mission for improving health care services in *the interest of the population*.

This section is included to show that a mission statement exists for this region. The italicised words suggest that the CEO's interpretation of the mission statement was grounded in the rule-utilitarian interpretation of maximising the population's interests. Both the first and third indicators from the utilitarian template are apparent.

This previous section that examined considerations and values in the allocation process has shown possibilities of incorporating the two types of theories. The next portion of the interview I will focus on was one that addressed the role of health care. The opinions surrounding the role of health care make up a very important area for gathering information. Responses to this topic were more personal and individualistic

than the responses to other questions, providing evidence of any distinctions between directives in policies and the CEO's personal values.

> **Question 5a:** In your estimation, what is the role of health care?
>
> **Response:** [I]'ll reflect upon the present role of health care is to treat illness, to support *individuals*, particularly through an acute phase of an illness, and to do that *equitably* and *accessibly*. I think that's what the role of health care is right now, the substantive role of health care.

The CEO stated that the present role of health care is to support individuals, and this concern for individuals is an indication of the first part of the deontological framework. The earlier section of this chapter concerned a preliminary discussion between individual and population needs and it seemed that maximising population health needs was the mandate of the board. The above response implies that the health care system exists to help those people who are presenting with illness, and does not mention medical utility. Yet, the CEO possibly contradicted this notion in his response to question 2b. Question 2b asked for considerations when making decisions, but the focus was on population health needs. Inconsistency between how he viewed the board's responsibility and the role of health care could have an impact on service delivery. On the one hand, the resources ought to be designated to create higher, healthier numbers in overall health, a utilitarian approach. On the other hand, the role of health care is to support individuals through an illness without overriding concern for the medical utility—a deontological approach. There is a possibility that unconsciously two logically distinct theories could be used to justify allocation processes. The

possibility for inconsistency is greater than if the CEO saw both the board's position and the role of health care functioning together.

The next key word employed by the CEO was "equitably". Ambiguities in the definition of "equity" were pointed out earlier. Here, too, the response implies a deontological perspective suggesting that an individual presenting with illness deserves opportunity to receive treatment. The tone suggests a universal opportunity, yet the CEO's application of population health–based service delivery would not allow for people in minority groups to have equally funded access; another instance of utilitarian reasoning processes merging with deontological ideals. "Access" is also highlighted for similar reasons.

The next question gave the CEO an opportunity to state his personal opinions.

> **Question 5b:** What do you think the role ought to be? Please explain.
>
> **Response:** What is ought to be…it should have a *better consideration* of the longer-term health care needs of *individuals* who are ill or disabled. *It hasn't addressed those needs.* Our system, our healthcare–funded system hasn't addressed those needs particularly well.

Two areas of interest have been highlighted. In the first, the CEO was suggesting that the individual's needs ought to have more consideration, a deontological perspective. "Better" is another ambiguous term, but the fact that the CEO considered the needs of individuals to be neglected suggests that following the policies of his position does not support individual needs well, and he did not agree with the results. I suggest again that a utilitarian population health based outcomes approach is how to clarify the earlier ambiguity from the second section regarding his reply to question 2a on hospital

restructuring. He mentioned population needs and then needs-based leaving an ambiguity in the exact interpretation. I believe that the CEO meant only population health needs as his response. This would mean that the board is focusing on population health outcomes as the guiding force in their region.

The second highlighted statement is also about needs and the role of the health care system. The CEO shifted from presenting an ideal to the reality, as he sees it. What is interesting here is that so far his justifications have demonstrated a utilitarian slant, and here he noticed that individual needs were neglected and that the health care system thereby falls short of his personal standards. The utilitarian drive of population-based health care needs stands in conflict with individual needs. As noted earlier, an individual in a minority illness group, or worse, a rare group, would not receive services compared to those in the groups that maximised aggregate utility. Again, a deontological theory appears to be framing the CEO's observations of what would constitute a "better" outcome; the individuals' actual health needs now seem to be driving his definition of "good." This is in contrast to my interpretation of his earlier justifications in favour of a population health–based process; the CEO fluctuated between deontological and utilitarian theories to justify both his present allocation decisions as well as those used as an ideal.

The next question is taken from the sixth section. It is included to establish the administrative process the board follows so that the CEO's responses may be compared to them.

Question 6a: What type of administrative model is being used by your region?

> **Response:** In our [group] it is simply a very small staff that are trying to support the board in making *broad-based health care planning decisions*. We would create task forces, consultation groups, days, and workshops, focus-groups, or a series of meetings to provide advice to that council about what is in the *best interest of the population* and what's practically implementable.

There appear to be more possibilities that distinct theories were applied in this response. The "broad-based" grounding of planning decisions could be interpreted as either deontological or utilitarian. If one regards "broad-based" as an egalitarian needs-based approach, then the meaning is deontological. However, in contrast, if one regards broad-based health care as the arrangement whose goal is to maximise aggregate utility, then a utilitarian perspective is driving the process. The utilitarian process could be in reference to the prevailing responses in the second section, where population health–based justifications occurred. As noted above, the deontological perspective could be used to define "broad-based"; however, the next italicised section makes reference to the best interest of the population. Given the tone of the response the context would support a utilitarian population health–based process.

I would argue that both definitions of the earlier "broad-based" response would lead to evidence of conflicting theories. If the phrase were defined in a utilitarian fashion, then the process would still be in conflict with earlier deontological responses concerning equity of service delivery across the population. It would also clash with the CEO's personal vision of the role of health care supporting individuals, but this conflict does not indicate direct mixing of theories, only a divergence between the reality of the board's decisions and his opinion. If the term "broad-based" is deontological in nature, then the contradiction is apparent within this one section of the response. Either

interpretation further supports there are conflicting theories at work when justifying allocation decisions.

While only particular parts of the interview were presented here in the analysis, there is sufficient information to suggest that this particular CEO and the board did use conflicting moral theories to justify their decisions. Utilitarian reasoning processes were evident in the responses to question 2g. The frequent expression of population interests grounding his allocation decisions indicated that the process was utilitarian. A deontological process, identifiable when discussing individual needs, was seen in the response to question 5b. The CEO either used both theories to respond to questions 2e, and 5a, or there was ambiguity in the responses such as 2a, 2b, and 6a. The ambiguity depends on how to interpret his answer in 2a concerning hospital restructuring and population health needs. Nonetheless, the analysis suggests that decisions based on distinctly different moral theories lead to problematic outcomes. The purpose of the analysis was to apply the template to a real situation and search for evidence of conflicting theories at work. I have shown that in this particular situation these conflicts can exist. I will suggest why these inconsistencies in the process can lead to different decisions in the delivery of services.

When the CEO valued the direction of the population as a whole as the core consideration, he was tacitly selecting a particular type of service delivery; one that maximises health status. To be consistent he would promote programs that produced the healthiest population, measured by aggregate utility. This would come into conflict with a deontological interpretation to equity of service delivery across the population. In that response individual needs and egalitarian concerns seemed evident. The board could

not support a program that maximised population health outcomes and was able to achieve equity across the population regarding service delivery.

Another possible conflict occurs when he stated that the present role of health care is to support individuals, particularly through acute illness, the allocation process would be a different format. Although the CEO was discussing the role of health care, and not the mandate of the board, there is a possibility that these beliefs would creep into the process. For example, how could resources be directed when the board had to choose between acute care and general population health care needs? Statistics from the region could be gathered and incorporated into the decision process to provide the most medical utility. However, as discussed in Chapter One, the definition of need is ambiguous, even from a utilitarian perspective. The population-health approach would also promote programs, such as the flu shot example, where the majority of people showed an increased health status. Contrast this with someone who arrived at the hospital with a rare and/or costly disease. According to the CEO these people should be supported by the health care system on the one hand, but would support service delivery that maximised population health outcomes. There would be a contradictory direction for how services should be delivered. The decision would then be *ad hoc* and the outcome would not be defensible. I suggest that to minimise this type of situation one theory should be used as a guideline for all procedures. The best method for achieving equity would be to incorporate an egalitarian needs-based approach, which is deontological and would be respecting the rights of individuals. The utilitarian framework that maximised population health would not be effective, particularly when achieving equity across the population for access to services.

The inconsistency that can occur from a consensus-based decision process was mentioned. Again, I suggest that a single theory used to guide the decision process would function to minimise the effects. I used an example whereby a program would be started and then lose its funding due to *ad hoc* procedures.[51] This would have a negative effect on the availability of resources. There can, of course, be valid reasons for discontinuing funding for a program. However, if the reason is based on a consensus-based decision, the possibility for mismanagement of funds is stronger. Again, I suggest that the mixing of theories throughout the process by the CEO and the board created ambiguous and confusing directions. Resources funnelled through this procedure would be misdirected and possibly wasted.

The difference between this CEO's view on the role of the board and the role of health care could create problems. The problem, however, is one of human nature. There will always be a possibility that with clear direction unconscious factors are working. Yet, when there are many theories at work, and if there is uncertainty amongst board members as to its function, the possibility for errors is increased. Results from a process that is streamlined and consistent are more defensible.

I began the chapter with an outline of the HEALNet study from which I selected the interview. Different responses to questions were analysed for contextual information that would suggest either deontological or utilitarian reasoning processes. The inconsistencies in the CEO's replies were indicative of different ethical theories

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[51] I understand that *ad hoc* processes do not necessarily result in ethical inconsistency. A board can have a decision-process that is ethically consistent and conflict can arise from similar ethical foundations. The point here is that the possibility is small, and the process that overtly created guidelines based on explicit guidelines would minimise the possibility of conflict at a covert level. The outcomes that followed from such a process would be overtly defensible from an ethical standpoint. The outcomes that followed from an *ad hoc* process would have to be analysed for consistency. The resources needed for such an analysis for ethical defensibility could be used in other areas.

underlying particular responses. I suggested that this type of inconsistency leads to a decision-making process that directs services in conflicting directions leading to results that are problematic. I claim that an approached based on a single-theory is superior to one based on mixed-theories and this will be discussed in the following chapter.

Chapter Five
Arguments for Incorporating a Single Deontological Theory into Allocative Decision-Processes to Respect the Spirit of the Canada Health Act

In this chapter I will present my argument that decision-makers ought to use a single-theory approach when allocating resources, and that the theory should be deontological in nature. I will begin by referring to Chapter One where I argued for a single-theory over a mixed-theoretical approach to decision-making. I will present the indirect-utilitarian approach, and show why it should not be followed by decision-makers allocating resources in consideration of the Canada Health Act. My reasons for choosing a deontological theory will incorporate my analysis of the Act's history in Chapter Three. I will discuss the differences between following a deontologically grounded approach versus the approach followed by the CEO and the board. This will highlight why consistency is important as it potentially affects the amount of resources available to society.

My arguments in support of following a single-theory approach to ethical analysis were discussed in Chapter One. Consistency was the main reason for supporting this type of analysis. Consistency is useful in the decision-making process to minimise confusion and to produce better outcomes. Wikler's view on analysis is noted because of his assertion that consistency minimises errors. I used the principles from the Canada Health Act to show the logical distinctions that can occur in an analysis containing two different theories. These differences supported the need for a single-theory to be incorporated into decision-making to minimise conflict. This conflict can occur when decision-makers are allocating resources and the underlying definitions of terms are different. Different theoretical approaches used by decision-makers can work

at cross-purposes making the process difficult and the outcomes problematic. Again, a decision-making process that uses a single-theory can help minimise these conflicts. It can also help one decision-maker achieve internal consistency and produce defensible decisions.

The principled approach could guide decision-making processes. However, the example from Chapter Two of whether the principle of accessibility could allow user-fees presents at least two different answers. A rule-utilitarian approach could advocate for allowing user-fees once population health was at a sufficiently low level to justify such a move to maximise health outcomes. A deontological interpretation would be more tenacious and not allow user-fees despite overall population health outcomes. If there are two different answers in applying a principle, then the principle does not offer consistent guidance. One could say that the principle could be 'user-fees are not permissible', but this is insufficient. The justification for why the fees are not allowed would entail at least two different answers. If the principle was left unchallenged, then this would not be a problem. However, if decision-makers wanted to create consistent policy, or a new policy the different justifications are not helpful. I agree with Engelhardt Jr. when he stated that middle-principles do not succeed in offering guidance at a deep level.

Another example is from Chapter One when both Childress and Harris advocate for a mechanism for allocating resources that respects equality of opportunity.[52] Childress, the deontologist, suggests a queue or drawing lots as the method for respecting dignity. Harris, the utilitarian, does not specifically state a queue, but I

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[52] The reference for Childress is from Chapter Ten in Practical Reasoning in Bioethics and for Harris is "Micro-allocation: deciding between patients".

concluded from his argument that he would support drawing lots. These mechanisms are based on a random process that respects equally individual's desire to survive. These two philosophers agree in the use of a method that best respects equality in accessing scarce resources. The same criticism that Engelhardt Jr. made against mixed-theories is appropriate here. The acceptance of the same principle, 'respect for equality of opportunity' via a queue, would most likely not offer a consistent response to other considerations beyond that small area. A decision process based on mixed-theories becomes *ad hoc* and exactly what a consistent procedure is hoping to avoid. As noted, the discussion involving mixed-theories versus single-theories was presented in Chapter One, but there is another area where a mixed-theoretical approach gives an intuitively acceptable answer.

In Chapter Three when discussing the history of the Canada Health Act, I addressed a potential criticism to my analysis. This criticism was that the deontological rights-based claims indicated by the template were actually rule-utilitarian derivative rights. The argument could be made that the motivation behind the health care system was to maximise health status and the best method for achieving this aim was to use certain rights as the appropriate rules to follow to maximise utility.

Kymlicka identified indirect-utilitarianism by stating that "the idea of maximizing utility enters only indirectly (if at all) into the agent's decision-making" (20). He wrote, "Morally right actions are those that maximize utility, but agents are more likely to maximize utility by following non-utilitarian rules or habits, then by following utilitarian reasoning (indirect utilitarianism)" (Ibid.). In my analysis of the history of the Canada Health Act in my conclusion, a deontological tone was indicated

throughout the history, which Kymlicka would consider suspect. He could argue that the primary aim for introducing a national health insurance program was to increase the health status of Canadians and the best route to achieve this would be to incorporate a rights-based claim to health care services.

I do not agree with the indirect-utilitarian approach because of a general criticism of utilitarianism. I do believe indirect-utilitarianism can be a valid method for creating policy, and so the focus of my criticism is not on its structure. I find that utilitarianism does not have the same tenacity as a rights-based deontological approach. I believe that the spirit of the development of the principles of the Canada Health Act suggests a need for a strong structure; stronger than one that is ultimately linked to maximising utility. Increasing the health status of Canadians was a catalyst for government involvement and, at that time, at an unprecedented level. However, the desire for social programs also addressed humanitarian concerns developed from the experiences of both World Wars and the Great Depression. These concerns appear to address fundamental rights-issues and merit a system where the rights-claims would be strong enough to withstand concerns of maximising utility.

Buchanan discussed utilitarian rights to health care where he stated, "[a] utilitarian moral theory, then, can include right principles that themselves prohibit or "trump" appeals to utility maximization, as long as the justification of those principles is that they are part of an institutional system that maximizes utility" ("Health Care Delivery and Resource Allocation" 308).[53] Deontologically grounded rights and utilitarian derived rights are described as "incompatible...only if rights exclude appeals

[53] The next quotations from Buchanan will come from this chapter, unless otherwise specified.

to utility maximization at all levels of justification, including the most basic institutional level" (308-309). I agree with Buchanan that the final decision for action/non-action cannot be grounded on maximising utility.[54] Buchanan's point was considered and incorporated into the development of the utilitarian template (the third indicator). As noted, egalitarian needs-based claims to access services could be interpreted as rights-claims functioning to maximise utility. There is a problem associated with this position.

One point Buchanan addressed in "Health Care Delivery and Resource Allocation" is that utilitarianism could effectively exclude groups, such as the disabled. He wrote, "[u]tilitarianism may mandate that even for basic and relatively inexpensive goods and services, what is guaranteed for most should not be provided for some, even though their needs are great and they would benefit very much from them" (310). The population health approach espoused by the CEO and the board is indicative of this procedure. The process is similar to traditional insurance schemes and will be discussed to show why I do not support the utilitarian approach in allocating resources.

One aspect of the commercial insurance industry is apparent in Taylor's discussion of health care needs in relation to insurance. He stated, "the *need* for health services is a less precisely determinable 'contingency' than is death or conflagration except at extremes such as serious injury or illness" (115, italics in original). Here Taylor was suggesting the randomness that accident or disease can strike, indicating that individual responsibility for one's situation is not the important issue regarding access to health care services. I highlighted a problem with conventional insurance programs in Chapter Two when I analysed the principle of universality. Taylor also addressed this

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[54] Cost/effective analysis can be used in a deontological process, but cost/benefit analysis would be counter to a deontological approach.

concern when he wrote, "for the insuring agency...the only feasible means of assuring a reasonable relationship between revenues and expenditures was to define strictly those who were considered 'insurable,' to screen out the physically impaired, the chronically ill, the aged, and other risks or 'uninsurables'" (Ibid.). Taylor continued, "[t]he net impact of the unavoidable underwriting safeguards was that those most in need of an insuring or budgeting system, but outside its protection, were the chronically ill, the less physically robust, the low income groups, and the aged" (Op. cit. Ibid.). The function of government and the health care region is not to maximise profit. The utilitarian argument could be changed so that maximising profit is replaced by maximising health outcomes. Population groups that would not improve population health outcomes could be excluded. However, I suggest that the Canada Health Act developed in such a fashion so that population groups would specifically not be excluded, starting with the poor and the indigent. These groups were given access to health care by the municipalities following the Elizabethan Poor-Law traditions (Cassidy). When the Saskatchewan government introduced the Social Assistance and Medical Care Plan on January 1, 1945 it was first directed towards those on social assistance, with the intention of including all of the residents in Saskatchewan (Taylor). The Canada Health Act was developed to banish financial barriers, which means that the poor were now given access to health services on equal footing to those in higher income brackets. However, the needy and those with illnesses outside of the population health outcomes that maximise utility could be considered the 'new poor'. Financial barriers no longer exist, but those who do have disabilities or illnesses that fall outside funded groups would not be given the same considerations. I suggest that the decision-making processes that incorporate these types

of considerations are contrary to the spirit of the Canada Health Act. With respect to indirect utilitarianism, the decision-process that followed the deontological principles would still function with a dependency on the fundamental mechanism for maximising utility. The deontological principles would not have the strength to hold when those who are the most vulnerable would demand it. This seems contrary to the traditional descriptions of rights-based claims. For this reason, I would not support a decision-making process that functioned within the confines of an indirect utilitarian approach.

I claim that decision-makers ought to follow a single-theory deontological approach when allocating resources. I further claim that this approach captures the spirit of the development of the Canada Health Act's principles. I have so far suggested why a single-theory approach is the best method to counter inconsistency. I have also given a reason for why utilitarianism is not the theory decision-makers should follow when allocating resources. Now I will suggest why I believe that a deontological approach is a better approach.

The template was based on a type of Daniels 'equality of opportunity' position that addressed health care needs as relating to normal species functioning (Just Health Care). The preamble of the Canada Health Act states its purpose, "to protect, promote and restore the physical and mental well-being of residents of Canada and to facilitate reasonable access to health services without financial or other barriers" (Canada Health Act Annual Report 2002, 3). I suggest that, with this purpose in mind, an approach that purports to restore physical and mental well-being can be based on an egalitarian needs-based approach. Addressing health care needs would function to respect the spirit of the Act.

In Chapter Three the template was used to analyse the historical evidence to search for examples of ethical considerations. The analysis pointed to deontological reasoning in the Act's history. The foundation of a deontological rights-based claim to access resources was based on health care needs. The remark by Prime Minister St. Laurent in the spring of 1955 where he addressed the premiers stated:

> For a number of years, through the national health grants program, we have provided assistance in the development of a full network of basic health facilities and services fitted to the needs of the Canadian people. We recognise that the building up of these facilities through the national health program constitutes, in the words of my predecessor, Mr. King, 'a fundamental prerequisite of a nationwide system of health insurance.' (qtd. in Taylor 211)

Although one comment cannot support my claim, it does indicate that the Prime Minister was considering a situation where health care needs 'developed' the system. A utilitarian approach identifies the outcome that maximises utility and then creates the system to meet that aim. The two methods are distinctly different. I suggest that a deontological method that is grounded on health care needs functioning in an egalitarian approach is a method that respects the spirit of the Act. For this reason decision-makers ought to incorporate a deontological theory when allocating resources.

A deontological approach that would balance competing rights is indicated in the legal case of Cameron v. Nova Scotia. The case involves an infertile couple that travelled to Calgary to receive *in vitro* fertilization procedures that were not covered by Nova Scotia.[55] One argument suggested that infertility was equivalent to a disability. In pursuit of this claim they addressed the Charter of Rights and Freedoms to argue for

[55] It is important to remember that services sought outside provincial borders need administrative approval prior to receiving such services.

consideration under the Charter. Useful sections in the case are found in sections 165 and 170 where concerns of cost/benefit and medical utility are mentioned in the conclusions regarding specific exclusion of *in vitro* fertilization and intra cytoplasmic sperm injection. Cost/benefit, an indication of utilitarian reasoning, was dismissed as a claim against the Charter: "this thinking is not consistent with values to be employed in making a s.15(1) Charter analysis" (Cameron v. Nova Scotia section 165). The next section mentioned, 170, states, "[n]ot every person denied a procedure can successfully mount a Charter challenge" (Section 170). It continued to state that if the procedure was deemed medically unnecessary then the claim would fail (Section 170).[56] The point here is that considerations of cost/benefit were not the proper procedure for addressing rights-claims against the Charter. The next section that is important is when the decision procedure turns to cost containment in the health care system. In section 236 it stated, "The policy makers require latitude in balancing competing interests in the constrained financial environment. We are simply not equipped to sort out the priorities" (Section 236). It continued, "We should not second guess them, except in clear cases of failure on their part to properly balance the Charter rights of individuals against the overall pressing objective of the scheme under the [Canada Health] Act" (Ibid.). This section illustrates that balancing of claims does not need to be grounded on maximising utility. The result of this case was that, although hardship was incurred by restricting access to this particular infertility treatment, there are others available and that "[t]he exclusion may work some hardship, but it does not work 'undue hardship'" (Section 245). It continued making a point addressed in this chapter: "The funding that would otherwise

[56] Two of the three judges, Chipman and Pugsley, did find that infertility could be interpreted as a disability making the claim for protection under the Charter, in their opinion, valid. For further interest see Cameron v. Nova Scotia.

be used for these procedures is available for other projects and procedures" (Ibid.). The final ruling was financial compensation for the cost of the treatments was denied, despite the validity of their claim. The purpose of selecting these sections is to illustrate a lack of formal procedure (consistency) and how competing rights-claims can be balanced without incorporating rule-utilitarianism mechanisms to maximise utility. The case was also mentioned to illustrate how rights-claims do not guarantee access to services, but the structure that restricts access is different from one that maximises utility. This case also strengthens the deontological approach against the black hole criticism that was mentioned in Chapter One.

There are important differences in resource allocation decisions between those that follow a deontological reasoning process and the mixed-theory approach found in the case examined in Chapter Four. The result from the analysis was that a mixed-theory approach was incorporated into the CEO and the board's reasoning processes. Throughout the analysis of Chapter Four, I mentioned potential problems associated both with *ad hoc* decision-making and with decisions geared towards servicing population health needs. One problem was that inconsistency might create a confusing environment where the board is unclear on following a particular procedure, or whether their decisions are successful. Resources could be wasted in the confusion, meaning that opportunity to use the resources to address other's needs were lost. The outcomes that are produced from this process may be different from one that followed the deontological approach. If there were consistent guidelines, then the confusion would be minimised and fewer resources would be wasted.

The main problem with following the approach that directed resources for population health is that, as noted earlier, the resources would not be allocated towards those who fell outside the population groups who maximised outcomes. The CEO presented the focus of the allocation process, which was addressing population-health outcomes. A successful delivery of services would be a system that addressed those needs. I have argued that this approach would restrict services to population groups. These groups may in fact be the most vulnerable, including those with expensive and rare diseases or disabilities. I have also argued that this would be counter to the spirit of the development of the Canada Health Act. The difference in the outcomes that promoted population health versus a system that was based on an egalitarian needs-based approach is important.

This chapter presented reasons for why a deontologically grounded single-theory approach is a suitable method for decision-makers to incorporate into their decision processes. I claim it is superior to a utility maximising theory geared towards maximising population health outcomes. The reasons for choosing a single-theory approach were referenced, but had been taken from Chapter One. The reasons for choosing a deontological theory were based on the analysis from the Canada Health Act's history from Chapter Three. I also presented reasons based on the tenacity of a deontological rights-based claim as well as excerpts from a legal case that challenged the Charter of Rights and Freedoms. I claim that this rigidity found in deontological rights-claims is important when allocation decisions are made because those who need support the most, the needy and the vulnerable, demand protection offered by these rights-claims. I rejected utilitarian considerations for allocation decisions referring back to

observations from the CEO interview from Chapter Four. I suggest that the allocation processes are *ad hoc* making the outcomes problematic. The primary difference in following a deontological egalitarian needs-based approach is that the population groups that did not maximise population health outcomes would be included in the funding procedure. This is an important difference. The next chapter will discuss the three claims I have argued for to support my claim that consistency in the decision-making process that respects the spirit of the Canada Health Act is possible is one that follows a single-theory deontological approach.

Chapter Six
Summary and Future Research Directions

This thesis examined the importance of ethical consistency in the decision-making process when allocating resources. The purpose of this work was to search for preliminary indications to substantiate these claims and provide support for further research directed in these areas. I claimed that for consistency a decision-process based on a single-theory produces better results than one based on a mixed-theoretical approach. I also claimed that the Canada Health Act of 1984 can be interpreted as expressing a particular type of moral theory and that this theory is deontological in nature. I further stated that decision-makers in Canada ought to incorporate a single-theory, deontologically grounded, when allocating resources if they are interested in ethically sound outcomes that respect the spirit of the Act.

The first claim was that consistency in the decision-making process is important. In Chapter Two I examined whether a single-theory would be the best method for producing consistent outcomes that could be defended from a logical and ethical perspective. I claimed that these types of outcomes were more defensible in these areas than those that resulted from a mixed-theoretical process. To support this claim I quoted Wikler who indicated that a single-theory minimises errors. I discussed the principled approach put forward by Beauchamp and Childress, but referred to Engelhardt Jr.'s claims that rejected the approach by identifying weakness in its structure. Certain weaknesses were identified as fallacious and a problem with the infinite regress. Another weakness was its inadequacy in offering guidance beyond a superficial level.

In Chapter One I discussed the work of contemporary utilitarians and deontologists in the area of health care resource allocation. Different arguments came from philosophers working within the same philosophical system, and there were similarities in philosophers' positions where they were in different traditions. The purpose was to show the importance of consistency, as evidenced by the disagreements within philosophical analysis. A single-theory would function to minimise the logical inconsistencies that can occur when using multiple theories and reduce the possibility for confusion. I created a template with indicators from both deontological and utilitarian theories to search for ethical considerations in the development of the Canada Health Act and the CEO interview. To illustrate how different theories produce logically distinct interpretations the principles of the Canada Health Act were analysed. I suggested that a consistent procedure for defining terms would minimise these tacit differences.

I examined a case interview with the template to look for examples where a decision-process incorporated single or mixed-theoretical elements to justify allocation decisions. I identified examples where a board mixed theories in their processes resulting in a discrepancy between the stated goal of the regional health board and values held by the CEO and the board. The goal of addressed population health needs indicated a utilitarian reasoning process, and this would fundamentally conflict with the egalitarian concerns regarding equitable service delivery identified by the board. Again, consistency would reduce confusion and restrict the number of debates that are fundamentally at cross-purposes, effectively freeing up resources to be used appropriately. For these reasons I suggest that I have supported a position that consistency is important in the decision process, and a process that is based on a single-

theory is the best solution for minimising logical errors and confusion. The outcomes produced by these processes would be less problematic from an ethical perspective.

My next claim involved the Canada Health Act of 1984. I presented historical research from 1934 to 1984 to present information that could be analysed by the template. I examined key developments in the Canada Health Act resulting in the conclusion that first, there were suggestions indicating moral considerations in the Act's history, and second, it embodies a particular type of moral theory that is deontological. I identified a possible criticism that an indirect utilitarianism could be functioning as an equally valid explanation for the historical analysis to point to a deontological interpretation of the development of the principles of the Act. I found fault with this criticism due to the foundational link to utility maximising. I suggested that this would be in contrast to the spirit of the Act; that it was created specifically to allow a rights-based claim to have strength against other considerations. I suggested that given the historical context, the humanitarian concerns that developed after the two World Wars and the depression, the catalyst for rights-based claims would be fundamentally opposed to utilitarian considerations at the highest and determining level. Despite the identical result from the analysis indicating that the indirect utilitarian interpretation is possible, for reasons stated above I suggest that the original conclusion, that a deontological interpretation, is the correct one.

The conclusion that the Canada Health Act is best interpreted using a deontological theory is valuable in addressing my third claim; decision-makers ought to use a single-theory that is deontological in nature when allocating resources. In the fifth chapter I discussed rule-utilitarian derived rights and the possibility of indirect

utilitarianism working with deontological principles as other examples of mixed-theoretical approaches. I stated that the indirect utilitarian method might be consistent with incorporating principles from a single-theory (deontology) to maximise utility. However, as mentioned, I identified problems with utilitarianism. The criticism does not affect the consistency of decisions that followed an indirect utilitarian approach, so long as the principles chosen to maximise utility were internally consistent. The outcomes produced would be valid, but as noted, I disagreed with the merits of utilitarianism and rejected the use of indirect utilitarianism. In Chapter Five I mentioned a legal case where the Charter of Rights and Freedoms rejected cost/benefit style analysis. It examined a claim from the perspective of balancing competing rights-claims. The purpose was to show that rights-based claims can function and limit claims to access health services. These arguments support the third claim that a deontological theory is the best choice for decision-makers to use when allocating resources.

One of the results from using a single deontological theory to allocate resources was that the method would be streamlined with less confusion, resulting in a more efficient use of resources. In Chapter Four I noted the conflicting goals of the regional health board. One was to addresses population health outcomes in the best way possible, and another was to ensure equity of service delivery. The time spent by board members resolving conflict, if resolution is possible, could be better spent on addressing other issues. Decisions to fund programs would not necessarily be consistent and susceptible to political whims. The resources wasted on programs that were the result of political *ad hoc* decision processes could be redirected. The potential increase in the amount and availability of funding is important. Another important feature of using a deontological

theory is that the direction of the funding mechanism would not be to maximise population outcomes. Creating a healthy society is a noble goal. However, if the result from its achievement is that the people who are most vulnerable in society are denied access to services, then there is a problem with the system. It would not be the one envisioned by those who helped develop the principles that resulted in the Canada Health Act. The problem with maximising population health outcomes is that groups of people would be restricted from accessing services along the lines of conventional insurance programs. I addressed the problem with this approach by discussing Buchanan and his criticism of utilitarianism in resource allocation procedures. I also quoted Taylor who presented problems with conventional insurance programs. Those who are the most in need of health care services would be denied access. I again claim that this type of system would work against the spirit of the Canada Health Act. For these reasons I suggest that the third claim, that a single-theory based on a deontological needs-based approach, would be the best method for decision-makers to follow.

My ability to fully address these issues was limited by the scope of the work leaving areas for future research. Examples of future work could be an in-depth analysis regarding a single-theory approach versus a mixed-theoretical approach in a board setting. The historical research is one area where further research would be interesting. The restrictions of this thesis did not allow an in-depth analysis of the history, but produced results that indicated ethical considerations were apparent in the development of the Act. It would be beneficial to investigate historical developments at a greater depth and breadth to discover whether these preliminary results are correct. I also limited the analysis to two types of moral theories. This is not meant to suggest that

other theories may be used to analyse the history of the Canada Health Act and produce fruitful results. This direction for future research would be exciting because I believe the results would be an important basis for policy discussions. The ethical analysis could be broadened in its scope producing more evidence for ascertaining the foundations of this significant piece of Canada's history. This thesis work, however, was a small survey into the historical research, yet the results were useful. The indication from the literature review is that the Canada Health Act is an important, but neglected area in decision-making processes. The pilot project from Prince Edward Island showed that there is an interest by decision-makers to include ethical considerations into their processes. The HEALNet project also indicated an interest in a tool to help decision-makers incorporate ethics into their decision-making. The effects of a consistent, streamlined process would help reduce the potential waste of health care resources, which is important. The process that is based on the Canada Health Act would enforce the rights of Canadians in an egalitarian fashion that would not restrict access to health services for the purpose of maximising population health outcomes. These deontologically grounded rights to access services would be an extension of my interpretation of the spirit of the Canada Health Act of 1984.

Bibliography

Aucoin, Peter. "Federal Health Care Policy." Meilicke and Storch. 244-268.

Almond, Brenda. "Rights." Singer. 259-269.

Anderson, Gary R. and Valerie A. Glesnes-Anderson. Eds. Health Care Ethics: A Guide for Decision Makers. Rockville: Aspen Publishers, 1987.

Bayles, Michael D. "The Price of Life." Ethics. 89.1 (1978): 20-34.

Baylis, Françoise, Jocelyn Downie, Benjamin Freedman, Barry Hoffmaster, and Susan Sherwin. Health Care Ethics in Canada. Toronto: Harcourt Brace, 1995.

Beauchamp, Tom L. and James F. Childress. Principles of Biomedical Ethics. New York and Oxford: Oxford UP, 1994.

Bell, Nora K. "The Scarcity of Medical Resources: Are There Rights to Health Care?" Journal of Medicine and Philosophy. 4.2 (1979) 158-169.

Boyd, Kenneth M. ed. Ethics of Resource Allocation in Health Care. Edinburgh: University Press, 1979.

Brandt, Richard B. Morality, Utilitarianism, and Rights. Cambridge: Cambridge UP, 1992. Chapters 1-11, 18.

British Columbia. Ministry of Health Planning. Picture of Health: How We are Modernizing British Columbia's Health Care System. Victoria: B.C. Health Planning, 2002.

Buchanan, Allen E. "The Right to a Decent Minimum of Health Care." Philosophy and Public Affairs. 13.1 (1984): 55-78.

---. "Health-Care Delivery and Resource Allocation." Veatch. 291-327.

Cameron v. Nova Scotia. NSJ 297. Nova Scotia Court of Appeal. 1999.

Canada Health Act of 1984. R.S. 1985 c.-C6.

Canada. Royal Commission on Health Services. 2 vols. Ottawa: Queen's Printer, 1964 and 1965. Vol.1: Chapters 1, 2, 3, 10, and 18. Vol. 2: Chapters 1, 7, and 8.

---. Health and Welfare. Canada Health Act Annual Report 2001-2002. Ottawa: Health and Welfare Canada, 2002.

---. Canada Health Act Annual Report 2001-2002 Annex C: Policy Interpretation Letters. Ottawa: Health and Welfare Canada, 2002.

---. Commission on the Future of Health Care in Canada. Building on Values: The Future of Health Care in Canada (Final Report). Saskatoon: 2002.

---. Department of Justice. Canada Health Act: C-6. Ottawa: Queen's Printer, 1984. http://laws.justice.gc.ca/en/C-6/index.html.

Canadian Medical Association. Health, a Need for Redirection: A Task Force on the Allocation of Health Care Resources. Ottawa: Canadian Medical Association, 1984.

Caplan, Arthur L. "Can Applied Ethics Be Effective in Health Care and Should It Strive to Be?" Ethics. 93.2 (1983): 311 – 319.

Caulfield, Timothy. "Introduction." Canadian Health Law and Policy. Ed. Jocelyn Grant Downie and Timothy A Caulfield. Toronto: Butterworth's, 1999. 1-4.

Callahan, Daniel. "Autonomy: A Moral Good, Not a Moral Obsession." Hastings Centre Report. 14.5 (1984): 40-43.

Cassidy, Harry M. "The Canadian Social Services." Melicke and Storch. 50-63.

Childress, James F. Practical Reasoning in Bioethics. Bloomington and Indianapolis: Indiana UP, 1997. Chapters 10 and 13.

---. "The Normative Principles of Medical Ethics." Veatch. 27-47.

Courchene, Thomas J. Medicare as a Moral Enterprise: The Romanow and Kirby Perspectives. Montreal: Institute for Research on Public Policy, 2003.

Cummiskey, David. "Kantian Consequentialism." Ethics. 100.3 (1990): 586-615.

Daniels, Norman. Just Health Care. Cambridge: Cambridge UP, 1985.

---. "Fair Equality of Opportunity and Decent Minimums: A Reply to Buchanan." Philosophy and Public Affairs. 14.1 (1985): 106-110.

---. "Is There a Right to Health Care and, if so, What Does it Encompass?" Kuhse and Singer. 316-325.

Davis, Nancy Ann. "Contemporary Deontology." Singer. 205-218.

Engelhardt Jr., H. Tristram. The Foundations of Bioethics. New York and Oxford: Oxford UP, 1996. Chapters 1, 2, 3, and 8.

Epp, The Honorable Jake. Letter to Ministers. "Letters to Provincial and Territorial Ministers." 18 June, 1985. Canada Health Act Annual Report 2001-2002: Annex C. 315 – 319.

Fletcher, James F. "Ethics and Health Care Delivery: Computers and Distributive Justice." Veatch and Branson. 99-109.

Flood, Coleen, M. "The Structure and Dynamics of Canada's Health Care System." Canadian Health Law and Policy. Ed. Jocelyn Grant Downie and Timothy A Caulfield. Toronto: Butterworth's, 1999. 5-50.

Frankena, William K. Ethics. Englewood Cliffs, NJ: Prentice Hall, 1963.

Freedman, Benjamin and Françoise Baylis. "Purpose and Function in Government Funded Health Coverage." Readings in Biomedical Ethics: A Canadian Focus. Ed. Eike-Henner W. Kluge. Scarborough: Prentice Hall, 1999. 56-69.

Gelber, Sylva M. "The Path to Health Insurance." Meilicke and Storch. 156-165.

Gewirth, Alan. Community of Rights. Chicago: Chicago UP, 1996. Chapter 1.

Gibbard, Allan. "The Prospective Pareto Principle" Securing Access to Health Care Vol. 2 153 – 178.

Goodin, Robert E. "Utility and the Good." Singer. 241-248.

Grandjour, Afschin and Wilhelm Karl. "Utilitarian Theories Reconsidered: Common Misconceptions, More Recent Developments, and Health Policy Implications." Health Care Analysis. 11.3 (2003): 229-243.

Hall, Emmett. Royal Commission on Health Services. 2 vols. Ottawa: Queen's Printer, 1964 and 1965. Vol.1: Chapters 1, 2, 3, 10, and 18. Vol. 2: Chapters 1, 7, and 8.

Hare, R. M. "A Utilitarian Approach." Kuhse and Singer. 80-85.

Harris, John. "Micro-Allocation: Deciding Between Patients." Kuhse and Singer. 193-205.

---. "Justice and Equal Opportunities in Health Care." Bioethics. 13.5 (1999): 392-404.

Kant, Immanuel. Groundwork of the Metaphysics of Morals. Trans. H. J. Paton. New York: Harper, 1964.

Klein, Rudolf. "Big Bang Health Care Reform - Does it Work?: The Case of Britain's 1991 National Health Service Reforms." Milbank Quarterly. 73.3 (1995): 229-333.

Kluge, Eike-Henner W. Ed. Readings in Biomedical Ethics: A Canadian Focus. Scarborough: Prentice Hall, 1999.

---. "Social Values, Socioeconomic Resources, and Effectiveness Coefficients: An Ethical Model for Statistically Based Resource Allocation." Medical Ethics at the Dawn of the 21st Century. Annals of the New York Academy of Sciences. 913 (2000) 23 – 31.

Kluge, Eike-Henner W., G. L.Scaletta, and J. R. Moehr. "Macro Allocation in Health: AN Ethically Based Model." International Journal of Informatics. 51 (1998): 205-13.

Kluge, Eike-Henner W. and Kimberley Tomasson. "Health Care Resource Allocation: Complicating Ethical Factors at the Macro-Allocation Level." Health Care Analysis. 10 (2002): 209-220.

Kopelman, Loretta M. and K. Danner Clouser. Building Bioethics: Conversations with Clouser and friends on Medical Ethics. Dordrecht and Boston: Kluwer Academic Publishers, 1999.

Kuhse, Helga, and Peter Singer. Eds. A Companion to Bioethics. Oxford: Blackwell, 2001.

Kymlicka, Will. Contemporary Political Philosophy: An Introduction. Oxford: Clarendon Press, 1990.

Lomasky, Loren E. "Medical Progress and National Health Care." Philosophy and Public Affairs. 10.1 (1981): 65-88.

Magna, Pran. Allocation of Health Care Resources: Ethical and Economic Choices, Conflicts and Compromise. Québec: Commission d'enquête sur les services de santé et les services sociaux, 1987.

Marleau, The Honourable Diane. "Letters to Provincial and Territorial Ministers." 6 January 1995. Canada Health Act Annual Report 2001-2002: Annex C 321 – 323.

Martin, Douglas K. M. Giacomini, Singer P. A. "Fairness, Accountability For Reasonableness, and the Views of Priority Decision-Makers." Health Policy. 61 (2002): 279-290.

Meilicke, Carl A and Janet L. Storch. Eds. Perspectives on Canadian Health and Social Services Policy: History and Emerging Trends. Michigan: Health Administration Press, 1980.

Mill, John Stuart. Utilitarianism. Ed. Oskar Piest. New York: Macmillan, 1957.

Miller, David. "Disruptive Justice: What the People Think." Ethics. 102.3 (1992) 555-593.

Mitton, Craig and Cam Donaldson. "Setting Priorities in Canadian Regional Health Authorities: A Survey of Key Decision Makers." Health Policy. 60 (2002): 39-58.

---. "Resource Allocation in Health Care: Health Economics and Beyond." Health Care. 11.3. (2003) 245-247.

Moatti, Jean-Paul. "Ethical Issues in the Economic Assessment of Health Care Technologies." Health Care Analysis. 7 (1999): 153-165.

Morgan, John S. "Social Welfare Services in Canada." Meilicke and Storch. 83-114.

Mythbuster. Ottawa: CHSRF, 2002.

Naylor, David C. Private Practice, Public Payment. Kingston, ON: McGill-Queen's UP, 1968.

Norcross, Alastair. "Comparing Harms: Headaches and Human Lives." Philosophy and Public Affairs. 26.2 (1997): 135-167.

Nord, Erik. "Evidence-Based Medicine: Excessive Attraction to Efficiency and Certainty?" Health Care Analysis. 10 (2002): 299-307.

O'Neill, Onora. "Kantian Ethics." Singer. 175-185.

Pettit, Philip. "Consequentialism." Singer. 230-239.

Pink, George H. and Peggy Leatt. "The Use of 'Arms-Length' Organizations for Health System Change in Ontario, Canada: Some Observations by Insiders." Health Policy. 63 (2003): 115.

Rawls, John. A Theory of Justice. Cambridge: Harvard UP, 1999. Chapters 1,2, and 3.

Reay, Trish. "Allocating Scarce Resources in a Publicly Funded Health System: Ethical Considerations of a Canadian Managed Care Proposal." Nursing Ethics. 6.3 (1999): 240-249.

Roy, David J., John R. Williams and Bernard M. Dickens. Bioethics in Canada. Scarborough: Prentice Hall Canada, 1994.

Schracker, Ted and Margaret A Sommerville. "Ethical Analysis of Health Issues: A Proposed Model." Prepared for the Departmental Executive Sub-Committee on Policy Analysis, Health Canada. March 2001. Unpublished.

Sherwin, Susan. "Feminism and Medical Ethics: Two Different Approaches to Context." Feminist Perspectives in Medical Ethics. Ed. Helen Bequaert Holmes and Laura M. Purdy. Bloomington : Indiana UP, 1992.

Singer, Peter ed. A Companion to Ethics. Cambridge. Blackwell, 1993.

Taylor, Malcolm G. Health Insurance and Canadian Public Policy: The Seven Decisions that Created the Canadian Health Insurance System and Their Outcomes. 2nd edn. Kingston and Montreal: McGill-Queen's UP, 1987.

United States of America. Securing Access to Health Care: A Report on the Ethical Implications of Differences in the Availability of Health Services. President's Commission for the Study of Ethical Problems in Medicine, Biomedical and Behavioral Research, 3 vols. Washington: The Commission, 1983.

Veatch, Robert M. "Professional Medical Ethics: The Grounding of Its Principles." The Journal of Medicine and Philosophy. 4.1 (1979): 1-19.

---. A Theory of Medical Ethics. New York: Basic Books, 1981.

---. "Autonomy's Temporary Triumph." Hastings Centre Report. 14.5 (1984): 38-40.

---. "Medical Ethics: An Introduction." Veatch. 1-26

---. Ed. Medical Ethics. Boston: James and Bartlett, 1989.

---. "Justice and Outcomes Research: The Ethical Limits." The Journal of Clinical Ethics. 4.3 (1993) 258-261.

---. The Basics of Bioethics. 2nd Edn. Upper Saddle River: Prentice Hall, 2003.

Veatch, Robert M. and Roy Branson. Ethics and Health Policy. Cambridge: Ballinger, 1976.

Wallace, Elisabeth. "The Origin of the Social Welfare State in Canada, 1867-1900." Meilicke and Storch. 25-37.

Wikler, Daniel and Sarah Marchand. "Macro-Allocation: Dividing up the Health Care Budget." Kuhse and Singer. 301-315.

Wikler, Daniel. "Philosophical Perspectives on Access to Health Care: An Introduction." Securing Access to Health Care. Vol 2. 109-151.

Winslow, Gerald R. Triage and Justice. London and Berkeley: University of California Press, 1982.

Yeo, Michael, John R. Williams, Wayne Hooper. "Incorporating Ethics in Priority Setting: A Case Study of a Regional Board in Canada." Health Care Analysis. 7.2 (1999) 177-194.

Appendix

Questions for CEO

1.a Do you ever have to make allocation decisions where you have to balance competing claims for limited resources?

1.b Can you give me some examples of the sorts of situations where you have to do this?

2.a People sometimes try to work out a process they can use when they have to balance competing claims. Do you do this, and if so, what types of considerations are typically at work?

2.b Do the types of considerations that you focus on when making decisions change from case to case? Are there any particularly important ones which come into play regularly? Please explain.

2.c What sorts of considerations do you consider irrelevant, or of lesser importance, when making your decisions?

2.d What role (if any) do values play in your decision-making recommendations?

2.e What sorts of values would you consider relevant?

2.f What role does the mission-statement of your organization play in your considerations?

2.g What would you say is the main point of that mission-statement?

3.a Do you ever have to defend your decisions to the Regional Board? If so, what sorts of reasons do you give them for balancing competing claims?

3.b Does the Board ever disagree with you? If so, is there a common thread in their disagreements and what would it be?

4.a Do you ever have to defend your position to the public in the media? In person?

4.b If you are confronted by angry hands-on health care professionals (such as nurses, physicians, therapists etc.) who are upset by your allocations decisions what do you say to them to defend your decisions?

4.c If you are confronted by angry health care consumers or interest groups who are also upset by your allocation decisions what to you say to them?

4.d Are there similarities between your answers, and if there are not, what are your reasons for the discrepancies?

5.a In your estimation, what is the role of health care?

5.b What do you think the role ought to be? Please explain.

5.c What is your thinking about the role of universal health care without a means test?

5.d What about running health regions on the model of an HMO? Please explain.

6.a What type of administrative model is being used by your health region?

6.b Does the Board exercise an oversight role in terms of macro-allocation decisions?

6.c What is the criterion of acceptability used by the board? Is it different from your criterion as a CEO?

6.d Is the focus of these criteria outcome measures, such as budgetary, or otherwise? If not, what are they?

6.e Is there ever any difference in opinion between the board and yourself? If so, please explain when these occur.

7.a What is your educational background? What type of training have you had in order to fulfill your mandate as CEO?

7.b What are some of the backgrounds of the board members?

7.c Are there areas where you feel the conflicts which may arise stem from the different types of training and areas of expertise?