

Waiting For Romanow: Canada's Health Care Values Under Fire

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ISBN: 0-88627-318-8

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Medicare is value-laden

Important as health care may be, the great Canadian health care debate is about more than health care. As our “Medicare” system has evolved over the past half-century, its basic principles have come to create, reflect, and symbolize many of the values that Canadians see as defining who we are.¹ When we talk about Medicare, therefore, we are talking about the values for which we stand as a community.

Recognizing this, Roy Romanow’s *Commission on the Future of Health Care in Canada* acknowledges that its first task must be to seek clarity “on what values Canadians want their health system to reflect in its policies and programs.”² The Commission then identifies universal access based on need as the value to which Canadians assign the highest priority:

Almost all Canadians I have heard from to date want to ensure that the poorest in our society have access to health care. They also believe Canadians should not be bankrupted by the costs of acquiring needed health care services, and that all Canadians should be protected against catastrophic illnesses and injuries. Most think that need should always be taken into account, with a majority convinced that it should be the sole factor in determining what core of medically necessary services the system should cover.³

This portrait of Canadian public opinion in the year 2002 corresponds

closely to what Canadians have been saying to pollsters for more than three decades. In a fast-changing world, our basic commitment to health care equity has remained constant and unwavering.

This makes it easy to understand why emotions run strongly against proposals to radically alter our health care system. Canadians seem willing to consider changes that genuinely deliver increased efficiency to the system, but are sharply hostile to changes that threaten to negate or undermine what are seen as the basics. Attacks against Medicare are viewed as attacks on underlying core values such as fairness, compassion, equality of opportunity, and social solidarity.

What the critics say

Opponents of Medicare (many of whom pose as mere reformers, to avoid public censure) argue that Canadian society has come to a crossroads. Comprehensive health care coverage for every citizen in every province of our country is simply too expensive, they say. Costs are “out of control.” The system is “not sustainable.” Since we cannot afford all of our values, we must chuck out some of them. If we want to preserve high-quality medical care (at least for those who can afford to pay what it will cost), then we must sacrifice hitherto sacrosanct principles, such as universal accessibility and comprehensiveness. Equality (of access), say the critics, is the enemy of quality (of care). Their central point is nicely encapsulated by an American corporate health care executive, writing in *The New England Journal of Medicine*: “Market-

based health care is the only means of guaranteeing high-quality care at affordable prices...”⁴

Opponents of Medicare generally want to introduce into our system significantly greater elements of market economics. Thus, they favour a variety of schemes that would shift the costs of health care from governments (public) to individuals (private): delisting of serv-

What all these market-oriented schemes have in common is that they shift health care financing “away from having larger segments of the population pool financial risk, toward more risk for the individual.”

ices, user-fees, high flat-rate premiums, vouchers, individual medical savings accounts, private insurance. By delisting services previously covered by Medicare, for example, they would substan-

tially narrow the scope of public health care, which would increase the need—for those who can afford to do so—to purchase health insurance privately.

What all these market-oriented schemes have in common is that they shift health care financing “away from having larger segments of the population pool financial risk, toward more risk for the individual.”⁵ When the risks of ill-health are assigned to individuals, then those with higher incomes are able to purchase the standard of care they desire, without having to pay, through higher taxes, for a similar standard for the rest of the community. In such a market-oriented health system, individual self-reliance replaces social solidarity.

How the proponents of Medicare reply

Defenders of Canada’s public health care system deny these claims of unsustainability and runaway costs. They point to empirical data showing that none of the three sectors which together make up our public Medicare system—government funding of hospitals, physicians’ fees, and administrative costs—has increased its share of our entire economy over the past quarter-century or so. “It is the private sector that has caused health expenditures to grow.”⁶ In particular, rapidly escalating drug costs have been the major overall driver of escalating health care costs.

The exclusion of drug costs from our national health insurance program has led to costly irrationalities in the system. For example, discharged patients who simply cannot afford to buy expensive drugs will find themselves back in hospital, suffering from a relapse. Since it is dramatically more expensive to treat patients in hospital than at home, this doesn’t make much sense in either human or economic terms. Nor does it make sense to force patients to choose surgery (more expensive as well as physically more invasive, but covered by Medicare) rather than drug therapy (less expensive than surgery and less physically invasive, but not covered by Medicare).

It would seem to follow, therefore, that those who are genuinely concerned about overall cost-containment ought to favour an *expansion* of Medicare to encompass a national Pharmacare program. Similar arguments apply to long-

term care and home care, neither of which is yet part of the Medicare system. The empirical evidence strongly suggests that making Medicare more comprehensive would “kill two birds” (inefficiency and injustice) with one stone.

Taxpayers, of course, would face increased taxes to pay for such an expanded service. But these tax increases, falling more heavily on the well-to-do than on the poor, would be more than offset by large cost reductions for everyone needing prescription drugs or home care services, and by a reduction in demand for hospital services. *Overall, the cost to Canadians would be less, not more.*

Proponents of Medicare conclude that the alternative proposed by the critics—some variant of the marketplace approaches adopted by our American neighbours—would offer a lower quality of care to most people (and especially to the sick and poor), less choice, less access to specialists and hospital care, and less accountability—all at a much higher financial cost. These inflated costs would generate a big income boost for private health care corporations, and for some doctors, but for everyone else it would be a dead loss. In sum: the American path towards health care privatization would simultaneously inflate costs and decrease access.⁷

The American model

“At least two million people lost their health insurance in the last 13 months as unemployment rose and growing numbers of consumers decided they could not afford steeply rising costs.”⁸

This opening paragraph of a recent *New York Times* story vividly illustrates the scope of personal hardship that large numbers of people face when health care is organized along American-style marketplace principles. The same *NYT* article goes on to point out that “Health care economists said that at least 40.4 million Americans, based on conservative estimates, were uninsured...” By contrast, it is one of the inestimable virtues of Canadian Medicare that those who lose their jobs don’t face the catastrophe of also losing their public health insurance. In good times and in bad, the principle of universality translates as health care security.

Two ancillary benefits of our universal Canadian system: Canadian workers, unlike their American counterparts, are not forced (by fear of losing health insurance) to stay in jobs they hate; and the labour market, in consequence, becomes more flexible and efficient. Thus, a universal system of health care insurance simultaneously promotes the values of fairness, personal freedom, and economic efficiency.

A key question

The great Canadian health care debate hinges, in large part, upon this key question: *can our health care system preserve equal access and still provide a high quality of care, at an affordable cost to society?* So long as most Canadians believe that our publicly-funded Medicare system will provide them with high-quality care when they need it, they willingly agree to forgo the right to buy health care services privately. This has been aptly termed “the middle class bargain”.⁹

Equality of access to health care is probably *the* defining value of our health care system. It is clearly the moral value in which most Canadians are most heavily invested.¹⁰ The principle of equal access—access based on medical need rather than on ability to pay—speaks both to our sense of fairness and to our sense of community. Nevertheless, polling data also suggest that political sup-

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port for Medicare is likely to erode substantially if people come to believe that escalating costs mean that preserving equal access will undermine the quality of care provided.¹¹

In other words, if *universal* access comes to be seen by the middle class as conflicting with access to *high-quality* care, then support for universal access among the prosperous classes of society will be difficult to maintain. Critics of Medicare insist that we are already faced with a trade-off between access and high quality. Proponents argue that we can have *both* justice and efficiency. Indeed, they insist that our universal health care program, with its administrative simplicity, provides high-quality care for many more people than does the American system, burdened as the latter is with enormous administrative costs and generous profit margins for private shareholders.

Marketplace economics

In present-day Canada, virtually everything is for sale. If one has sufficient pur-

chasing power, one can “vote with one’s dollars” for the package of goods and services one desires. If not, one simply does without. “The good society,” as frequently pictured on television and in the cinema, sees human happiness as a function of individuals competing freely with one another in the marketplace, each attempting to maximize self-interest or profit. In such a society, it is not only luxury goods, such as laptop computers and DVD players, whose availability is contingent on one’s ability to pay. Food, housing, and transportation are necessities of life, but they are also treated as *commodities*, for sale in the marketplace, and available, therefore, only to those who have sufficient purchasing power. The rest must rely on government provision or private charity. Or do without.

Ideological critics of Medicare typically contend that health care (like food, housing and transportation) should also become a commodity in the competitive marketplace.

Health care: justice or charity?

Remarkably, however, despite a powerful neoconservative tide in the affairs of our nation, it is still the case that every Canadian who needs to see a doctor can do so without direct charge, regardless of how fat or thin his/her wallet may be. Everyone who needs hospital care receives that care at no direct cost, wherever s/he may live or travel in Canada. Our Medicare system pays—from tax revenues—for all services deemed to be “medically necessary,” whether doctors’ bills or hospital expenses.

The reason this happens is that Canadians (in common with citizens of

most European nations, but in contrast to our American neighbours) have accepted a vision of social justice that sees health care as a fundamental human right. According to this social justice tradition, every citizen—regardless of ability to pay—is part of the same moral community. In consequence, all are entitled, as a matter of *justice* rather than *charity*, to receive the medical treatment they need.

Significantly, this principle of justice in health care was incorporated into the 1966 United Nations General Assembly Covenant on Economic, Social and Cultural Rights, which Canada ratified in 1976. The Covenant affirms:

The right of everyone to the enjoyment of the highest attainable standards of physical and mental health... through the conditions which would assure to all medical services and medical attention in the event of sickness.

Although a majority accepts the philosophy of competitive individualism, it is striking that Canadians simultaneously maintain their allegiance to a communitarian health care system: one based essentially upon the values of equal access and compassion for the weak and vulnerable. Since there is also strong empirical evidence¹² to show that Medicare is much less expensive and significantly more efficient than the American model, there appears to be a happy coincidence here between justice and efficiency.

As discussed earlier, Canada's Medicare system, although currently under serious attack, continues to elicit passionate loyalty, mostly because it is, for

ordinary citizens, the living institutional embodiment of their commitment to such core values as social justice and human decency. Equally important, perhaps, Medicare provides every Canadian with a great deal of personal security, knowing that, whatever their economic future, they will always be able to access first-rate health services on the same basis as every other Canadian. "Two-tiered health care" remains a negative term in our national lexicon because of the widely shared philosophical conviction that everyone in our community is equally entitled to high-quality health care.

Canada is, of course, a highly unequal society in many ways. Still, most Canadians continue to defend the egalitarian assumption that, rich or poor, all lives are of equal worth. "Equality of worth of human lives" is a value both reflected in and reinforced by the commitment to universal health care accessibility. We may live our working lives within a predominantly marketplace *economy*, but most Canadians insist that they don't want to live in a totally marketplace *society*.

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Tony Clement's Cat

There are some Canadians—a small minority at present, but disproportionately represented among the wealthy and powerful élites of our society—who contend that health care should be viewed as simply one more commodity to be

bought and sold, for profit, in the marketplace.

Consider, for example, the rhetorical question posed by Tony Clement, during his campaign for the leadership of the Conservative Party of Ontario:

“Does it make any sense to you that your cat can get an MRI at 2:30 in the morning and you can pay \$20 to do that, but your mother can’t? Does that make sense to you? Is your cat more important than your mother? How about your daughter, is she more important than your cat? It doesn’t make sense.”

—*Globe and Mail*, January 10th, 2002

Now, any cat owner in this country could inform Mr. Clement that, when he takes his pet for an MRI scan, his vet bill is likely to be much closer to \$1,000 than to \$20; but that is not the point. Clement’s cat, like his Lincoln Continental, is a commodity that he purchased in the marketplace. And if the cat falls ill, or the Lincoln needs repair, the financial burden for purchasing the services and parts needed to set things right will fall entirely upon the Clement family. If they cannot afford the vet’s bill, then the cat will die. A pity, if it happens, but most Canadians would accept this sad result with a shrug of resignation.

Very few Canadians, however, share Mr. Clement’s view that chemotherapy for his wife’s breast cancer or by-pass surgery for his own blocked coronary arteries should be viewed as commodities, no different in principle from chemo for his cat. One wonders if even Mr. Clement truly believes that we ought to view health care for sick patients as in-

distinguishable, morally speaking, from health care for pets.

Suppose that health care in Canada were to become a commodity, as Mr. Clement advocates. Suppose further that Mr. Clement himself were to lose his job and his life savings, so that he could no longer afford to pay privately for the medical treatment needed by his family or himself. If his wealthy neighbour were then to receive prompt diagnosis and treatment in the pleasant surroundings of a private hospital, while the treatment available to the Clement family in a dilapidated public hospital was delayed for weeks or months, would the destruction of one-tiered medicine still seem so “common-sensical?”

In the United States, this is not a hypothetical question. Dr. Bernard Lown, professor emeritus at Harvard School of Public Health, describes the current American health care situation as follows:

At a time of unprecedented affluence, one-third of Americans are inadequately insured. Compared with the fully insured, they are sicker, poorer, and die younger. Nearly 45 million Americans are uninsured, and their numbers swell by one million annually.¹³

The 45 million or so Americans who cannot afford health insurance can nevertheless hope or pray for private charitable assistance. If/when that charity is not forthcoming, some of them will be condemned to watch their children or other loved ones die from treatable but untreated illness.¹⁴ Many will receive second-rate treatment in overcrowded, underfunded public or charity hospitals.

Additional millions live with the fear that their insurance will be inadequate to a medical emergency and that, in consequence, they could be forced to spend their entire life savings on needed treatment.

In sharp contrast, Canadian society has established a health care framework that, for all its imperfections, guarantees to every member of society a fundamental right to health care services, based solely on medical need. Our system falls short of its highest aspirations in ways to be discussed below, but it does provide a certain guaranteed basic level of health care to everyone. This may not fully qualify us for the label “Good Society” or “Just Society,” but it is, surely, an important step in the direction of achieving what might be called a “Minimally Decent Society.”

A final word about Tony Clement’s cat. There does seem to be something truly amiss when wealthy pet owners have quick and easy access to high technology diagnostic services for their pets at the same time as many Canadians wait anxiously for weeks or even months, in a health care queue, for the scan which will confirm whether or not they have cancer. Clement’s proposal that we enable a few of the wealthy to jump the queue by “going private” doesn’t answer the question: why should anyone, rich or poor, have to wait for months to receive urgently needed medical services?

The scandal would appear to reside partly in the process whereby public diagnostic equipment is rented out to private entrepreneurs during “off-hours” (for use by vets, say), instead of being employed round-the-clock to deliver the

care that human patients need. There is a strong case to be made for reforms to the system as it is now operating.

Common sense might seem to suggest that, when the rich jump the queue for public health services, then everyone else will receive speedier service because there will be fewer people in the queue. This argument has been advanced by, among others, the governments of Ontario and Alberta. However, once the privileged élites of any society lose their personal stake in the public health care system, there is very real danger that the public system will quickly become a slum.

Something very much like this is already happening in Britain. Deterioration of public health care results partly from the fact that the private system drains off key health care personnel from the public system. Partly it comes about because, when the upper and middle classes opt to go private, the public system loses its most powerful and influential advocates. So long as the privileged élites *cannot* buy their way privately to essential health care services, they have a big stake in ensuring that Medicare offers high-quality services to everyone in a timely manner. So long as we are “all in it together,” it’s much more likely that public health care will provide a high quality of service.

Social cohesion

According to the pure marketplace model of society, as imagined by American neoconservatives, each individual is expected to look after him or herself. Society is seen as a quasi-Hobbesian war

of each against all: a competitive struggle for individual advantage in which the sole legitimate role of government is to offer protection against force or fraud. Those who are unsuccessful in the competition (because they are insufficiently entrepreneurial or untalented, or simply unlucky) are, nevertheless, held responsible for ensuring their own well-being. If the “losers” fail to make adequate provision for themselves or their families then they must suffer the attendant consequences unless others, moved by individual beneficence, decide to intervene charitably. Self-reliance is the watchword. Marketeers of a somewhat less rigorous orientation may, however, assign to government the residual role of providing some minimal level of social support to those whose poverty is “undeserved.”

In contrast, the gentler image of society favoured by many Canadians—derived historically from the European welfare state tradition—assigns legitimacy and importance to the values of social justice and social solidarity. These communitarian values are seen as no less legitimate than the search for corporate profit and private competitive advantage. In this view, altruistic pursuit of the common good is to be fostered and preserved, rather than subordinated completely to prudential calculations of individual self-interest. Accordingly, commitment to the basic principles of Medicare represents symbolically the larger commitment by our society not to abandon entirely the ideal of the common good. It is the bond we have as Canadians which transcends geography, ethnicity, language, gender, race, and class.

Marketplace medicine: marketplace doctors and nurses, marketplace hospitals

To this point, our discussion of values has centred primarily on issues of *financing mechanisms*: universal publicly-financed health care insurance with no payment at point of service [Canada] vs. marketplace insurance provided by a multiplicity of private and governmental insurance schemes [U.S.A.].

But there are also major value concerns raised by choice of *delivery mechanism*. Several provincial governments want to introduce or greatly expand the role of for-profit hospitals and clinics. Other provinces, and the federal government, are fighting to preserve a system in which hospitals and health care clinics remain not-for-profit. In either case, Medicare will continue to pay for all “medically necessary” services. So: why should Canadians care whether for-profit private health care corporations run an increasing number of our hospitals and clinics? Here’s why.

The highest ideal of the medical professions, since the time of Hippocrates, has been to heal the sick. Nevertheless, despite this fundamentally altruistic core commitment, the health care debate in contemporary America has come to be dominated by the market metaphor.¹⁵ In this cultural climate, patients are now commonly referred to as health care “consumers,” and physicians as health service “providers.”¹⁶ This linguistic shift both reflects and reinforces the fact that the humanitarian orientation of the health care professions, developed and

internalized over centuries, is giving way to the values of business.

There is undeniably some element of truth—especially in the American context—to the view that medicine is a business, in which providers of goods and services [doctors and private hospitals, for example] compete with one another for customers. However, the great danger of applying the market metaphor to medicine is that it may obscure the more fundamental truth that physicians are pledged to behave as health care *professionals*, altruistically committed to their patients' well-being. The inescapable danger of adopting a corporate model for health care delivery is that such a model results in patients being depersonalized, while doctors and nurses are deprofessionalized.

When consumers consult life insurance salespeople, seeking information and advice, they should not be overly surprised when their agents recommend the purchase of “whole life” insurance, which carries a large commission (for the agent), rather than, say, “term insurance,” which offers the agent only a modest commission. This is a marketplace transaction, and *caveat emptor* is the guiding maxim. Let the buyer beware. In the commercial marketplace, every individual is assumed to be responsible for protecting his or her own best interests. If you don't want to be “suckered,” then consult *Consumer's Report* or some other independent source of reliable information.

When, by contrast, a patient consults a cardiac surgeon about a heart murmur, we would be shocked to discover that the surgeon (or private hospital) was viewing this encounter primarily from

the point of view of profit maximization. As the wealthy American businessman and philanthropist, George Soros, has commented: “Medicine is too important to be left to the mercy of marketplace values.”

These days, of course, many patients do search the Internet in an effort to become better informed about their health problems. Some even engage in “doctor shopping” or “hospital shopping.” But, “unlike the independent shoppers envisioned by market theory, sick and worried patients cannot adequately look after their own interests, nor do they usually want to.”¹⁷ No amount of web-surfing can enable most patients to shop wisely for the best health services at the best price.

Patients seldom enjoy equal power in the relationship they have with their doctor or with the hospital in which they are being treated. The typical imbalance of the power relationship between doctor and patient creates a situation of patient vulnerability. Very few patients possess the specialized medical knowledge necessary to make informed choices about health care options, at least not without professional assistance. Most patients lack medical expertise and cannot easily acquire it. Moreover, sick patients often experience attendant discomfort or even pain. They may be dulled or stupefied by analgesics. Fear of illness, disability, and unpleasant treatment modalities cause patients to

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experience anxiety and upset. None of these factors is conducive to the educated “comparison shopping” which figures prominently in the marketplace model of the “sovereign consumer.”

Moreover, although it is almost too obvious to need stating, good health is not simply one among many components of the “good life.” Health enjoys a high priority, perhaps the very highest

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priority in our hierarchy of values, because it is important for virtually every other life project we may have. Health care is such an intimate part of our lives that it should not be

regarded as a mere commodity. Health care is special. When we are sick and vulnerable, we need to be able to count upon health care professionals and health care institutions to serve unequivocally as our impartial advisors and advocates.¹⁸

It is therefore no accident that health care has evolved as the domain of “caring professions.” We absolutely need our physicians and our nurses to conduct themselves as beneficent professionals—people we can trust to place our interests above all others.¹⁹

It is agreed by all that physicians (and hospitals) have a fiduciary duty to patients, a duty to assign the highest priority to the patient’s interests. They are committed by oath to one version or another of the fundamental maxim of physician ethics: “The life and health of my patient will be my first consideration.” [Declaration of Geneva]

Writing about the transformation of American medicine over the past few decades, the esteemed American physician and journal editor Dr. Arnold Relman comments:

[H]ealth care has become commercialized as never before, and professionalism in medicine seems to be giving way to entrepreneurialism. The health-care system is now widely regarded as an industry, and medical practice as a competitive business. [1992]

This warning of a decade ago seems highly pertinent to Canadian society today, as we debate the wisdom of adopting an American-style model of privatized health care. For, if Canadian health facilities become part of a medical-industrial complex, under the covering guise of such buzzwords as “choice” and “diversity,” as has happened in the U.S., then the values upon which Canadian medical and nursing practice is based will also be transformed so that they approximate more closely to the values of business.

If we allow the phenomenon of medical corporatization to strengthen its toehold in Canada, we can expect that our hospitals, clinics, diagnostic laboratories, and nursing homes will increasingly see themselves as “beleaguered businesses,” and their patients as “consumers” to whom they advertise and sell as many of the most expensive services as the market will bear. The prime measure of success in the health care business will become, as it is in every other business, profit-maximization.

In sum, when our hospitals, clinics and nursing homes become profit-mak-

ing enterprises, the doctors and nurses who work in those institutions will also tend to become more entrepreneurial, with one eye on their patients' health, and the other eye on the balance-sheet. The corporatization of health care may open many wonderful new opportunities for profit-generation by the business community, but the human price to be paid by the larger community will likely include a severe erosion of trust in the doctor-patient relationship. Since trust between patient and doctor is the very soul of medicine, this is not a bargain that most Canadians are willing to make. It's not a bargain most Canadians **should** be willing to make.

It is important to stress the point that, despite the creeping—some would say “galloping”—infiltration of business values into the practice of medicine, many Canadian doctors and nurses strive mightily to meet the highest ideals of their profession, and they often succeed in providing the excellent care to which Canadians are entitled. Among health care professionals, the values of justice and beneficence still predominate over marketplace values—though for how much longer is an important question for every Canadian.

Who stands on guard for Medicare?

Now is surely the time for our political leaders to show leadership. The professionalism and commitment of Canada's health care community needs to be supported and reinforced by a renewed political dedication to the core values of Medicare. We need our political élites

and, in particular, our federal politicians to “stand on guard” for us, as a caring community.

An earlier generation of federal politicians had the moral vision to sign covenants committing our society to the principle that health care is a universal human right. As human beings, we are all vulnerable to illness and pain. Medicare was created by politicians unafraid to create a health care system that gives practical effect to the principle of basic human equality. It would be a great pity if this achievement were allowed to expire, salami-style, slice-by-slice.

Nor can we, as citizens, simply sit back comfortably and allow the politicians and “experts” to repair what's wrong with Medicare. The public would be naive to count automatically on the Canadian political system to protect what is most vital and essential to Canadian community life. Individual citizens and community groups have a duty to join the great national values debate. If we wish our federal government to play a more vigorous role in defending and promoting the core values of Medicare, then we will have to speak out ourselves about what we value, and why we value it.

If not now, when?

Endnotes

- ¹ See: National Forum on Health, 1997. *Canada Health Action: Building on the Legacy*, Vol. II. Minister of Public Works and Government Services; and Nuala P. Kenny, “Reframing the Discourse: Rethinking Medicare”, *HealthcarePapers*, vol. 1, no. 3, summer 2000.
- ² Commission on the Future of Health Care in Canada, Interim Report, February 2002, p.4.

- ³ *Ibid.*, p.9.
- ⁴ Malik Hassan, *New England Journal of Medicine*, 18th April 1996. A subsequent issue of the *NEJM* provides evidence contrary to this claim. See: EM Silverman, J Skinner and E Fisher, "The association between for-profit hospital ownership and increased Medicare Spending", *NEJM* 1999: 341: 420-426.
- ⁵ Kieke Okma, "The genesis of medicare", *Globe and Mail*, 13th February 2002.
- ⁶ Robert Chernomas, "As privatization grows, so do our health care costs". *The Canadian Centre for Policy Alternatives Monitor*, Vol. 6, No.3, July/August 1999.
- ⁷ References to "the American path" are not meant to suggest that a market approach to health care delivery is an exclusively American phenomenon. It is not. In both Britain and Europe, for example, the marketplace approach seems to be gaining in popularity with governments, if not with ordinary citizens.
- ⁸ "Coalition Forms to Reverse Rising Trend of Uninsured Americans", Milt Freudenheim, *The New York Times*, 9th February, 2002.
- ⁹ Michael Mendelson and Pamela Divinsky, "Canada 2015: Globalization and the Future of Canada's Health and Health Care", Draft Report, prepared for the Future of Global and Regional Integration Project, Institute of Intergovernmental Relations, Queens University, August 2000.
- ¹⁰ See: the National Forum on Health, *op.cit.*
- ¹¹ "The twin pillars of access and quality", Publications of the National Forum on Health, Volume 2, 1997.
- ¹² For details, see the companion essays to this one, authored by Armine Yalnizian and Colleen Fuller, publication forthcoming, Canadian Centre for Policy Alternatives.
- ¹³ "For-profit care's morbid results", *The Boston Sunday Globe*, 1st August, 1999.
- ¹⁴ It should be noted that many charitable hospitals in the U.S. do provide care to the non- or underinsured, and some hospitals and doctors give care without full compensation. This somewhat softens the impact of health care rationing by income. Despite this amelioration, however, data show that millions of Americans go without routine physical examinations; and when it comes to such crucial public health measures as prenatal care and immunizing young children, America's world ranking is scandalously low. The unavailability of affordable primary care in the USA means that large numbers of Americans die from treatable illnesses, while the health of even larger numbers is prejudiced by the unavailability of timely primary care.
- ¹⁵ See, for example, Ruth E. Malone, "Policy as Product: Morality and Metaphor in Health Policy Discourse", *Hastings Center Report* 29, no.3 (1999): 16-22; and G.L. Annas, "Reframing the Debate on Healthcare Reform by Replacing our Metaphors", *New England Journal of Medicine* 332: 744-47.
- ¹⁶ As Ruth Malone rightly points out [*ibid.*, p.17], in its genesis this "consumer-provider" metaphor was partly intended to promote a more egalitarian relationship between doctors and patients, in which unwarranted medical paternalism would be checked. It's current use is, however, more questionable.
- ¹⁷ Arnold Relman, "What Market Values Are Doing to Medicine", *Atlantic Monthly*, March 1992, p.100.
- ¹⁸ Note that citizens have a right to health care not just when they are sick, but when they are well, too. E.g., access to such preventive non-medical services as home care for the frail elderly is a highly effective way of delaying or preventing the need for costly future medical interventions.
- ¹⁹ See: Susan Dorr Goold, "Trust and the Ethics of Health Care Institutions", *Hastings Center Report* 31, no. 6 (2001): 26-33.

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