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Jocelyn Downie

Nuala Kenny

Chantelle Rajotte

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Problematic Principles: The CMA on Public/Private Health Care

**Jocelyn Downie, Nuala Kenny
& Chantelle Rajotte**

In June 2006, the Canadian Medical Association [CMA] published a discussion paper, "It's about access! Informing the debate on public and private health care," to evaluate how best to manage the public and private health care sectors in order to improve access to high-quality health care.¹ The report comes at a critical time for the health care system in Canada, with talk of renewal and reform at the forefront of public discussion. In their report, the CMA "identified 10 first-order policy principles that should guide any policy and decision-making related to the public-private interface."² The CMA's use of these principles is problematic on four levels.

First, the principles embraced by the CMA, as they are defined in the report, should not be considered "first-order." The Oxford English Dictionary defines a "first principle" as "a primary proposition, considered self-evident, upon which further reasoning or belief is based."³ But how can one have ten "primary" propositions? The CMA's misunderstanding of a first-order principle can be illustrated further by examining one of its listed principles: choice. The CMA defines "choice" as patients having a choice of physician and physicians having a choice of practice environment.⁴ However, this principle, as defined, should not be considered first-order. As noted by Beauchamp and Childress in their leading bioethics text, choice is a tool for respecting autonomy and is therefore, a "mid level" principle subsidiary to the higher order principle of respect for autonomy.⁵ In a specifically Canadian context, one can refer to the National Forum on Health report which identified the health care values that are held by Canadians. One of the values was "dignity and respect," defined in terms of treating individuals

with dignity and respecting their innate self-worth, intelligence and capacity of choice.⁶ Again, choice is considered a secondary principle, in this case, grounded in dignity and respect. Viewed in this way, choice must be defined in a way that respects the dignity of all Canadians. However, because the CMA failed to appropriately define its first-order principles, it has defined choice in a way that could jeopardize the accessibility of quality health care for the more vulnerable members of society and, thus, threaten their dignity.

Second, the CMA provides no justification for the selection of its principles. Perhaps the principles could have been justified by reference to physicians' principles (given that the report was written by the CMA). However, the traditional principles of physician ethics – altruistic/fiduciary commitment to the patient's welfare, competence, and medicine as a public trust – are not directly identified. Perhaps the principles could have been justified by reference to the *Canada Health Act*. However, only one of the five values recognized in the *Canada Health Act*, comprehensiveness, is included on the CMA's list of first-order principles.⁷ How does the CMA account for these discrepancies? It is difficult to respond to a selection of principles that is not justified. If the CMA provided a justification for their choice of starting principles, it would facilitate dialogue.

Third, the CMA appears to give equal weight to each of the ten principles. For example, "clinical autonomy," defined as "autonomous decision-making within the patient-physician relationship," and "equity," defined as "[a]ccess to medically necessary care...based on need," are given equal importance.⁸ This stands in contrast to the qualitative evi-



dence collected by the National Forum on Health, which found that “[e]quality of access was one of the most important values” held by Canadians,⁹ and by the Romanow report,¹⁰ which found that Canadians prioritize equity. If the CMA provided a hierarchy of their principles, it would increase the usefulness of its policy scenario analysis and improve its contribution to the health care discourse in this country.

Fourth, the principles chosen by the CMA do not accurately reflect the “social values” it identifies as important in its paper.¹¹ The CMA’s list of principles contains several self-interested principles, such as “physician choice” and “clinical autonomy,” which are not found in other leading reports on Canadian health care.¹² Perhaps more problematic, however, the CMA’s list of principles fails to include a number of collective values, such as “accessibility” and “universality,” that are contained in the *Canada Health Act* and endorsed in The Standing Senate Committee on Social Affairs, Science and Technology’s final report, *The Health of Canadians – The Federal Role*. Accessibility means that all Canadians, regardless of their income, must have access to needed health care, whereas “[u]niversality means that public health care insurance must be provided to all Canadians.”¹³ The National Forum on Health found “compassion” to be a Canadian health care value, yet this is also excluded from the CMA’s report. This principle recognizes the importance of “[s]ocial solidarity and concern for the specially vulnerable.” The National Forum found that Canadians view these values as being strongly tied to their national identity.¹⁴ The CMA’s report privileges the values and perspective of doctors. While this is an important perspective, the failure to consider societal values, which are the hallmarks of the Canadian health care system in its collection of first-order principles demands an explanation.

In order for our health care policies to be a principled and accurate reflection of societal values, we need to keep in mind the core values of Canadians and the foundational duties of doctors. Only when our guiding principles are truly first-order and our selection of them is justified will the policy and decision-making process itself be principled. Perhaps then, the CMA will realize that it’s not **just** about access. It’s surely about so much more.

Jocelyn Downie, Professor, Faculty of Law and Faculty of Medicine, Dalhousie University, Halifax, NS.
Nuala Kenny, Professor, Departments of Bioethics and Pediatrics, Faculty of Medicine, Dalhousie University.
Chantelle Rajotte, Law Student, Dalhousie University.

1. CMA Task Force on the Public-Private Interface, Discussion Paper, “It’s about access! Informing the debate on public and private health care” (June 2006), online: Canadian Medical Association <http://www.cma.ca/multimedia/CMA/Content_images/Inside_Cma/Media_Release/pdf/2006/about_access_e2.pdf>.
2. *Ibid.* at 25.
3. *The Oxford English Dictionary*, 2d ed., s.v. “principle”.
4. *Supra* note 1 at 25.
5. Tom L. Beauchamp & James F. Childress, *Principles of Biomedical Ethics*, 5th ed. (New York: Oxford University Press, 2001).
6. Canada, National Forum on Health 1994 to 1997, “Values Working Group Synthesis Report” in *Canada Health Action: Building on the Legacy Vol. II: Synthesis Reports and Issue Papers*, online: Health Canada <http://www.hc-sc.gc.ca/hcs-sss/com/nfh-fns/index_e.html>.
7. Accessibility, comprehensiveness, portability, public administration and universality are the five values recognized by the *Canada Health Act*. *Canada Health Act*, R.S.C. 1985, c. C-6, online: Canadian Health Care <<http://www.canadian-healthcare.org/page2.html>>.
8. *Supra* note 1 at 25.
9. *Supra* note 6.
10. Canada, Commission on the Future of Health Care in Canada, *Building on Values: The Future of Health Care in Canada* (November 28, 2002) (Commissioner: Roy J. Romanow, Q.C.), online: Health Canada <<http://www.hc-sc.gc.ca/english/care/romanow/hcc0086.html>>.
11. *Supra* note 1 at 26.
12. *Supra* note 1 at 25; Neither choice nor clinical autonomy are listed as guiding principles by The National Forum on Health, *supra* note 6; The Commission on the Future of Health Care in Canada, *supra* note 10; or Canada, The Standing Senate Committee on Social Affairs, Science and Technology, *The Health of Canadians - The Federal Role - Final Report, Volume Six: Recommendations for Reform* (October, 2002) (Chair: The Honourable Michael J.L. Kirby), online: Parliament <<http://www.parl.gc.ca/37/2/parlbus/commbus/senate/com-e/soci-e/rep-e/rep02vol6-e.htm>>.
13. *Supra* note 7; The Standing Senate Committee on Social Affairs, Science and Technology, *ibid.* at 27.
14. *Supra* note 6.

