

**HEALTH POLICY AND ECONOMICS****The “Romanow Report” and the Ethics of Health Care**

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**WHAT ETHICS MESSAGES DOES THE ROMANOW REPORT COMMUNICATE AND WHAT ETHICS ISSUES DOES IT RAISE?**

**E**thics are values and, in the context of health care, shared values. The Report finds our core values as a Canadian society are at the heart of Medicare. They include “equity, fairness and solidarity...[in access] to medically necessary health care services on the basis of need as a right of citizenship, not a privilege of status or wealth.” These values are of major importance, well beyond health care, in setting the ethical tone of Canadian society as a whole. We all personally identify with health care and, therefore, our values in that context are the ones most universally shared and most likely to spill over into other areas. As well, the ethical tone of a society is best tested by how it treats its weakest, most in need, most vulnerable members. For many of us, that is when we are sick and need health care.

Both through its own practice of extensive public hearings – citizens’ dialogue sessions, consultations, televised forums, open public hearings, expert workshops, regional forums, surveys, site visits, and round tables – and in its Report, the Commission recognizes that all Canadians have a right to be involved in the decision making about this area of public policy. Indeed, such inclusion is, itself, an ethical requirement.

The Report recommends a series of measures to improve transparency across the health care system and “to make decision-making structures more inclusive...and to give Canadians a greater say in shaping the system’s future.” The goal is, the Report says, to change “a system that is a complex and unfriendly mystery” to “a more comprehensive system whose component parts fit together more seamlessly.” The proposed measures include adopting a *Canadian Health Covenant* that articulates, first, the basic principles which are to inform the health care system, and, second, the responsibilities and entitlements of individual Canadians, health care providers, and governments.

The Commission also recommends establishing a *Health Council of Canada* to de-politicize the decision-making within Medicare.

It will be a major challenge to design and establish the range of structures that will be needed to promote real public participation in health care decision-making – and, not, as has often happened on the infrequent occasions on which it has been attempted in the past, just a façade of it. These structures must be based on an ethics of complexity – because the reality with which they must deal is complex – but they must function with elegant simplicity, if they are to be both effective and embed ethics in the decisions they facilitate.

Systems ethics, organizational ethics, and institutional ethics are all relevant to structuring the health care system of the future, but are still in their infancy. They respond to the need to develop ethics at the macro (societal) and meso (institutional) levels. As well, we will continue to require ethics at the micro (individual) level of the health care professional-patient relationship. But ethics at different levels can conflict. What might be an ethically valid consideration for politicians or health administrators at the macro or meso level – for instance, giving priority to efficiency – may not be ethical at the micro level – for instance, an individual physician seeking to maximize efficiency, when doing so would harm the patient. Some of the most difficult ethical dilemmas arise in relation to such conflicts. We must take great care in addressing them, whichever level of player we are in the decision-making.

The “Romanow Report” finds that “Canadians view Medicare as a moral enterprise, not a business venture.” But some participants in the health care system are businesses and some elements of the system involve business. Just as ethics can differ at different levels of decision making, the domain in which one operates may affect what is ethical. Consequently, how we characterize a domain can matter ethically. For instance, how should we characterize the pharmaceutical industry?

As the Report recognizes, the importance of prescription drugs as treatments has increased enormously. What ethical principles should govern the pharmaceutical industry, and such matters as patents and profits? Businesses that operate in the health care arena have responsibilities to the people who are treated with their products, not just to the market. They are not businesses just like any other business; they must also fulfill a public trust. Ethically, they are mixed systems, that is, ones in which both guardian/protector ethics and commercial ethics apply. Such systems are the most difficult to govern from an ethics perspective, because the safeguards that ensure ethics in each system when it is “pure”, may become inoperative in mixed systems. They require treading a narrow path, that may be very difficult to identify, between quite different sets of ethical principles and sometimes implementing principles from one set and other times from the other.

The “Romanow Report” states that “[t]ossing overboard the principles and values that govern our health care system would be betraying a public trust.” The idea that we should hold Medicare on trust for present and future generations – and, interestingly, that in part we have such an obligation, because Medicare is a legacy we have inherited from past generations – conveys a powerful ethical message. It also raises ethics issues. What does fulfilling that trust require that we both do and not do? Political talk about doing the right thing is not enough: “We need more than rhetoric, we need action.” Moreover, the Report recognizes that getting to the system it recommends “requires national leadership,” if we are to create “a truly national, more comprehensive, responsive and accountable health care system.” We would do well to add the adjective “ethical” before the word leadership, although it is implied.

The Report dismisses alternatives to the present socialized Medicare system – “user fees, medical savings accounts, de-listing services, greater privatization, a parallel private system” – on the grounds that there has been no evidence forthcoming that these measures “would improve and strengthen our health care system.” The harms involved in the denial of personal choice and liberty this rejection entails, are curtly dismissed as follows: “Some have described it as a perversion of Canadian values that they cannot use their money to purchase faster treatment from a private provider for their loved ones. I believe it is a far greater perversion of Canadian values to accept a system where money, rather than need, determines who gets access to care.” No ethical arguments against such an approach are canvassed and there is no discussion of the ethics of well-known people (for example, politicians or celebrities), or physicians and their friends and families, going to “the front of the line” because of their connections and influence and not because they have more urgent medical needs than those people already in line.

Health care costs more because there is so much more that we can do now than in the past – overall, more than we could ever afford to do fully. That means we will have to choose. Informed choice requires measurement of health care outcomes, which the Report recommends. But some of the most important aspects of health care – such as empathy, kindness and caring – are very difficult to assess objectively, because they are qualitative and not readily quantifiable. Focusing on the measurable in health care can exclude the essential. That often results in breaches of ethics and loss of respect for patients. Progress is being made, however, on developing research tools to assess qualitative factors.

Along the same lines, the Report focuses on giving health care professionals and Canadians better health information, and supports evidence-based medicine. Such tools are useful, but they must be employed in an ethical manner. The straightforward use of statistics to justify treatment decisions in relation to individual patients can sometimes be unethical, especially when it results in denying access to treatment.

In the same vein, assessment of the relative benefits and costs of new health technologies is recommended. Both identifying benefits and costs and weighting them are value judgements, and the process used to make these judgements, and the principles on which they are based, must be ethically acceptable. That may require taking into account a wide range of ethical considerations. For instance, when a choice must be made between spending money on one technology or another, one of which would benefit people with low health status or restricted access to care, as compared with others, who are receiving substantial care, what principles should guide us? Ethically, we can argue for a preferential option in favour of the least advantaged, most vulnerable, most in need Canadians. That would indicate, as the “Romanow Report” recommends, that there should be special consideration of the needs of dying people, mentally ill people, and aboriginal people. But are there other groups of people who, from an ethics perspective, should also be given preference in access to care, for instance, all people struggling to provide long term care at home for their loved ones?

On the other side of the equation, some people may be unfairly advantaged in their access to health care. For example, the “Romanow Report” points out that some people receive treatment within the Medicare system more rapidly than others, because they skip wait lists for diagnostic services by having earlier access to these services through private payment or compensation schemes. The commission recommends remedying such hidden disparities in access to care, through a designated fund to increase diagnostic services and cut wait lists for them.

The Report also focuses “squarely on primary health

care.” What constitutes primary health care is a moving target: tertiary care of even just five years ago, may be primary today. Many ethical issues are raised when people disagree on the characterization of certain care, when access to it depends on its characterization in one or other way. Health care decision makers sometimes characterize a given treatment in a particular way – for instance, as experimental – in order to avoid the costs involved in providing it. Unless such decisions are made honestly and in good faith, they are unethical.

The “Romanow Report” is especially noteworthy for its last chapter, *Health Care and Globalization*. As far as I am aware, uniquely for such a national report, it recognizes that we have international responsibilities in relation to health care. Fulfilling those responsibilities is fundamental to our humanity, respecting others’ human rights, and implementing human ethics. What does bioethics for a small planet – not just for Canada – require of us as Canadians, in relation to health care? The question is very

broad and the possible range of responses even broader. However, the “Romanow Report” makes one important recommendation in this respect: that we should not be stealing doctors from developing countries, because they are the least able to sustain such a loss in terms of its impact on the health of their populations. It usually means people in developing countries have no access to health care, not even their already minimal level of access.

Knowingly creating such a situation compounds the breaches of human ethics we manifest in failing, to the extent that we are able, to provide at least some health care to others in desperate need. †

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