Submission

To

The Standing Senate Committee on Social Affairs, Science and Technology

Submitted by
The Ecumenical Health Care Network

of

The Commission on Justice and Peace
The Canadian Council of Churches

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Presented by
Mr. Stephen Allen

Introduction

On behalf of the Ecumenical Health Care Network of the Canadian Council of Churches' Commission on Justice and Peace, I appreciate this opportunity to comment on some of the Options being suggested by this Senate Committee in *Volume 4, Issues & Options*.

Historically, Canadian churches have contributed to the development of Canada's publicly funded and administered health care system, as service providers (eg. religious hospitals, homes for the chronically ill and aged, programs for the poor), as stakeholders (eg. pastoral ministries and chaplaincy services to the ill and dying), and as supportive advocates of new ideas and approaches (eg. community based programs such as parish nursing.) For Christians, Jesus has taught us that illness, or, more importantly, wellness, requires spiritual as well as physical well being.

With this in mind, I will focus my comments on six areas; (1) principles for the provision of health care, (2) financing health care, (3) accountability of all levels of government, (4) the need for evidenced based research, (5) expanding care to include pharmacare and home care, and (6) support for use of the determinants of health in insuring integrated strategies and programs.

Principles for the Provision of Health Care

Members of the Ecumenical Health Care Network support the five principles of the Canada Health Act. These principles enjoy widespread public support and must serve as a starting point.

Our support is based upon the following principles and values, which serve to uphold and supplement those included in the Canada Health Act. These include:

- The dignity of the person.
- The right to health care regardless of one's wealth or status.
- Health care as a service available in response to need. Health care service should not be viewed as a product or a commodity.
- Health care providers should not be diverted from their primary responsibility B the relief of suffering, the prevention and treatment of illness and the promotion of health. Underlying this responsibility is a relationship between provider and patient based on trust.
- Wise stewardship B it is not possible to do everything we might wish to do. Making decisions about priorities will involve policy debates and decisions involving citizen and Parliament.
- Equity, collective responsibility to each other, compassion and caring are the values we consider foundational and these values should guide us in reforms that need to be made.

Principles of social justice must inform whatever reforms are made to the provision of health care. "Fairness" as it has been articulated in *Vol. 4: Issues & Options* is not sufficient. Treating people of unequal means and situations equally is not fair nor does it support Canadians' commitment to social justice.

Financing Health Care in Canada

(Comments on Chapter 8 B Issues and Options for Financing Role)

The Committee has proposed several objectives of the federal government's financing role in health and health care on page 19:

1. To provide a stable level of funding that ensures the sustainability of Canada's health care system and that fosters reform and renewal.
2. To ensure that every Canadian has timely access to all medically necessary services regardless of their ability to pay for those services.
3. To ensure that no Canadian suffers undue financial hardship as a result of having to pay health care bills.
4. To ensure that the four patient oriented principles of the Canada Health Act (universality, comprehensiveness, accessibility and portability) are applied.

We find these objectives helpful.

Our health care system is based on the value that all citizens share the risks. No one wants to have an accident or to develop a life threatening disease. We draw comfort in knowing our health care system is there should we need it. Sharing this risk represents something of a social covenant among citizens. It is a value to be lifted up, protected and cherished.

Most churches are committed to the principle of public administration because it remains, for the most part, more efficient as well as enabling us to have a systemic approach to the provision of health care in Canada. In this context, we would continue to support tax revenue as the source of revenue for health care (see Chapter 8 and section 4.2 -- Increase General Revenue through income tax or sales taxes)

Let me make three observations in this regard.

Firstly, Noble prize winning U.S. Economist, Joseph Stiglitz in commenting on the growing unemployment in the U.S. (prior to the tragic events of September 11) said, "What worries me is that we don't have a safety net. We don't have adequate welfare or unemployment insurance"[i]. Mr. Stiglitz went on to say that worse still, U.S. workers who lose their jobs typically also lose their health coverage, exacerbating the pain[ii]. Many of the 40 million Americans who do not have health coverage, and the additional 40 million who are underinsured, are working, but cannot afford private insurance. Canada's publicly administered system provides an important sense of security for Canadians.

Secondly, we agree there is some confusion about the adequacies or inadequacies of funding levels in the health care system. One the one hand, media reports suggest we are spending too much on health care and tough choices need to be made. On the other hand, we seem to be at or below expenditures in other OECD nations. Health care expenditures currently represent slightly over 9% of GDP. This has not changed appreciably in the past decade. This is less than the 14% figure in the US. It is slightly more than some European members. The WHO study, *World Health Report 2000,* indicated that in terms of public expenditures, Canada had the lowest public expenditures in the G7, other than the US[iii]. As well, within the OECD, Canada ranks low in terms of public expenditures.

Raisa Deber (among other health policy analysts) reminds us that our universal insurance has contained costs in a way that has not been possible in the U.S. where so many citizens are excluded and left extremely vulnerable[iv]. In the same article, Professor Deber draws our attention to the fact that Canada ranks only above Australia, Portugal and the U.S. among OECD members in terms of public expenditure on health as a proportion of total spending on health[v]. This committee will need to provide clear and independent evidence that Canada's current approach is inefficient when compared to what appears to be inefficient private sector delivery mechanisms in other jurisdictions.

Thirdly, Canada's current approach insures that we have a health care "system". Our church partners in the United States have noted, for example, the lack of a systematic approach to health care there. Steven Derks is Vice President of Advocate Health Care, a religious based health care provider in Chicago providing over US$2.7 billion in care annually. He recently said of U.S. health care, "We do not have a health care *system* (our emphasis added) in the U.S. What we have is a constellation of services that exist in separate silos, that are hard to trade off and which are responsive to the reimbursement mechanism…. Whole patient care is good but it is awkward for (U.S.) providers."[vi] Before expanding for-profit provision, much more evidence is required to avoid fragmenting the Canadian system, which offers a greater potential for integrated health care public policies.

In weighing various options for financing, we would ask if the proposed options enhance the availability of publicly administered services to the vulnerable sectors of society and to the poorer regions and provinces of our country. The Committee's own research points to serious flaws in user charges. This system does not generate much revenue. It can be a disincentive for poorer citizens seeking care. Would a user fee system based on income further stigmatize poorer members of our national community? If poorer people were excluded from user fee charges, would this lead to resentment by those who would pay user fees? Your report cites the user fee system in Sweden. This system is not designed to generate revenue, but, as you note, it is intended to change the behavior of citizens to prevent misuse of the system. Has it in fact done this? Do Swedes as a rule, misuse and abuse the health care system. Do care givers contribute to this problem?

Accountability of Governments

We concur with your observation on page 56 that it is impossible to trace how provinces and territories use federal funds. Citizens need to know that, if they are presented with tax cuts, that this will mean fewer dollars for health care (or for that matter for social programs and post-secondary education). We welcome a national transparent annual reporting on how provinces use federal funds for health care and for that matter the other programs that are provided through the CHST. We would hope that your committee would offer models that would be more than merely voluntary, models which would provide for mechanisms to insure the mutual accountability of all levels of government to each other for the principles, values, and objectives of Canada's health care system.

The Need for Evidenced Based Research

As the Committee develops various options that involve changes in the health care system, we welcome your commitment to draw on evidence based research.

We acknowledge the vital role of the federal government in strengthening the health research capacity across Canada, including, as you note in Chapter 8, innovative pilot projects that improve the delivery of health care. An emphasis on outcomes in terms of health status and on health services utilization may contribute to wiser stewardship of resources. Earlier this summer, *The Ottawa Citizen* published an excerpt from a chapter Steven Lewis has written for a book[vii]. Lewis reminds us that we need to focus on quality and on changing some of the practices and procedures. Focusing on quality may get us on the track of improving care and improving the system.

Regarding a greater role for private insurance[viii], the Committee states that evidence from your international review indicates there are a number of benefits generated by allowing private insurance in health care, including enhanced patient choice, increased competition and improved efficiencies in the public sector.

For our own consideration, it would be useful to understand the evidence for such assertions. If this approach is a cost containment strategy, why are costs so much higher in the U.S. where there are multiple private insurers? What impact will a public and private system have on citizens who depend on publicly funded coverage? Will those who can afford private coverage resent their taxes being used to help pay for public coverage? Will this further weaken our notion of a covenant among citizens and among provinces and territories rich and poor? What would the Committee expect in terms of outcomes in such a system? What outcome might be expected from competition between a public system and multiple private insurers? What efficiencies might we expect to find?

In Chapter 8 Section 6 Two Tier Health care (page 67), the Committee suggests several options including user charges for publicly funded services, MSAs and private health care insurance (which I touched on above). You outline three options to circumvent the

negative aspects of two-tier health care systems. One option is that Aall doctors would be required to work a certain number of hours in the publicly funded system, meaning that they would not be permitted to work exclusively in the privately funded system≅. Frankly, this option is confusing. Many doctors already work long hours. Many complain of overwork. We read of doctor shortages in different regions of the country. How would your option alleviate this problem? Who would decide on a reasonable breakdown of public and private hours? How would the public system be assured that the doctor is not overworking in the private system so that he or she has little energy for his/her public hours?

The Committee, we trust, is aware of the Alberta Auditor General's report about the growing potential for conflict of interest in light of increasing private ownership of health care facilities. On October 9, the Auditor General in Alberta called for stringent controls on the contracting out of surgical services to prevent senior doctors from diverting public health dollars to clinics in which they have a financial stake[ix].

These are among the many questions that your report raises which require independent and verifiable research before its recommendations are adopted.

Including Pharmacare and Homecare
(see Chapter 8: Section 7.2 Expanding Coverage)

The National Forum gave considerable attention to expanding programs to include Pharmacare and Home Care. National programs in these areas, under the Canada Health Act, would recognize the changes in health care and, as your Committee notes, focus on the patient and result in a more seamless system - a continuum of care and coverage from hospital to home. While a national home care program would be an important expansion of health care, home care is not necessarily the preferred option for all those requiring care and for those family members providing the care. Home care needs to be implemented in a way that does not unrealistically unload responsibilities onto the caregivers. This responsibility generally but not always, falls to women.

The Determinants of Health
(see Chapter 12: Issues & Options for the Population Health Role)

We welcome the attention the Committee is giving to Population Health and the determinants of health. The World Health Organization's 1978 Declaration of Alma Ata defined 5 principles for primary health care:

1) Equitable distribution of health care services.
2) Community participation.
3) Focus on prevention.
4) Appropriate technology.
5) Multi-sectoral approach to health care which takes us beyond treatment of illness to include determinants such as education, employment, housing, quality of the

environment.

While it may be beyond the remit of this Committee, may I suggest that more attention be given to the determinants of health, the various public policy initiatives and the need for more integrated thinking about how these public policies can impact on health.

We agree with the Committee's recognition of the scandalous lack of attention to the health of Aboriginal peoples in Canada. We would support recommendations for a holistic and culturally appropriate approach developed primarily by Aboriginal peoples and organizations with assistance as requested.

Conclusion

In summary, may I say that:

- We affirm all five principles of the Canada Health Act and we would welcome an expansion of programs.
- The values I articulated in my introduction provide a solid foundation for our health care system. Our health care system has a vital role in building a society where we are committed to healthy individuals and healthy communities.
- We are uncomfortable with the emphasis Vol. 4 gives to market based options. The growth in private expenditures as a share of the health dollar warrants much more public debate and discourse. We ought to remind ourselves that we enter the health care system as citizens requiring care and compassion, not as consumers shopping for a product. Health care need not be treated as a commodity.
- We acknowledge that our health care system can be improved. We support policies and programs that improve health outcomes and which also result in wise stewardship of resources.
- We live in community. We are inter-dependent. We need to support each other. Such notions as human solidarity, care, compassion for the weak are foundational issues of social justice for churches. Health care is a public good vital to the common good which is a vision we believe is important to Canadians and a vision worth holding up to the world.

We remain both committed and concerned about Health Care. For our part we are planning to participate in the Commission on the Future of Health Care in Canada. We hope to engage in further discussions with church members and we are planning a Roundtable in Ottawa in February on the ethical imperatives for the future of health care.

On behalf of the Ecumenical Health Care Network of the Canadian Council of Churches' Commission for Justice and Peace, I would like to thank the Committee for the opprtunity to share some of our responses to *Vol. 4 - Issues & Options*.

Endnotes

[i] . "U.S. ill-prepared for bust, Nobel prize winner says", by Barrie McKenna, *Globe and*

Mail, Oct. 12/01, p. B11

[ii] ibid

[iii] "Canada's health care ranked 30th by WHO", by Anne McIlroy, *Globe and Mail*, June 21/00, p. A2

[iv] "Thinking before Rethinking: Some Thoughts about Babies and Bathwater", Raisa B. Deber, *Healthcare Papers*, Vol. 1 No. 3, Summer 2000, p.29

[v] Ibid. p.29

[vi] Comments by Mr. Derks, at meeting of Public Policy Directors, Evangelical Lutheran Church in America, Chicago, Oct.13/01

[vii] *Memos to the Prime Minister: What Canada Could Be in the 21st Century*

[viii] chapter 8, section 4. 6 -- Private Health Care Insurance is Allowed to Compete with Public Coverage

[ix] "Privatization worries Alberta Auditor-General", Bob Weber, *Globe and Mail*, October 10/01, p. A16