

# Commission on the Future of Health Care in Canada

Phase 1

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A SUBMISSION BY  
THE  
CATHOLIC HEALTH  
ASSOCIATION OF CANADA

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## Introduction

**T**he Catholic Health Association of Canada (CHAC) is a national health organization committed to advancing a vision of health and healing that encompasses the physical, emotional, spiritual, and social well-being of people. As the national voice for Catholic health care, the CHAC represents seven provincial associations, 127 hospitals and homes, sponsor organizations, health care professionals and individuals.

By working with others to build strong communities that foster health, the CHAC provides a forum for issues analysis and policy development incorporating values and knowledge of health policy. The members of the CHAC are extensively involved in Canada's health care system from Newfoundland to British Columbia and in the Northwest Territories. Indeed, Catholic health organizations have provided an essential role of leadership and pioneering service in the health care field from the earliest days of our country's history.

The CHAC believes the work of the Commission on the Future of Health Care in Canada provides an opportunity for us as a nation to go beyond simply a restructuring of certain health services. It provides an opportunity to reaffirm the vision and values that gave rise to our health system, and to reorient our health system based on an enlarged vision of health and a deeper understanding of the determinants of health and well-being. It is also an opportunity to build upon the hard work and sacrifices of all those who have contributed to a legacy of caring and service in health care in Canada.

The CHAC appreciates the Commission's identification of Canadian values as one of its four specific areas of inquiry. This submission focuses on those values and principles we believe can direct public policy to build upon and improve Canada's publicly funded, universally accessible health care system. Before we can address specific policy questions as a nation, we need to first get a sense of common values and goals, and a common understanding of the kind of society we are seeking to build and want to see reflected in the health system.

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**Part 1 —  
A Question of  
Values**

Canada's health care system has become a defining feature of our national identity and a central element of our social programs. In 1964 the *Health Charter for Canadians* highlighted a goal that was to provide a vision for health care policy throughout the country.

The achievement of the highest possible health standards for all our people must become a primary objective of national policy and a cohesive factor contributing to national unity, involving individual and community responsibilities and actions.<sup>1</sup>

This challenge remains as pertinent today as it was almost four decades ago, and as Canadians consider new directions for our health care system it is appropriate to stop and ask to what extent this goal is being achieved – or lost sight of.

**Health policy driven  
by economics**

The current health policy environment is driven almost exclusively by economics. When the basis of policy development is economics, it is not surprising that the implementation of such policy focuses on cutbacks, downsizing and withdrawal of services as a primary focus. While there is a need to restructure health care services, the way this has been done thus far has undermined caregiver and public confidence. The outcome is an atmosphere of crisis, anger and insecurity. For many Canadians the goals of the health care system have become unclear and there is a growing sense of insecurity about the sustainability of our public, not-for-profit system and its ability to meet our needs in the future.

**Putting first things  
first**

Numerous “fixes” have been put forward to address this “crisis”. The Interim Report of the Standing Senate Committee on Social Affairs, Science and Technology, Volume Four: *Issues and Options*,<sup>2</sup> presents a detailed summary of the many such options – proposals that focus primarily on how to finance the health care system in a time of rising costs, an aging population, and increasing health care demand.

This paper will suggest, instead, that there is a need to be clear about the starting point for any reflection on the future of Canada's health care system and a rethinking of medicare. Such a rethinking requires an exploration of the societal values that gave rise to the health system, a critical analysis of new and emerging values, and a change in the focus of the discussion from the marketplace toward a discussion of the core values that will make for a humane future, an equitable social order, and a quality health care system.

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**Articulating the core commitments of Canadians**

A report by Suzanne Peters entitled *Exploring Canadian Values: Foundations for Well-Being* discusses the core values of Canadians in the mid 1990s. The document highlights broad recognition by Canadians of the need to renovate our social contract and to be fully engaged in a democratic public dialogue that can generate new principles for action.

The urgency of articulating the core commitments of Canadians – what we hold dear, what trade-offs and sacrifices we are willing to make, and what we see as the optimal level of well-being that can be achieved – has never been greater...

One challenge before all of us – politicians, the corporate sector, media, policymakers, researchers, community leaders and the public – is to understand the foundations on which we can build a new social contract. Recognition and acknowledgement of shared values are critical to Canadians' sense of belonging and our ability to move forward. An equal challenge is to involve Canadians in the debates that define those common values and the processes that set out the country's social and economic objectives.<sup>3</sup>

**Without attention to values there can be no good policy**

Nuala Kenny, MD has written that there is something about a health care system that reflects the moral and ethical fibre of a nation. Values have to do with *those things that are of ultimate importance to us*. It is not surprising, therefore, that the values held by a society influence and direct its public policy. Kenny writes: "Without an explicit reflection on the values Canadians hold in common there can be no good judgement as to which new values to incorporate and which to reject. And certainly, without attention to values there can be no good policy."<sup>4</sup>

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**The Canada Health Act —  
reflective of a set of  
values**

The Canada Health Act reflects a set of values that Canadians have come to embrace as being important and in some way definitive of what it means to be Canadian.

At a time when other traditional expressions of Canadian values have been placed under demonstrable stress, health and health care have increased in importance and prominence as a shared and common value. In fact the health system has always engendered strong support among Canadians. In recent years, however, its significance has broadened into symbolic terms as a defining national characteristic...

Canadian underpinnings of the health care system include the premise that it ought to be government-run and not-for-profit, that money is not the primary consideration and that all are entitled – as a matter of citizenship – to equal access to health care. This typically Canadian approach is, for many people, emblematic of a commitment to compassion, to equality of opportunity, to a sense of community and to a common purpose.<sup>5</sup>

The CHAC affirms and promotes these enduring Canadian values that are captured in the principles of the Canada Health Act. The principles of universality, portability, comprehensiveness, accessibility, and public administration reflect fundamental communitarian values directed toward the common good.

A meaningful rethinking of medicare necessitates that we do address the flaws and problems that mark the health care system – a failure to make decisions based on good evidence, a lack of accountability within the system, and narrowness in focus. However, in confronting and meeting these challenges, we must not lose sight of the fundamental values that have formed the foundation for Canada's health and social policy and which can provide direction in the effort to build a more responsive and effective health care system in the future.

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**Market values**

As has been noted, the values underlying the Canada Health Act and the Canadian health care system are essentially “communitarian values.” According to Kenny, the strongest forces pressuring the sustainability of such “socialized” health care systems as Canada’s are the values of the market paradigm: individualism and self-reliance, unlimited choice, competition, rapid service, and guaranteed outcomes.

These market values are extremely powerful in Canadian society today and are influencing the direction of discussions about future directions for Canada’s health care system.

The forces framing the rethinking of medicare as a resource allocation crisis (i.e., a market issue) are powerful. The commodification of care, the commercialization of medicine and health systems, and even economic evaluations such as cost-effectiveness analysis, compounded by the “marketing” of health services and products in an era of declining community and religious/spiritual values guarantee that more and more money will go to healthcare and there will never be enough.<sup>6</sup>

The work of the National Forum on Health (1997) found that the deeply held Canadian values that have given rise to social programs in Canada have not changed dramatically over time. While the values are clear, there is often a healthy tension among them (e.g., the value of self-reliance is in tension with the value of compassion/collective responsibility). These tensions are exacerbated, however, in times of fiscal difficulty and constraint.

**A values system that will promote a common citizenship, human dignity, community, solidarity and democracy.**

At this important moment in Canada’s history, as we seek to reshape the health care system, we need to reflect on how the “market paradigm” has come to dominate our thinking about health care. The CHAC joins with those who argue that there is a need for a new paradigm to direct the discussion – a values framework that will promote a common citizenship, human dignity, community, solidarity and democracy.

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**Part 2 —  
Core Values:  
Link to the Past and  
Guide to the Future**

**T**he CHAC believes a values perspective can provide the kind of paradigm needed for responding to the key issues and challenges involved in improving both the health care system and the health of Canadians. This section of the paper highlights those values that we believe must inform health care decision making and policy. Though presented individually, these values complement each other forming a foundation for improving the health system.

**Dignity of the person**

1. *Dignity of the person* – All persons possess an intrinsic dignity and worth. Respect for the dignity of the human person must remain the basic principle of health care delivery.

**The right to health care**

2. *The right to health care* – Everyone has a right to health care. Maintaining both universality and the accessibility of comprehensive health care, without discrimination and without financial or other barriers, must remain a prime objective of government and a shared commitment of the citizens of this country. The principle of distributive justice<sup>7</sup> can provide criteria for the distribution of such benefits as health care.

**Good health for all**

3. *Good health for all* – Good health, understood as meaning physical, emotional, spiritual and social well-being, is an essential core value. Good health represents the harmonious balance between these various resources. The fostering of good health for all citizens entails both individual and collective responsibilities.

**Health care as a service**

4. *Health care as a service* – Health care is an essential social good, a service to persons in need. It is not, and cannot be treated as, a mere commodity exchanged for profit, to which access depends on an ability to pay.

**Collective responsibility and community**

5. *Collective responsibility and community* – As Canadians we have valued a deep sense of caring for persons in need. That sense of collective responsibility has motivated us to empower governments to play a direct role in alleviating economic disparity and in addressing threats to well-being posed by illness or disability. A basic moral test of any society is how the weak and poor in its midst are treated.

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**Compassion and caring**

6. *Compassion and caring* – The offerings of modern science and technology cannot replace the healing impact of an atmosphere of compassion and sensitivity. A danger in permitting “market thinking” to dominate our understanding of health care is that the caring, human side of health care will be lost. It is always important to help people to find peace, healing, pain relief and comfort in the midst of suffering.

**Good stewardship**

7. *Good stewardship* – Our traditional health care system has developed without a sense of limits and, in some ways, without a sense of accountability in the organization of health care. Today, more than ever before, we need to recognize that resources are not unlimited and learn how to manage resources wisely. Good stewardship also recognizes that caring for the caregivers has a direct impact on those receiving care.

**Social justice**

8. *Social justice* – The work of addressing injustices and its role in improving health is increasingly recognized in society. Working to promote health and well-being is not only about curing symptoms, it also means confronting the causes of suffering and injustice which can be found in personal attitudes and lifestyles, and in the way our social structures are organized.

**Ethical reflection**

9. *Ethical reflection* – Values and ethical reflection are an essential aspect of good policy development. Any rethinking of medicare must include ethical reflection and incorporate it as an aspect of the ongoing system.

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**The core values  
of Canadians**

*Exploring Canadian Values* concludes that Canadians, while supporting government efforts to contain spending, do want to maintain the compassion and commitment to quality that are at the heart of the country's social programs. In particular, they want to maintain the basic value of health care for all. "Our examination of polls results and group discussions points to a sense of mutual responsibility and caring at the centre of Canadians' core values."<sup>8</sup>

The CHAC believes the core values presented above, when applied to the issues and challenges that confront health care and health policy in Canada today, can provide both a vision for health in the future, as well as a means to assess the wide range of alternatives currently being promoted for organizing, funding and expanding health care services in Canada.

In part three of this paper this values base is applied to some of the most pressing issues in the work of ensuring the long-term sustainability of a high quality, universally accessible publicly administered health care system for all Canadians.

## 1. The Need to Maintain a Publicly Funded Model of Health Care

*Health care is a social good belonging to all citizens. Universal access to core health services, regardless of the ability to pay, must remain the defining feature of our health care system.*

The claim is made that Canada's publicly funded health care system is no longer workable. Promoters of this position have steadily escalated their use of scare tactics in the health care debate. The public is told that waiting lists have grown out of control, the system is becoming unaffordable, and that in the future care for the elderly will bankrupt the health system.

In fact, Canada's single payer health system has worked well in terms of providing access, economic efficiency, a compassionate system, and high quality care. Medicare has done what it was created to do – provide equitable care and controlled costs. While costs that need to be paid for privately by Canadians (for example, prescription drugs and home care) have risen dramatically, the publicly funded and administered system has controlled costs.<sup>9</sup>

Contrary to the view promoted by some commentators, Medicare was not intended solely as a public insurance against “catastrophic” costs due to acute illness. Rather, the Canada Health Act defined insured health services broadly, as including all services “medically necessary for the purpose of maintaining health, preventing disease or diagnosing or treating an injury, illness or disability.” A central problem today is what has been termed “passive privatization.” As complex care is now being transferred into the community, provincial governments have allowed the costs associated with this care to move outside of the publicly financed system. Health policy professor Raisa Deber suggests “... this makes no sense on either ethical or economic grounds.”<sup>10</sup>

Medicare faces many problems, however, the CHAC believes these problems can be fixed while still preserving the public health insurance system.

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## 2. The Federal Role in Health Care

*The federal government has a leadership role to play in protecting the right of all Canadians to health care. The goal of eliminating fiscal debts must not take precedence over health for all as an overriding guiding principle.*

The history of the development of Canada's health care system illustrates why federal involvement in health and health care policy is vital. It has played a central role in addressing regional inequalities in the country. In addition, the commitment of federal funds to the provinces, and the penalties established under the Canada Health Act, which allow Ottawa to withhold or reduce funds if provinces fail to abide by the principles of the Act, ensures medicare's integrity and continued vitality.

The drastic reductions in federal transfers to the provinces for health care in the 1990s undermined public confidence in the federal government's commitment to preserve the health care system.

The announcement of new federal investments on September 11, 2000 re-confirmed the presence of the government of Canada in the health policy field and helped to lay the groundwork for re-building of the health system. However, the CHAC believes additional funding is needed to stabilize the current system and to meet the health needs of Canadians. To meet the future health needs of Canadians, CHAC supports the implementation of an escalator formula<sup>11</sup> for the Canada Health and Social Transfer (CHST).

In addition, the federal government's role in health policy should be more explicitly defined, made more visible, and enhanced. Among the key roles it should play are the following:

- cultivate a sense of national community;
- strictly enforce the Canada Health Act;
- establish an overall strategy for health, one based on national principles and goals for health and health care;
- ensure universal access to appropriate health services across the health continuum, not limited to hospital or doctor-based services.

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### 3. The Need to Develop a Continuum of Care

*Responsible stewardship and respect for the physical, emotional, spiritual, and social aspects of persons, demand that we try to arrange health services, and the funding of those services, so that they follow people according to their health needs. The provision of health services and the allocation of funds should be directed toward those areas that will provide the greatest health benefits.*

The need to reorient health services toward a more balanced approach that places sickness care in a broader framework, oriented toward health promotion and disease prevention, is a central challenge to be faced in ensuring the long-term sustainability of the health care system. The health services system needs to become a continuum that flows from health-promoting community-based services (with an emphasis on health promotion and disease prevention), to community and home care, and on to hospital care for the most ill members of the community.

Such a shift in the provision of health services will require an effort to arrange funding so that funds follow people according to their health needs. It represents a fundamental change to the way the system is currently funded and structured. The CHAC believes that public funding for health services should not be restricted simply to physician and hospital care. It should be reoriented and expanded to focus on a range of services that covers the continuum of care.

Home care, in particular, requires immediate attention. If we believe in the principles of medicare – that health services should be universally and publicly available regardless of the ability to pay – then home care services must be brought under the full protection of the public health care system.

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## 4. A Universal Public Drug Plan (Pharmacare)

*Policies relating to the use of drugs in the health care system should promote the following goals: accessibility, cost control, effectiveness and appropriate use.*

The establishment of a national plan to cover drug costs has been on the political agenda for several decades. In 1964 the Royal Commission on Health Services recommended that prescription drugs be included in a national medicare system. In 1997 the National Forum on Health concluded that:

Because pharmaceuticals are medically necessary and public financing is the only reasonable way to promote universal access and to control costs, we believe Canada should take the necessary steps to include drugs as part of its publicly funded health care system.<sup>12</sup>

In *Health Care in Canada 2001*, the Canadian Institute for Health Information reported that drug sales now account for 15% of total health care spending in Canada – prescription drugs accounting for the bulk of costs.<sup>13</sup> Between 1985 and 1998, drug spending grew more than twice as fast as overall health expenditure.

Today, more than 3 million Canadians, mainly the poor and those with low incomes, lack any drug insurance, despite medical need. In some provinces, seniors have to pay large out-of-pocket expenses to cover their drug costs. A recent study published by the Canadian Centre for Policy Alternatives concludes that there is compelling evidence that a national drug plan would actually reduce costs, not increase them.<sup>14</sup>

In 2000, the CHAC Annual Assembly endorsed a resolution calling on the federal and provincial governments to adopt as a goal full public funding for medically necessary drugs.

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## 5. Primary Care Reform

*The values of freedom of choice, appropriate use of resources, and individual responsibility call for changes to the current gatekeeper role in primary care. A guiding principle must be that health comes from empowering people to take personal responsibility for their lives and health.*

In 1978 the term “primary health care” was coined by the World Health Organization. Primary care was identified as the delivery of a comprehensive set of services that include first contact and ongoing care in response to the first contact. The vision of primary care is one that sees the role of the physician change from being the sole gatekeeper to becoming a partner with other health professionals, practitioners, individuals and communities in the provision of a wide range of services.

In 1997 the National Forum on Health concluded that primary care reform is required and that such reform need not increase costs. It pointed to two necessary actions: 1) realignment of funding to patients, not services; and 2) a remuneration method that is not based on the volume of services provided by physicians but promotes a continuum of preventative and treatment services and the use of multidisciplinary teams of providers.

Such changes must be integral to a new health care system since many of the other necessary reforms cannot be achieved until primary care reform has been implemented. In 2001 the CHAC Annual Assembly called on the federal government to support the following goals for primary care reform:

- to improve access to care through the creation of multidisciplinary practices;
- to incorporate health promotion and disease prevention in primary care;
- to realign funding to patients, not services; and
- to establish a remuneration method that recognizes curative services and promotes a continuum of preventative and treatment services.

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## 6. Sustainability and Accountability

*Health care, like all other areas of life, must live within limits. As a grounding assumption, this means it will always leave much good undone. Clear public reporting with appropriate independent verification will enhance the performance of health services and is necessary for ensuring the long-term sustainability of the system.*

As a society we tend to accept that the demands of responsible stewardship require us to impose limits at many levels of human endeavour. When it comes to health care, however, we seem to be unwilling to accept such limits. This unwillingness is based, in part, on assumptions we have about health care – assumptions we need to question and in some cases modify or reject.

Central to modern medicine has been the notion that the roots of illness are primarily biological. Working within such a model, there is a tremendous pressure from both patient and health care provider to try all available means to produce a cure or to get quick results. Not only is such a model inadequate, there is considerable evidence which suggests that not all drugs, devices, and procedures have been rigorously tested to ensure both effectiveness and safety.

Measuring, tracking and reporting on health care performance and effectiveness remains a key challenge for the health care system. In 1998, former members of the National Forum on Health advised the federal government not to hand over more money to the provinces for health care without putting strict conditions on how it will be used and accounted for. In 1999 the federal Auditor General criticized the Liberal government for what he said was a severe lack of accountability at the national level. The report said the government was taking such a “passive stance” to health care that it was unable to say how billions of federal medicare dollars are spent.

The CHAC was pleased to see that accountability and reporting to Canadians was a major element of the First Ministers’ Communiqué on Health (Sept. 11, 2000). Such an accountability mechanism is necessary to ensure the stability and sustainability of the system.

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## 7. For-Profit Health Care

*Every Canadian has a right to health care that is both accessible and equitable. This being the case, there is a fundamental difference between the provision of health care and the production and distribution of other goods and services.*

Increasingly, provincial governments are considering contracting clinical services to for-profit corporations as a response to the challenges facing the health care system. Such a move is based on a number of assumptions: first, that health care is like any other marketable commodity, and secondly, that giving a larger role to for-profit health providers will decrease costs and improve quality care.

The CHAC believes the availability of good health care is vital to the character of community life. It involves the most intimate aspects of people's lives – their bodies, as well as their minds and spirits. As such, it cannot be reduced to a mere commodity. The moment health care is rendered for profit, it risks being emptied of genuine caring.

The argument is heard often today that competitive markets have produced an abundance of inexpensive, high-quality, and widely available food, shelter and clothing, and that competitive markets would do the same for Canada's health care system, if only the constraints of medicare were removed.

Is private, for-profit health care cheaper and more efficient than public health care? "No peer-reviewed study has found that for-profit hospitals are less expensive... For-profit hospitals cost more to operate, charge higher prices, spend far more on administration, and often provide poorer services than non-profit and public hospitals."<sup>15</sup>

On several occasions the CHAC has urged the Prime Minister and the Minister of Health to actively oppose plans by any province that would lead to the further commercialization of health care and to an expanded role for for-profit health care providers.

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## 8. User Charges

*In our current health care system access is intended to be based solely on need. In a system with user charges access depends in part on ability to pay. This represents a change in the fundamental values that Canadian society has chosen to guide the provision of health care.*

There are two popular arguments for user charges. The first suggests that because services in our system are free, people will abuse the system. The second argument is based on a belief that health care costs are out of control – therefore, more money is needed in the system. Why not let people who can afford to pay a little more do so?

These arguments for user fees, however, are not as simple or innocent as it seems. The goal may be to reduce unnecessary use of services, but the end result of user charges is to transfer costs from public to private budgets with the burden of these transfers falling disproportionately on the sicker members of the population.

One report from the Canadian Institute for Advanced Research summarizes the problems associated with user fees as follows: “No doubt there is a very small number of patients who (perhaps even blatantly) misuse the health care system, but to try to eliminate this problem with a general policy of user charges for most services for most Canadians seems like weeding your lawn with a bulldozer, without any guarantee that will get all of the weeds.”<sup>16</sup>

While acknowledging that there are serious fiscal pressures on the health care system, the CHAC believes a shift to a system with user charges would represent an unacceptable move away from the primarily income-tax financed system of paying for health care which we have today. As outlined above, it would also involve an unacceptable change in the criteria for obtaining access to health care.

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## 9. The Impact of Trade Agreements on Health Care

*The Canadian government must unequivocally affirm that safeguarding Canada's health care system takes precedence over securing market access for Canadian exports. Canada should insist on a general exception for health care in trade negotiations.*

The North American Free Trade Agreement (NAFTA), the General Agreement on Trade in Services (GATS), and ongoing international negotiations to open all public services to trade and foreign investment are major threats to an equitable, public health care system in Canada.

A recent study of the GATS by the Canadian Centre for Policy Alternatives notes that the Minister of International Trade and Canadian trade officials have repeatedly assured Canadians that health care will not be affected by the GATS. The report finds, however, that Canada's health care system is already more exposed to GATS rules than Canadians have been led to believe.

Our report confirms concerns that Canada's trade policy is driven by narrow commercial interests which conflict with the public interest in maintaining a universal publicly funded health care system.<sup>17</sup>

Given that the work of the Commission on the Future of Health Care in Canada will likely result in changes to Canada's health care system, immediate action is required to safeguard Canada's ability to modify public health insurance in accordance with domestic public policy priorities without fear of provoking trade challenges under NAFTA or the GATS.

In May 2001 the CHAC wrote to the Prime Minister and the Minister of International Trade calling on Canadian trade negotiators to insist on a general exception for health care in the GATS and the proposed Free Trade Area of the Americas Agreement (FTAA).

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## 10. The Role of Faith-Based Organizations in Providing Health Care

*The faith communities' presence in the world is a radically human one. It is directed toward the service of the human person, the service of human dignity. The Catholic health care ministry seeks to continue the compassionate, caring ministry of Jesus by laying hands on life at its critical points, where people are cured and healed, where they are born and die, and where they are cared for when they are in need.*

The Commission has identified as an area of inquiry “the role of institutions in creating and sustaining public values and ethics.” The distinctiveness of care found in faith-based health care organizations throughout Canada is a constant, deeply felt commitment to Gospel values of respect, dignity and compassion.

Catholic health care is committed to a vision of health and healing that encompasses the physical, emotional, spiritual, and social well-being of people. This vision is concretized through an emphasis on the importance of spiritual care, ethical reflection and just stewardship of human and material resources.

The history of this country records the many ways in which the church has contributed to the development of the health care system. Today, this health ministry continues to bring values and ethics to bear on public policy considerations. Such reflection is vital in our technological world where there is an ever-increasing danger of reducing persons to objects. Sustaining a strong faith-based presence in health care is particularly important in our society where contrary values such as individualism and consumerism constantly erode respect for the dignity of human life.

The CHAC is committed to the maintenance of an authentic Catholic presence in Canada's health care system. We encourage the Commission, in its consideration of issues related to the governance of health care institutions, to recognize the important role of faith-based care in delivering value-driven services and the necessity of ensuring the continued existence of denominational health care institutions.

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## Conclusions

**W**hile acknowledging the financial challenges now being faced within the health care system, and the dominating climate of uncertainty, the CHAC believes Canadians can still be hopeful about the future of health care. We believe it is both necessary and possible to implement required changes while preserving the core values that helped to give rise to our health system.

We hope the work of the Commission on the Future of Health Care will provide an opportunity for us as a nation to accomplish three important goals.

### **1. To recommit ourselves to fundamental values**

The climate of fiscal restraint which is pushing us to reshape our social programs is generating debates that raise questions about our sense of identity as individuals, as communities, and as a nation. The foundation of Canada's health care and social policy has been based upon a vision founded on social values. The need to affirm and act on those core values that will provide a vision on which to build a new social contract has never been greater.

### **2. To reorient public policy based on an enlarged vision of health and a growing knowledge of the determinants of health**

The task of transforming the health system, and public policy in general, requires us to take seriously an enlarged vision of health, one that recognizes health as a state of physical, mental, spiritual and social well-being. While medical and other health services play a vital role in dealing with suffering and illness, real improvement of health lies in directions not addressed by health care systems. What is needed is a population health approach based on knowledge of the full range of determinants of health.

### **3. To organize an equitable, cost-effective, and high quality health care system**

In recent years virtually every province has undertaken a major study or inquiry into its health care system. Commenting on these studies, health economist Robert Evans has written: "... they have also concluded that at present much of the health care being provided in Canada is ineffective, or unevaluated or unnecessarily expensive, or

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otherwise inappropriate.”<sup>18</sup> The long-term sustainability of Canada’s health care system requires mechanisms that will assure accountability for the effectiveness, efficiency, and appropriateness of the care within the health system.

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The Catholic Health Association of Canada wishes the Commission well in its Phase 1 work of determining the central issues and challenges facing the public health care system. We look forward to reviewing the interim report in January 2002 and participating in the consultation phase later in the new year.

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## Notes

1. *Royal Commission on Health Services* (Final Report), 1964, Vol. I, pg. 11.
2. Senate Standing Committee on Social Affairs, Science and Technology, Interim Report, *The Health of Canadians: The Federal Role*, Volume IV: *Issues and Options*, September 2001.
3. Suzanne Peters, *Exploring Canadian Values: Foundations for Well-being*, CPRN Study No. F01, Canadian Policy Research Networks Inc., 1995, pg. 1.
4. Nuala Kenny, "Ethical Dilemmas in the Current Health Care Environment," *Do We Care? Renewing Canada's Commitment to Health*, Kingston: McGill-Queen's University Press, 1999, pg. 110.
5. National Forum on Health, *Canada Health Action: Building on the Legacy, Volume II*, Synthesis Reports and Issues Papers, Minister of Public Works and Government Services, Ottawa, 1997, pages 5 and 11.
6. Nuala Kenny, "Reframing the Discourse: Rethinking Medicare," *Healthcare Papers*, 1 (3) (2000): 45.
7. "Distributive justice is that part of justice concerned with problems of distributing resources and opportunities which are essentially common but which for the sake of the common good must be appropriated to individuals." For a discussion of the basis on which health care should be distributed see *Healthcare Allocation: An Ethical Framework for Public Policy*, edited by Anthony Fisher, OP, and Luke Gormally, Bristol: The Bath Press, 2001, pp. 97-98.
8. *Exploring Canadian Values*, pg. 69.
9. For more information see Robert Evans, "The Role of Private and Public Health Care Delivery in Alberta," a keynote address sponsored by the Alberta Congress Board, Edmonton, Feb. 5, 2000.
10. Raisa Deber, "Thinking Before Rethinking: Some Thoughts About Babies and the Bathwater," *Healthcare Papers*, 1 (3) (2000): 27.
11. While there have been substantial financial additions made to the CHST, due to the 11 September 2001 First Ministers' Agreement, the CHAC and other members of the Health Action Lobby (HEAL) have called for the implementation of an escalator formula for the CHST to account for inflation, a growing and aging population, or the diffusion of new technologies.
12. National Forum on Health, *Canada Health Action: Building on*

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- the Legacy*, Volume I, Minister of Public Works and Government Services, 1997, pg. 22.
13. *Health Care in Canada 2001*, Canadian Institute for Health Information, Ottawa, 2001, pg. 76.
  14. Joel Lexchin, *A National Pharmacare Plan: Combining Efficiency and Equity*, Canadian Centre for Policy Alternatives, March 2001.
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