The Health of Canadians: The Federal Role

Interim Report of the Standing Senate Committee on Social Affairs, Science and Technology

Volume Four: Issues and Options

A SUBMISSION BY THE CATHOLIC HEALTH ASSOCIATION OF CANADA

November 8, 2001

The Catholic Health Association of Canada

The 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, numerous 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 appreciates the opportunity to respond *to Volume Four: Issues and Options* of the Senate Committee report on the *Health of Canadians – The Federal Role*.

Points we affirm in the report

The Committee is to be commended for having highlighted key issues concerning the state of the health care system in Canada. We note, in particular:

- the importance given to incorporating more fully the social determinants of health;
- recognition of the necessity of federal financial support for health services research and research into the determinants of health;
- the emphasis placed on government accountability to the public concerning health and health care;
- recognition of the need to act now on primary care reform and to determine how to incorporate home care and prescription drugs in the system;
- and finally, the identification of the obstacles to change that arise out of perverse incentives and built-in adversarial relations in the system.

Our brief addresses a variety of issues addressed in the report with a particular emphasis on those values and principles we believe can direct public policy in building upon the fundamental principles of Canada's health care system and ensuring its sustainability.

Introduction – 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.[1]

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*,[2] 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.

Point 1 – Without attention to values there can be no good policy

> "*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.*"[3]

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.

Articulating the core commitments of Canadians

> 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.[4]

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.

The Canada Health Act — reflective of a set of values

Chapter 7 of *Issues and Options* presents a very narrowly defined discussion of the *Canada Health Act* that focuses primarily on a single question: Are private health care provision and private health care insurance permissible under the Act? We believe such an approach overlooks what the National Forum called the "underpinnings" of the health care system:

- the premise that it ought to be government-run and not-for-profit;
- the belief that all are entitled — as a matter of citizenship — to equal access to quality care;
- a commitment to compassion, to a sense of community and to a common purpose.

The Committee's report sets out a wide-ranging list of proposals and options — many of which represent a radical renegotiation of the key elements of the system. In effect, through your report you are asking Canadians — what values do we choose now? This, for us, is where the discussion must begin.

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 believes 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.

Core Values

Such 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.

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[5] 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.

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 under-standing 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.

* * *

The core values of Canadians

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 the remainder of the paper, the values framework presented above is applied to a number of issues addressed in the Senate Committee's report.

Point 2 – Medicare is Workable

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.

In recent years, Canadians have been subjected to what sometimes appears to be an organized campaign to weaken confidence in the nation's health care system. The motto of this campaign is heard daily: Medicare is not working and is not sustainable. We believe that examining the myths behind the rhetoric of crisis must be an important element of any review of the health care system.

Chapter 8 of the report takes up the question of affordability and sustainability. It concludes that more money is needed in the system and that Canadians must now explore new ways of raising additional funding. It is our understanding that evidence does not support this conclusion.

There is a strong negative tone to this section of the report. It suggests that those who hold that Medicare's problems can be fixed by increasing efficiency and still preserving the public health insurance system are not being prudent and are avoiding the tough financial questions. The committee does acknowledge that efforts to enhance sufficiency and effectiveness have been hampered by the attitudes and behaviour of those with vested interests in the current health care system. We believe more attention should be paid to this problem.

Many of Canada's most respected health policy analysts have concluded that our country's single payer health system has worked in terms of providing access, a compassionate system, high quality and equitable care, while controlling costs. Health research reveals that spending on hospitals and physicians — those areas covered by Medicare — shows very clearly the pattern of steady escalation of share of GDP prior to 1970, followed by stability in the decades of universal coverage. At the same time, it is those costs that need to be paid for privately that have risen dramatically.

There is a tendency today to overlook the successes of our current system — to abandon what is judged to be a tired past in order to progress to something entirely new; to consider only what are perceived to be new solutions. John Ralston Saul has called this tendency "one of our era's most dangerous failings."[6]

Point 3 – 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[7] for the Canada Health and Social Transfer (CHST).

We commend the Senate committee's work in clarifying issues and possible directions for the federal role in transferring funds for the provision of health care to the provinces and territories and in administering the *Canada Health Act*. In particular, we emphasize the importance of adequate federal funding for all aspects of research.

Point 4 – Health Care Cannot be Treated as a Mere Commodity

Not all of society's institutions have as their essential purpose earning a reasonable rate of return on capital. The essential purpose of education, health care and social services is a non-economic goal: the advancement of human dignity. The value of human life and the quality of the human condition are seriously diminished when reduced to purely economic considerations.

Chapter 5 of the report acknowledges that health care is different from other goods and services, but it defines this difference in terms of "market failures." Throughout the report the essence of health care is reduced to market ideology. Framing health care as a strictly economic issue and resource allocation crisis ensures that the problem analysis and solutions will be sought only within the realm of the marketplace.

Central to our analysis of the strengths and weaknesses of the options developed by the Committee is the conviction that health care is a service. It is — first and foremost — 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.

We believe the strongest forces pressuring the sustainability of the health care system are linked to those values that view health care as a commodity: individualism and self reliance, unlimited choice, economic competition, rapid service and guaranteed outcomes.

Point 5 – Building a More Integrated System of Services

> *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 health system in Canada has evolved in a way that privileges hospitals, physicians and health care interventions. Clearly, this reality must change. There is a need to reorient health services toward a continuum that flows from health-promoting community-based services to community and home care, and on to hospital and palliative care for the most ill members of the community.

Home care

The Senate Committee has identified home care and prescription drugs as two key areas for action in developing such an integrated system. As technology has allowed increasingly complex care to be provided within the community and in the home, provincial governments have allowed the associated costs to move outside of the publicly financed system — a move rightly termed by some as "passive privatization." We believe prompt action is required to reverse this trend and to ensure that home care becomes an integral part of publicly funded health services. We applaud the committee's recognition of the importance of integrating home care to acute hospital services, chronic illness care and palliative care.

Prescription drugs

The Committee, in its presentation of its main findings from Phase Three (Sect. 2.3) appears to favour the participation of the private sector either through the imposition of user charges or the involvement of private insurance as the preferred method of expanding public health care coverage to include prescription drugs, home care, and long-term care.

This approach differs sharply from the funding recommendations for pharmaceuticals set out by the National Forum. It said public financing — without deductibles or co-payments — is the only reasonable way to promote universal access and to control costs. We are surprised that the Forum's extensive research in this area is not referred to in the Committee's discussion of prescription drugs.

Point 6 – 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.

Primary care has been identified as the delivery of a comprehensive set of services that include first contact and ongoing care in response to the first contact. 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.

The vision of primary care reform 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 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.

The CHAC endorses the Senate Committee's recognition of the need to move forward with primary care reform. We question, however, the assertion that primary health care services need to be "accountable through community governance" (Section 11.4). We believe service integration can be achieved without governance integration. We encourage the Committee, 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.

Point 7 – 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 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 agrees with the Committee's conclusions presented in Section 4.3 which state that given the substantial amount of money the federal government gives to the provinces for health care delivery, accountability to tax payers requires that the government understands well how those contributions are being spent. Reporting on the performance of the health care system is also essential to enhancing the overall quality of Canada's health care system.

Point 8 – 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.*

Chapter 8 presents an excellent overview of a range of new funding sources. However, the report's conclusion — that user charges, medical savings accounts, contracting with private for-profit health care providers, and private insurance could be implemented in ways that would avoid the risks associated with these approaches — appears to ignore the authoritative research on these subjects.

In particular, what evidence is there that private, for-profit health care is cheaper and more efficient than public health care? Health economist Robert Evans has studied this question extensively and has concluded that: "Hopes for increased efficiency through increased for-profit provision of health care have no empirical support, and face extensive counter-evidence."[8] There is strong evidence that the growth of for-profit health care will increase — not decrease — costs, and tends to decrease quality.

We are especially concerned about the impact of some of these options on persons who are poor and vulnerable in our society. In Chapter 6, the value of understanding the experience of other countries is presented as one of the criteria for assessing new directions for the health care system. The experience of the public/private system in Ireland is one we hope the Committee will give serious attention to. The latest study of health care in that country shows the system overwhelmingly favors the patient with private insurance and leaves public patients facing lengthy waits for treatment. Published in the *Medical Post*, the author — the director for Insurance Studies in the University College Dublin School of Business — says: "the public/private acute hospital system is inequitable, regressive and skewed against those who are most disadvantaged."[9]

Point 9 – 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.

User charges are addressed in Section 8.4.3 of the report. In addressing this issue the CHAC urges the Committee to ensure that any recommendation for policy changes in favour of user charges must be evidence-based.

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."[10]

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.

Conclusion

While 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 Standing Senate Committee 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

otherwise inappropriate."[11] 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.

* * *

The Catholic Health Association of Canada wishes the Standing Senate Committee well as it completes its mandate to examine and report on the state of the health care system in Canada. We look forward to reviewing the Committee's final report in the new year.

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. 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.
4. Suzanne Peters, *Exploring Canadian Values: Foundations for Well-being*, CPRN Study No. F01, Canadian Policy Research Networks Inc., 1995, pg. 1.
5. "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.
6. John Ralston Saul, "Health Care at the End of the Twentieth Century: Curing Systems," *Do We Care: Renewing Canada's Commitment to Health*, edited by Margaret Somerville, Kingston" McGill-Queens University Press, 1999, pg. 3.
7. 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.
8. 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.
9. "Public/Private System in Ireland Not Working," *The Medical Post*, Sept. 18, 2001, pg. 68.
10. Greg L. Stoddart, Morris L. Barer, Robert G. Evans and Vanda Bhatia, *Why Not User Charges? The Real Issues*, The Canadian Centre for Advanced Research, Working Paper No. 29, 1993, pp. 7-8.
11. Robert G. Evans, "Health Care Reform: 'The Issue from Hell'," *Policy Options*, 14 (6) (1993): 35.