Prescription for a Healthier Canada

Catholic Health Association of Canada

Position Paper

CHAC — Catholic Health Association of Canada

The Catholic Health Association of Canada (CHAC) is a national Christian association supportive of health care in the tradition of the Roman Catholic Church. Its members include provincial/regional associations; hospitals and homes; health, social service, and other organizations that share our values, and individual members. The CHAC, the national voice for Catholic health care, strives to have a concern for health in all its aspects: physical, emotional, spiritual and social.

Since the inception of publicly financed hospital and medical care, respect for a diversity of religious-based health care organizations, and appreciation for the high quality of care and values these organizations bring to health care, has been an important part of Canada's health system.

Motivated by their faith, Christians have brought to the health care field a tradition of excellence, dedicated service and unselfish caring, as well as a strong sense of mission. The Catholic community and health care organization fulfill a unique role in witnessing to the Christian attitude toward suffering and healing.

Ours is a tradition of health and healing that is grounded in the inherent dignity of each person, seen as created by God and destined for God. The holistic approach is central to Christian health care. The spiritual dimension of this care is based on a profound respect for the faith tradition of each individual.

Central to who we are as Christians is this mission to carry on the healing ministry of Jesus. We see in his concern for the sick and his attentiveness to the feelings, relationships, and physical well-being of the sick person, a model for our ministry of caring. Whether we work as volunteers, nurses, physicians, are involved in parish ministry, or respond at home to the needs of our family and friends, we share in this healing ministry.

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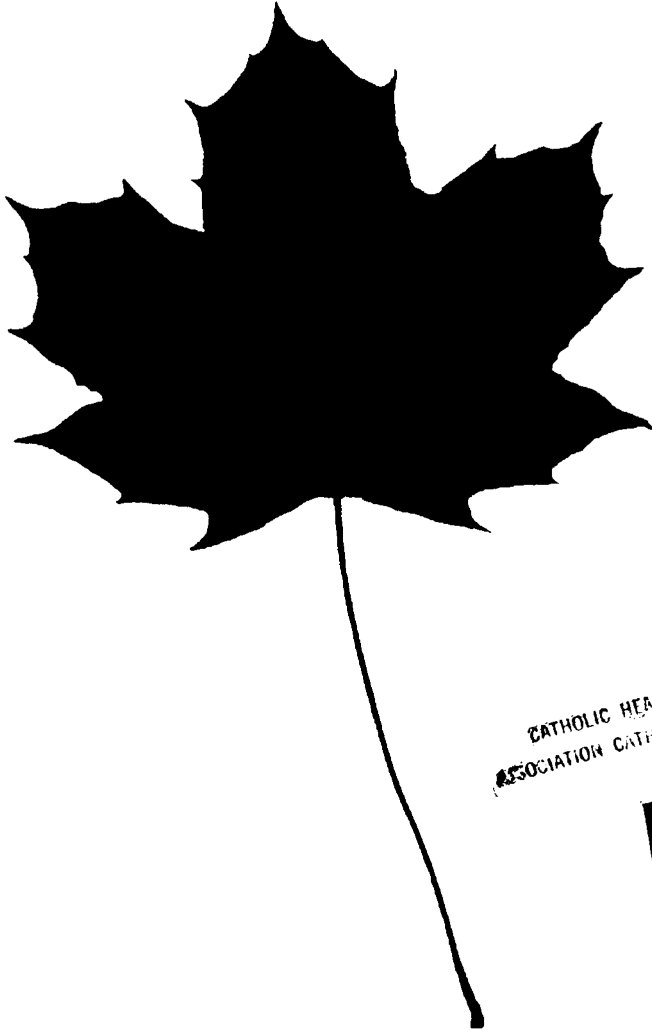
Prescription for a Healthier Canada



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Preface

The Catholic Health Association of Canada (CHAC) is a national Christian organization supportive of health care in the tradition of the Roman Catholic Church. The CHAC's mission is to promote and foster the Christian healing ministry. By working with others to build strong communities that foster health, CHAC provides a forum for issues analysis and policy development incorporating values and knowledge of health policy. The Association strives to have a concern for health in all its aspects: physical, emotional, spiritual and social.

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 organizations have provided an essential role of leadership and pioneering service in the health care field even prior to the beginning of our country's history.

In December 1996, the CHAC's Board of Directors identified the preparation of a position paper on Canada's health system as a priority for action in 1997. Through it the Association hopes to contribute to the national debate on the future of Canada's health system in a way that reflects the Catholic community's strong convictions and broad experience in health care.

The CHAC believes that the current debate over the future of Canada's health care system 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 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. 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.

Introduction

Canada's health system has become a defining feature of our national identity and a central element of our social programs. Today, with restructuring of health services taking place throughout the country, that health system is at a crossroads. In 1964 the *Health Charter for Canadians* highlighted a goal which was to provide a vision for health care efforts 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 three decades ago, and as Canadians consider new directions for our health system it is appropriate to stop and ask to what extent these goals are now being achieved — or lost sight of?

While there has been no shortage of valuable reflection about transforming the system, when it comes to action, the tendency has been to focus on issues related solely to the financing of the health care system and the management of ongoing crisis situations which funding reductions have caused, and continue to cause. Such an approach overlooks a key issue which is yet to be resolved — that involves our values as a society.

In this position paper the CHAC outlines the values and principles that are necessary in order to build upon and improve Canada's publicly funded, universal health care system. The Association believes such a values perspective can provide guidance for addressing the key issues and challenges involved in improving both the health care system and the health of Canadians.

A number of strategic directions are also presented which will enable Canadians to achieve the following goals:

- To preserve a national publicly funded health care system based on the five principles of the *Canada Health Act*.

- To ensure that access to appropriate and effective health care is retained everywhere in the country.

- To reinforce in the health system the goals of human dignity and the common good.

- To develop an overall plan and strategies to improve Canada's health care system and make it more responsive to the needs of Canadians.

- To focus on health and the building of a healthy society.

1. Health Care is About People

Story #1: Linda

Linda is five years old. While walking with her mother to the neighbourhood grocery store, Linda spotted her friend Eddie on the opposite side of the street. Eddie, his mother and their pet poodle were on their way home. Wanting to see Eddie's new dog, Linda darted across the street without looking for oncoming traffic. The driver of an approaching city bus could not stop the vehicle quickly enough and it struck Linda. As Linda's mother and bystanders attempted to comfort the child, a shopkeeper called 911 requesting an ambulance.

Story #2: Calvin

Calvin has lived all his life in Comfort Cove, Newfoundland. Like his father, and grandfather before him, Calvin has lived the life of an inshore fisherman since his teens. Because of the moratorium on the cod fishery, Calvin has been unemployed for almost four years. Prospects for better times in the fishery in the near future do not look good. Jeannie, Calvin's wife, used to work in the fishplant in a nearby town, but she is also now unemployed.

Being unemployed has been hard on the whole family. A shortage of money has meant eating poor food and constant worry about paying bills and providing for the children. It has also eroded Calvin's sense of self-confidence and pride. There have been periods of heavy drinking which have further increased tensions in the family. On this particular morning Calvin is visiting his family doctor with complaints about worsening stomach pain which was recently diagnosed as being caused by an ulcer.

* * *

While the settings and health status of the individuals portrayed in these two stories vary greatly, each reveals a fundamental truth about health care; health care is about serving people, people in need. Their needs demand from us a response, both as individuals as a society.

Care in one instance will mean having efficient health care systems in place to provide necessary support for those who are sick, injured, or suffer from chronic illness. In another situation care might mean not only treating symptoms but also being especially attentive to the roots of suffering. When the hope of cure is no longer possible, the primary goal of care should be to provide quality of life through physical, emotional and spiritual care for the patient/resident and his or her family.

Over the past five decades in Canada we have established policies and systems which reflect a commitment to health as a public good, and to the principle that the costs of treating illness and caring for the sick will be broadly shared by all citizens of the nation. Our health system, Medicare, has not developed without challenges, struggles and confrontations. Nonetheless, it has evolved over the years in an effort to better respond to the needs of Canadians.

As Canadians approach the turn of the century we are at another important point in the evolution of the health system. Governments and care providers are rethinking how health care systems are organized. New technologies and advances in medical science are resulting in changes which put into question the number of providers, institutions and hospital beds that are necessary. The fiscal goals of governments are leading to serious questioning about the way the system is financed. The way that we define health today is also challenging us to adapt our traditional approaches to health care and to recognize the health implications of public policy in general.

The CHAC believes that in responding to the challenges and pressures facing the health care system, we must not lose sight of our overriding goal. The goal of health care is to respond to the human need for healing and wholeness. This goal must be kept constantly in the forefront, especially in a culture that tends to put productivity and profitability before the human factor. Fundamentally, when we speak of restructuring the health system, we are talking about better responding to the need to promote and restore wholeness of life, and to exercise more fully our responsibility to care for others in need.

Sickness Care

Linda's story reminds us of our mortality and vulnerability. It also highlights the need for a health care system that can respond effectively to those who are sick, injured, or suffer with chronic illnesses. Canadians are concerned today that the care they will need in the future might not be there for them. People see hospitals closing. Increasingly, there are reports of conflicts between health care providers and governments, and the amount of funding allocated for health care continues to decline. As health care continues to evolve, treating sickness through effective care must remain as one of the primary goals of the health system.

There is ample evidence, however, that our health care system could be used more effectively and efficiently. The system would benefit from better use of evidence about the effectiveness of treatments and procedures. A large proportion of hospital beds continue to be used by people who do not require acute care. Inappropriate testing and use of drugs represent major costs to the system and pose added health risks to the public.

The pace with which change has taken place in the health care sector, and the apparent lack of an overriding plan for change, has left many Canadians wondering whether talk of restructuring the system is not really a smoke screen for simply reducing the amount of money that will be directed toward health care. Such a situation would leave health care providers simply trying to do more with less. Unless there is assurance that sickness care will be available to Canadians when needed, it is unlikely that they will support efforts to address other important factors outside the health care system that contribute to the health and well-being of the population.

Promoting Health and Well-Being

While our health care system has been well designed to respond to sickness care needs in most cases, it is less able to direct strategies that will promote health and the building of healthy environments.

As Calvin's story shows, if we are going to meet the health needs of Canadians effectively, it is necessary that we be clear on how we understand and define health. Curing illness has been the primary function of our health care system. Curing focuses on the symptoms of an illness. The goal is to identify the cause of the symptoms and to take actions that will eliminate or reduce their impact. Within such an approach, there is a tendency to define health in terms of an absence of illness.

Today, a vision of health is emerging that distinguishes between healing and curing. Healing suggests a more holistic vision and gives rise to a definition of health which emphasizes that we are made of biological, psychological and spiritual factors. It stresses that each of us is deeply affected by our physical and social environments. If the result is a harmonious balance, then we are in "good health". If one of our inner resources is deficient or comes under continual attack of some kind, then we fall prey to some sickness or other. For science to reduce sickness to physical symptoms alone represents a failure to understand the true nature of the whole human being. The disease will be treated while the human being who is sick is neglected.

In Calvin's case, having meaningful work that would instill a renewed sense of dignity and self-worth to his life would be an essential part of restoring his health and well-being. The decimation of the fish stocks on which his livelihood depended reminds us, as well, that our health and well-being is directly related to the environment and to our treating the resources of the earth with respect. Increasingly, we are seeing that the traditional health care system alone cannot compensate for the ill effects caused by social, economic and environmental conditions.

The Challenge

The challenge we face in working to improve the health of Canadians is twofold. First, working to prevent and treat illness must remain as the primary goals of the health care system. As a society we will always be faced with sickness. This does not mean, however, that we can simply proceed trying to operate as we've done in the past. We need to continue to look seriously at how services are organized and delivered, and undertake a wide range of changes to eliminate inefficiencies and inappropriate practices in the system.

Second, we need to acknowledge that the health care system is only one component of a broad range of determinants that impact on health and well-bing. Being healthy requires safe and clean environments. It is linked to meaningful work that enhances a sense of self worth and dignity. Creating health also means acting on our growing awareness that spiritual, emotional, and social well-being are an integral part of physical health and healing.

The CHAC agrees with those commentators who suggest that the goal of improving the health of Canadians must not be reduced to a competition for resources between sickness care and health promotion. Health and well-being are broad concepts for which no one sector can or should claim sole responsibility and accountability, but toward which all sectors must contribute. "If society is serious about promoting well-being and population health, there needs to be a reconfiguration of resources throughout the economy, not just the health sector."[2]

* * *

Having identified some of the challenges confronting the health care system, and public policy in general, we look back now to the evolution of health care in Canada. The roots of some of the current challenges, as well as guidance for addressing those difficulties, lie in that history.

2. Evolution of Health Care in Canada

In their examination of Canadian health care, *Wasting Away: The Undermining of Canadian Health Care*, Pat and Hugh Armstrong demonstrate that it was the issue of how to pay for hospital care that provided the impetus for the emergence of the health system we have come to know in this country.

> In the years before the war, Canadians had suffered through the Great Depression. Returning to peace after years of another kind of sacrifice, Canadians demanded government action to provide them with security and to prevent another depression.... One of the risks they demanded be shared was the cost of health care. They wanted equal access to health care without the individual financial risk it then entailed.[3]

The first universal public health insurance program was established by the province of Saskatchewan in 1947. In 1957 the federal government built upon this initiative through the introduction of the *Hospital Insurance and Diagnostic Services Act*. Under this Act, the provinces continued to direct their own health plans with the federal government agreeing to cover half the costs of specified services. Payment by the federal government was conditional on five principles that were concerned primarily about equality in access to health services.

Health coverage had to be *universal*. Services had to be provided to all insurable residents without regard to ability to pay, age, or illness. Services also had to be *accessible*, meaning that there had to be reasonable access without financial or other barriers. They had to be *comprehensive*, covering all necessary services. Coverage also had to be *portable*, ensuring that medically required services could be received by residents while temporarily outside the province. Finally, services had to be non-profit and *publicly administered* by an authority responsible to the federal government.

Through this legislation Canadians were guaranteed hospital care without fear of personal debt. It represented a commitment on the part of the

larger community to share in the risks of illness. It was not until the *Medical Care Act* was implemented in 1966, however, that costs related to physician services were covered. In this legislation, the government offered to pay half of the cost to any province that set up public insurance plans for doctors' services. The five principles established in 1957 were strengthened by the Act and were imposed once again as conditions for participation in the plan.

By the late 1970s there were concerns that access to care was being threatened. This time the issue involved extra billing — some doctors and hospitals were billing patients directly over and above the fee established for a particular service. In response, the federal government passed the *Canada Health Act* in 1984.

The Act reinforced the principles that had been developed for public health insurance and established penalties for user fees and extra-billing. The Act stipulated that federal transfers to the provinces would be reduced, dollar for dollar, by the amount collected through direct charges to patients. The provinces complied and quickly eliminated user fees and extra-billing for insured services.

Since the 1980s the federal government has been withdrawing from the health care field. Drastic reductions in transfers to the provinces for health care have undermined public confidence in the federal government's commitment to preserve the health care system. The Canada Health and Social Transfer (CHST), established in 1995, calls for federal payments to be reduced by millions of dollars each year beginning in 1996-1997. In November 1996, the Health Action Lobby (HEAL) stated that despite repeated claims that Medicare is a sacred trust that will be defended, the federal government has done little to demonstrate this commitment.

Today, we are at another important moment in the history of the evolution of health care in this country. Canadians are calling on governments to provide leadership once again in responding to the health needs of the population. They expect actions to be taken that will preserve the best of what has developed within Medicare, and they are looking to governments to provide a clear sense of direction for addressing those areas in need of change.

3. Chaos: Potential for Creativity

While acknowledging the severe financial constraints now being faced within the health care system, and the dominating climate of chaos and uncertainty, the CHAC believes Canadians can still be optimistic about the future of health care. A time of chaos can be a catalyst for a burst of new creative energy. We believe it is both necessary and possible to implement changes while preserving the core values and principles that helped to give rise to our health system. The current debate over new directions for the health system provides an opportunity to:

- recommit ourselves to fundamental values;
- reorient public policy based on an enlarged vision of health;
- act upon our knowledge of the determinants of health;
- get serious about managing care effectively.

1. A time to recommit ourselves to fundamental values

Ours is a time of drastic change and radical questioning of many of the structures and institutions that have provided the foundations of our society. 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 principles of universality, comprehensiveness and accessibility are rooted in a sense of equality, fairness and concern for others in need. The results of a recent study entitled *Exploring Canadian Values: Foundations for Well-Being*[4] reveal that compassion leading to a sense of collective responsibility remains one of the enduring values shared by Canadians. The need to affirm and act on the core values that will provide a vision on which to build a new social contract has never been greater.

2. A time to reorient public policy based on an enlarged vision of health

As we have seen, the struggle for Medicare was a struggle for access to health services, first to hospital services and then to physician services. Public funding supported the development of a health system centred on a model of care that linked health with the treatment of illness through the practice of curative medicine. The treatment and prevention of illness is essential and must be preserved, but, as we are discovering today, health is about more than health care services.

The working paper of former federal health minister Jake Epp, *Achieving Health for All*, summarizes well this new awareness: "We draw the conclusion that our system of health care as it presently exists does not deal adequately with the major health concerns of our time".[5] 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.

3. A time to act upon our knowledge of the determinants of health

Most of the decisions that have been made concerning the focus of health policy over the years have been founded on the belief that appropriate health care is the most important determinant of health. 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 traditional health care systems.

We are beginning to understand how social determinants affect the body and cause illness. We are also gaining knowledge into the impact of social and economic conditions on children and on their health as adults. Because of its link to a person's sense of self-worth and self-esteem, employment is being acknowledged as a crucial determinant of health. What is needed is a population health approach based on our knowledge of the full range of determinants of health: biological factors, lifestyle, physical environment, social and economic environment, and spiritual well-being.

4. A time to get serious about managing health care effectively

In recent years virtually every province has undertaken a major study or inquiry into its health care system. The findings of these studies present a picture which is quite different from that presented by those who maintain that we can no longer afford a publicly funded system.

> In general, each [inquiry] has concluded that the fundamental principles of the Canadian funding system—universality, comprehensiveness, public funding from taxation— are sound... None has supported claims of general underfunding, or the need for a return to private funding. But 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.[6]

The challenge we face is to establish mechanisms that will assure accountability for the effectiveness, efficiency, and appropriateness of care provided. Our current system has evolved without such mechanisms.

4. Core Values — Link to the Past & Guide to the Future

Core Values

Values are defined as beliefs, standards or principles upon which action is based. The following list highlights those values which must inform health care decision-making and policy. Though presented individually, these values complement and build upon each other forming a foundation for improving the health system.

1. ***Dignity of the person*** — The dignity of the human person must remain as the basic principle of health care. This fundamental dignity applies to every human being. The rights of every person, therefore, deserve equal respect. Within such a view of the person, health care is a right that all enjoy. Maintaining both universality and the accessibility of appropriate health care, without financial or other barriers, must remain a prime objective of government and a shared commitment of the citizens of this country.

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

3. ***Health care as a service*** — The radical changes that have occurred in our society over the past thirty years have left their mark on all established institutions, including health care. In the process, health care has grown increasingly mechanistic and soulless.[7] The traditional caring function of health care must be re-emphasized. Health care is an essential social good, a service to persons in need; it cannot be a mere commodity exchanged for profit, to which access depends on an ability to pay. Because health care must encompass both curing and healing, spiritual care is a central element of this core value.

4. Compassion / caring — The offerings of modern science and technology cannot replace the healing impact of an atmosphere of compassion and sensitivity. One of the criticisms levelled against contemporary health care is its denial of our need to deal culturally and ritually with pain, sickness and death. Concerted efforts must be taken to eliminate sickness and suffering. However, when suffering and death are truly unavoidable, it is important to assist people to discover that these experiences can have a positive meaning in life.

5. Collective responsibility and community — As Canadians, we have valued a deep sense of compassion and 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 are treated.

The enlarged vision of health described in the opening pages of this paper acknowledges the importance of community and supportive relationships, and the essential role they play in health and healing. Some of the most effective healing today is being done by small informal communities of men and women who meet to share with one another their common sufferings and to work out ways of addressing their illnesses together.

6. Responsible stewardship — Our traditional health care system has developed without a sense of limits. Today, more than ever before, we need to recognize that resources are not unlimited, and learn how to manage resources wisely. Given its central role in our economy, the health care sector needs to ask how to best provide care, protect human life, and enhance human dignity in a situation of limited resources.

Stewardship also involves a responsibility for those men and women who are employed in health care. It calls for an appreciation of work and its role in making us whole persons. It also calls for the rejection of an understanding of power as domination over others.

7. Social justice — The work of justice and its link to health is increasingly recognized in society. Working to promote health and well-being is not only about curing symptoms, it also means confronting the sources of suffering. A concern for health must include a commitment to explore and change the roots of ill health found in personal attitudes and lifestyles, and in the way our society is organized.

8. Ethical reflection — Health care is becoming more and more complex. Health care providers and institutions are faced constantly with the necessity of deciding how best to promote the good of the patient/resident and the community. When judgements of ethical value, rights, duties, and responsibilities conflict, there is a need for a moral framework for analysis through which care givers and policy makers can arrive at sound decisions.

* * *

The CHAC believes these core values, 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 new health care efforts and initiatives.

In the following pages this values base is applied to 12 of the most pressing issues facing efforts to preserve Medicare and to further improve the health and well-being of Canadians.

5. Twelve Key Issues

1. Health System Values

Care of those who are sick and dying is an important measure of the moral character of a society. Health care is critical both to human dignity and to furthering the common good.

In a presentation to the 1996 Catholic Health Association of Manitoba Annual Assembly, Dr. Nuala Kenny, a member of the National Forum on Health, emphasized that the Canadian health system emerged from a Christian tradition based on a set of core values. This theme has also been addressed by the late Joseph Cardinal Bernardin. Commenting on the upheavals and social changes that have marked our time, he points to health care's gradual disconnection from that original values base and its underlying moral foundation.[8]

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 this 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."[9]

Today, with the power of decision-making concentrated in government and corporate boardrooms, and with many conflicting voices trying to influence decisions, it is all the more important to re-examine and reaffirm the fundamental social values on which our health care system is based. Once this has been achieved, the challenge will be to incorporate values into the health and health care decision making process.

2. Expectations and the Need to Acknowledge Limits

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.

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.

Lord Beveridge, one of the founders of Britain's National Health Service, predicted in the 1940s that "... when everyone had access to health care, the demand for care would decrease over time as their needs were met".[10] Our current situation suggests that in making this ambitious prediction he failed to anticipate a significant development. Health systems such as ours have generated an inner dynamism toward continuous expansion. New treatments and therapies give rise to increased demands. New needs continue to be defined to which the system is expected to respond.

Our unwillingness to accept limits within the system 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 is the notion that the roots of illness are primarily biological. The goal of medical intervention is to bring about cure. It follows, therefore, that it is better to intervene if intervention is at all possible. Treatment within such a model most often means drugs or surgery.

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. This is so despite the considerable evidence which suggests that not all drugs, devices, and procedures have been rigorously tested to ensure both effectiveness and safety. When it comes to drugs, testing is left to those who are developing and manufacturing them for profit. As regards medical procedures, it is estimated that only 15 to 20 per cent of medical procedures have ever been subjected to any clear scientific examination.[11]

Such an approach also disregards a growing awareness that a high percentage of physical symptoms have their roots in the psychological and spiritual concerns of people. This helps to explain why one Alberta study found that "the three most frequently prescribed drugs in the province were mood modifiers that mask rather than fix problems".[12]

This is not to say that there are no cures or that treatment is irrelevant. Rather, it is to argue that in reforming health care we need to constantly question both our assumptions about the health care system and the need for tests, interventions and for drugs. At the same time we must work to improve the techniques used for cure and for the relief of pain and suffering.

3. The Needs of the Most Vulnerable

> *The needs of the poor must have special priority. The wealthy and the well must not ignore their obligation to help the poor and sick.*

In 1984 the Canadian Conference of Catholic Bishops produced a discussion paper entitled *Ethical Choices and Political Challenges*. In it they point to the necessity of raising fundamental ethical questions about the values and priorities that govern our socio-economic order. That document says that "to be authentic, development must be integral, encompassing the social, economic, cultural and spiritual needs of the whole person."[13]

In assessing Canada's socio-economic order, the Bishop's Conference highlighted a number of major problems. These problems deeply affect the health and well-being of Canadians, and contribute to the alienation and suffering of large numbers of people in our society: the working poor; the jobless; Native people; elderly people, and children. Those problems, identified in 1984, are perhaps even greater today.

- Massive unemployment — Current restructuring of the economy has generated the highest levels of unemployment since the 1930s. Some analysts suggest that unemployment is the greatest health risk of our time.

• Social deprivation — Social spending at federal and provincial levels continues to undergo major cutbacks. Despite safety net provisions, the victims of these cuts are still the poorest sectors of the population.

• Increasing poverty — Figures released by the National Forum on Health show that between 1984 and 1993 the number of two-parent families living in poverty increased 54 per cent. In Canada today, 45 per cent of single parent families live below the poverty line.

• Social disintegration — Research is showing that there is a direct link between a person's sense of self-esteem, their need to have a meaningful role in society, and their health. The CCCB document warns that underneath conditions of unemployment and deprivation "... lies a deepening human tragedy.... These personal traumas tend to translate into social crises such as increasing alcoholism, family breakdown, vandalism, crime, racism, and street violence".[14]

Addressing the health needs of the poor and marginalized must be a central element of an over-riding health policy. Investing in the health and well-being of children, and taking immediate steps to address child poverty in Canada, must become a priority.

4. The Role of Government

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 over-riding guiding principle.

a) Federal Government

Cash Transfers to the Provinces

The overview of the development of the health care system presented above highlighted why federal involvement in health and health care policy is so vital to Medicare's integrity and continued vitality. Since the 1970s, however, the federal government has been withdrawing from the health care field; this is evident primarily in the decline of direct funding to the provinces.

The establishment of a cash floor of $11 billion by the federal government in 1996 for the CHST (to take effect in the year 2000) is a positive step. Nonetheless, there remains a grave concern throughout the country as to whether this truly represents a long term commitment to transferring enough cash to the provinces so that they can provide reasonably equal access to health services.

It needs to be acknowledged that the declining cash component of health transfers has brought enforcement of the *Canada Health Act* into question. In spite of the promised cash floor, under the CHST the government will cut $2.5 billion in 1996-97 and $4.5 billion in 1997-98. The health care system cannot sustain these kinds of cuts. Given that federal deficit reduction targets have been exceeded, the CHAC believes the federal government should forgo future cuts in CHST payments. Moreover, these transfers should grow at the same rate as the economy (measured by the gross domestic product) to preserve the real value of the total transfer and take inflation and population growth into account.

Health Promotion — Reconfiguring Resources Throughout the Economy

In 1974, the federal government discussion paper *A New Perspective on the Health of Canadians* (Lalonde Report) referred to findings which indicated that health care plays a limited role in determining health status. Since then, it would seem that the federal government has at times used this analysis as an

excuse to abdicate its funding responsibilities for health care. We believe that efforts to reorganize the health system must not diminish the federal responsibility to provide sufficient funding to ensure access to appropriate health care when people are ill. Improving conditions that will foster the health and well-being of Canadians requires a reconfiguration of resources throughout the economy, not just the funds allocated to health care.

In the Lalonde Report health prevention and promotion was (and continues to be) seen largely in terms of an individual's lifestyle and personal choices. This new perspective has resulted in strategies aimed at empowering individuals to take greater responsibility for their health. While we support the effort to achieve an appropriate balance between health care and health promotion and prevention, from our perspective, there are troubling implications to an approach in which responsibility for health is increasingly being placed firmly on the individual. Such a focus on personal behaviour in achieving and protecting health, when combined with the ideological shift that is occurring in our society toward individual rather than collective responsibility, is undermining society's commitment to some of the core values that gave shape to our health care system.

An Overall Strategy for Health

A greater federal presence in health policy, and a recommitment to the vision of Medicare, is essential. Through our participation in HEAL, the CHAC has joined with 27 other national health and consumer organizations in calling upon the federal government to demonstrate its leadership by upholding a national health vision. The federal government has an important role to play in sustaining and building a national health care system. As persuasive as the practical reasons listed above are, "... the more compelling is the emotional rationale: Medicare, the linchpin of Canadian social programs, is the embodiment of the Canadian identity. Thus, Canadians are united in the belief that saving and strengthening the health care system with national standards and goals is the right thing to do."[15]

We think the federal government's role 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, and thus induce a fair degree of consistency across the country.

- Establish an overall strategy for health, one based on national principles and goals for health and health care.

- Take a leading role for creating the social, economic, and physical environments that would support achieving those goals.

- Determine a framework and strategies for appropriate resource allocation.

- Ensure universal access to appropriate health service across the health continuum, not limited to hospital-based services.

- Exercise explicit responsibility for the health needs of those populations under federal jurisdiction (eg. Aboriginal people, military personnel and veterans).

We also think there is merit in the recommendation of some commentators to form a permanent National Council on Health which would become a policy forum for national debates about Canada's health policy. Such a council could report annually to Canadians on the measure of success achieved in attaining national health goals. Struggles within the current health system have highlighted the need for permanent structures that will improve our ability to discuss key health policy questions. The goal of such a council would be to bring health policy development into the open.

The challenge is to engage all Canadians in visioning the future of health care. The work of the National Forum on Health has been an important step in this direction. Such efforts need to be expanded to better include the average Canadian.

b) Provincial Governments

Provincial government strategies for dealing with the health care system have focused almost exclusively on financing. Although specifics vary from province to province, the pattern is similar. Strategies target the two most expensive elements in provincial health budgets, physician costs and hospital care.

In response to reduced federal funding, the provinces have taken various actions in relation to doctors ranging from freezing or lowering doctors' fees, attempts to place caps on income, and limiting the number of doctors who graduate. It is perhaps too early to judge the impact of these approaches, but it is the view of some health policy commentators that while such approaches may serve to limit the amount paid to doctors, they do not adequately address the costs of health care, nor do they address issues related to quality of care.

The provinces have taken more drastic measures in reducing the funding of hospitals. Most provinces have established a set amount to be provided to each hospital or group of hospitals. It is up to each facility or the regional hospital authority to determine how to work within that budget.

The resulting strategies have been to shorten hospital stays, shift to out-patient services and day surgery, cut beds and hospital staff, contract out services, and move people out of long-term care facilities into other residential care facilities or into the community.

Problems associated with these strategies are becoming increasingly apparent. While new technologies do make it possible to shorten hospital stays, few households have the time, skills or ability to provide the kind of care and support that is still often needed after people are sent home. The threat this situation poses to overall health care costs and the health of the community has been ignored.

Unfortunately, reduced costs and shorter hospital stays have become the defining standards for efficiency and effectiveness. Staff cuts have further compounded difficulties; remaining staff need to concentrate on the most necessary curative tasks which leaves little time to provide presence, and the comfort and understanding that are essential for healing.

Everywhere, facilities have felt the pressure to contract out food, laundry and cleaning services. Too often the one criteria used in selecting the contracting company is their ability to cut costs, without regard for the effect on the institution's employees. Also significant are the underlying assumptions behind contracting out, namely that a hospital is a business like any other business and that private, for-profit companies are more efficient at managing cost effectively.

Finally, as regards the shift toward deinstitutionalization, the promised community-support systems which were to accompany this move have yet to realize their full potential. This, combined with the tendency of some voices within governments to talk about care as a community and private responsibility, has led to a spirit of cynicism among the public concerning government plans to reform the system.

The CHAC's view is that provincial governments have proceeded without a sense of the long-term impact and costs associated with their decisions. Recent actions by several provinces to put money back into health care are perhaps indicative of these difficulties. Only now are governments beginning to formulate overall plans for a health system. Too often there is no

plan other than to simply cut costs. Moreover, there is little or no supporting evidence or research for many of the underlying assumptions behind strategies adopted to date, namely, bigger is better, regionalization will necessarily bring more efficient and cost-effective care, and deinstitutionalization is always in the patient's best interest.

5. Health Care is not a Marketable Commodity

Every person 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.

Some people maintain that the expansion of private funding in the health care system would provide advantages that would help to preserve and benefit the entire system. Proponents of such an approach argue that health care is not only a social institution, it is also a marketable commodity. They point to market gaps that exist in the public sector system which could generate revenue — private enterprise, the argument goes, should be able to respond to these unmet needs. These people are quick to add that while private sector activity is motivated by profit, that does not exclude a concern for quality care and customer satisfaction.

Canada's health system has always accommodated private funding for certain kinds of services which are not deemed medically necessary by provincial insurance plans. The entry of private sector funding for services that have traditionally been publicly funded moves us toward the establishment of a parallel health care system and to the commercialization of health care. We believe such a change would pose serious threats to not-for-profit health care. It could also have potentially damaging consequences for patients, and for society as a whole.

From our perspective, there is a fundamental difference between the provision of medical care and the distribution of commodities. "Not all of society's institutions have as their essential purpose earning a reasonable rate of return on capital.... the value of human life and the quality of the human condition are seriously diminished when reduced to purely economic considerations."[16] The availability of good health care is vital to the character of community life. It involves the most intimate aspects of our lives — our

bodies, as well as our minds and spirits. As such it cannot be reduced to mere commodities.

The emergence of parallel, privately funded hospital and medical services would, in our view, also undermine the integrity of Medicare. First, because as the American example has shown "multiple source coverage, rather than universal public funding, leads to uncontrollable cost escalation,"[17] and secondly because moving toward a parallel system explicitly challenges the principles of equity and universality.

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

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

The System Has Worked

The claim is made that the health system is no longer working; that it is underfunded and needs more money. In the face of the uncertainties caused by current fiscal pressures it has been easy for proponents of increased private funding to argue that the only way to preserve access and quality care is to pump private dollars into the system. As mentioned above, this claim has been refuted by numerous inquiries into the existing health system.

When Canada's health care spending is examined as a proportion of our national income (Gross Domestic Product, GDP), it compares well with that of other developed countries. Such an examination also refutes the common misconception that the escalation of health care costs is a result of the public funding system. Robert Evans argues that "exactly the opposite is true... the most rapid escalation [of costs] *ended* with the establishment of universal coverage."[18] Comparisons to the health spending of other countries during the same period show that Medicare has, in fact, given rise to a system that does work and that does keep health care affordable.

> The Canadian health care system has achieved a remarkably good record in both preserving universal access to comprehensive coverage and moderating the growth of health care costs. This performance has been outstanding in comparison with that of the U.S. system, which displays accelerating cost escalation, increasing radical institutional change and deteriorating equity. The Canadian performance also looks good in comparison with that of Western Europe — a more demanding comparison.[19]

Saying "No" to User Charges

The debate about user charges is one that has been going on for decades. Promotion of the supposed benefits of such an approach is particularly strong at times when efforts are being made to hold down increases in health care costs.

There are two popular arguments for user charges. The first suggests that because services provided by our health care system are free, people will abuse it; user fees would reduce unnecessary charges and encourage people to act responsibly. The second argument is based on a belief that health care costs are out of control, therefore, more money needs to be put into the system. Why not let people who can afford to pay a little more do so?

There may be a common sense appeal to this line of thinking. However, recent studies prepared for the Canadian Centre for Advanced Research (CIAR) reveal that these arguments for user charges are not as simple or innocent as it seems.

The Canadian experience with user charges shows that the healthy rich stand to gain the most from the introduction of user charges, while the sick poor stand to lose the most.[20] 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 CIAR report summarizes the problem 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 you will get all of the weeds."[21]

While we need to acknowledge that there are serious fiscal pressures on the Canadian health care system, a shift to a system with user charges would

represent a move away from the primarily income-tax financed system of paying for health care which we have today. It would also involve a change in the criteria for obtaining access to health care. In our current system, access is intended to be based solely on need. In a system with user charges, access depends in part on ability to pay. What may be promoted as a common sense approach, in fact, represents a change in the fundamental values which Canadian society has chosen to guide the provision of health care.

7. A Population Health Approach

Health policy should favour initiatives that will assist Canadians to become healthy and stay healthy. Greater gains in health can be made through policies and programs that affect Canadians' living conditions, as well as by restructuring health care services.

Although there have been significant benefits from the public financing of health care, there have also been some negative consequences. Public funding supported the expansion of a system centred on acute care. This served to increase the focus on care by a physician and on institutional care, especially hospital care. In 1993, for example, hospital expenditures accounted for 38 per cent of all health spending.[22]

The focus of health care reform thus far has been on cutbacks, rather than shifting the focus to prevention, health promotion and the determinants of health. "As a result, health care has become less accessible and the focus on the medical model within the system has intensified."[23]

Our health system requires a transformation that goes beyond bed reductions, hospital closures, and changing the methods by which doctors are paid. We share the position promoted by the Canadian Public Health Association (CPHA) in its issue paper, *Focus On Health*, that the restructuring process that is going on across the country could provide an opportunity to invest in health.

That health gains can be achieved through a broader focus on health has been recognized for decades, and yet, there is little evidence that this broader understanding is reflected in the changes that are being contemplated for the health system. Transformation of the health system requires that we invest in the health of the whole person and the community.

The CHAC takes a broad and holistic view of what constitutes a population health approach. We maintain that the cornerstone of a healthy society lies in the recognition of the value and dignity of each human person. From this perspective, our primary concern is to promote the basic health and well being of people, both as individuals and as members of the larger community. This requires an approach that affirms the importance of necessary sickness care as well as consideration of a wider range of determinants of health including, biological factors, lifestyle, physical environment, housing, income, education, employment, spiritual well-being and social supports.

We are concerned that at the very time in which we are coming to understand the significant health impact of social and economic conditions, and of unemployment in particular, governments are cutting back in the areas of social programs and spending. We realize that, in order to provide conditions for economic and social security, our federal and provincial governments must have the necessary fiscal resources. It must be acknowledged, however, that the economic restructuring which governments are undertaking to eliminate fiscal deficits is having major social impacts.

From this perspective we are concerned that deficit elimination and debt reduction have become the over-riding priority of government policy to which all other public policies and programs, including health, are subordinated. We are also concerned that making social programs the prime target of deficit cutting has contributed to rising levels of economic and social insecurity. Such an approach reveals blatant disregard for the fact that the health of individuals, families and communities is vulnerable to stresses caused by rapid economic and social changes.

8. Developing 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.

We believe the need to reorient health services toward a more balanced approach that places sickness care in a broader framework, oriented toward health prevention and promotion, is a central challenge to be faced in transforming the health system. According to CPHA figures the vast majority of federal and provincial spending on health, approximately 90-95 percent, is for treatment services. The remaining 5-10 per cent fund services and programs which are oriented towards keeping people healthy, i.e., health promotion and disease prevention.[24] Funding for the spiritual dimensions of care remains sporadic and is many times non-existent.

A move to a more holistic system and approach to health requires an understanding in which "... the health services system [becomes] a continuum that flows from health-promoting community-based services, to community care and on to hospital care for the most ill members of the population.[25] This continuum extends to palliative care and the right of individuals to receive care that will enable them to live as fully as possible until they die.

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, rather than flowing to institutions and practitioners according to their activities. Such a shift represents a fundamental change to the way the system is currently funded and structured.

In recent years several provincial governments have established various types of regional structures. The intent has been, in part, to develop health systems that will provide necessary service at the appropriate time and place, and do so effectively and cost-efficiently. Population-based funding arrangements within integrated delivery systems (IDSs) is another option that is being considered as a way of establishing such a coordinated continuum of services.

Transforming the system to achieve such a goal requires a dramatic change in our concept of a health services system. It means moving from one with the hospital at the centre, to one in which the system revolves around the users.

It requires the coordination and integration of primary care through a network of services and health providers. Such a change would support the use of clinical practice guidelines and "care mapping" across the continuum. The use of such practices would reduce costs and improve quality of care.

Promoting a continuum of care would also provide a way to develop a broader community perspective within the system, and would enable it to become more responsive to the needs of particular communities by providing a way to coordinate the efforts of a wide range of care providers in the delivery of home, support and social services.

The pursuit of this goal will require the adoption of new delivery systems that balance the illness treatment model with health promotion, disease prevention and health protection. It also means restructuring the way care is delivered to ensure integration of all aspects of medically necessary care ranging from acute care to home care and including prescription drugs.

We believe it will be necessary to analyze and evaluate the effectiveness of the various approaches that are emerging to ensure that they are contributing toward the development of a continuum of care while preserving both accessibility and quality.

9. Comprehensiveness

> *The provision of health services and the allocation of funds should be directed toward those areas that will provide the greatest health benefits.*

The goal of transforming the delivery, funding and management of health services as described in the previous section, represents a dramatic change from current structures. That discussion highlighted the need to respond effectively to the specific health needs of distinct communities. It also pointed to the need for a new application of funding rules which would allow for the allocation of funds to those areas that will provide the greatest health benefits. The organization and funding rules that exist today limit what policies can be implemented, or even contemplated. As was mentioned previously, the *Canada Health Act* only covers hospital and physician services.

We agree with those who argue that attempts to define precisely "medically necessary services" and to develop a list-based approach would probably do more harm than good. And yet, changes need to be made if we are to create a health system that covers the continuum of care and has the flexibility to meet the needs of specific communities, while ensuring that equitable access to core health services is protected.

The CHAC believes that funding for core heath services should not be restricted simply to physician and hospital care, but should be reoriented to focus on a range of services, provided by a variety of health professionals, which address health promotion, disease prevention and health protection, as well as sickness care. This would also include aspects of social services, home, respite and day care, as well as pharmaceutical, vision and dental care.

Canada's health system has developed with a mixture of public and private funding. This is an arrangement that is likely to continue. The question remains, however, as to what proportion of private funding compared to public funding we want. The question is especially important in the long-term care environment which responds to the needs of a very vulnerable population.

10. Pharmaceutical Policy

Policies relating to the use of drugs in the health care system should promote the following goals: accessibility; cost control; effectiveness, and appropriate use. Sufficient resources need to be allocated to monitor and report on safety, quality, and effectiveness.

Addressing the challenges presented by current prescription drug policies and practices must be a central element of any plan to transform the health system. The following list highlights some of the difficulties:[26]

- Patent-protected drugs account for 86.7 per cent of all drug costs in Canada (1995).
- Number of visits to a GP that result in a prescription being issued: **1 in 2**
- Percentage of health care budget spent on drugs: **12.7%**
- Percentage of all new drugs released from 1991 to 1995 that do <u>not</u> substantially improve therapy: **92%**
- Number of top 24 industrialized nations (besides Canada and the U.S.) without universal drug insurance: **0**

The dramatic rise in the cost of prescriptions in recent years is due primarily to the cost of new patented drugs. The 20-year patent protection afforded to multinational drug companies by Bill C-91 delays market competition by keeping cheaper Canadian generic drugs off the market. We call on the federal government to take whatever steps are required to ensure that generic drugs reach the market quickly. The Parliamentary review of C-91 which is scheduled to take place in 1997 provides an opportunity to address some of these difficulties.

Reference-based pricing is an option that should be given greater consideration as a means of controlling drug costs. The program has been employed successfully in countries such as Germany and New Zealand. The goal is to provide physicians with up-to-date scientific and cost information so that they can prescribe drugs which have the lowest cost to the taxpayer, without compromising medical care. The province of British Columbia introduced the program in October 1995. Within ten months the program made a notable impact on doctors' prescribing patterns, and during that initial period saved $21 million in drug costs.

No province in Canada has a universal drug plan. As a result, a significant share of drug costs is left to private insurance. An estimated 3.6 million Canadians are not covered by any drug benefit plan.

Added to this are difficulties related to inappropriate use and over-prescription of pharmaceuticals which has resulted in an ever-increasing rise in the use of medications. It is not always the case that prescribing drugs can be equated with good care.

The time has come for the introduction of a national, universal drug insurance plan to replace the current patchwork of plans. The goal of the plan should be to control drug expenditures and costs, and improve appropriate access and use, through a publicly financed system in which access to drugs is included under the *Canada Health Act* as a necessary medical service.

11. Payment of Physicians

Physicians, and all other care givers, deserve a just wage. The practice of medicine, however, is more than a commercial or economic enterprise. It is a vocation which places the good of the patient over all other interests.

"In 1993, 15.1 per cent of all health money was spent directly on physicians. However, it has been estimated that doctors account for as much as 80 per cent of health spending through their orders for drugs and tests, surgery and institutionalization."[27] If our goal is to ensure the provision of appropriate care, and to assure that health care becomes more effective and efficient, our current fee-for-service approach must be seriously questioned. A number of alternatives are being considered.

There are benefits that could be gained by implementing a system of salaried physicians. Evidence suggests that there are some situations in which a salary system does work well. For example, salaried physicians who work in public clinics tend to order fewer tests, prescribe fewer drugs, recommend less surgery, and spend more time on issues related to health promotion.[28] One of the drawbacks of such a system, however, is the lack of feedback on the appropriateness of services that have been provided. This calls for a monitoring mechanism for measuring outcomes and ensuring quality care.

Capitation is a second reimbursement arrangement to be considered. Under this system a doctor is paid a set fee for each patient on his or her roster, irrespective of the number or level of services that person receives. There are pros and cons to this approach as well. "Despite the savings from capitation of specialists and the reduction in downstream costs of primary-care physicians, there is the risk of inadequately serving people in order to maximize profits."[29]

We support the removal of the fee-for-service system, except where it can be proven that it is the best arrangement in specific circumstances. In whatever approach is adopted, however, the goal should be to reduce what Robert Evans calls the "inertial forces" within health care. We should not be surprised, he says, when, for example, we fortify the monopoly position of pharmaceutical companies or expand the supply of physicians per capita, and then wonder why health care costs are soaring.

12. Primary Care — Who Should be the Gatekeeper ?

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 their health.

In 1978 the term "primary health care" was coined by the World Health Organization. It was declared to be the key to attaining health for all and was promoted as part of development in the spirit of social justice. It represents a change in focus from a "medical" to a "health" perspective which seeks to reduce the fragmentation between such human service systems as health care, health-related social services, and education.

Primary care was identified as the delivery of a comprehensive set of services which include first contact and ongoing care in response to the first contact. It assumes referral to appropriate services in response to identified needs and cultural values. The definition emphasizes the full range of health determinants. The goals of primary health care focus primarily on accessibility, increased emphasis on prevention and health promotion, and inter-sectoral cooperation.

Historically, physicians, particularly family physicians, were seen as the first point of contact for the health system and, as such, were and continue to be defined as the gatekeeper. The vision of primary care, however, is one which sees the physician move 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.

This shift in the gatekeeper role, however, has not yet occurred. This is due in part to the provisions of the *Canada Health Act* which stipulate that insured primary care services are restricted to physician and hospital-based care. The Act does include enabling legislation for provincial governments to insure health care professionals, other than physicians, but this has had only limited application to date, e.g. dentists and chiropractors in some provinces.

A move to recognize a variety of health and health-related service professionals who could act as entry points to the health system will require changes to existing structures.

First, it calls for the realignment of funding. It also requires a new remuneration method that would recognize multidisciplinary teams of providers as points of entry to the system. Such teams would work within an authorized structure that would set operational controls and guidelines. One of the goals behind such a change is to encourage appropriate interventions, thereby eliminating unnecessary costs.

The goals of primary care are dependent, as well, on an informed and involved public. As a process for enabling people to increase control over, and to improve, both their health and the factors which influence health, primary care consists of more than health services and educational programs. The aim is to develop an approach that combines personal choice with social responsibility for health, and empowers individuals to make more effective and appropriate use of health care services.

6. Conclusion

At the outset of this position paper we emphasized that the purpose of health care is to respond to the human need for healing and wholeness. It reflects a concern not only for the patient but also for the overall health of the community. The work of reorienting the health system and society's vision of health must be guided by a shared commitment to better respond to the need to promote and restore wholeness of life.

We believe the core values outlined in this paper can provide an important measure for evaluating and responding to the many issues to be faced in seeking to improve the health and well-being of Canadians. Restoring wholeness requires attention not only to the physical conditions of persons, but also to their spiritual and social well-being. To fulfill this purpose, our health care system must embody a set of values so that it advances the goals of human dignity and the common good. Without such a values framework we fear that economic goals will supplant health goals and objectives.

In applying these core values to some of the most pressing health issues, we have recommended a number of initiatives which call for action, not only by governments, but also by health care providers and by individuals. This position paper is intended to nurture dialogue among the CHAC membership and other partners, and to assist them in their efforts to improve the health care system and foster the health of Canadians.

Notes

1. *Royal Commission on Health Services*, 1964, Vol. 1, p. 11.

2. "Striking a Balance Working Group Synthesis Report," p. 10, in *Canada Health Action: Building on the Legacy*, Vol. II. National Forum on Health, 1997.

3. Pat Armstrong and Hugh Armstrong, *Wasting Away - The Undermining of Canadian Health Care*. Toronto: Oxford University Press, 1996, pp. 53-54.

4. Suzanne Peters, *Exploring Canadian Values: Foundations for Well-Being*. Ottawa: Canadian Policy Research Networks Inc., 1995.

5. Jake Epp, *Achieving Health For All: A Framework For Health Promotion*. Ottawa: Supply and Services Canada, 1984, p. 4

6. Robert G. Evans, "Health Care Reform: 'The Issue from Hell,' " *Policy Options*, 14, (6) (1993): 35.

7. J. Cardinal Bernardin, *Renewing the Covenant With Patients and Society*, an address to the American Medical Association House of Delegates, Dec. 5, 1995. Published by the Catholic Health Association of the United States, p. 5.

8. Ibid., p. 4. Discussing the reasons for health care's gradual disconnection from its original values base, Cardinal Bernardin states: "For example, advances in medical science and technology have improved the prospect of cure but have de-emphasized medicine's traditional caring function. Other contributors include the commercialization of medical practice, the growing preoccupation of some physicians with monetary concerns, and the loss of a sense of humility and humanity by certain practitioners."

9. S. Peters, *Exploring Canadian Values*, p. 69. Note: On Jan. 23, 1997 the *Globe & Mail* published the results of a poll indicating that 57% of 2,000 adult Canadians questioned between Dec. 15 and Jan. 15 said they wanted the government to put money back into programs; spending on jobs and health care were their top priorities.

10. Michael Rachlis and Carol Kushner, *Strong Medicine - How to Save Canada's Health System*. Toronto: HarperCollins Publishers Ltd., 1994, p. 11.

11. P. Armstrong and H. Armstrong, *Wasting Away*, p. 28.

12. Ibid., p. 35.

13. Canadian Conference of Catholic Bishops, *Ethical Choices and Political Challenges - Ethical Reflections on the Future of Canada's Socio-Economic Order*, 1984, p. 5.

14. Ibid., p. 13.

15. Health Action Lobby (HEAL), *The Federal Role in Health: A Discussion Paper*, (preliminary version) 1996, p. 7.

16. Joseph Cardinal Bernardin, "The Case for Not-for-Profit Health Care," *Origins*, 24, (32) (1995): 539.

17. R. G. Evans, "Health Care Reform," p. 37.

18. R. G. Evans, "Health Care Reform," p. 37.

19. Robert G. Evans, "Health Care in the Canadian Community," in *Looking North for Health Care*, New York: Jossey-Bass, 1993, p. 25.

20. Greg. L. Stoddart, Morris L. Barer, Robert G. Evans and Vandna Bhatia, *Why Not User Charges? The Real Issues*. The Canadian Centre for Advanced Research, Working Paper No. 29, 1993, pp. 7-8.

21. Ibid., p. 7.

22. P. Armstrong and H. Armstrong, *Wasting Away*, p. 168.

23. Ibid., p. 93.

24. Canadian Public Health Association, *Focus on Health: Public Health in Health Services Restructuring*, February 1996, p. I-13.

25. Ibid., p. I-6.

26. The Canadian Health Coalition, *A Prescription for Plunder - A Resource Book on Canada's Pharmaceutical Industry*, 1996, p. 20.

27. H. Armstrong and P. Armstrong, *Wasting Away*, p. 168.

28. Ibid., p. 171.

29. Larry Bryan, *A Design for the Future of Health Care*. Toronto: Key Porter Books, 1996, p. 73.