The United Church of Canada General Council

GC35 Health Care Policy (1994H211)

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The Canadian health care system is under severe pressure (for example, reductions in federal transfer payments to support provincial health care programmes, cutbacks in hospital budgets and in community services, layoffs to hospital and other health care system personnel, the threat of user fees, and the potential of a two-tiered system). In response to this pressure and sparked by a sense of urgency, Unit IV of the Division of Mission in Canada established a Health Task Group in 1991 to engage the church in a process of education, animation and policy formation.

The Health Task Group prepared a process to involve congregations in a four-workshop dialogue on the state of health care in Canada. Resource materials were developed for an education/animation kit for congregational use, including a video and a background paper on the threats to the health care system. Approximately 60 congregations expressed strong interest in participating in the workshop dialogue – 30 in the spring and summer of 1993 and 30 during the fall and winter of 1993/94.

Results of the congregational discussions were fed back to the Task Group. The congregations that participated in the workshops strongly endorsed the continuing importance of the five pillars of medicare – universality, accessibility, portability, comprehensiveness and public administration. Many equated universal access to

health care with equality of access to all diagnostic and therapeutic procedures. They stated that, because God’s love has no boundaries, universality includes all regardless of race, colour, creed, social or financial status, class, et cetera. Everyone has the right to health care, and universality preserves the dignity of all. They also emphasized community responsibility (strong caring for the weak), the value of life (precious and valued, but there is a time to die), and a holistic approach to health (care for the whole person – physical, spiritual, mental, social). They also strongly endorsed reforms which would move the health care system toward a preventative, wellness-based model with regional and community-based delivery options. They felt strongly that our health care system is social responsibility in action! Ensuring access to health care is an act of justice.

Current United Church Health Care Policy

General Councils of the United Church have repeatedly declared a commitment to a national health care system in order to make health care available and accessible to all Canadians. The 1966 report of the Royal Commission on Health Services urged the Government of Canada to implement a national insurance scheme. In its 1962 brief to the Royal Commission, the United Church reiterated strong support for “an integrated and contributory national health insurance programme.” The 1962 brief was backed by General Council resolutions passed in 1952, 1954, and 1960. The 1952 resolution urged quick establishment of such a programme. The 1954 resolution reaffirmed the 1952 resolution. The 1960 resolution re-endorsed the principle of a National Health Insurance Plan and again urged quick establishment of such a programme.

In 1964, the General Council passed a resolution calling on the government of Canada “to proceed to develop such a comprehensive, universal health services programme, with the co-operation of the provinces and the health professionals involved.” Again in 1968, the General Council passed a resolution commending “the enabling action of the federal government and the action of provinces making provision for medicare plans in accordance with” legislation passed by the federal government. The General Council also requested all other provinces to “seek to bring similar plans into being as soon as is practical.” In its 1980 brief to a Health Services Review conducted by Chief Justice Emmett Hall, the Division of Mission in Canada urged action by provinces to deal with fee schedule complaints and provincial measures to guarantee all citizens (regardless of geographical location or

income) access to full medical services. The Division, in this brief, also urged the government to shift its financing of the health care system from a contribution-based method to a tax-based method of funding.

At each point in the debate concerning the continuation of a comprehensive, universal health care programme, The United Church of Canada pushed for changes that became law soon after its interventions.

Recent Developments in Government Health Care Policy

By 1961, all provinces chose to participate in the 1957 Hospital Insurance and Diagnostic Services Act by adopting provincial universal hospital insurance. By 1971, all provinces had accepted the terms of the 1968 Medical Care Act, a federal-provincial cost sharing programme which covered physician services. For the past two decades, both hospital coverage and insurance for medical services have been available to all Canadians regardless of income, geographic location or degree of disability. Canadians took pride in a national health care system that evolved in the 25 years following World War II.

By the late 1970s, however, rising costs for medical care prompted some of the provinces to impose user fees for hospital visits and to permit extra billing by physicians. In order to discourage these practices, the federal government passed the Canada Health Act in 1984. This legislation allowed the federal government to withhold cash transfers to provinces that permitted measures that violated the basic principles of medicare.

The introduction of the Government Expenditures Restraint Act in 1990 supported growing concerns that the federal government was prepared to abandon to abandon its former commitment to universality and accessibility enshrined in the 1984 Canada Health Act. The federal government announced its intention to make serious cutbacks in federal transfer payments to the provinces for health care, education and other social programmes. By reducing and eventually eliminating cash payments, the federal government was relinquishing the only means at its disposal to enforce national health care standards. By the end of the 1980s, the imposition of user fees and the introduction of a two-tiered health system were being discussed with increasing frequency.

Many concerned groups have launched campaigns in the 1990s to save medicare and to shift the focus of the health care debate from the defense of a predominantly treatment-based-system to the promotion of a more balanced and holistic one that emphasized health promotion, disease prevention, and community-based care.

Importance of the Five Pillars of Medicare to Current Health Care Reform Discussions

It is important to remember that the Canadian health care system grew out of the period following the Great Depression and World War II. These dramatic and broadly shared experiences of war and wide-spread economic hardship brought about a growing determination among Canadians that they would never again have to face such common crises in life without a basic network of socio-economic support programmes and health care services.

Canada is today going through a serious economic restructuring, similar in the minds of many to the severity of that depression and post-war period. Even with such a comparison, however, we live in an era of relative economic prosperity.

In addition, our vision of health care is still based on the core values that shaped the development of those social support programmes during the 1940s and 1950s. These core values include:

- equity (universal access, good health as a goal for all)
- individual dignity (respect for persons)
- quality of life (precious, made in God’s image)
- community responsibility (caring for one another)
- stewardship (responsible use of resources).

There are increasing calls for limiting the health and social services benefits available to Canadians. While recognizing the urgent need to scrutinize the health care system to improve its effectiveness, efficiency, and co-ordination, and to ensure that we do all we can to promote health and well-being, the Task Group does not accept the view that we should risk destroying the social equity we have achieved to date through our system of health and social benefits. This would return us to an earlier and harsher ethic that is contrary to the Christian concern for one’s neighbour.

The Task Group strongly recommends that The United Church of Canada reaffirm its support for the principles of medicare-universality, accessibility, comprehensiveness, portability, and public administration. The five pillars of medicare exist as a monumental achievement of our health care system as it has developed over the past several decades. In addition to their historical significance, however, they are a critical foundation and framework for reform of and innovation to the health care system. Reaffirmation is necessary at this time because they are inconsistent with our values and because they are under attack.

Implications for the Reaffirmation of the Five Pillars of Medicare

Reaffirming the five pillars of the Medicare system has several serious implications in the current context. First of all, there are real limits on federal and provincial resources. Provincial health care spending has increased in recent years from 25% to 33% of total provincial spending, while spending on other social services has been diminished. Provincial education budgets are in serious danger. Levels of social services and quality of education have strong implications for health in our society. As Canadians, we may need to make tough choices about our limited resources, but the Task Group insists that decisions regarding allocation of social and health programme dollars be made only within the framework of the five pillars.

The Task Group acknowledges the complexities involved in such decision making. Several government programmes under several ministries, both federal and provincial, may be affected by such decisions. Effective change will require all of them working together. In addition, these discussions take place in a dynamic and changing context. There needs to be ongoing examination of the questions raised – the debates cannot be static. Some of the questions that need examination include: “what is essential?” “what can we afford?” “what can be covered under universal entitlement?” “How comprehensive can we be with limited resources?” “what should be covered (for example, types of care for first and last six months of life)?” “what is core and what’s not?” “How do we ensure access to the poor, the elderly and the marginalized in our society?” We are up against the relative value issue. We are down to: “Is this more important than that? How do we decide?”.

In addition, how do we allow for a setting where current health care can continue to be provided while at the same time necessary innovations and developments to the

system are encouraged?

The Role of the Federal Government in the Canadian Health Care System

With the introduction of health insurance as a public programme in the late 1950sand early 1960s, the federal and provincial governments assumed the cost in order that health services would be available to all Canadians on equal terms and conditions. Health care costs would no longer be borne primarily by the sick of those able to obtain voluntary insurance. Since the public would fund the system, its programmes and services would be administered through public agencies that were accountable to the legislatures and electors. Public administration became one of the five national standards of health care in Canada.

In response to what were widely perceived as threats to the integrity of the national medicare system, the federal Canada Health Act was passed in 1984. It reaffirmed the five principles of medicare and gave the federal government the power to levy financial penalties by withholding funds from provinces breaking the principles.

Through the Expenditures Restraint Act of 1990, the federal government announced its intention to make serious cutbacks in federal transfer payments to the provinces for health care, education and other social programmes. By so doing, the federal government was relinquishing the only means at its disposal to enforce national health care standards.

In light of the current debate over the future of our social programmes in Canada, the Task Group believes that it is imperative that the federal government maintain a strong, central role in ensuring that Canada’s health care system is universal, accessible, comprehensive, portable and publicly administered.

Directions for the Reform of the Canadian Health Care System

The Health Task Group believes that any health care system in Canada must care for all, and especially meet the needs of the poor, the elderly, and the marginalized in our society.

There are some aspects of our health care system that clearly need reform. Such reform will not be easy because the present system has served us well for the most part, and because, in such a complex system, intricate relationships and many interests must be taken into account. Yet the patter of illness itself has changed and requires a shift in the way we address it.

Over the past century, health care professionals have been preoccupied with diagnosing and treating illness. Thanks to science, dedication, and the application of many resources, spectacular results in such areas as the control of childhood infectious diseases have been realized and strides have been made in the control and treatment of cardiovascular disease. Through the present system, care and commitment to the well-being of our neighbours has been demonstrated in many significant ways.

More recently, with new information, we have begun to realize that health depends on a range of social factors such as income, education, housing, food, a safe, non-violent environment, and a valued role to play in family, work and community. This, in turn, has led us to the realization that a health system must be built not only on treatment of disease, but perhaps more importantly upon those factors that promote health and wellness.

Such a shift to health promotion and disease prevention is unlikely to save resources, at least in the near term. It does make sense, though, to spend a portion of what money we have on health promotion and disease prevention, if we, by so doing, end up with a healthier population.

Many health care experts have pointed out that current financial resources are sufficient to operate the health care system, with some redistribution of dollars from acute care (hospital based, physician based) services to community care (prevention, health promotion, home care) services. The Task Group supports a shift from a treatment-based system to a more balanced and holistic one that emphasized health promotion, disease prevention and community-based care.

Need for Continued United Church Advocacy and Education

The United Church of Canada has been a forceful advocate for a Canadian health care system based on compassion and justice. Our voice is needed again at this critical time in the evolution of Canada's health care system.

Community, regional, and provincial dialogues on health reform are well under way across the country, and many pressures would move us away from the achievements embodied in our present system.

Now, as much as ever before, voices and energies are needed that promote strong partnerships between communities, health agencies and governments, partnerships which would lead to necessary changes in the structure of our health care system but preserve the justice inherent in it. This is not a job for health professionals alone. If we are to have a system in which each person has a place and a voice, congregations, presbyteries, and Conferences have important and even prophetic roles to play in health reform.

We, therefore, encourage congregations to study the implications and opportunities for health reform in their local areas and to participate in community, regional and provincial dialogues on health care reform. Presbyteries and Conferences, if not already doing so, have an opportunity to develop task forces on health care and to make important contributions in that respect.

Since some of our earlier work in health care advocacy was ecumenical, it would be appropriate to encourage our ecumenical and interfaith partners to work with us in efforts to reaffirm the five pillars as the foundation for health care reform. We should consider reconvening the 1966 ecumenical charter for health care.

Conclusion

There is new and increasingly strong scientific evidence that individuals are affected in a positive way by being part of a supportive community where faith, hope, nurturing, challenge and encouragement are part of daily life. The physical evidence is strong enough for one reputable author, Norman Cousins, to refer to a "biology of hope."

These findings suggest that faith is healing – something that Christians have always known. This knowledge, now supported by research evidence, renews our responsibilities. It means that, as communities of faith, we, too, have a major

contribution to make to the health of our communities, based on the recognition of the value of community, the provision of hope, and the presence of joy.

It also places new challenges and opportunities for congregations to become communities, or centres of healing. With confidence, we can take up the challenge to support people and congregations with the knowledge that faith, hope, humour, and nurturing can lead to the physical changes that fight disease, contribute to health, and bring healing.

This is a time of unique opportunity and challenge. We have the foundation, in the five pillars, upon which to build a health system based upon faith and community. This is an opportunity for the church to move with determination toward actions clearly supporting a health care system that states our obligation to care for one another, as Christ has called on us to do.

WHEREAS General Councils of The United Church of Canada have repeatedly declared a commitment to a national health care system in order to make health care available and accessible to all Canadians; and

WHEREAS there are increasing calls for limiting the health and social services available to Canadians; and

WHEREAS the five pillars of medicare are important as a critical foundation and framework in the current health care reform discussions, both because they are consistent with our values and because they are under attack; and

WHEREAS tough choices may need to be made about our limited social and health care resources; and

WHEREAS the strong, central role of the federal government is crucial, in the current health care reform debates, to ensure that Canada’s health care system remains universal, accessible, comprehensive, portable and publicly administered; and

WHEREAS a health system must be built not only on treatment of disease, but also upon those factors that promote health and wellness; and

WHEREAS The United Church of Canada has been a forceful advocate for a Canadian health care system based on compassion and justice;

THEREFORE BE IT RESOLVED that the 35th General Council of The United Church of Canada:

1. Strongly affirms its support for the principles of medicare – universality, accessibility, comprehensiveness, portability and public administration – as a critical foundation and framework for reform of, and for innovations made to, the Canadian Health Care System. This affirmation is made recognizing: (1) the limits to current health care resources, and (2) the complexities involved in the health care reform decisions facing us as Canadians.
2. Reaffirms the critical role of the federal government in maintaining the five principles of medicare.
3. Affirms its support for reforms to the Canadian Health Care System which reflect a shift from a treatment-based system to a more balanced and holistic one that emphasizes health promotion, disease prevention and community-based care.
4. Encourages congregations, presbyteries and Conferences to continue to study the implications of health care reform in their local areas, and to participate in community, regional, and provincial dialogues on health care reform.
5. Engages in interfaith and ecumenical advocacy efforts to secure widespread support for the five principles of medicare.
6. Directs that the study of Canada’s health care system be continued with emphasis on the well being of the whole person, including such aspects as health promotion, disease prevention, mental health, spiritual health and community based care with concern for the whole range of social and personal factors that affect individual and family health. Encourage the Division of Mission in Canada to allocate sufficient resources to provide infrastructure that will support above recommendations.

BE IF FURTHER RESOLVED that the 35th General Council communicates resolutions 1, 2 and 3 to the ministries of health of the federal, provincial and territorial governments of Canada.

BE IT FURTHER RESOLVED that the 35th General Council directs resolutions 4 and 5 to its Division of Mission in Canada for action.

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