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HEALTH CARE FOR ALL PEOPLE IN CANADA

REPORT ON THE ECUMENCIAL HEALTH CARE NETWORK'S FORUM ON THE FUTURE OF HEALTH CARE INCANADA FEBRUARY 28, 2002

Executive Summary

The Ecumenical Health Care Network convened a special Forum on the Future of Health Care in Canada on Parliament Hill on February 28, 2002. Over 100 religious leaders, church based health care providers and professionals, as well as politicians and representatives from community and labour organizations attended.

The Forum focused on the values and visions for the future of health care. Participants agreed Canada's system needs to be preserved and strengthened based upon a vision of social justice. They concluded that Canada's health care system is not in crisis, that for profit delivery mechanisms are too expensive and exclude people, and that the system could be improved by primary care reform. Among the recommendations were calls for a parallel Health Act that would expand the system to provide pharmacare, improved home care, palliative care and hospice services without having to reopen the Canada health Act. The Forum also recommended a health charter or covenant which is appended to this report.

Concern was expressed that political leaders were losing credibility for their lack of action to support health care. There was a fear that the voices of "interest groups" that would profit from further privatization were more influential to policy makers than the needs of average people. The question that must be asked about any reforms is, "Who benefits?" For their part, churches agreed to undertake a national wide series of workshops to help their members contribute to the debate about the future of health care.

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PARLIAMENT HILL, WEST BLOCK, FEBRUARY 28,2002

THE ECUMENICAL HEALTH CARE NETWORK

The Ecumenical Health Care Network is a project of the Canadian Council of Churches' Commission for Justice and Peace. Members of the EHCN include the Anglican Church of Canada, The United Church of Canada, the Canadian Conference of Catholic Bishops, the Evangelical Lutheran Church in Canada, the Presbyterian Church in Canada working in partnership with Kairos-Canadian Ecumenical Justice Initiatives and the Catholic health Care Association. Convened in 1998, the Network coordinates the works of the Canadian churches that have provided health care to Canadians for over 100 years.

PURPOSE OF THE FORUM

In response to the continuing concern about the future of Canada's health care system, the Ecumenical Network has been engaged in a program of education and discussion across the country during the past two years. The Canadian churches have made presentations to the Senate's Standing Committee on Social Affairs, Science and Technology and to some of the provincial committees considering health issues. The churches have published numerous educational resources and have also been working on the issues related to the use of new technologies through the Canadian Council of Churches' Biotechnology Taskforce. Health care has been discussed by numerous church committees and governing bodies. There have been consultations with church-based heath care providers. With the release of the Interim Report of the Commission on the Future of Health Care, the churches organized 16 workshops in various centres across the country. As this process began, the Ecumenical Network convened this Forum on the Future of Health care in Canada to begin this nation-wide discussion. The Forum was held in the West Block on Parliament Hill. It brought together some 100 religious leaders, church-based health care providers, and politicians.

The Rev. David Pfrimmer, Chairperson of the Commission for Justice and Peace and Forum Moderator, began the day with a brief overview. He noted the three reasons for holding the meeting:

- The Church has a long history in Health Care in Canada as a provider of health care service and as an advocate for Canada's universal public system. A similar meeting to the Forum took place when the original Health Care legislation was being debated in the 1960s.
- The churches have a pastoral concern since many clergy are very involved with people living with illnesses and facing health care decisions.

- There is a pastoral concern for the political process itself. Many Canadians are increasing cynical and lack confidence that the political leadership is able or willing to strengthen and preserve our envied system.
- The churches also have a prophetic concern to raise the ethical questions and affirm the important values that are necessary to sustain the Canadian system. The health care debate involves a broader debate about what form of justice will prevail in Canada. The churches must assert a vision of social justice.

He also indicated that three outcomes from the meeting could be expected:

- A full assessment of the ramifications of the issue
- A solid beginning of the process of elaborating a Church position
- Developing what message to take back to congregations.

A HISTORICAL OVERVIEW OF THE CHURCHES AND HEALTH CARE

To begin the discussion, the **Rev. Bill Jay and Ms. Rachelle Audet, United Church of Canada**, narrated a slide presentation prepared by **Mr. James Roche, Catholic Health Care Association of Canada,** that provided a historical overview of the churches involvement in health care. Churches have been involved in the provision of health care since the 1747 when the Grey Nuns established the General Hospital in Montreal.

The presentation reviewed the origins of Canada's Health Care system in the 1960s and the vision of the Hall Commission that led to the five principles of the Canadian health care. The presentation provided a succinct overview of recent health studies: the Fyke Commission in Saskatchewan, 2001; the Clair Commission in Quebec, 2001; the Mazankowski Report, Alberta, 2002; the Romanow Commission, Canada and the Senate Review on Health Care chaired by Senator Michael Kirby, 2001. The changing federal and provincial positions were noted and the general shift in thinking about "for-profit" health care was noted.

Six common myths about health care were addressed in the slide show. Participants found the section *Challenging the Myths* of particular concern and interest. The following was the response to the main myths:

- Medicare is Workable
- For-Profit Health Care is more Expensive
- Health Care is not just another commodity
- For-Profit Health Care will not lead to improved quality care.
- Medicare is good for business.

OVERVIEW OF THE WORK OF THE FEDERAL COMMISSION

Dr. Robert McMurtry, special advisor to the Commission, outlined the history of the Romanow Commission since its formation in April 2001 when the Privy Council gave the mandate for its' work. The Commission has sought research and discussion papers, has held discussions with stakeholders and experts, and has provided education about the present system.

The Canadian Policy Research Network has held twelve forums representative of all cross-cultural and socio-economic groups. Eighteen Public Consultations were held in every province and territory; in addition, 9 Stakeholders' Roundtables will be held and five Regional Conferences to be held in May and June will provide synthesis of the information gathered.

Public forums will allow opportunity for debate about consumer choice, values, and sustainability of the present system. It is expected that by September 2002 the Commission will be in a position to validate its findings and prepare the final report which is due in November 2002.

The Commission website is available to provide information and opportunity for public education and input. It is important for all Canadians to be involved in this process of reviewing the healthcare system. Canadians cannot be spectators in this process. "Our health care system is uniquely ours. The tie that binds Canadians together is hockey and health care." There are two approaches we can choose: the "we-self" or the "me-self". The need is to focus on the "we-self" if our system is to survive while remaining faithful to the five basic principles of the *Canada Health Act,* namely, publicly administered plan, comprehensiveness, universality, portability and accessibility.

Dr McMurtry emphasized that this debate is crucial to the future of Canada as a sovereign nation. He stressed the following:

- The pace of change in the field must be kept in mind;
- The matter relates to Canadian identity; it has icon status;
- The problem of sustainability must be addressed;
- We have to look creatively and "think outside the box;"
- The issue is fraught with tensions and the need for clarity is paramount;
- It is a time for true public involvement;

He explained the Commission's process and noted the importance of the countrywide consultation. He felt that the need to provide a final report by November made for a very tight schedule but he opined that the political context required such. He concluded by saying that this was a very important historical moment for Canada and it was important to ***get it right.***

In the ensuing discussion participants made the following points:

- Consultation is often skewed by Media simplification and the great reliance on anecdotal discourse rather than principle driven argument;

- Has the page already turned as a result of various Provincial initiatives; is there danger that such initiatives would lead to NAFTA challenges;
- The issue is but a small part of the massive changes that the world economy is undergoing; to forge a special sovereign Public Health option for Canada will require close and well coordinated action;
- Public involvement will be particularly required for the post-Report phase.

In thanking Dr. McMurtry, David Pfrimmer underscored the point that ". . .the stature of a healthy society is measured not by how it treats those who are perceived as "deserving" or "successful" but rather by the degree to which a society is prepared to insure it meets the needs of those who are most vulnerable: the old, the young, the poor, the disenfranchised , those who are ill and those who are dying."

MODERNIZING MEDICARE FOR THE 21ST CENTURY
PRESENTATION BY DR. MICHAEL RACHLIS

Dr Michael Rachlis, private consultant and associate professor Department of Health Policy, Management, and Evaluation at the University of Toronto, in his presentation contended that Medicare requires reorganization rather massive infusions of money. The real issue in the debate is the quality of health care. The debate should not be about public payment or an aging population. He recalled the hope of the Hon. Tommy Douglas who proposed two points:

- To provide health care to all independent of their wealth
- To organize health care delivery in the most efficient manner

Tommy Douglas wanted a *different* system; he wanted to reorganize the delivery of health care into a regional system of care where physicians are integrated into the system. Dr. Rachlis suggested that the second of the Douglas points had never been taken seriously. Indeed the real problem with the current delivery of Health Care is quality of service. So often relatively minor changes seem to be systematically blocked by the hospitals and the doctors.

What is vital for the sustainability of Medicare is the development of Primary Health Care that may dispense in community-based clinics and favour prevention. Dr. Rachlis' plan of action would be to provide seed money to begin the process of Primary Care. Once initial results would lead to savings in hospital care such savings would then fund the Primary Care. He also advocates 5 year funding arrangements that would provide stability and the atmosphere to foster innovation.

Medicine has divorced Health Care from ordinary life. The link between ordinary living and staying healthy must be restored and it is through a holistic approach to Health Care that this will occur.

Dr. Michael Rachlis raised the question, "What is the current political state of Medicare?" and "How do we get evidence about innovation in primary health care into the public debate?"

Average Canadians still support Medicare even though at a fundamental level we all know the system isn't efficient. Canadians do not want a private system. Political and economic elites increasingly do not support Medicare. The Kirby Report is not encouraging. One could be distressed by the rhetoric of the Mazankowski Report. There is need for further support of such concepts as medical savings accounts and more "for-profit" provisions within the public system. Talk among certain provincial premiers is not helpful. We know the stance of Ralph Kein and Mike Harris;. It is not likely to get Quebec on side. What about the remaining premiers? Can the Romanow Commission stem the tide? Mr. Romanow wants the Commission to be seen as an honest broker.

There is need for concern. We are not in a neutral zone. There are those with resources who can mobilize the media. There is concern that the myths are not being dealt with adequately. A media blitz to deal with these myths may not be effective because of the time constraints for completing the report.

Has health care spending has outstripped the cost of living index? In Ontario the percentage of the GDP has diminished only marginally. The health care system has not been starved for funding. Funding has diminished in the other areas of social funding such as early childhood education, public housing and other areas which in turn, influence these percentages as well as the health of citizens. The Fyke Report (2001) in Saskatchewan points out that "good quality care often costs less than poor care."

Dr. Rachlis then went on to describe some of the challenges and possible solutions. He listed them as follows;

1. **Management of Chronic Care Patients**:
The shift to an aging population with chronic care illnesses raises issues. There is a need for a well-organized system of ambulatory care; proper outpatient management is essential. At best, 50% of the population are receiving the best care for chronic illness. At present, the system is set up on a "battlefield" model that is not helpful.

2. **Fixing the System**:
There is a need to do things differently. Issues: reduction of pressure on hospitals; management of chronic illness; prevention of illness; community care of frail elderly; palliative care to allow death with dignity.

3. **Best Practices should be shared**:
- Edmonton model of palliative care;
- Sault Ste. Marie Group Health Care: management of heart failure patients;
- Better outpatient nursing;
- Holistic care models.

4. **Keep People out of Institutions:**
- Move resources into the community with the patients and keep the funding "on-going."

- Extra resources in community care are needed to prevent readmission of patients.

5. **Shorten the Wait for Care:**
- Utilize human resources more effectively.
- "Wait list" management: the Sault Ste. Marie model is good.
- Better management of this could greatly improve the treatment of cancer care patients; allocation of operating theatre time.
- How do we utilize doctors more effectively? Higher fees are not necessarily the solution to this. Canada has never had as many doctors as we have today. Creative solutions are needed to stem the tide of family practitioners who are leaving comprehensive care practice. One suggestion: create teams of practitioners.

6. **Why are drug costs rising?**
- Possible reasons: poor prescribing practices; doctors receive little training in drug management.
- Newer, costlier drugs are not always the answer.
- Use non-pharmacological therapies.
- Improve the quality of prescribing.
- Drug companies spend more on marketing than on research and development.

7. **How do we introduce the evidence on innovation?**
There is a need for more public debate on the issue. Demonstrate how things can be improved. Community Coalitions on Health Care should mobilize for the Romanow Commission and ensure follow-up on the report.

-Innovation is a slow process. The dysfunctional federal/provincial situation is a complication.
-Long term planning in health care is dependent upon a guarantee of predictable funding to provide care.
-Primary health care is critical to the other health care issues.
-Canadians need to mobilize to ensure the continuance of health care as we know and need it.

Dr. Rachlis concluded by quoting Tommy Douglas who said in 1982 that "The ultimate goal of health care is keeping people well; not patching them up when they are ill."

In the discussion with participants, a number issues and proposals were identified. They were;

- Concern about private clinics and suggestions that the church and non-profit organizations can be more creative; for example in the area of supportive care for seniors which has been declining in recent years.
- The need overcome barriers to paying physicians in any other way that "fee-for-service" and to use nurse practitioners more effectively and establish more multi-disciplinary clinics.

- "Organized Medicine," such as the Ontario Medical Association which makes it difficult to fund other models of health care delivery, is an obstacle to change.
- A national scheme for drug purchases would lower pharmaceutical costs.
- Good primary health care strategies may mean that investing in more sophisticated high-tech service in some centres and using the fascilities in smaller centres for respite care, step down care, regular visits by specialists from larger centres, and the use of teams of doctors and nurses.
- "User Fees" make no difference in the overall cost of health care but they do discourage low income people (wealthier people make more frequent use of physicians) causing increased suffering and anxiety.
- There is a need for a change in attitude by physicians and more patient education about the myths about nurse practitioners so that people understand they need "care" not necessarily a "doctor."
- Need to reconnect health care to the greater society and recapture the spiritual and cultural aspects to maintain the social aspects of health care at the same time as preserving the scientific rigour.

CANADIAN MEDICARE: COMPETING VISIONS AND VALUES
DR. NUALA KENNY

Dr. Nuala Kenny, former Deputy Minister of Health for Nova Scotia , Professor and Head of the Department of Bioethics, Faculty of Medicine, University of Dalhousie, observed that persons of all faith must name for Mr. Romanow the fundamental values that remain for health care. They must also name the competing and conflicting values that are emerging. This is an issue upon which all faith communities must come together.

As Canadians consider changes to health care, there are two important points to ponder: "Who is served by the status quo? Whose interests are at stake when we cannot make the needed changes to the system?"

The paradigms in health care have shifted. There are many advances in medicine. "Dead is not dead anymore" (organ transplantation, cardiac rescusitation, genetics) It is not correct to assume that there is an enduring set of values. We need to consider the values, visions, interests vested in the *Canada Health Act.* People have transferred belief in science and technology and the place (and power) of the public state has declined. People believe in medicine the way they used to believe in God.

The context of the discussion is important: We live in a world of science and technology with an emphasis on individualism, a rejection of authority and an emphasis on rights rather than responsibilities. Here there are competing values and visions.

We must understand the traditional values of health care. (traditional means 'nostalgic' in this context) The *Canada Health Act* is uniquely about Canada; it quintessentially speaks about Canadians as a people. Change to this Act is not simply about policy issues; such

changes will result in profound consequences. What will we do? Tommy Douglas' vision of Medicare came in two phases:

1) the removal of financial barriers between those giving care and those receiving care (a value statement in itself)

2) the reorganization of the health care system

Values are the essence of Medicare. There are at least two views: "We are Canadian" vs. "I am Canadian." Dr. Kenny then went on to review the five exisiting principles of the Canada Health Act;

- **Universality**: solidarity, no exclusions, we are all in this together
- **Accessibility**: to doctors, to interventions, to hospitals. The underlying value is the concept of justice and fairness. This Canadian model is 'egalitarian' vs. the 'libertarian ' model of the USA.
- **Comprehensive**
- **Portability**
- **Public Administration** of a not-for-profit system: Historically, we have said something very important about efficiency, i.e. a public good is provided most efficiently in the public sector. Today, some say that the government way is not the most efficient way. The market wants competition.

A key concept is that the Health Care Encounter is a place of moral meaning. Health needs are different from other needs; they are experienced at a time of great vulnerability. In sickness we lose control and we become dependant. Medical care is not a commodity; it is not *like buying socks*. The values that we must defend all deal with justice. She made the distinction between *Egalitarian Justice* and *Libertarian Justice*. Libertarian Justice ensures the right for the individual to purchase what he needs according to his wealth and under rules of competition, is what governs most of our life. However, Medicare requires Egalitarian Justice where one receives according to one's needs based on collective responsibility. One cannot purchase "extra" care. In health care issues, Canadians do not allow only a market response; Canadians believe in equity. We will 'privilege' those who have the greatest needs.

Today there are many conflicting values. Canada is the healthiest nation in the world, yet Canadians are constantly worried about health. The bar is constantly raised; and expectations about health cannot be met. There is a growing dependence on technology in health care. There is an increasing demand for choice and for freedom of choice. Alternative medicine is bigger than all the pharmaceuticals. Another conflict in values: major medical advances now benefit individuals, not society as a whole: e.g. dialysis, transplantation of organs. Earlier medical advances were to the benefit of society as a whole (e.g. vaccines).

There are also issues of accountability. Conflicting ideas emerge as we attempt to contain the costs of medical care. (e.g. "You smoked, you deserve it!") The case for user fees assumes that people use health care irresponsibly. This is wrong. In fact, the cost of

irresponsible use is a miniscule part of the whole picture. These are dangerous positions for our Canadian society.

Dr. Kenny decried the fact that Doctors remain gatekeepers often thwarting the introduction of more efficient practices. Also what is distressing is the relative ignorance of Doctors about the emerging drugs and their great reliance on the advertising of the pharmaceutical companies. Doctors are the gatekeepers of medical care. They determine what is spent.

There are also competing values to the way Canada has organized health care. These include;

- Self-reliance
- Commercialization
- Commodification
- Globalization

Dr. Kenny challenged participants to think about the ways in which health care is, or is not, a market and a commodity. She pointed out how global influences seem to make it impossible to resist the forces of the market. However, she went on to add, the fact that others are doing it, doesn't make it right.

Among the key points to Dr. Kenny challenged the Forum to ponder we the following questions:

- What is the best definition of 'health'?
- What kind of 'good' is health care?
- What conception of justice do we want for the future?
- What place is there for 'care'?
- What is our process for decision-making?

Dr. Kenny pointed out that if Canadians believe that public policy is a manifestation of public values (always respecting diversity), then we must hold sufficient values in common to be a united country. There is a prophetic role for policy. Public policy can support justice, fairness, and compassion. We must ask ourselves, "Why would we set aside our values in the name of cost?" We must put our money where our values are! Market-driven health care will not address issues of homelessness, end of life care, other social concerns. The key values are at stake today are solidarity, equity, compassion, efficiency, and civility

There are those who want to 'privilege' the wealthy. Private insurance companies do not act out of love! We must publicize the facts that the 'state' does it better. In terms of civility (1) We must find a forum for the issue of health care as citizens, (2) We must find a means to carry on a civil discourse about health care, (3) What are the new ways to discuss issues like this, and (4) We must find a means to bring out the competing interests.

Health care bring to the fore the spiritual and communal concerns of Canadians. This is not a rhetorical issue. There are profound questions and challenges raised when we consider changes to the *Canada Health Act*.

ROUNDTABLE CONVERSATIONS

The Forum then divided into smaller roundtable discussion groups. They were asked to address the question, "In the light of the discussion to date, what would your like to tell the Commission on the Future of Health Care?" While there were varied responses to this question, some general themes did emerge as follows;

AFFIRMATIONS

- There was a strong affirmation of the five principles of the Canada Health Act;
- There was strong affirmation for not-for-profit delivery of health care.

CONTEXT CHANGES

- There was recognition of the global pressures; particularly those drive by for-profit interests, being placed on health care.

POLITICIANS CREDIBILITY

- There was a recognition that in spite of the considerable time given to health care, politicians seem to be getting nowhere and are loosing credibility;
- There was also recognition of the need to dispel the myths about health care (e.g. it is too expensive, costs are out of control, the system is in 'crisis,' private for-profit delivery is more efficient) There is public suspicion that this is an 'invented crisis' to allow more private interests to benefit.
- There was a recognition that the federal-provincial conflicts are not helpful and some means to resolve disputes that is both transparent and publicly accountable, needs to be put in place;
- There was a recognition that the federal government does need to increase its contributions;
- There was also the belief that the "special interest lobby groups" (pharmaceutical companies, health management organizations, Medical Associations etc.) have too large an influence and do not reflect the values held by Canadians.

CHURCHES ROLE

- Churches need to be challenged to encourage the necessary values in their members;

- Churches need to speak out forcefully to "name" the destructive values that impact the health of people and communities;

- Churches need to help decision makers and the public understand the importance of the "common good" which can be difficult if people have never experienced the vulnerability and marginalization caused by severe illness, poverty, or unemployment.

PROPOSALS

- There was a proposal for a second parallel act to expand the current system to provide, pharmacare, home care, palliative care and hospice services.

- There was a suggestion that more ways should be developed to share "best practices" across the country.

- There was support for primary care reform and particularly a multidisciplinary approach that utilized various health care professionals.

THE CANADA QUESTION

- There was a feeing that "If we do not win the fight to preserve and strengthen Medicare, we will lose our country." Many felt that if we do not build a health care system based upon our values, we will not be able to address other issues such as poverty and homelessness based upon our collective values. "This is a fight for our soul."

A CROSS COUNTRY CHECK UP – CLOSING PLENARY

The Forum assembled a panel of people from across Canada to reflect on what they had heard in the conversation and the implications for their region of the Country.

Mr. Don Junk, former Deputy Minister of Health in Alberta, noted that although there is a perception that Alberta is leading the nation in health care turmoil, this is not the case. Actually, care is quite good at this point.. He pointed out that he was less sanguine about the Mazankowski Report. No one is sure yet of the implications of the Report for Alberta. There was a decline in spending for health care from 1991-95, followed by an incline in 1995-2000; presently, there has been a return to the spending levels of 1991. In Sept. 2000, big dollars were added to the system by the Federal government. However, no conditions were attached and no commitment was given from politicians to actually spend this money on health care.

In reality, at this time, concerns over drought conditions may in fact overshadow the health care issue. People are worried about the rhetoric in the press around health concerns. The implications of NAFTA also cause concern. One-third of regional health authorities were elected in the past;. The new system will change the debate significantly. The rural regional health commissions are now being chaired by former cabinet ministers, which is causing great uncertainty. There are major challenges to maintaining the five principles of health care enshrined in the *Canada Health Act*.

What should be said to the Romanow Commission?

- The basic values must be emphasized.
- Poverty is a real threat to well-being.
- There is an issue of caring about the vulnerable in our society.
- Maintain the sense of community.
- 'Community' is not defined by geography or markets; health care is bigger than this.
- Deal with the issue of 'deserving/non-deserving' members of the community.
- Develop alternatives to drugs as the only treatment model; address the issue of rising drug costs.
- Necessity of an increase in federal funding which is tied to improving the system(not to bringing tax cuts).
- There is a need to emphasize the importance of exposing the 'myths' about the system at present.

What do we do when we get home? This presents a big challenge. People are confused and the media contributes to this confusion. We must debunk the myth that the private sector can deliver health care better and more efficiently. How do we 'fix' the "access problem." Many are tired of the debate and just want the system 'fixed' now! The key issues are to engage in advocacy with elected people, undertake education with the public and work to preserve our values. This issue is difficult everywhere in the country.

Sister Lucille Goulet SSA of the Social Justice Committee of the Canadian Religious Conference of Quebec, pointed out that people are becoming more impoverished because of cuts in health care and the lack of adequate home care affects many particularly women, children, and single parents.

The Claire Commission in Quebec has advocated for more staff and nurses to improve the system. However, many nurses have left the system and new staff are inexperienced. Money is not the only solution to the problem. The health portfolio has seen three provincial ministers in recent times all of who have tried to find solutions. Quebecois are interested in the Romanow Commission despite what the provincial government might say to the contrary.

In light of the discussion about privatization, the Claire Commission is more important than ever. Family care clinics are very controlling of the way by which patients access health care services. There is no miracle solution to the question of hospital mergers. There are

delays in operating time not addressed by mergers. Many persons turn to private system to get care quickly.

Quebec Health Network will address the Romanow Commission.

- Keep the *Canada Health Act* aand its five principles.
- Values don't always sell but health is not a commodity.
- People need a humane accessible system of health care.
- Home care is not working. Some people not able to access. Many must leave jobs to care for parents.

Middle class is moving closer to the poorer class than ever before. The Canadian Religious Conferences will say "no" to privatization of the health care system.

Dr. Jan Storch, Professor and Director of Nursing at the University of Victoria, described the report in Bristish Columbia which was mandated in August 2001 and delivered in December 2001.
The Principles set out in that report are:

- Equity
- Patient-centred care
- Accountability
- Restructuring the system

Some proposals of the set out in the B.C. Report: include health as a taxable benefit, increase of premiums, privatization, and the use of medical savings accounts. There was an emphasis on inappropriate use of the system. Much blame was laid on the consumer of health care.

There is a sense of powerlessness on the part of the people. Members of Parliament say that it is important to talk to Premier Campbell since he is the decision-maker. There is disappointment with the Premier and his view of his and his government's role. "We live in a world where the rich get rich and the poor get poorer". This is the view of one Cabinet Minister.

Churches can do much to change attitudes about value shifts. They can create cases to demonstrate the values that we treasure. They can rally the citizens of Canada, especially church members. They can demonstrate the difference between word and action. Church might propose a "charter on health care." It might include:

- A Statement of Beliefs that is 'values' driven.
- How would primary health care look? Give it meaning by suggesting clear models.
- Discussion of the appropriate use of medical technology.

Dr. Storch concluded that, "Today's exigencies are created not so much by scarcities of resources, but by our unwillingness to share them."

CLOSING REMARKS

ERIC BEREFORDS AND JANET SOMMERVILLE

The Rev. Dr. Eric Beresford, Consultant for Ethics and Interfaith Relations, Anglican Church of Canada, brought together some the various strands of the Forum's conversation. He noted that if the Churches are to be helpful in this debate, the questions would need to be framed in theological terms. It must reflect our experience and history as community. There must be recognition that moral choices are made from particular interests. Our choices are based on identification with the vulnerable, poor, excluded and marginalized. Things look different from this point of view.

He then went on to note how Canadians need to be careful about our preference for "we" and "me". We need to ask, "Why are we not adopting some of the models and options outlined by Dr. Rachlis?" He underscored Dr. Kenny's observation that it is important to find space for civil discourse and to model alternatives. Dr. Beresford pointed out that churches <u>are</u> the space to the degree to which churches model community.

The Churches reach every level of civil society: municipal, provincial, and national. We have political influence. Regional differences need to be reflected in the discussion. One common approach is not enough. The approaches and critiques must reflect regional needs and disparities. We are community and we are communities. This provides the Churches with a mechanism to address the assault that is being made on our values.

Janet Somerville, General Secretary of the Canadian Council of Churches concluded the day with thanks to the organizers and participants. In her remarks she pointed out that in the health care debate forces us to ask, "What does justice really mean in human society?" Nurturing a really good health care system echoes God's providence for creation. It mirrors our vision of what God is like and how God is passionate about life in his creation. "Love your neighbour as yourself." "Who is your neighbour?" This is the Law!

Ms. Somerville concluded the day praying Psalm 139;

"O LORD, you have searched me and known me.
You know when I sit down and when I rise up; you discern my thoughts from far away.
You search out my path and my lying down, and are acquainted with all my ways.
Even before a word is on my tongue, O LORD, you know it completely.
You hem me in, behind and before, and lay your hand upon me.
Such knowledge is too wonderful for me; it is so high that I cannot attain it.
Where can I go from your spirit? Or where can I flee from your presence?
If I ascend to heaven, you are there; if I make my bed in Sheol, you are there.
If I take the wings of the morning and settle at the farthest limits of the sea,
even there your hand shall lead me, and your right hand shall hold me fast.
If I say, "Surely the darkness shall cover me, and the light around me become night,"
even the darkness is not dark to you; the night is as bright as the day, for darkness is

as light to you.
For it was you who formed my inward parts; you knit me together in my mother's womb.
I praise you, for I am fearfully and wonderfully made. Wonderful are your works; that I know very well.
My frame was not hidden from you, when I was being made in secret, intricately woven in the depths of the earth.
Your eyes beheld my unformed substance. In your book were written all the days that were formed for me, when none of them as yet existed.
How weighty to me are your thoughts, O God! How vast is the sum of them!
I try to count them--they are more than the sand; I come to the end--I am still with you.
O that you would kill the wicked, O God, and that the bloodthirsty would depart from me-- those who speak of you maliciously, and lift themselves up against you for evil!
Do I not hate those who hate you, O LORD? And do I not loathe those who rise up against you?
I hate them with perfect hatred; I count them my enemies.
Search me, O God, and know my heart; test me and know my thoughts.
See if there is any wicked way in me, and lead me in the way everlasting."

APPENDIX I

A Health Care Covenant for All People in Canada

Proposed by the Ecumenical Health care Network
Of
The Canadian Council of Churches
April 2002

Preamble

Canadians understand that how we care for others defines the nature of who we are as a national community. Canadians also know that what we owe each other is essential for who we are as a people. Thus, we have empowered our governments to steward public resources and develop and administer social policy for the common good of all; to ensure that,

> *Everyone has the right to a standard of living adequate for the health and well-being of himself and his family, including food, clothing, housing, and medical care and necessary social services, and the right to security in the event of unemployment, sickness, disability, widowhood, old age or other lack of livelihood in circumstances beyond his control.*
>
> - U.N. Universal Declaration on Human Rights, Article 25

As signatory to the World Health Organization Charter, Canadians have pledged themselves to a holistic vision of well-being that understands 'health' as *[...] a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity (p.).*

As members of a national community, Canadians understand that a community actively promotes and nurtures health through compassion, mutuality, care, trust, respect, security and active attention to what justice requires of us.

Thus, in fulfillment of our mutual responsibilities, Canadians and our governments solemnly promise to actively pursue and safeguard a holistic and integrated vision of health care for all citizens of Canada.

A Health Care Covenant for All People in Canada

Through government, Canadians pledge to:

Universal Access, Comprehensiveness and Portability

- provide access to comprehensive health care services for individuals, families and communities that places the priority on the worth and dignity of the whole person and their biological, emotional, physical, environmental, social and spiritual needs wherever they may be in Canada;

Social Solidarity and Justice

- uphold a health care system through which all people in Canada share the benefits of health and the burdens of illness with particular compassion for the weak, caring for the vulnerable, solidarity with our neighbours and a commitment to social justice for all;

Open to All People in Canada

- preserve inviolate a health care system that applies to all people in Canada without discrimination toward race, colour, sex, sexual orientation, ability, disability, ethnic origin, language, place of residence, economic status, religion or any other distinction;

Social Health and Well-being

- utilize a systemic approach to creating public policies that, intentionally integrate the social, economic, cultural and environmental determinants of well-being with health;

Human Right and Public Good

- ensure that access to health care is maintained as a human right and a public good, recognizing that health care interactions have meaning to people as a place of caring; health care is not a commodity;

Honour the Vocation and Contribution of All Health Care Providers

- utilize fully the capabilities of all health care professionals and honour the vocation of all who provide care, whether paid or unpaid;

Public Stewardship and Accountability

- safeguard public administration and limit for-profit delivery of care through mutually enforceable federal and provincial regulations upholding standards of public accountability for a system that addresses the health care needs of individuals, families and communities;

Collaboration and Shared Responsibility

- develop and sustain a health care system founded upon the principles of collaboration and shared responsibility between governments and among providers, not competition or market imperatives; and

Participation and Decision-making

- recognize that health is unique to individuals, families and communities and as such, to honour the right of people to participate in the decisions that affect them and their health.