A STATEMENT TOWARDS ADEQUATE HEALTH CARE FOR ALL CANADIANS

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The church believes that the healing arts come from God and part of his good gifts to the whole human family. The marvelous medical and scientific discoveries and the growth of technology are evidence of God's continuing creativity in which man participates as co-creator. The paradox of our age is the lack of will to distribute fairly what has been given lavishly. The Royal Commission on Health Services, 1964, described the paradox in these technical terms:-"The enormous gap between our scientific knowledge and skills on one hand, and our organizational and financial arrangements to apply them to the needs of man, on the other."

The church has a long tradition of providing care for the sick and disabled. But equally it cares that each person shall have wholeness according to his potential and is concerned, therefore, with everything which prevents enjoyment of that fullness of life Jesus Christ came to bring. Hence it sees health as "a state of complete physical, mental and social well-being and not merely the absence of disease and infirmity" (World Health Organization definition of health).

What is new, but not uniquely new, in the rediscovery of human solidarity, the brotherhood of all mankind proclaimed explicitly in Holy Scriptures. An increasing awareness of our interdependence in modern society confirms this oneness. We discover that we must act together responsibly to achieve individual well-being as well as the common good. This acceptance of human solidarity has implications related to the issue of good health care for all Canadians.

It implies that we recognize what is stated in the charter of the World Health Organization, to which Canada is a signatory, namely.

> *The enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being without distinction of race, religion, political belief, economic or social condition.*
>
> *The health of all peoples is fundamental to the attainment of peace and security and is dependent upon the fullest co-operation of individuals and states.*

Implied also is our recognition of Articles 22 and 25 of the Universal Declaration of Human Rights:

Article 22

> *Everyone, as a member of society, has the right to social security and is entitled to the realization, through national effort and international co-operation and in accordance with the organization and resources of each state, of the economic, social and cultural rights indispensable for his dignity and the free development of his personality.*

Article 25 *(1)*

> *Everyone has the right to a standard of living adequate for the health and well-being of himself and of 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.*

Human rights are being understood today in new dimension. The right to dignity encompasses social rights as well as civil and political rights. In *Canadian Welfar*e, November-December 1968, Pierre Laroque, an eminent authority on European social welfare, states, "Social rights include a decent standard of living, social security in illness or misfortune, medical aid, employment, and education."

Because of the high cost of health care today only a few at the top of the income scale in Canada could emerge from serious illness or injury without being financially crippled. Because we cannot know which of us will be affected, due to the unpredictability of illness and our inability to know what to insure against, the logical solution is to extend mutual aid to include every citizen. This Canadians did through the Medical Care Act of 1966. Through the democratic process a people made a collective decision for the common good in order to achieve a socially desirable goal. Seen in this light the argument about compulsion becomes invalid for as Pierre Laroque puts it, "Then the community action is no longer conceived in terms of imposed constraints but as an accepted discipline, an act of joint voluntary effort for the benefit of each and everyone." Because health care is a basic need and because a universal risk is involved, the Canadian people through the process of law decided on program which is universally available.

Our increasing awareness of human solidarity, of the need for a society where we accept responsibility for our fellow-beings, and of the fact that social rights can be realized only by the community-as-a-whole makes inappropriate anything which artificially or by official recognition emphasizes a distinction between social groups, e.g., deterrent fees. These have the effect of impeding the goal of "reasonable access to insured services by insured persons."[1] Perhaps the best statement on this issue is the view set forth by the Royal Commission on Health Services that deterrent fees would "simply deter the poor and have no effect on the necessary demands of those in middle and high-income categories. Such a policy wold mean that Canada was simply continuing to ration health resources on the basis of ability to pay."[2]

According to the Economic Council of Canada[3] close to 30 per cent of the population lives on an income as the "poverty level."[4] To emphasize the disparity between such a substantial number of Canadians and the rest of the Canadian population is hardly a positive step towards the Just Society.

In the light of the above considerations, the Lutheran Church in America--Canada Section:

1. Commends the federal government for enactment of the Medical Care Act, 1966, and for provisions that permit extension to include health services personnel additional to those of a physician.[5]

2. Believes that in the reallocation of function the federal government should keep in mind its continuing responsibility to assure that health services are distributed equitably and uniformly throughout Canada, to undergird much-needed research, and to strengthen and augment Canada's health manpower.

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[1]Medical Care Act, 1966, Section 4(b).

[2]Report of the Royal commission on Health Services (Ottawa, Queens' Printer, 1956), Vol. II, p. 6.

[3]Economic Council of Canada, Fifth Annual Review, Sept. 1968, p. 109.

[4]The 1961 Census shows that some 916,000 non-farm families and 416,000 individuals--a total of about 4,200,000 people, including 1,700,000 children under 16 years of age--are in the low-income group. In addition, the number of farm families in the low-income group is estimated to be 150,000 consisting of possibly 550,000 persons, or more than half the estimated 275,000 families primarily dependent on farming for a livelihood. The total estimated low-income group is thus just under 29 per cent of the population. The Dominion Bureau of Statistics identifies low income as less than $1,500 for one, $2,500 for two, $3,000 for three, $3,500 for four and $4,000 for five or more in 1961 dollars. These amounts are based chiefly on the criterion that any individual is in the low-income group if he has to spend 70 per cent or more of his income on the necessities of life, i.e., food, clothing, shelter. J. R. Poduluk, *Incomes of Canadians* Census Monograph (Ottawa: Dominion Bureau of Statistics, 1968).

[5]Such personnel might be physiotherapists, social workers in a medical setting, homemakers, and other persons who provide counselling services.

3. Believes that because health and health care are so important to Canadians, health considerations should not be secondary to costs and federal-provincial jurisdictional disputes. If Canadian unity is to have reality in daily living, it means a basic level of health care for Canadians, whatever the place of residence.

4. Urges that an integrated and co-ordinated program of comprehensive health services, not just medicare, be the goal of the people of each province and that the provincial administration aim to develop a broad integrated health services program and to maintain and improve the quality of those services, in co-operation with the health professions.

5. Supports the principle of free and self-governing professions and institutions. In the words of the Royal Commission on Health Services this "means the right of members of health professions to practice within the law, to free choice of location and type of practice, and to professional self-government. With respect to institutions it means academic freedom for medical, dental and other professional schools, and for hospitals, freedom from political control or domination and encouragement of administration of the local level."

   But at the same time, our view is that the Canadian public, which through the state has authorized the medical, para-medical, and other professions to practice in the health field, does not relinquish its right to decide where service is to be made available and on what general basis. The general public must also be free to protect itself against high cost of health care and to make its decision concerning method of payment.

6. Commends the flexibility permitted by the Medical Care Act and recommends that provincial governments apply this flexibility in defining the method of payment for health personnel in include those who do not wish to practice as self-employed persons, e.g., salaried physicians in hospitals, doctors in group practice, and salaried personnel practicing in isolated areas. Group practice could be sponsored by public or non-profit agencies or by private groups. Such flexibility would increase the availability of services.

   In this connection we support the use of preferential incentives to encourage personnel to work in isolated or disadvantaged areas of the country.[6] Also , we firmly believe that there ought to be new financial arrangements to enhance the status and to strengthen the work of the general practitioner. A review of the fee schedule method is past due as it seems to give preference to certain surgical procedures to the detriment of other medical services which are basic to good health care, especially early diagnostic and preventive services.

7. Recommends that the federal and provincial governments collaborate, in co-operation with the professions, to introduce new methods and arrangements to deliver health services more equitably in poorly served rural areas, in isolated settlements, and in depressed urban neighborhoods. Establishing facilities to which are attached specialized health services personnel on a full-time or consultative basis is an important aspect of availability. To this we believe capital assistance ought to be available where required to establish community health centres, group practice, and possibly other facilities as new treatment techniques become available.

8. Recommends that the existing hospital services program under the Hospital Insurance and Diagnostic Services Act 1957, and medical care under the Medical Care Act 1966, be financed entirely out of general revenues, since they are social programs designed to provide universal access to service benefits on a uniform basis.

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[6] Preferential incentives include not just more money but also such things as housing, well-equipped hospitals or clinics, availability of consultation, etc.

9. Recommends that in the development of health care programs under provincial governments there be universal coverage on a uniform basis without co-insurance, part-payment at the time of service, or any similar economic barrier to access to covered services such as "extra billing." Our concern is that the poor be able to make the same demands for services as the middle and high-income groups with any necessary restraint being exercised through professional decisions by the personnel concerned.

10. Calls upon the federal and provincial governments to expand their programs of public education to enable the individual to carry out his responsibilities and above all, to find better ways to educate and motivate the public concerning the unmet health needs of disadvantaged groups. In the educational process an essential ingredient is citizenship participation representative of various groups of consumers and involved with both the authorities and the health professions in future planning at all levels, public and private.

11. Expresses its continuing concern to the federal and provincial governments and to the general public that many of the health needs identified by the Royal Commission on Health Services remain unfinished business, e.g., the burden of our aged population, the treatment of retarded children, the problem of mental illness. While recognizing that it may be necessary to proceed by stages, we urge that the development of services to meet these needs be integrated and co-ordinated with the framework of a comprehensive health services program.

12. Calls upon the members of the Lutheran Church in America--Canada Section to recognize their responsibility in helping all Canadians to experience optimum health and their part in helping a rich nation to make those financial and organizational arrangements through taxation and other means by which the right to good health care can become a reality for every Canadian.