A STUDY PAPER ON A HEALTH CHARTER FOR CANADA: A CONCERN OF THE CHURCH

A Study Report issued by the Continuing Committee on Social Issues and Concerns. Lutheran Church in America-Canada Section
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FOREWORD

Public Debate on the issue of Health Care Services, including the implementation of the Medical Care Act of 1966 (Medicare) continues. Those doing the debating are mainly politicians, the professionals, and spokespersons for powerful corporate groups. What does the consumer have to say? Is this a subject coming within the orbit of Christian social responsibility? Are there basic Christian principles which take precedence over political expediency, professional concerns, commercial interests, or economic considerations? Will all Canadians receive the health care they need or will it depend upon the province in which they live? What about the kinds of services needed? What about the disparities in the quality and distribution of services and facilities? Should more attention be given to integrating other health services into a comprehensive program?

In order to continue discussion and to provide more information, the Continuing Committee on Social Issues and Concerns presented a viewpoint to the Lutheran Church in America - Canada Section at its Convention June 19-20, 1967. The Convention authorized the following report be published as a background paper in the Synods and their congregations. It also authorized the Committee to continue its work towards development of a possible position on an integrated health services program as a desirable goal for all Canadians.

The Medical Care Act was approved by the Parliament of Canada in December 1966. Because of this federal legislation there may be a mistaken assumption that we have achieved the goal of good health care for all Canadians. The Medical Care Act of 1966 is an enabling financial mechanism. It provides under certain conditions financial assistance to those provinces that initiate their own health care services. Thus the intent of the Act depends upon the development of actual programs by the provinces. Because much yet needs to be done provincially and federally in the health care field, this report express a viewpoint.

The church has an interest in a health charter for Canada because it professes its concern for the wholeness of persons. It recognizes optimum health as an important factor in the well-being of the whole man. The church has had a long tradition of providing care for the sick and disabled. It feels such concern is an integral part of the Christian witness to Jesus Christ who "went about all Galilee teaching in the synagogues, preaching the gospel of the Kingdom and healing every disease and infirmity among the people". Through its understanding that the body is a temple of God, it implicitly teaches individual responsibility for one's own health. Through its emphasis on the stewardship of God's resources for a man's own family and for his neighbor, there is implicit the importance of individual responsibility for the health of others.

In an urban industrial society individual responsibility by itself is insufficient. We are very much interdependent. Therefore, Christian concern involves a great deal more than the responsibility for one's own health and personal concern for the sick and dying. When the church becomes concerned with wholeness, it ought to see health as a state of complete physical, mental, emotional and social well-being and not merely the absence of disease and physical well-being (World Health Organization (WHO) definition of health). When it becomes concerned with justice it ought to see health as a fundamental human right. The charter of WHO, to which Canada is a signatory, states:

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 cooperation of individuals and States.

> Today many societal goals are achieved through the political process. Large corporate groups seek to influence public opinion and through it the politicians. As issues are debated, the facts may become distorted. The individual becomes confused. As a result he may become apathetic. But ignorance due to apathy is irresponsible. Today, then, Christian concern for the health needs of one's neighbor requires us to use our heads as well as our hands and feet. This means involvement in study of the facts and issues.

THE ROYAL COMMISSION OF HEALTH SERVICES

One issue is the Hall Commission Report Royal Commission on Health Services, also known as the Hall Commission Report. Royal Commissions have been used by governments as a device to evade or smother an issue. This Commission meant business. But this report, like others, can be ignored unless Canadians become concerned about unmet health needs and major gaps in health care services. It ought to be the concern of the church that this report, one of the most significant and far-reaching ever presented in Canada, is not receiving the attention it merits. The present focus on "Medicare", which deals mainly with the method of payment for physicians' services, obscures what are the health needs of Canadians and what the Commission recommended for the whole spectrum of health services.

MYTHS

With the enactment of Medicare legislation, strong feelings based on myths are likely to continue. In order to explode these myths, some facts should be established.

1. There is the myth of higher administrative costs and less efficiency when a plan is run by government. The Saskatchewan plan has demonstrated that administrative costs are substantially less than the administrative costs of private plans. In addition, the Saskatchewan plan pays doctors' bills faster than any other plan in Canada. Furthermore, the costs of the Saskatchewan plan have been rising more slowly than the costs of private plans.

2. There is the myth that universal coverage will mean over-utilization of health services. The Saskatchewan experience to date indicates that any increased utilization is doctor-generated and not patient-generated. Regardless of whether a plan is governmental or private, there will be increased utilization because of rising expectations. Fantastic advances in medical science and technology have become public knowledge. The public has come to expect "miracles" and this has motivated more people to seek health care. Experience has shown that "where the services are regarded as important to individuals, regardless of status, one demand has been that the services be made universally available by some means."[1] In an urban industrial society demands for services increase. Hence the tendency will be to move towards universal health insurance. There are those who argue that this universal coverage should be provided through private plans, while saying that the health professions will not be able to meet the demands created by a universal public plan. This seems to be inconsistent. If the health professions can meet the increased demands stimulated by universal coverage through private plans, then it seems they should be able to cope with the increased demands under a universal plan. Those who use the British National Health Service as an example do not take into account that the physician in Canada can control the number of his patients through the appointment system.

3. There is the myth that free selection of doctor by patient and patient by doctor will be interfered with. The Royal Commission on Health Services underscores the principle of "freedom of choice." This means the right of a patient to select his physician or dentist and the right of the

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[1]P. J. Giffen, "Social Control and Professional Self-Government: A Study in the Legal Profession in Canada," *Urbanism and the Changing Canadian*, ed. S. D. Clark, University of Toronto Press, 1961, p. 125.

physician or dentist to accept or not to accept a patient except in emergency or on humanitarian grounds.

4. There is the myth that government intervention will interfere with the doctor-patient relationship. But, if a third part does interfere, the same danger is inherent in any private plan. Over against the expressed fear there are those who argue that the entrance of a third party as the financial agent actually enhances the doctor-patient relationship.

5. There is the myth about state medicine. Some references to it seem like scare tactics. State medicine means that physicians and other health professionals become functionaries of the state, i.e., civil servants. Confusion has been engendered by using "socialism" and "socialization" synonymously. The former is a political philosophy. The latter is the tendency to unite for the common good, i.e., for individuals, e.g., Hydro, the Postal System, the School System, the Universal Hospitalization Program. The Health Charter recommended for Canadians by the Hall Commission is based upon free and self-governing professions and institutions. This "means the right of members of health professions to practise 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 at the local level." For the professional only the manner of receiving payment is altered.

6. There is the myth that a service or deterrent fee will prevent unnecessary or excess utilization of health services. The application of such a fee militates against the principle that all Canadians are entitled to adequate health care at the time they need it without hindrance of any kind. Such a fee deters only the poor. It does not prevent over-use by higher income groups. It favors those with more ability to pay. Surveys show that use of medical services indicate a high correlation between high incomes and high use of services. The Royal Commission comes strongly for the principle of no co-insurance payment as follows:

   We are compelled to conclude, therefore, that a policy imposing part-payment would simply deter the poor and have no effect on the unnecessary demands of those in middle- and high-income categories. Such a policy would mean that Canada was simply continuing to ration health services on the basis of ability to pay, a policy which was overwhelmingly denounced in submissions to the Commission.

7. There is the myth that quality of services will decline if a universal, comprehensive health care program is implemented. It would seem that with self-governing professions policing their own members, having selection of patients, and having control over the selection and training of candidates for the professions, the case for a declining quality of services will not stand close scrutiny.

THE MEANS TEST

The Hall Commission Report Royal Commission on Health Services rejects the Means Test for those who cannot afford the prepayment premiums. This is consistent with its premise that adequate health care is a right. It recommends that premiums should be within the ability of all incomes and that general tax revenues be used to subsidize an insurance fund. The alternative, namely to subsidize individuals or family heads, means that a person would have to submit to a type of means test. Some provincial plans have tried to remove any impression of dependency when application for a subsidy is made. But no matter how you look at it any request for subsidy smacks of charity. It sets such people apart by having to ask for assistance for that which is a right. Hilary M. Leyendecker in his book, "Problems and Policy in Public Assistance" said, "No matter how humane the method, it cannot be made palatable." (p. 194) He goes on to say, "It is difficult enough for a person to accept the fact of dependency, no matter how understandable the cause, and it is made more painful by the necessity of proving one's helplessness in order that public

aid can be justified." (p. 195) When premiums are not within the ability of all incomes and individuals have to be subsidized, this is charity. The Commission in suggesting that tax revenues subsidize an insurance fund pointed out that the incomes of a significant portion of individuals and families are not only inadequate to meet the costs of illness but also to meet the prepayment premiums. It could not accept a program of health care which divided the nation into first- and second-class citizens on the basis of their ability to pay.

A UNIVERSAL PLAN

The Hall Commission Report Royal Commission on Health Services attempts to deal with the paradox of our age --"the enormous gap between our scientific knowledge and skill on one hand, and our organizational and financial arrangements to apply them to the needs of men, on the other." Hence its basic recommendation is that Canada "take the necessary legislative, organizational decisions to make all the fruits of the health sciences available to our residents without hindrance of any kind." Thus universal means "that adequate health services shall be available to all Canadians wherever they reside and whatever their financial resources may be, within the limitations imposed by geographical factor." The Commission says, "There is a growing consensus that since we do not know which of us may be affected, all should make a contribution to a common fund to assist those who are." It points to an unequal distribution of resources in Canada, varying health standards in Canada, and unequal access to needed services. Recent studies on poverty by the Canadian Welfare Council have demonstrated that access to good health services for a substantial number of Canadians is another myth.

One characteristic of an industrial society is the mobility of people. It is in the national interest that a universality of health services be attained. "Illness knows no provincial boundaries" and surely no Canadian should be less equal because of his choice of provincial residence.

While the Hall Commission Report Royal Commission on Health Services underscores that health care should remain with the jurisdiction of the provinces, there must be intervention at the federal level in order that all Canadians have comparable benefits. The health of Canadians is not a bargaining item. Human needs are paramount to federal-provincial jurisdictional rights. Given the facts of efficiency of government or a quasi-government body in an age of computers and the high cost of health care services, we cannot afford the luxury of individual insurance plans. Only a universal plan can close the gaps in our health care services.

SOME DIFFICULTIES IN PROVIDING UNIVERSAL COVERAGE

One difficulty relates to the present coverage provided by voluntary insurance. The Royal Commission, when making its report, said: "After more than 35 years of endeavor on the part of the voluntary plans and commercial insurance companies, only slightly more than one-half the population of Canada has any degree of voluntary insurance protection and this for medical services alone. Of these, the coverage held by nearly three million is wholly inadequate. Over 7.5 million Canadians had no medical insurance whatsoever." It should be noted that this refers only to medical and surgical care and does not take into account dental care, drugs, optical services, nursing, etc. The issue is that our present focus on payment for physicians' services (Medicare) ignores the concern of the Canadian people for coverage of the full range of health care services.

Because of the 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. As costs increase substantially, even the well-to-do who incur heavy health expenditures may find it desirable to have health services at zero cost at the time of service.

Another factor is that the free market system does not work in the health care field. Professor J. J. Madden at the Conference on Implications of a Health Charter for Canadians, November 28-December 1, 1965[2], pointed out several shortcomings of the free competitive market as applied to health services. One is the "unpredictability of illness for the individual." He does not know what his needs will be and what action to take. Secondly, he is not "qualified to choose the kind of health insurance that he needs." He does not know what to insure against and furthermore, he does not know whether his insurance will be adequate in later years. Thirdly, it is doubtful whether "there exists free consumer choice in the health insurance market at the present time." For example, participation in a health insurance plan may be a condition of employment. Fourthly, the consumer does not have any say in the limitation placed on entry into professional schools. Fifthly, "there are individuals in our society that are not free to choose the health services they need." These are the children and dependent teenagers of parents who are poor, in fact, all poor people.

THE ISSUE OF COMPULSION

This is an important issue in a democracy and gives concern to many people. We should recognize, however, that it is a part of a democratic process to make a collective decision for the common good in order to achieve a socially desirable goal. A people decide it is in the public interest to achieve an objective through the process of law.

We have decided that an industrial nation cannot do without compulsory education. The Health Charter for Canada, in which there is less compulsion than our educational system, takes into account that healthy people are a country's most important national resource.

In many areas Canadians have already decided to promote good health through the process of law. There are laws concerning sewage systems, pure water supply, pasteurization of milk, communicable diseases, tuberculosis sanitaria, cancer diagnostic and treatment clinics, mental illness, and the like.

Through the implementation of the National Hospital Insurance Program Canadians have demonstrated that a universal comprehensive program is feasible, practicable, economical to administer, and effective for the total population. This program has worked and would be difficult to find advocates suggesting discontinuance. It has created freedom--freer access to facilities and freedom from fear of financial consequences.

The core of the matter seems to be whether we want good health for all Canadians or whether we are prepared only to meet the crises of sickness and accidents. The Royal Commission on Health Services rightly states:

> *There is a fundamental difference between a health service oriented to the prevention and treatment of illness and a voluntary or commercial insurance plan organized to meet sickness and accident costs. In its own interest, a society must strive for the greater objective.*

A COMPREHENSIVE PROGRAM

By a comprehensive program is meant, according to the Hall Commission Report, the inclusion of "all health services, preventive, diagnostic, curative and rehabilitative, that modern medical and other sciences can provide." It should be noted that there are other pressing health problems in addition to those to which the Medical Care Act gave attention.

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[2] J. J. Madden, "Some aspects of the Economics of Health Services," *Health Services in Canada: Report of a Working Conference on the Implications of a Health Charter for Canadians*, November 28-December 1, 1965, pp. 72-85.

The Commission urged quick action in the field of mental illness. It recommended that retarded children and crippled children be given high priority. Programs for the aged and infirm are suggested. It pointed to the unsatisfactory dental health of the nation. It addressed itself to the burden of drug costs. It made far-reaching recommendations regarding trained personnel and research facilities. It had a considerable amount to say about improving service to the sparsely populated areas of the North. It made recommendations to increase the status of the doctor engaged in general practice. It examined the group practice method and explored the application of this to rural areas. Probably it is not generally known that of the more than 250 recommendations made by the Commission only ten were referred to medical services. By contrast, sixty-one recommendations made by the Commission only ten referred to medical services. By contrast, sixty-one recommendations deal with health research and the training of the health professions. Twenty-four recommendations relate to Prescription Drug Services. Twenty-one recommendations focus on health services in the North. Twelve to optical services.

An extreme urgency, in addition to trained personnel, is the lack of facilities and financial resources needed to support health research. This has a bearing on the number of professional schools we can have, the quality and size of the instructional staff in those schools, and the persons who will be attracted to the health service field. The quality of health services is related substantially to the amount of money we are prepared to spend on research. The lack of research money, it is claimed, is related to the so-called "brain-drain." In 1964 Dr. W. Stanley Hartroft, head of the research institute of the Hospital for Sick Children, Toronto, said that inadequate research support in Canada is causing a medical brain-drain to the United States equal to the annual graduation classes of three medical schools. He went to say that we are literally running medical schools for the United States, because of poor financial support for research.

Probably, too, the general public does not always realize that a whole host of people are involved in providing health services. There are the familiar figures such as the physician, the psychiatrist, and the nurse. But other professions and occupations are involved in prevention, treatment, and rehabilitation. There are the social workers, the physiotherapists, the psychologists, the dieticians, the architects, the chaplains, to name only a few.

THE PUBLIC INTEREST

The healing arts belong to the general public. In order to assure expert service, the people grant a monopoly to a profession. The State delegates responsibility through the statutes of legislatures and parliament. When it does grant a monopoly to an exclusive group to provide an indispensable service, it does not relinquish its involvement in whether the service is available and on what terms and conditions.

The public has a huge capital investment in hospitals, research centers, and in the universities which provide professional education. Public funds have developed physical facilities and many scientific discoveries, all of which greatly assist professional practice.

The public interest is involved in the economic costs to society through unemployment due to poor health and through unnecessary social welfare costs due to inadequate health care. It is said that the budgets of welfare services, public and private, are loaded with the price of unavailable and inadequate health care. It is also said that half of our present mental defectives would be normal if their mothers had had proper health care. It has been concretely demonstrated that the increase of facilities in ophthalmology under the National Health Service in Great Britain accompanied by a free system of medical care has in 15 years decreased in the incidence of blindness from cataract by some 25% and reductions for other causes of blindness were also noted. "No similar trends registering substantial declines in the incidence of blindness among the total population have been recorded for any other country."[3] This is another example of

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[3] Richard M. Titmuss, "The Welfare Complex in a Changing Society: Recent Developments in Britain," a paper presented to the Canadian Social Welfare Conference, Vancouver, B.C. June 22, 1966.

substantial economic savings in reduced demands for long-term care in hospitals, in institutions for the aged and the blind, and for community services, not to mention the prevention of human misery.

THE FINANCIAL COST AND OUR VALUES

In all the discussion concerning a comprehensive health care service the problem of financial costs is ever present. Perhaps it is within the concern of the church to ask what is our value system. It is not unfair to say that when principles have been discussed, the dollar sign has often been just around the corner.

If it is necessary to set some priorities in achieving the goals envisaged by the Hall Commission ReportRoyal Commission on Health Services, then we should spell out those goals and the timetable to achieve them. Any piecework approach will leave in doubt whether we desire adequate health care for all Canadians.

Reference is often made to education as a priority over against the extension of health care services. If the Gross National Product is our pervading interest, then education ought to be a priority. But if we see education as a means to help an individual to achieve his potential and a satisfying life, then health and education are twins. They go together to achieve human well-being.

If we are really sincere about our mutual well-being in terms of optimum health, but argue against a comprehensive health care programme because of cost, then we must assess our sense of values. A full range of health care services must be considered a social utility in the same way we regard services provided by public utilities. We have accepted the pooling of our resources through law to build super-highways for our expensive cars. We do not seem to be overly concerned that the maiming and killing on our highways is causing over-utilization of medical and hospital services. We do not seem overly concerned that the motorbike fad is over-utilizing hospital beds set aside for brain surgery. A nation that was spending more than $90.00 per capita on alcoholic beverages and tobacco in 1962 should be able to afford in 1971, as projected, $177.00 per capita for all hospital, medical and other health services, assuming the programs recommended get underway in 1971.

The Royal Commission puts its case this way:

> *Two things must be clearly appreciated: first, the only thing more expensive than good health care is inadequate or no health care; and second, the bulk of the expenditures to be made on health care will be made even if there are no programmes.*

A patchwork approach to planning for health care would seem to be poor business. A well-planned health care program would appear to be good business. Above all we would be applying good stewardship in the use of our resources for the good of our fellow-men. In the words of Dr. Bowlby, ". . . the foundations of good health can only be laid in a social and economic system which is fair to everyone."[4]

It is noted that the Medical Care Act permits the inclusion of services additional to those of a physician. By implication there is opportunity for the development of an integrated program of health services. Furthermore, it should be noted that we have a precedent in the Canada Assistance Plan whereby we have accepted the principle of an integrated approach to social assistance.

Much will depend upon the initiative of the provinces in making possible the provision of health care services. But a financing mechanism by the Federal Government does not ensure standards of service, meaning not only the skills of the health professionals but also the kinds of services needed. Nor does it ensure the availability of good services from the point of view of distribution and facilities.

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[4] John Bowlby, *Child Care and the Growth of Love*, a Pelican Book, 1953. p. 105.