The English Speaking Catholic Council

Le conseil catholique d'expression anglaise

ESCC Brief to the Romanow Royal Commission on the Future of Health Care in Canada

Introduction:

The English Speaking Catholic Council welcomes the opportunity to present its perspective and its recommendations to the Commission on the Future of Health Care in Canada.

We bring to the task great respect for the efforts of Mr. Romanow and his team and a firm conviction that the Commissioner is correct when he writes in his Interim Report that "the Medicare house needs remodeling but not demolishing."

The English Speaking Catholic Council was formed in 1980 as a focal point for coordinating community activities among English-speaking Roman Catholics in Montreal and later across all Quebec.

In keeping with the mission of the Church and with its teachings on the role of the laity in the modern world, the English Speaking Catholic Council acts in the educational, health and social services, social justice and cultural realms to develop a sense of community identity and common purpose, to encourage development of leadership in the community, to assist in coordinating human resources in community-based

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institutions and to ensure effective representation before government bodies and on various boards, committees and councils.

Nearly a quarter of a million strong, the members of our community are an active element in Quebec's English-speaking minority community. Through the English Speaking Catholic Council, our community's voice has been accepted as an important and credible one by local, provincial and federal governments on a range of issues.

As a community-based organization, as a Catholic organization**,** and as the representative of an important minority community, health care issues have been perennial concerns for us. Over the past century through our community developed institutions such as youth agencies, seniors**'** residences/long term care homes, home care programs and hospitals, we have gained a clear and practical vision of the needs and expectations of our community. Our approach to health care issues is always patient-centred and we would invite the Commission to consider a similar basic orientation for its own work.

Values:

The early history of health care in Quebec and in Canada is intimately linked with churches and church communities. Hospitals and other health care institutions were a

natural expression of Christian values. These church-based health care institutions have been integrated into a fully secular network of universal health care. But the values that inspired their creation remain strong in the Catholic community.

We welcome the Commission's focus on values as the foundation for the future of health care in Canada. We believe that strong values are necessary for the defense of progressive and effective social policy.

As Roman Catholics we view health care that is universal and accessible as an expression of our commitment to the dignity of the person, of our compassion for the sick and the dying, of our desire to give hope to those who suffer and of our search for justice for all people.

Our commitment to these values is the basis for our unwavering commitment to Canada's Medicare system and to the five principles on which it has been constructed. Like the majority of citizens in this country, the English Speaking Catholic Council sees universal, comprehensive, accessible, portable and publicly administered health care as a vital component of who we are as Canadians. And like many Canadians, we see also the need for these principles to be reinforced and updated.

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The enormous institutional networks that we have developed to provide health care to Canadians often fail to live up to the high principles of the Canada Health Act when individual Canadians or specific communities within Canada seek services from the health care system. When universal principles meet the reality of the diverse mosaic of Canadian society, our health care network is often found wanting.

Our experience as Quebecers and as members of an official language minority community leads us to a number of conclusions about how we must “remodel” Medicare to avoid “demolishing” it. The challenge for Canadians, we believe, is to bring the reality of our health care systems closer to the promise of our health care principles. To accomplish this, we would recommend to the Commission that any reforms to the Health Act and to the Canadian health care system include explicit recognition that all our efforts in this field must be patient-centred. The individual patient and his or her family must come first and the success of any reform can only be determined by its evidence-based impact on those who need care. All other professional and political considerations must take a back seat to this fundamental requirement.

Leadership is required to bring about consensus among Canada’s first ministers on how the principles of Medicare are to be interpreted. Right now there is too much room for political influencing, creating tension and apprehension about the future among health care providers and also among the citizens who depend on them.

Principles for the Future:

In Canada we are already living the future of health care. The most basic challenge for policy and law-makers is to catch up with the new ideas and best practices that are already benefiting Canadians.

Canada's Health Act and the five foundational principles of Medicare were adopted at a time when "health care" was synonymous with what doctors did to treat sick people in hospitals.

Medicine has developed in amazing directions since the 1960's. The role of physicians and of hospitals in the health care network has also evolved. Health care is now as much about wellness as sickness. The "physician" recognized in the original Health Act as the primary health care provider has become the health care team. And the hospital, while remaining a cornerstone of the health care network, is now at the centre of a growing network of clinics, long-term care facilities and community and home-based health care services.

The relationship between health care providers and health care recipients has changed profoundly as well. In an era of informed choice enhanced by new information technologies and services, the patient and his or her family has become a full partner in the medical decision-making process. This creates new challenges for health care

professionals and unprecedented intellectual and ethical responsibilities for health care recipients.

Therefore, we would recommend to the Commission that serious attention be given to developing an updated interpretation of the Canada Health Act principle of "comprehensiveness".

The legal requirement that "all medically necessary services provided by hospitals and doctors must be insured" has become too narrow to encompass the health care system of 2002 and of the future.

Most obviously, the wording of this important principle misses community-based health care centres like the network of local community health centres (known by their French language acronym as CLSCs) in Quebec, home-care programs that are increasingly in use, and pharmacare.

In Quebec we have lived through a number of reforms designed to emphasize primary and preventive care and to move services as close to people in communities as possible. We have also seen the development of the beginnings of effective home-care services and we have gone through an experiment in implementing pharmacare.

These changes and innovations have not been without problems**.** Nevertheless, the experience of our community with these new approaches to health care has been

generally positive and we would encourage governments and local health authorities to learn from best practices and continue to push in these directions.

The evolution of modern health care forces us to address our definition of what constitutes comprehensiveness in more subtle ways as well. For example, our ability to prolong life brings with it new challenges to create quality of life and hope for those who benefit from new therapies and technologies. Allied with that is a trend to de-institutionalize care so that family and friends are routinely called upon to provide direct support to patients living with challenging medical conditions in home care settings. As well, “lay people” are increasingly confronted with huge ethical and moral choices in the face of genetic testing and other advanced diagnostic and therapeutic technologies.

In visioning the future and developing a modern definition of “comprehensiveness”, the Commission must recognize what we would call the spiritual dimension to health care provision. We believe the Commission should encourage traditional pastoral ministry services but we also call for the extension of this kind of moral and spiritual support beyond the walls of hospitals into the new community and home-based care environment. This spiritual support is as important for care-givers as it is for patients. The development of appropriate spiritual support services and psychological counseling would also go a long way to meeting the challenge of ensuring that our health care system is culturally sensitive to an increasingly diverse Canadian population.

Our recommendation that an updated definition of “comprehensiveness” be developed also arises from the demographic realities of our community. Quebec’s English-speaking population is one of the oldest, on average, in Canada. We are living now what Canadian society in general will face in fifteen to twenty years with its aging population. We are already dependent on a range of services including many community and home-based services for chronic medical conditions. Our experience convinces us that these services must be formally recognized as essential elements of comprehensive medical care

Similarly, we believe that the Canada Health Act principle of “accessibility” needs attention after three decades of experience in the provision of universal, public health care.

As English-speaking Quebecers, we are proud of how our society has dealt democratically and constructively with the potentially explosive Canadian issue of linguistic duality. We are also proud of how our community has organized and represented itself through organizations like the English Speaking Catholic Council on a variety of critically important community issues. We believe that as Quebecers we have developed insights and expertise on a range of language-related issues and have learned how to resolve tensions that can arise in a multi-lingual and multi-ethnic society.

The fifth principle of the Canada Health Act states that “reasonable access by insured persons to medically necessary hospital and physician services must be unimpeded by financial and other barriers.” Our concerns about the restrictive wording recognizing only hospital and physician services outlined above also apply here. However, the experiences of many members of our community trying to access services in predominantly French-speaking institutions have also convinced us that language must be seen as an important barrier to service for many Canadians.

In Quebec, finding the health care services that you need in English can be a challenge. Depending on where you live and on what services you need, the challenge can be very great.

This reality has implications that go far beyond the “frustration factor” that it creates – it affects health outcomes negatively. A recent comprehensive review of research into language barriers in access to health care prepared for Health Canada concludes that “there is compelling evidence that language barriers have an adverse effect on initial access to health services. These barriers are not limited to encounters with physicians and hospital care. Patients face significant barriers to health promotion/prevention programs: there is also evidence that they face significant barriers to first contact with a variety of providers.” (from *Language Barriers in Access to Health Care* by Sarah Bowen, Health Canada, http://www.hc-sc.gc.ca/hppb/healthcare/equity/pdf/barriers.pdf)

The report also suggests that language barriers can raise diagnostic and treatment costs, reduce quality of care, and create problems in guarding patient confidentiality and securing informed consent. To repeat, language barriers affect health outcomes negatively and these barriers exist in Canada. They cause insecurity and uncertainty among individuals within our own community and can lead to inappropriate or inadequate care.

The English Speaking Catholic Council can point approvingly to a number of steps that have been taken in Quebec to develop legal and administrative systems to ensure access to English language services in the health care system. These laudable efforts have also recognized that there is a precious link between minority communities and their institutions that must be preserved. We applaud these efforts, noting that they represent decades of hard work, activism and good will between minority and majority communities and leaders. But we also recognize that minority language protections are, by their nature, fragile and in constant need of enhancement and reinforcement. For that reason, we encourage the Commission to address seriously the issue of language as a potential barrier to accessibility.

On the challenge of creating a more effective definition of “accessibility”, we would also invite the Commission to recognize that timeliness has become a critical factor in Canadians’ evaluation of the effectiveness of Medicare. We understand that “waiting lists” are a complex phenomenon in the Canadian health care system, but for patients in

need, timely access to care is fundamentally important. The level of public support for "single-tier" public health care is tied inextricably to this aspect of accessibility.

Other Considerations:

In addition to these specific recommendations, the English Catholic Council adds its voice to the call for the de-politicization of the issue of health care funding. We recognize the difficulties inherent in managing a shared jurisdiction like health in a federal system. However, we also believe that agreements and mechanisms can be developed that bring greater stability to health care funding, accountability built on outcomes-based performance indicators, as well as genuine, hassle-free portability across provincial and territorial boundaries. We encourage the Commission to challenge our leaders to put these agreements and mechanisms in place. We also support all efforts aimed at encouraging more dialogue and sharing of information among governments, especially information concerning best practices for effective and efficient health care delivery.

As a volunteer-led organization, we are sensitive to the importance of volunteerism and philanthropy in the provision of the highest quality care for Canadians. This essential element in the system must be formally recognized by the Commission and the instinct of Canadians to give of themselves, in time and in money, must be encouraged. We

recommend that the Government of Canada undertake a review of policies that would recognize the contribution of volunteers in health care, including enhanced tax credits for home care providers and tax-based incentives to encourage employers to give charitable support to patient-oriented, community-based health care initiatives. In making this recommendation, we recognize the concerns of organized labor that increased volunteerism not become simply a source of cheap or unskilled manpower.

Our respect for health care professionals in Canada is very great. We worry, however, that their contribution may not be valued highly enough and we are convinced that we face an ongoing challenge recruiting the brightest young people for training and retaining the most capable professionals. We believe that the working conditions of our nurses, physicians and other health professionals and support staff have become very difficult. We also see the impact of strong inter-regional and international competition for their talents. The Commission must emphasize the respect and gratitude that Canadian citizens feel toward our nurses, doctors, and other health professionals. The Commission must challenge our leaders to work with Canada's health care providers to develop workplaces that are professionally satisfying.

And finally, we recognize that a commitment to a modernized version of the Five Principles of the Canada Health Act may not be cost neutral. We believe that attention to best practices in the development of community-based primary care and better home-care as well as language access guarantees modeled on Quebec's "access

plans" will allow us to enhance health care in Canada without breaking the national health care budget. But a commitment to comprehensive home-care or pharmacare may indeed require us to put the question of how we will pay for such services before Canadians.

We cannot predict where such a discussion will lead us. We will insist however that this kind of debate recognize that a healthy population is the responsibility of all sectors, not only the "health care system". The issue of health touches many fields of public endeavor, particularly education. And all elements of both the public and private sectors have an important stake in developing and maintaining a healthy citizenry and workforce.

We also expect that any debate on how much we will invest as a society in health care will be conducted in the light of the fundamental values that make our health care system and our nation strong.

The dignity of each person, compassion for all, the need for hope in the life of each individual, and the demands of fundamental justice – these must remain our guides in the discussions and decisions that await us.

Thank you for this opportunity to share our concerns and to present our recommendations. We wish the Commission great success in moving Canadians forward to fresh and effective approaches to health care provision for this new century.

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Medicare needs our attention and our best energies. Let's work hard to ensure that the health care system we build for all Canadians is the health care system that we would want for ourselves and for our loved ones in a time of need.

Recommendations:

The English Speaking Catholic Council affirms the five principles of the Canada Health Act as a necessary basis for single-tier, universal access health care for Canadians. From within that framework, the Council presents the following recommendations:

1) The Canada Health Act and Canada's health care systems must make the patient the explicit focus of all their attention. Patient-centered care should be the fundamental goal of our efforts.
2) The Canada Health Act principle of "comprehensiveness" must be updated and expanded to reach beyond "physicians and hospitals" to include the range of professionals and the community and home-based services that characterize the new reality of necessary health care.
3) The English Speaking Catholic Council also recommends that a new definition of "comprehensiveness" include recognition of culturally sensitive spiritual support as an integral element of effective health care.

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4) The Canada Health Act's definition of the principle of "accessibility" must recognize that language can be a formidable barrier to quality health care. This is of particular concern to (though not limited to) official language minority communities.
5) Canadian governments must enhance recognition for volunteers and for charitable contributors and philanthropists who support our health care system. This recognition should take many forms – including enhanced tax credits – that reflect best practices in Canadian and other jurisdictions.
6) The issue of health care funding in Canada must be de-politicized to the extent possible by developing agreements and management mechanisms that guarantee stable funding and encourage outcomes-based accountability.
7) The appreciation and respect that Canadians feel for health care providers must be reflected in their remuneration and their working conditions as negotiated and provided by governments and by regional health planners.

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