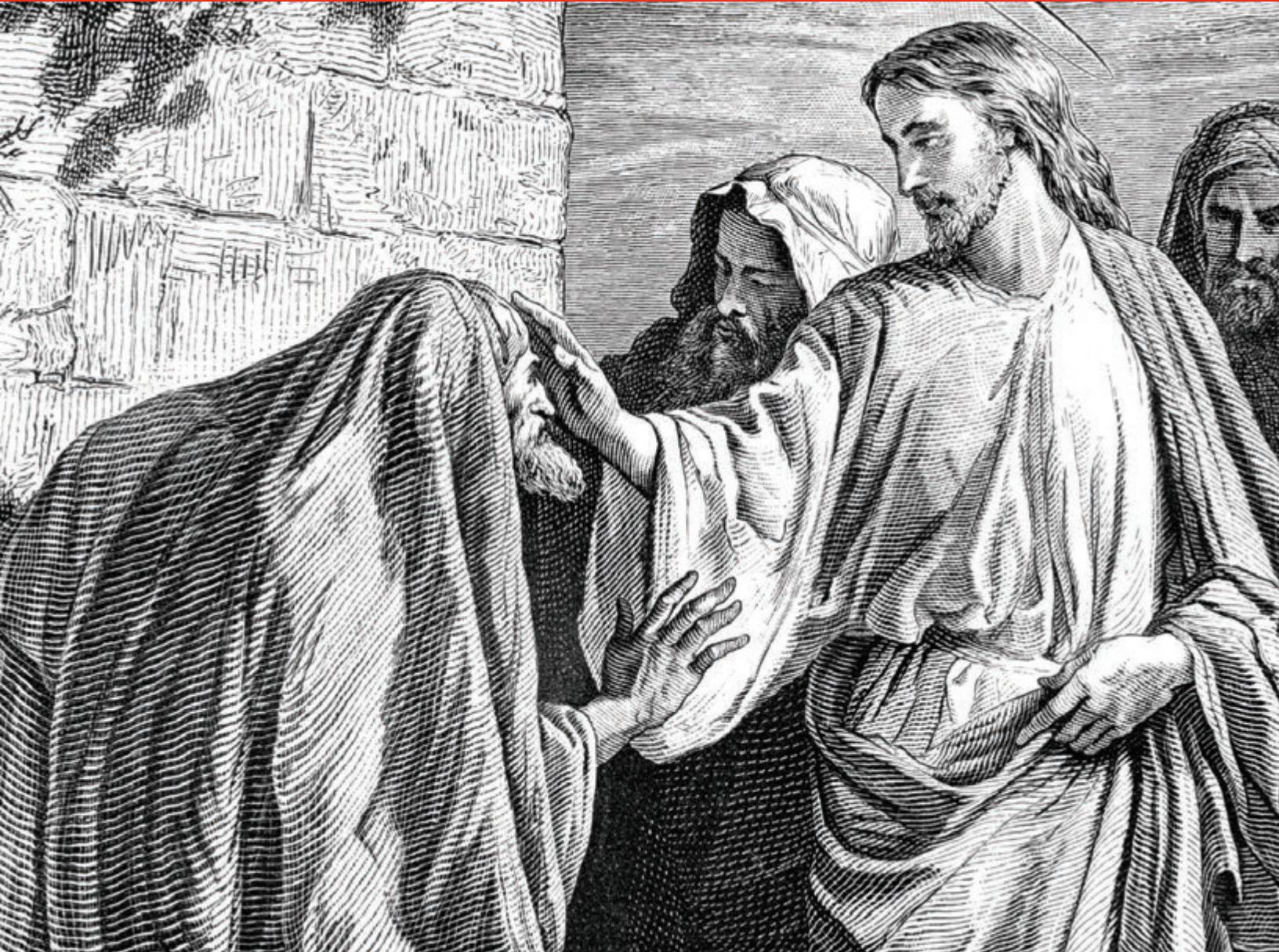


Charter and Covenant:

The Churches and the Struggle for Public Health Care in Canada



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Charter and Covenant: The Churches and the Struggle for Public Health Care in Canada

by Joe Gunn

Churches have been involved in the provision of health care services in Canada since the mid 17th century. In terms of health care institutions, the Augustines Hospitalières founded the *Hôtel-Dieu de Québec* in 1639. Many other religious groups comprised especially of religious women and Christian laypersons have been in the forefront of every effort against disease that this country has known.

What explains such active involvement in health care? The main reason for this commitment of Christians was their desire to respond to the massive need for health care services that was so painfully obvious in Canadian society since the first Europeans arrived. In the early years of European settlement in Canada, as in Europe religious orders were the primary deliverers of health care services. By the end of the 19th century, both the Methodist and Presbyterian churches had operated hospitals, often as part of their medical missionary work in isolated communities. The Lutheran church began a tradition of caring for the elderly with the founding, in 1926, of St. Paul's Home in Melville, Saskatchewan. Until well into the 20th century, societies did not demand that the state play a preponderant role in the delivery of health care services, often leaving that role to charitable, and especially religious, organizations.

The history of Christianity is a record of service to the sick and commitment to health.¹ In the time of Constantine (4th century), Aesculpapia was a temple and a refuge for the sick. In 660 A.D., Bishop Landry founded the *Hôtel-Dieu* in Paris. During the Crusades, hospitals were founded in Palestine as well as in London.²

The churches recognized that, "If one member suffers, all suffer together with it; if one member is honoured, all rejoice together with it."³ From their reading of biblical texts, Christians recounted the many stories of Jesus' healing ministry.⁴ The purpose of the Christian life was to imitate this Jesus who "went about doing good and curing all."⁵ And so the churches attempted this same ministry, which included *both* these aspects of healing. Therefore, churches became providers of health services as well as social justice advocates who attempted to influence policies to improve health care. The churches saw human beings as images of a God of life who desired healing and health of not only the body, but also of the mind and soul. As we shall see, this was described by all of the churches as "holistic" ministry, the realization that, "Your faith has made you whole."⁶

1 Canadian Conference of Catholic Bishops (CCCCB), A pastoral message on sickness and healing, "*New Hope in Christ*," September 1, 1983, p. 17.

2 Division of Church and Society of the Evangelical Lutheran Church in Canada, "A Study Paper on Canada's Health Care System: Our Responsibility, Our Challenge," Winnipeg, 1988, pp. 3 - 4.

3 1 Cor. 12: 36.

4 Matthew 8: 16 - 17; John 9: 1 - 3; Matthew 25: 36; John 10: 10.

5 Acts 10: 38.

6 Mark 10: 52.

How the churches intervened in the development of Canada's public health system over the last half-century is the focus of this short paper. It is a fascinating part of the social history of our country. It is also a tribute to the development of ecumenism in action in Canada, where joint efforts were often far more efficacious than the sum of their individual efforts could hope to be. Beyond interesting reading in itself, however, this account is also filled with valuable lessons for the future comportment of these very churches as they struggle to face the challenges of the years ahead.

The Debate Over Hospital Insurance – 1940s

In the 1940s, Canada was swept up in the war effort. This country of only twelve million people mobilized to put a million young people in uniform. Some 55,000 soldiers lost their lives in the conflict, and tens of thousands returned home wounded. Obviously, the hospital system underwent substantial stress in its attempt to meet such increased demand. But the war years, following as closely as they did on the ravages of the Great Depression, also created a powerful societal impetus for the involvement of government in new areas of public life. As a result, in 1942, Prime Minister Mackenzie King established a committee to study the possibility of a national health insurance plan.

As hospital operators, many Christian communities were very concerned with the possible implications of the government's intentions. Since at this time Catholic religious sisters were responsible for 34 per cent of all hospital beds and 42 per cent of nursing schools in Canada, they were particularly wary. As described in the official history of the Catholic bishops, the very first meeting of what was to become the permanent organization of the Canadian Catholic episcopate, held in Quebec in 1943, took up with some substantial urgency the question of Catholic hospitals and healthcare.⁷

Noting that the religious orders had already established (in 1942) a "health insurance committee" to prepare for the expected public debate, the bishops named four of their members to a study committee. These men were assigned the task of preparing guidelines for the religious orders that were involved in the discussions of this question through the Catholic Hospital Council of Canada (CHCC).⁸ Indeed, with rumours flying in September 1941 of an impending government intervention in hospital administration and financing, the Canadian Advisory Board of the Catholic Hospital Association of the U. S. and Canada, meeting in Montreal, had already "condemned in the strongest terms any scheme of socialized medicine."⁹

Little wonder then, that when the bishops' committee issued its guidelines to the CHCC in January of 1944, the document explicitly stated, "*State Medicine, which implies ownership and operation of all Hospitals, is condemned. State Health Insurance, while not approved, is tolerated, because of the proximity of its introduction by the present Government, and because of the impracticability of opposing it at this stage....*"¹⁰

The result of these internal discernment processes was major organizational change and development. In 1943 the CHCC became a truly Canadian organization (whereas since 1916 Canadian religious orders had participated in the larger U.S. organization.) With this move that same year, the government permitted the newly independent CHCC to name a representative to its Health Insurance Advisory Committee, which was

7 Bernard Daly, *Remembering for Tomorrow: A History of the Canadian Conference of Catholic Bishops, 1943 – 1993*, CONCACAN, Ottawa, 1995, pg. 22.

8 The Catholic Hospital Council of Canada was the precursor of today's Catholic Health Association of Canada (CHAC). Although less directly involved today in the CHAC's affairs, the bishops still name one of their members to the organization's board and receive an annual written and verbal report at their Plenary Assembly.

9 André Cellard and Gérald Pelletier, *Faithful to a Mission: Fifty Years with the Catholic Health Association of Canada*, English translation by David Miller; Catholic Health Association of Canada, Ottawa, 1990, pg. 38.

10 Ibid, pg. 42.

looking into health insurance. With the release of the Advocacy Committee report, however, the government (after failing to achieve agreement with the provinces) “unceremoniously shelved” its proposal in 1946.¹¹

The reasons for the initial and vociferous opposition by Catholic health care providers to government proposals for hospital insurance are better understood in the context of that time, suggests the official history of the Catholic Health Association of Canada:

“While the Church remained keen to preserve its image as a defender of the poor and the sick, a function it had performed since the Middle Ages, it viewed this proposal as an implicit challenge by the state to one of its fundamental roles and an encroachment on an area of responsibility that had long been its exclusive preserve. Furthermore, the Church was prone to see the spectre of socialism lurking behind such interventionist policies and it viewed a takeover by the state of responsibility for the care of the needy as an infringement of the principle of individual freedom. In short, the Church was intent on defending its traditional status in a country in the throes of a veritable revolution of social policy.”¹²

Nonetheless, “despite the official position taken by the (Roman Catholic) Church on this question, a substantial number of Catholic hospitals remained supportive of the concept of a health insurance program.”¹³ This was because the proposal entailed both risks as well as advantages for private hospitals. A 1942 letter from Bishop Rosario Brodeur (eventually to become chair of the Episcopal Commission on Hospitals), to Mother Berthe Dorais SGM, chair of the CHCC, summed up the dilemma. On the negative side, state intervention could be seen to pose a genuine threat to the independent administration of Catholic hospitals, the bishop wrote. In effect, the state might ultimately permit practices judged contrary to Catholic morals. On the other hand, the implementation of such a health insurance program would “unquestionably benefit the downtrodden of society,” while at the same time provide valuable financial assistance to Catholic hospitals.¹⁴

Debate about public medical and hospital insurance was not new in Canada. Saskatchewan had introduced legislation in 1916 allowing rural municipalities to offer financial retainers to doctors, in order to attract them to isolated communities. A parliamentary committee discussed medical insurance in 1928. And even the Canadian Medical Association had supported public health insurance during the 1930s - those years of the Depression when such public interventions were seen as a way to guarantee payments to physicians when their impoverished patients had no resources.

By the mid-1950s, the federal government had discussed possible programs with the provinces, and carried out consultations with some interested groups. Saskatchewan brought in hospital insurance on January 1, 1947. This led to the April 1957 (unanimous) passing of the Hospital Insurance and Diagnostic Services Act, which came into effect on July 1, 1958. In return for grants of one-half of their per capita hospital spending, the provinces were to make sure that quality standards were established and met, as well as made universally available. At this time, private hospitals accounted for 75 per cent of all hospital beds in Canada.¹⁵

Catholic hospitals were more or less resigned to the fact that such plans would be forthcoming, and most devoted themselves to improve those aspects of the legislation that needed correction. A 1957 motion passed

11 Ibid, pg. 42.

12 Ibid, pg. 38.

13 Ibid, pg. 39.

14 Ibid, pp. 39 – 40.

15 Brief of the Canadian Hospital Association, June 1958, as quoted in Cellard and Pelletier, *op. cit.*, pg. 84.

at the CHAC Convention actually commended the government for its plan.¹⁶ However, some representatives of Catholic hospitals, including a prominent Conservative Saskatoon lawyer by the name of Emmett Hall, were described as “staunch opponents”, and “dead set against” the federal plan.¹⁷ Their discontent focussed on the seven items excluded from federal coverage, especially building depreciation costs and interest payments on construction loans. It was argued that such arrangements would threaten the future financial existence of private (including religious) hospitals. Here was a foreshadowing of some of the debates that would eventually lead to strong support among Christians for the adoption of Medicare in Canada.

The Struggle for Medicare

Canadians of previous generations still recall the days before Medicare was introduced when many distressing situations transpired whenever serious illness struck their families. Such accounts chronicle the costs of care for services like childbirth, stories of how operations at religious hospitals were delayed until legal papers were signed to secure the pending debt, and even accounts of suicides attempted when payments could not be made.¹⁸ By the 1960s, after more than 35 years of endeavour on the part of the voluntary plans and commercial insurance companies, only slightly more than one-half of the population of Canada had any degree of voluntary insurance protection, and this was for medical services alone. Of these, the coverage held by nearly three million people was wholly inadequate. Over 7.5 million Canadians (of a total of 18 million) had no medical insurance whatsoever.¹⁹

Some of the churches had begun to attempt to influence the federal government to move to correct this situation of grave structural injustice. By 1952 and again in 1954, for example, the General Council of the United Church called for the establishment of a “National Health Insurance Program.” In the following year, the Anglican Church’s General Synod urged the federal government to “consider ways and means of providing comprehensive health care for all Canadians.” (See Table #1 for a chronology of the development of policy in several of the churches.)

Events moved quickly after Prime Minister John Diefenbaker rose in the House of Commons before Christmas, 1960 to announce his intention to name a Royal Commission into a national health plan. Unaccustomed to being in opposition, the Liberals moved to the left by endorsing public health insurance less than a month after the Prime Minister’s announcement. They may have been hearing footsteps, as the charismatic CCF premier of Saskatchewan, T. C. Douglas, was rumoured to have been contemplating a move to Ottawa to lead the new NDP. Douglas had just won a provincial election based on his promise of the introduction of Medicare in that province (a province with the highest per capita debt in the country!)²⁰ In that election the Liberals under Ross Thatcher had joined the province’s doctors and the Chamber of Commerce to oppose the CCF – and Medicare. After the CCF health insurance plan took effect in Saskatchewan in 1962, a contentious Doctors’ Strike took place for 23 days.

Douglas, a Baptist minister in Weyburn, Saskatchewan before he entered politics, once said: “You’re never going to step out of the front door into the kingdom of God. What you’re going to do is slowly and painfully

16 Cellard and Pelletier, *Ibid.*, pg. 83.

17 *Ibid.*, pp. 82 – 83.

18 Lois L. Ross, “Passion and Persistence, Cooperation and Commitment: The Roots of Public Health Care in Canada, in *The Global Right to Health: The Canadian Development Report 2007*, North-South Institute, Ottawa, 2006, pp. 5-6

19 The Royal Commission on Health Services in Canada, as quoted in the Lutheran Church in America – Canada Section, “A Study Paper on a Health Charter for Canada: A Concern for the Church”, Winnipeg, Sept. 1967, pg. 4.

20 Lois Ross, *op. cit.*, pg.11

change society until it has more of the values that emanate from the teachings of Jesus or from the other great religious leaders.”²¹ Douglas was, and remains for many Canadians, the epitome of the Social Gospel tradition. The first leader of a social democratic government in North America once described the relationship of his faith and politics in the following way: “How do you talk to a man about saving his soul if he’s got a toothache? Or worse, if he’s got a child that needs medical care and can’t get it? Or the landlord’s going to put him out of the house because he hasn’t got any money to pay the rent? Are you going to be able to get him concerned about his soul? Sure, you have to be concerned about people...Jesus was...Christian religion and democratic socialism were part of the same thing...that you were out to build a New Jerusalem.”²²

Sensitive to the polls showing that a majority of Canadians favoured the introduction of a national health scheme, Diefenbaker called a law school classmate, Emmett Hall, and offered him the job as commission chair, citing his colleague’s experience on the St. Paul’s Hospital Board and the CHAC.²³ Hall’s brother, a priest, has suggested that although Hall had a “secret horror” of using religion to justify political goals, his faith was always there in the background, in a subtle way.²⁴ Hall’s biographer found it instructive to compare Hall’s approach to what theologian Gregory Baum calls Social Catholicism; that is to say, a Catholic social teaching resembling the old British “Tory” social philosophy, which defended private property (and opposed socialism), but supported unionization of labour (hence opposing economic liberalism.) It saw the task of government to stand above the conflict of the classes, promote the common good of society (best seen as an “organic” body) and to protect the poor from exploitation by the rich.²⁵

In May of 1962 the United Church of Canada presented an impressive 60 page brief to the Royal Commission on Health Services in Ottawa. The membership of the committee that prepared the document was comprised of 31 individuals from various walks of life, and eight pastors were named as chairmen of regional committees that were involved in the deliberations. Examples of health dilemmas specific to various realities across the country were described, such as situations in the medical missions to Indians (which included hospital services), as well as care in homes for the aged or to new immigrants to Canada. No other church undertook such an in-depth process, nor developed such a detailed brief to the Royal Commission. Obviously, for the four million members of the United Church, this issue had become a serious priority.

The major recommendations of the United Church included the call for an “integrated and comprehensive contributory National Health Insurance Program.”²⁶ But the Church also stated, “we firmly believe that it is the most immediate and pressing duty of our society to meet more adequately the needs of our citizens who, by reasons of isolation, low income or age, are receiving sub-standard medical care.” The Church’s brief also considered the problems of alcoholism, the need to train chaplains, and the health education of the public (including in the contentious area of family planning, where the brief welcomed “voluntary parenthood” as the view reinforced by the Anglican Church in the Lambeth Conference of 1958.)²⁷

19 The Royal Commission on Health Services in Canada, as quoted in the Lutheran Church in America – Canada Section, “A Study Paper on a Health Charter for Canada: A Concern for the Church”, Winnipeg, Sept. 1967, pg. 4.

20 Lois Ross, *op. cit.*, pg.11

21 <http://www.canadianchristianity.com/cgi-bin/na.cgi?nationalupdates/041201cbc>

22 CBC Archives, “From minister to MP: T.C. Douglas enters the political fray,” Interview aired October 18, 1974. http://archives.cbc.ca/IDC-1-73-851-4956/politics_economy/tommy_douglas/clip2

23 Dennis Gruending, *Emmett Hall: Establishment Radical*, Fitzhenry & Whiteside, Markham, 2005, pp. 96 – 99.

24 *Ibid.*, pg 76.

25 *Ibid.*, pp. 73 – 74. See also Gregory Baum, The Shift in Catholic Social Teaching, in Gregory Baum and Duncan Cameron, eds., *Ethics and Economics: Canada’s Catholic Bishops on the Economic Crisis*, James Lorimer, Toronto, 1984, pg. 22.

26 United Church of Canada, Brief to the Royal Commission on Health Services, May 1962, pg. 1.

27 *Ibid.*, pp. 20 – 21.

The Catholic Hospital Association also presented a brief, which “implored the government to safeguard the financial survival of Catholic hospitals so they could maintain, without fear of going under, high quality hospital care and professional training.” The brief noted that almost half of the nursing schools in Canada were owned and operated by communities of hospital sisters.²⁸

In 1963, the 89th General Assembly of the Presbyterian Church in Canada adopted a report of the Board of Evangelism and Social Action dealing with health care. The report stated:

“...all people have been created in the image and likeness of God and are of infinite value in His sight. Every person, therefore, deserves to be treated with dignity and respect and is entitled to a decent standard of living and adequate medical care. When a national health service is provided for all people indiscriminately, the dignity of each is enhanced and the possibility of some being branded as second class citizens is eliminated.”²⁹

The 900-page report of the Commission was released in June 1964, proposing essentially the Saskatchewan model of a universal, compulsory, tax-financed health insurance program on a national scale. However, Hall called for a wider range of health services to be provided: a prescription drug plan, free dental care for children, expectant mothers and those on welfare, eye care and eye glasses for children, fluoridation of all community water systems, organized care for physically and mentally handicapped children, hospital insurance for mental and TB patients, improved service in remote areas and new medical and dental schools at universities. In the report, Hall made reference to Pope John XXIII, in recommending action based on “social principles and the co-operation and participation of society as a whole,” which was what the pope had called for in his last encyclical.³⁰ But the report’s main intentions could be summarized best in the two-page “Health Charter for Canadians.”

The physician lobby and the insurance industry led the criticism of the report. The Canadian Medical Association decried Hall’s proposals as “heavy-handed” and “monopolistic.”³¹ After all, four million Canadians at the time were enrolled in some 11 doctor-sponsored insurance plans, so these groups had a lot to lose. “Next you’ll be proposing grocery care,” scoffed Alberta’s Premier Ernest Manning at a federal-provincial meeting.³² A Lutheran study guide would have none of this prevarication. “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.”³³

Prime Minister Lester B. Pearson had delayed Medicare legislation until after the November 1965 election when he hoped to achieve an elusive majority government. When that didn’t occur and Finance Minister Walter Gordon resigned, his replacement Mitchell Sharp believed the country could not afford Medicare. Pearson’s chief advisor Tom Kent remembered, “The government was dispirited...whether Medicare would be implemented and when was thrown into doubt. At that point a public expression of desire for it was needed.”³⁴ Into this breach stepped the first interfaith sortie of the churches into the health care debate.

28 Cellard and Pelletier, *op. cit.*, pp. 103 – 105.

29 Presbyterian Church in Canada, Acts and Proceedings, *89th General Assembly*, pg. 316.

30 Dennis Gruending, *op. cit.*, pp. 111 – 112.

31 Fr. Bill Ryan SJ, author’s notes from a meeting of the Ecumenical Health Care Network, Ottawa, May 29, 2002.

32 Bob Chodos and Jamie Swift, *Faith and Freedom: The Life and Times of Bill Ryan SJ*, Novalis, Ottawa, 2002, pg. 76.

33 The Lutheran Church in America – Canada Section, “A Study Paper on a Health Charter for Canada: A Concern for the Church”, Winnipeg, Sept. 1967, pg. 8.

34 Ibid.

Health Services in Canada: the Implications of a Health Charter for Canadians

Some 250 people came to Ottawa for three days in late November 1965 to discuss the Health Charter that Hall had proposed, as well as the Commission's other recommendations. The Conference Chair was Claude Ryan, a highly respected and influential former editor of *Le Devoir* who had held several cabinet posts in the Quebec government (Liberal), and Emmett Hall was the main speaker. Although the Château Laurier Conference originated among the labour and cooperative movements, almost half of the 21 co-sponsoring groups were churches, including the Anglican Church, the Baptist Federation, the Canadian Catholic Conference, the Canadian Jewish Congress, the Canadian Lutheran Council, Churches of Christ, the Presbyterian Church in Canada, the Salvation Army and the United Church.

Fr. Bill Ryan has recounted that his good relationships with the labour movement initiated the request for intense church participation in the Conference. After contacting Ted Scott in the Anglican Church in Toronto, several other church staff persons quickly assumed the tasks necessary for the success of the Conference. Ryan described a time of “easy” ecumenical co-operation that was “real,” where church staff developed friendships and trust in each other that allowed future projects to proceed.³⁵ The full Steering Committee met four times before the Conference and an Ottawa-based Executive Committee implemented its decisions.³⁶ Unfortunately, besides the preparation of the Conference report, no further activities were undertaken as a group. Bill Ryan attributed this to the fact that energy flowed to other pressing events, and that political developments, international gatherings and new societal dilemmas later became the focus of many of the church staffs' attention.³⁷

Among the Conference highlights was a presentation by economics Professor J. J. Madden, who pointed out several shortcomings of the free competitive market applied to health services. One is the “unpredictability of illness for the individual.” He (sic) 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 include the children and dependent teenagers of parents who are poor, in fact, all poor people.³⁸

Perhaps the most impressive presentation, according to Father Ryan, was made by M. l'Abbé Jean-Marie Lafontaine, who reflected on the philosophical underpinnings of Hall's Charter, which was the moral argument for health care for all. “An economy of affluence cannot remain the privilege of one part of mankind (sic) without ceasing to be authentically human. Far from satisfying the human being it would degrade him. Such is the most important “challenge” to which the human search for satisfaction seems to lead today,” he argued.³⁹ It was clear that the churches saw the necessity for support for universal health coverage in Canada, and were supportive of Hall's conclusion that private insurance could never deliver that guarantee.

35 Author's notes from a meeting of the Ecumenical Health Care Network with Bill Ryan SJ, Ottawa, May 29, 2002.

36 “About the Conference...,” *Health Services in Canada: Report of a Working Conference on the Implications of a Health Charter for Canadians*, November 28 - December 1, 1965, pg. 118.

37 Author's notes from an interview with Bill Ryan SJ, Ottawa, August 24, 2006.

38 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.

39 M. l'Abbé Jean-Marie Lafontaine, “Health Charter for Canadians: A Moral Issue in Canadian Life,” *Report of a Working Conference on the Implications of a Health Charter for Canadians*, November 28-December 1, 1965, pp. 86 - 94.

The Conference delegates, especially those from the churches, did undertake educational follow-up in many of their organizations. The Lutheran Church in America – Canada Section published an excellent study paper for congregational use on “this (Hall) report, one of the most significant and far-reaching ever presented in Canada.” It stated, “The church has an interest in a health charter for Canada because it professes its concern for the wholeness of persons... 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 (sic) 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 definition of health). When it becomes concerned with justice it ought to see health as a fundamental human right.”⁴⁰

Indeed, in spite of the forces opposing Medicare, “public sentiment as evidenced by events like the Château Laurier Conference provided a counterweight that tipped the balance.”⁴¹ After a vote in the House of Commons in 1966 (which the Conservatives supported), the Government of Canada passed the Medical Care Act which was enacted in 1968.

Medicare Established

The 1970s were a heady period when Medicare was established throughout the country. By 1971, all of the provinces had bought in to the program. For their part, the churches were preoccupied with the establishment of what became a dozen social justice coalitions active on a wide range of national and international issues.⁴² Health care issues almost disappeared entirely from church agendas.

Nonetheless, by the end of the decade, cracks were beginning to appear in Medicare, as the federal government insistently attempted to shift costs to the provinces. In 1979, labour and other organizations organized the “S.O.S. Medicare Conference” which was attended by several of the churches. As a result, the Canadian Health Coalition (CHC) was formed, with several of the churches actively participating. By the 1980s, Rick Haughian, Director of Education of the CHAC became chair of the CHC. He remembers a particularly colourful CHC initiative, when petitions in defence of Medicare were collected from across Canada, and deposited in a coffin, which was then carried up to Parliament Hill and eventually presented to Prime Minister Pierre Trudeau! Several years later however, most of the churches had become infrequent participants in CHC activities, although relations with the Coalition are ongoing and cordial. The United Church remains the most active CHC member, with the Rev. Bill Jay of Montreal serving on the CHC Board.

In this same 1979 – 1980 period, Mr. Justice Emmett Hall was asked by a Conservative government to carry out another review of Medicare. But Joe Clark’s government fell in December, and the new Liberal Health Minister Monique Bégin soon realized that the issue of most public concern was the increasing practice of extra-billing by doctors. Among the Canadian churches, only the United Church and the CHAC presented briefs. Hall’s report, delivered in August of 1980, rejected extra-billing and called for binding arbitration

40 Lutheran Church in America – Canada Section, “*A Study Paper on a Health Charter for Canada: A Concern for the Church*,” Winnipeg, Sept. 1967, pg. 1.

41 Chodos and Swift, *op. cit.*, pg. 77.

42 See: Christopher Lind and Joe Mihevc, *Coalitions for Justice*, Novalis, Ottawa, 1994. For many years the churches did not work together consistently on issues of domestic social policy through the coalitions. When KAIROS was created in 2001, a distinctive feature of the new structure was the establishment of a new programme committee specifically charged to work on “Canadian Social Development.”

as a solution. Bégin's Canada Health Act, passed unanimously in 1984, allowed the federal government to withdraw the same amounts of money that any province allowed doctors to extra-bill or charged in hospital user fees. The five conditions for funding are the Act's lasting testament: universality, affordability, comprehensiveness, portability, and public administration.

“The society requires healing as well as the individual.”

By 1986, the Evangelical Lutheran Church was concerned enough to name health care as a priority for the church for the next three years. In 1988 a Study Paper was produced that reported that the “health care system is currently being eroded, both intentionally and by neglect. Canada is headed toward a two-tier system, one for those who can pay extra for physician and hospital care, and another which provides minimum services to those who have fewer financial resources...If we are to keep down the cost of curative care, we must become serious about programs to reduce poverty, child abuse, spouse battering, abuse of the elderly, and unemployment. Thus, the society requires healing as well as the individual.”⁴³

In the 1990s, health care advocates were engaged in the National Forum on Health, which convened from 1994 until 1997. However, the biggest threat to Medicare arose in Paul Martin's deficit-cutting budget of 1995, which established the Canada Health and Social Transfer. Under the CHST, provinces would receive federal funding for health, post-secondary education and welfare essentially in a single block, to be allocated as they wished. The United, Presbyterian and Evangelical Lutheran churches responded by re-iterating their support for the five pillars of health care as mentioned in the Canada Health Act. They did this by passing resolutions at the appropriate decision-making forums, and by communicating their concerns to government. The United Church developed a Health Care Task Group in 1991 – 1994 that engaged some 60 congregations in a process of education, animation and policy formation on health issues.

The Need for an Ecumenical Response

Some veterans of ecumenical initiatives and coalition building realized that the voices of the church could become stronger and more effective if joined together. The Rev. Bill Jay of the United Church first initiated the conversation. Jay had been serving for some time as a Board member representing the United Church of Canada to the Canadian Health Coalition. He felt that the public discourse about public health care could be considerably enhanced by wider faith community reflection and input, and suggested that Jim Marshall of the UCC national office and he try to draw together representatives from sister churches to consider this possibility.

A first meeting of what was to become the Ecumenical Health Care Network (EHCN) took place on March 29, 2000 at McLeod-Stewarton United Church in Ottawa where Jay was then serving as pastor. This first meeting was also attended by Stephen Allen of the Presbyterian Church, Rev. David Pfrimmer of the Evangelical Lutheran Church, Anne Cruickshank, Mary Rowell and Dr. John Dossetor representing the Anglican Church, Jim Roche of the CHAC and Don Junk and Peter Newbury, also from the UCC.

Rev. Bill Jay remembers that those present at that first meeting were all quite delighted, and humbled, to find that after that first morning of sharing respective denominational positions on public health care and commitment to its preservation and enhancement, “we were indeed standing on common ground. We decided that our immediate focus needed to be on health care reform, and committed to further meetings to that end.”⁴⁴ The EHCN's first co-chairs were Marshall and Allen, and the Network was eventually housed under the Canadian Council of Churches Commission for Justice and Peace. The most effective efforts of the churches in health care debates had thus begun.

⁴³ Division of Church and Society of the Evangelical Lutheran Church in Canada, *A Study Paper on Canada's Health Care System: Our Responsibility, Our Challenge*, Winnipeg, 1988, pp. 1 - 2.

⁴⁴ Electronic communication with Rev. Bill Jay, 9/11/2006.

Early meetings of the Network produced the determination to develop a half dozen bulletin inserts or Fact Sheets for use in congregations, each on a relevant health care topic such as privatization, wait times, pharmacare or homecare. As well, letters to political leaders and ideas for briefs were developed. Already in 2001, Stephen Allen appeared before the Kirby Commission on the EHCN's behalf, and stated, "Historically, Canadian churches have contributed to the development of Canada's publicly funded and administered health care system, as service providers (eg. religious hospitals, homes for the chronically ill and aged, programs for the poor), as stakeholders (eg. pastoral ministries and chaplaincy services to the ill and dying), and as supportive advocates of new ideas and approaches (eg. community based programs such as parish nursing.) For Christians, Jesus has taught us that illness, or, more importantly, wellness, requires spiritual as well as physical well being." Allen went on to address (1) principles for the provision of health care, (2) financing health care, (3) accountability of all levels of government, (4) the need for evidenced based research, (5) expanding care to include pharmacare and home care, and (6) support for use of the determinants of health in insuring integrated strategies and programs.⁴⁵

Health Care Roundtable on Parliament Hill

At the end of February 2002, the Ecumenical Health Care Network, with the support of the Canadian Council of Churches, organized a Canadian Churches' Forum on the Future of Health Care. More than 100 health care advocates, guest speakers and politicians gathered to discuss health care concerns in light of the Kirby and Romanow Commissions. The churches used the event to motivate some of those in positions of leadership (four Roman Catholic bishops were in attendance, among other leaders, for example) and to build momentum for church groups to develop briefs for input into the Commission into the Future of Health Care in Canada (Romanow.) Dr. Robert McMurtry, special advisor to the Royal Commission on the Future of Health Care, provided an update on the progress of the Commission's work. Dr. Michael Rachlis developed thinking on what kind of health reforms would be most useful and appealing to Canadians. But the most impressive presentation came from Dr. Nuala Kenny who developed her key message 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, she said. Medical care is not a commodity; it is not like buying socks. The values that we must defend all deal with justice...In health care issues, Canadians do not allow only a market response; Canadians believe in equity. We must 'privilege' those who have the greatest needs.⁴⁶

Sister Kenny went on to develop the five key values involved in health care, an issue she later described in detail in her book on this topic: solidarity, equity, compassion, efficiency, and civility.⁴⁷

Several of the churches (Lutherans, United, the CHAC) also presented their own briefs to the Romanow Commission. Because the analysis was developed around the common table of the EHCN, however, all took care to emphasize similar and complementary issues and to promote the concept of the Health Care Covenant for All People in Canada. All of the churches promoted the use of the educational Fact Sheets, and with the assistance of KAIROS – Canadian Ecumenical Justice Initiatives, more than 17 workshops were held in communities across Canada.⁴⁸ These events deepened analysis of health care issues, especially the churches' view on them, and encouraged local groups to make their voices known to the Commission.

⁴⁵ EHCN, *Submission to the Standing Committee on Social Affairs, Science and Technology*, October 29, 2001, pg. 1, See: <http://www.ccc-ccc.ca/english/justice/health.htm>

⁴⁶ See: <http://www.ccc-ccc.ca/english/justice/health.htm#bb>

⁴⁷ Nuala Kenny, *What Good Is Health Care? Reflections on the Canadian Experience*, CHA Press, Ottawa, pp. 197 - 201.

⁴⁸ For information on the ecumenical social justice work of KAIROS, see: www.kairoscanada.org

In May 2002, the EHCN brief was presented to Mr. Romanow at a Commission hearing in Ottawa. The presentation, made by Rev. Dr. David Pfrimmer and Dr. Janet Somerville, General Secretary of the Canadian Council of Churches, had a substantial effect. When the Commission's report was released in November, its first recommendation was exactly that of the churches – for Canada to adopt a Health Care Covenant. The nine elements of the Covenant, although differently worded than Romanow's articulation, unabashedly borrowed from the churches' inspiration, and served as a useful introduction to his report's title, *Building on Values*.⁴⁹ It was also interesting to note how Romanow echoed the *Health Charter for Canadians* proposed forty years previously by Emmett Hall, and discussed by the churches at the 1965 Château Laurier conference.

The churches spent the next years attempting to ensure that federal governments would implement the major recommendations of the Romanow report. Although the Health Council was established, the Covenant was never adopted. The EHCN later met with Romanow at St. Jerome's College at the University of Waterloo, on February 18, 2005. He was full of praise to the churches for having provided him with the idea of the Covenant, but expressed his concern that without constant and sustained public vigilance of the sort that the broad-based church community could provide, very few of his recommendations for health care reform would ever be realized. An on-line petition to promote the Covenant developed by the EHCN was a failure, due to the lack of an active animation strategy by the Network members and the Council of Churches. However, educational work continues to proceed among church congregations, often by beginning with Romanow's important line, "Canadians view medicare as a moral enterprise, not a business venture."⁵⁰

"...that they might have life, and have it abundantly..."⁵¹

The story of the involvement of the churches in health care issues is not simply a description of an ancient past when faith communities performed functions that they can no longer be expected to play today. Rather, the history of church involvement in health care is a history of which Canadians can be proud, and build upon. As so many of the documents of different churches hold, a Christian view of healthcare provides a holistic vision. Our God is a God of abundant life who desires healing and health for our body, mind and soul.⁵² And the churches have not been afraid to enter the political fray around health policy in order to elucidate the social foundations of this wholeness.

The churches have realized that, in their stated intentions to be a voice for society's most vulnerable members, they need to continue to speak out on health care issues today. This voice has changed in tone from the days when churches spoke primarily as institutional stakeholders in the provision of hospital care. Medicare is recognized as that most cherished of Canadian cultural icons (perhaps along with hockey!⁵³) Health care is also the most redistributive program of the social policy mix in this country. The churches working together in the EHCN now see the continual attempts to privatize medicine pushed by some doctors, politicians and insurance companies as dangerous threats to the well-being of the poor in this country, as well as attacks on the very *ethos* of institutional health care as provided by Christians. They find no holistic solutions there.

49 See: <http://www.hc-sc.gc.ca/english/care/romanow/index1.html>

50 Roy Romanow, *Building on Values, Report of the Commission on the Future of Health Care in Canada*, Ottawa, November 2002, pg. xx.

51 John 10: 10

52 Canadian Conference of Catholic Bishops (CCCC), A pastoral message on sickness and healing, "*New Hope in Christ*," September 1, 1983, p. 17. Canadian Conference of Catholic Bishops (CCCC), A pastoral message on sickness and healing, "*New Hope in Christ*," September 1, 1983, p. 17.

53 Dr. Robert McMurtry, Feb. 28, 2002, comments at the EHCN forum on Parliament Hill.

And even at the level of institutional service providers, collaboration has reached heights that could not be imagined by previous generations. Today hospitals inspired by different religious backgrounds and histories are working together to provide enhanced services, and some have even merged.

Because today the state plays a bigger role than ever in health care policy as well as service delivery, the ability to monitor and to address government policy has taken on increased importance. Ecumenical and even interfaith collaboration is more essential than ever when the common voice of the churches needs to be heard. And the history in these pages has shown that churches working together are more efficacious in presenting their views, than when they work alone. The history of the influence of the churches, from supporting the Health Charter for Canadians to proposing a Health Covenant for All People in Canada, illustrates this point. The record shows that the whole is greater than the sum of the parts.

That is why groups like the Ecumenical Health Care Network are so important, even at a time when some churches are cutting back on social justice and ecumenical commitments. Not only are these ecumenical structures agile and inexpensive repositories of some of the Christian history of health care advocacy and ministry, but also they recreate and continually renew that ministry today. Not only do they point to the way to restore health, but also to restore healthy relationships. And not only are they hopeful signs of the ecumenical witness that has taken a half-century of constant effort to develop, but they have even begun to embody the wholeness that we seek as a Christian community today.



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