

RESEARCH GROUPS

U.S. AND CANADA HEALTH CARE ETHICS

- Topic: Catholic Health Care and Public Policy
Convener: Regina Wentzel Wolfe, St. John's University, Collegeville
Moderator: Mark Miller, St. Paul's Hospital, Saskatoon
Presenters: Melody Isinger, Duquesne University
Ronald Mercier, Regis College, Toronto

The presentations of the research group on health care issues had a decidedly Canadian bent. Melody Isinger sketched the successes and weaknesses of the Canadian publicly funded medical system. Providing an historical overview of the socialization of medical insurance, including the complex federal/provincial relations on payment and control, Isinger demonstrated the manner in which the Canadian system attempts to operate in accordance with the five principles of the Canada Health Act of 1984: comprehensive coverage; portability; accessibility; universality; and public administration. Isinger pointed out that the principles have been loosely applied. For example, the system has never been fully comprehensive, with coverage either lacking or being minimal for dental work, many drugs, chiropractors, and so forth. She also pointed out the ways in which the coverage system struggles, as do all modern systems of medical coverage, with financing and control issues, the use of waiting lists as a form of rationing, and, in particular, the politicization of health care. As a response to these concerns, she proposed a Royal Commission on health care reform through which a broad-based societal consensus might be developed.

Ronald Mercier examined the Catholic commitment to health care in Canada and the way of being church through this commitment. He focused on three major issues: the public presence of the church; the meaning of ownership/sponsorship in a changing society; and the proposed "point of insertion" for the church in the future. Unlike the United States, he noted, Canada has a long history of cooperation between church and state in health, social services, and education. Nonetheless, there is a growing loss of "privilege" for the church today. Consequently, new models of service are being developed. As the religious orders of sisters give way to involved laity—beginning with governing boards and moving toward "juridical persons" to carry on the mission of the sisters—establishments centered around bricks and mortar are giving way to cooperative ventures within the larger community. The Catholic aim is to bring a broader influence on health care systems as a whole (for example, through an emphasis on spiritual/pastoral care, ethics, and mission), to incorporate local parish communities in the provision of health care, and to develop local initiatives. While the control of public funds is a limiting

factor, it is also an opportunity for creativity. Mercier presented three possible models for the public face of the Church in health care: (1) a defensive, traditional model based strongly on "juridic persons"; (2) a model which links life and justice issues from a distinctive Catholic perspective as a way of raising new options in the public debate, especially where the most vulnerable, such as the dying, are affected; and (3) a model which unites Catholic health care organizations with other like-minded organizations as advocates in the face of government, market, and public forces. There are significant new ecclesial possibilities in these last two models.

A vibrant discussion followed focusing on such questions as: What is the Catholic identity today and is it evaporating? Can the government simply remove Catholic ownership of health care facilities (as happened in New Brunswick)? It was pointed out that in the U.S. such removal today takes place through bankruptcy.

Further discussion arose around the last two models that Mercier presented. There was a strong sense of their potential for creating a new Catholic institutional presence which would bring "values in integration," spiritual care and mission awareness, and ethics to daily health care. The atmosphere of change current in health care has allowed many positive and exciting initiatives.

Finally, the financial efficiencies of public and private health care provision were compared. It was pointed out, for example, that the Canadian public system spends 11 cents on the dollar for administration compared to 24 to 26 cents in the U.S. system.

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