

Renewing Faith in Healthcare

What Faith-Based Healthcare Offers Canada, and How to Sustain It

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Table of Contents

Introduction 5

Symposium Background and Goals 5

Symposium Lessons and Themes 7

A Mission of Love, Rooted in the ***Imago Dei***, Enables Whole-Person Care 7

A Community of Care and Responsibility, Founded in Reciprocity 8

"You Did It to Me" 9

Toward a Hopeful Future for Faith-Based Healthcare: Considerations for Next Steps . 9

Maintaining Mission Fidelity 9

Leaning into Strengths 9

Education 10

Connecting Across Sectors 10

Communicating with Canadians 10

What Makes Faith-Based Care Distinct? 10

References 13

Introduction

Faith-based healthcare institutions, and persons of faith who work in healthcare, have long been a mainstay in serving the needs of Canadians, dating back even before Confederation. Faith-based institutions such as hospitals, retirement communities, parish-based nursing programs, and psychological support services continue to provide essential care to Canadians within and beyond their particular religious communities.

Many challenges confront faith-based health institutions today, including challenges of conscience that threaten the very ethos upon which their approach to healthcare is founded. Many are concerned about how to protect the integrity of these institutions. At the same time, new opportunities are arising for faith-based healthcare to meet evolving needs.

The Renewing Faith in Healthcare Symposium brought together a key group of faith-based healthcare leaders and practitioners from across the country, from varied backgrounds and institutional types, for two days of robust discussion in February 2026. Hosted by Cardus in downtown Ottawa, participants engaged on the past, present, and future of faith-based healthcare in Canada.

This paper summarizes the key themes and lessons that emerged from the discussions and lays out opportunities that the participants identified for building a hopeful and more united future for faith-based healthcare in Canada. We hope that it might lay a foundation for ongoing engagement with those who participated in the symposium and with stakeholders in the faith-based healthcare sector more broadly.[1]

Symposium Background and Goals

The concept for the symposium was identified through conversations with stakeholders in the sector over the past several years. Through these conversations, Cardus determined that, despite important differences among Canada's various faith-based healthcare institutions, common concerns existed—though cross-sector points of connection were minimal. Some networks do exist, but they tend to be organized along denominational lines, or by geography or type of institution, such as hospitals or long-term care facilities. Stakeholders expressed an appetite to bridge these gaps.

Cardus thus convened this gathering with the following goals:

- strengthen relationships among faith-based healthcare institutions across the country;
- discuss how to protect the vital contributions of faith-based healthcare in the current, increasingly secular, context;

1 The structure and some of this paper's content is drawn from (1) a presentation made toward the end of the symposium by Rebecca Vachon, which summarized key themes from the symposium discussions as they applied to lessons for the future of faith-based healthcare, and (2) an article written by Ray Pennings for his "Insights" newsletter, March 2, 2026, https://22159095.hs-sites.com/cardus-insights-online-archive/keeping-the-faith-in-health-care. Complete citations are provided for all sources at the end of this report.

- discuss how faith-based institutions can be part of broader discussions in Canada about healthcare reform.

Each session featured a short presentation by a key leader or thinker in the faith-based healthcare space, followed by roundtable-style discussion. The symposium consisted of the following sessions:

- Introduction, facilitated by Ray Pennings, Cardus's executive vice president and co-founder;
- "The Historical Legacy of Faith-Based Healthcare," opening with a presentation by Sonya Grypma, PhD, RN;
- "Contemporary Challenges of Faith-Based Healthcare," opening with a presentation by Covenant executive James Liebenberg, MBA, CHE;
- "Pioneering Care for Marginalized Populations," opening with a presentation by Nancy Lefebre and Fr. Matthew Durham, DMin, Saint Elizabeth Foundation/SE Health;
- "A Hopeful Future for Faith-Based Healthcare," opening with a presentation by Rebecca Vachon, PhD, Cardus Health program director.

The keynote presentation, titled "How Does Faith Lead to Human Flourishing? Insights from the Global Flourishing Study," was given by Matthew Lee, PhD, professor and associate director of the Institute for Global Human Flourishing at Baylor University, and director of the Flourishing Network at the Human Flourishing Program at Harvard University, where he is a research associate.[2]

Covenant, Saint Elizabeth Foundation, and Elim Village sponsored the event, and this support was integral to its success. Special thanks are also due to Marten Van Huizen of Field & Marten for sponsoring the keynote dinner.

Symposium participants were Canadian healthcare leaders and practitioners, including CEOs and other executives or senior leaders from Catholic and Protestant hospitals, retirement homes and care facilities for seniors, and a hospice. Persons of faith who have worked in Christian and Jewish care settings as well as in secular settings also provided important context about the role of spiritual care and its integration across healthcare generally. Likewise, participants working within faith-based and secular healthcare associations offered a wider, sectoral understanding. Participants generally possessed clinical and/or administrative expertise, with a smaller number coming from a background in law or philanthropy. Participants almost exclusively came from British Columbia, Alberta, Saskatchewan, and Ontario; there is an evident need for engagement in other Canadian provinces and territories.

2 A recording of Dr. Lee's presentation can be viewed at Cardus's YouTube channel: https://www.youtube.com/watch?v=lI0UGWuJ9Qw.

Symposium Lessons and Themes

A Mission of Love, Rooted in the *Imago Dei*, Enables Whole-Person Care

The roots of organized healthcare in Canada are deeply faith-based, beginning with Catholic religious sisters such as the Grey Nuns and the Sisters of Charity, whose very vocation of religious life was bound up with responding to healthcare needs, dating back to the 1600s. The roots of many Christian faith-based healthcare institutions go back even further, inspired by the healing ministry of Jesus Christ, which is a particular emphasis of the Gospel of Luke.

Symposium speakers emphasized this mission-driven history as much more than a historical fact. It was affirmed as an engine that continues to challenge faithful persons individually and corporately to care for others, particularly those in the most need.

One challenge to this calling that was identified is that the approach to healthcare is evolving in our society. As articulated in Dr. Grypma's presentation and the roundtable discussions, heathcare is moving from a social-based response to illness and suffering toward a justice-based response that prioritizes patient rights and autonomy. The role of healthcare professionals is changing, from applying expertise to affirm life, potential, and opportunity to instead facilitating patient choices and demands.

This more transactional system has consequences for how our society understands and approaches suffering and vulnerability. Although healthcare will never fully conquer disease and suffering, it is still framed as a system that aims to do so. Thus, vulnerability and suffering have become pathologies to avoid or eliminate through primarily material means, rather than inherent parts of human nature or human experience, which may not always be best addressed through medication or clinical protocol.

Faith-based healthcare recognizes that how we answer ultimate existential questions affects how we deal with the temporal challenges of vulnerability and brokenness, whether in our bodies, relationships, or souls.

Faith-based healthcare continues to exist for a reason. It has a value that goes beyond the additional hospitals, beds, and professionals it offers. Healthcare institutions across Canada may have the same technologies and techniques at their disposal, but faith-based healthcare depends not on what it shares with other parts of the healthcare system but on fidelity to what makes faith-based healthcare distinct.

Beyond these institutional reasons for being, symposium participants affirmed that faith also remains intrinsic to their individual work. Their faith was key to drawing them to their work in healthcare in the first place, and it sustains and leads them forward, even when facing significant challenges.

Symposium participants frequently used words such as "sacred," "reverence," and "intimacy" when describing the ethos of faith-based healthcare. Christian and Jewish anthropology is rooted in belief in the *imago Dei*, a Latin phrase meaning that humankind is made in "the image of God" (Genesis 1:26–27). The Catholic faith, for example, holds that, "Being in the image of

God the human individual possesses the dignity of a person, who is not just something, but someone."[3]

Thus the *imago Dei* imbues every human being with an inherent dignity. Viewing the human person in this way means that healthcare practitioners should not pathologize without love, nor focus on the body to the exclusion of the totality of the person. This grounding is exceptionally important in the healthcare context. Healthcare ultimately encounters people in moments of vulnerability and need: Some of those moments are joyful, some are banal, and some are deeply difficult. All too often, people feel dehumanized in healthcare settings—just a patient number in an overfilled waiting room, or just an assemblage of body parts. But healthcare settings can also produce moments of profound humanity, moments in which one's personhood is acknowledged and lifted up.

And while technical skill and effective administration are important for patient care, they will never on their own sufficiently *care* for patients. Beyond them, and transcending economic considerations, faith-based healthcare is rootedness in love of God and love of neighbour, enabling it to respond more fully to human needs because it offers reverence to what is fundamentally sacred: the human person.

A Community of Care and Responsibility, Founded in Reciprocity

Symposium discussions frequently emphasized the reciprocity inherent in healthcare relationships. Rather than approaching patient care in a purely unidirectional way, in which healthcare professionals treat patients and their families as service recipients, healthcare professionals who work from a faithful understanding of the relationship of care recognize the value that patients and their families impart to them. In other words, faith-based healthcare relationships aim to be ones of solidarity, which transcends a consumer model of healthcare because it recognizes the responsibility of each of us to care for our neighbour and transforms healthcare into a mutual relationship of care rather than a one-way service between a provider and a recipient.

The principle of solidarity also emphasizes that the healthcare providers themselves need relationships of care. Healthcare institutions must care for their own personnel, recognizing their needs as whole persons rather than as mere employees. In the words of the late Pope John Paul II, solidarity "helps us to see [others] not just as some kind of instrument, with a work capacity and physical strength to be exploited at low cost and then discarded when no longer useful, but as our 'neighbor,' a 'helper' (cf. Gen 2:18–20), to be made a sharer, on par with ourselves, in the banquet of life to which all are equally invited by God."[4]

3 *Catechism of the Catholic Church*, para. 357. See also *Compendium of the Social Doctrine of the Church*, para. 144.

4 John Paul II, *Sollicitudo Rei Socialis*, para. 39.

"You Did It to Me"

The symposium participants repeatedly emphasized the role of faith-based healthcare in providing care that otherwise would be lacking: "We take the patients no one else will take." "We fill the gap." "We meet that need." It provides care to people that the public system may struggle to provide for, such as those who lack stable housing, and often has a specific focus on the most vulnerable. One example of this commitment to the marginalized that was mentioned is Journey Home Hospice, a program of the Saint Elizabeth Foundation. This hospice provides care, at no cost, to those experiencing homelessness at the end of life. It is not only a safe and welcoming home for those without a home, but also offers spiritual care, bereavement services, and psychosocial services and therapies, by staff trained in meeting the often complex needs of this population.[5]

Vulnerability itself is intrinsic to all of us in our nature as embodied beings. Yet this fact should not distract us from responding to the particular vulnerabilities of some, whether due to age, illness, ability, or socioeconomic situation. Instead, it should more deeply connect us to one another. Ultimately, vulnerability should be generative—of relationships, families, communities, and institutions.[6] As such, it lies at the heart of healthcare. Although some illnesses or conditions can be alleviated or cured, vulnerability itself is a natural part of our lives, deserving care and respect.

Toward a Hopeful Future for Faith-Based Healthcare: Considerations for Next Steps

Many challenges and opportunities were discussed throughout the symposium, and each of them warrants deeper discussion. The brief articulations provided below are intended to open further discussion and work on each theme.

Maintaining Mission Fidelity

One challenge pertains to identifying and cultivating leaders who have both the healthcare skills and the religious faith needed to maintain faith-based institutions' fidelity to their mission and carry it forward. The skills and the faith are both needed, to ensure high-quality and whole-person care that accounts for the dignity of each patient and healthcare professional.

Leaning into Strengths

The smaller size of many faith-based institutions can facilitate nimbleness and innovation, particularly when responding to evolving needs in society. Often, however, these institutions may lack awareness of innovations and their benefits. Increased awareness could also increase

5 Journey Home Hospice, "Services."

6 See discussion in Labreque, "Vulnerability, Dependency, and Trust."

opportunities for learning, replicating, or adapting models, which could enhance broader access to care across the country. It could also increase opportunities for obtaining funding and engaging volunteers.

Another strength of many faith-based institutions is the grassroots connections they have with the broader community. The connections strengthen these institutions and also contribute to broader civic engagement and overall trust in institutions.

Education

Despite faith-based institutions being important providers of healthcare in Canada, faith-based healthcare education is almost entirely lacking in this country. Symposium participants mentioned Trinity Western University's nursing program as the only such program in Canada. Further discussion is needed about opportunities for other faith-based colleges and universities in Canada to likewise support healthcare education. Educational courses could be directed not only to nurses but also to personal support workers, social workers, pharmacists, and others. Such education could contribute to meeting the leadership and personnel needs of existing institutions, as noted above, and also infuse healthcare generally with a vision of care that goes beyond the physical, addressing spiritual care needs in an integrated way.

Connecting Across Sectors

Participants identified the opportunity to learn from others in faith-based healthcare, both domestically and internationally, as a positive step forward.

Communicating with Canadians

A major challenge mentioned was how to better share the value and purpose of faith-based healthcare with Canadians generally, whether persons of faith or not, as well as with Canadian policy-makers.

What Makes Faith-Based Care Distinct?

The relationship between faith-based healthcare providers and governments that they work with has always been complex. In recent years it has become more so, particularly when touching on contentious social and cultural issues. Beyond history and nostalgia, what is the value proposition faith-based institutions offer today?

While none of the following differentiators are exclusive to faith-based institutions, together they form a distinctive contribution that makes a practical difference, when consistently and consciously applied.

Motivation

The same motivations that compelled religious communities to pioneer healthcare in what is now Canada remain alive today. While religious traditions each have their distinctive theologies, a shared feature stands out: a missional orientation rooted in the dignity and worth of the human person and a call to respond to vulnerability with compassion and love. The symposium participants readily acknowledged the difficulty of living up to these ideals and the challenge of measuring how closely the reality aligns with them, but the language of "vocation" or "calling" was unmistakable. Those in the room did not see themselves merely as service providers; they were pursuing something deeper.

Capacity

Capital campaigns are supported by charitable foundations, themselves often funded by faith-motivated individuals and faith communities. Reliable national data that quantify faith communities' additional contributions to healthcare are difficult to find, but the stories shared in the room suggest tens of millions of dollars in infrastructure, such as buildings and equipment. Add to this the volunteer dimension, and the scale becomes titanic. Rough calculations, using Statistics Canada data and focusing on non-family informal care, suggest that faith communities and affiliated providers supply healthcare in the range of $4 billion to $12 billion annually (even using conservative wage assumptions). Clearly, the landscape of healthcare in Canada would look very different if faith-based providers were absent.

Serving the Marginalized

Historically, faith-based healthcare emerged at a time when government-provided healthcare did not exist, and it emerged primarily as a response to those most in need of care. That legacy continues. Faith-based organizations often pioneer programs for the homeless, prisoners, those living in poverty, those living with mental illness, and others. The motivation is intrinsic to the sense of calling and, when authentically lived out, draws attention to those on society's margins. Faith-based care "to the least of these" (Gospel of Matthew, chap. 25) occurs daily in Canada but often goes unnoticed by the wider society.

Holistic Care

Faith-based institutions are explicit about caring for the whole person. Symposium participants consistently affirmed that, while practices vary and there are sensitivities to consider, spiritual and emotional needs accompany physical ones. Several participants described intentional spiritual care programs for both patients and staff, along with training to equip staff to talk with patients about emotional and spiritual realities. This approach contrasts with how such matters are often handled (or not) in secular settings. It also offers a perspective on suffering and vulnerability as not only problems to be solved but also realities that caregivers and patients may learn from.

Morale

Levels of burnout and stress among healthcare providers remain high across the sector, contributing to retention and workforce challenges. Faith-based organizations are not immune to this reality, but explicit attention to spiritual formation, meaning, and community can help sustain staff in demanding contexts.

Community Ecosystems

Governance structures in the faith-based sector vary widely, from longstanding Roman Catholic sponsorship to independent, not-for-profit social enterprises. Most of the organizations remain formally or informally connected to broader faith communities. Such networks can enable more integrated care than may be possible in the public healthcare system alone.

While these elements may be present in secular healthcare—including, for example, among faith-motivated personnel working in secular settings—explicitly faith-based organizations offer a distinctive value proposition by bringing all the elements together in an intentional fashion. These organizations serve not only the more than half of Canadians who identify as religious, they also serve the broader public. Canadian healthcare confronts systemic pressures that cannot be resolved by inertia, and there is much to learn. Faith-based providers have much to offer and play a critical role. They need to become more intentional about telling their stories and defending their contributions. This symposium provided one such venue, and it speaks to the need for further engagement, within the faith-based healthcare sector and between the sector and Canadians as a whole.

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