CUPE

# Submission

## by the Canadian Union of Public Employees (CUPE)

## to the

## Senate Standing Committee on Social Affairs, Science and Technology

**In relation to its**

**Examination of the progress in implementing the 2004 10-Year Plan to Strengthen Health Care**

**Canadian Union of Public Employees**
**November 8, 2011**

## Summary

Canadians are deeply concerned about their health and the health of their families and neighbours. Canadian Medicare is the deepest expression of the way in which we care for each other, and is one of the foundation stones of Canadian society. Eighty-seven percent of Canadians support public solutions to make Medicare stronger,[1] and a recent poll shows that Canadians expect their federal government to take the lead in health care reform.[2]

The Canadian Union of Public Employees represents 600,000 workers, with over 190,000 members in the health care sector. CUPE members are on the front lines providing direct care to patients in hospitals, long-term care facilities and in home and community care settings. CUPE members cook and deliver the food that nourishes patients, safely transport patients, and provide a social connection for patients every day. We keep health care facilities clean, safe and well maintained. CUPE members are the organizational backbone of our hospitals, admitting patients and handling medical records. We are first responders in our communities. We are nurses and personal support workers caring for seniors and others in long-term care facilities and at home. We perform these and many other essential roles. Our members are concerned about health care as workers, and as members of families and communities who rely on our public health care system.

This brief follows from CUPE's submission on the 2008 review of the 10-Year Plan (Health Accord),[3] highlighting area of continuing concern, and making recommendations to strengthen Medicare. Our recommendations apply to the final years of the 10-Year Plan and to renewal of the Health Accord.

The 10-Year Plan stabilized the health care system following deep cuts in the 1990s that seriously compromised access and quality of care. It provided long-term funding with steady increases, in a legislated framework. It reaffirmed the *Canada Health Act* and set a number of worthy goals. Unfortunately, the goals were not tied to funding, and in many areas they fell short of what was needed. This submission will identify what CUPE sees as major gaps in the 10-Year Plan, areas where progress has stalled or reversed, and recommendations for the next Health Accord.

### Accountability and Funding

The federal government is unable to properly account for spending under the 10-Year Plan, stemming in part from weak conditions on the funding and gaps in *Canada Health Act* reporting, but more importantly due to this government's refusal to play a leadership role in defending and improving Medicare. In fact, the federal government is ignoring violations of the *Canada Health Act* and signaling that provinces are welcome to expand for-profit delivery. Conservative advisors and at least one MP are even suggesting that the federal government get out of funding health care entirely, and the security of other major federal transfers is also at risk.

The federal government has not hosted a First Ministers meeting on health since Prime Minister Stephen Harper was elected in 2006, and there is no commitment to such a meeting even as the expiry of the 10-Year Plan approaches. These Senate hearings have excluded as witnesses CUPE, other health care unions, the Canadian Labour Congress, and the leading Medicare advocacy group, the Canadian Health Coalition. This bodes poorly both for progress on the 10-Year Plan and for consultations on the next Health Accord.

The Health Accord has injected stable escalating funding for health care over a ten-year period after deep cuts in the 1990s. It is crucial that the federal government continue with at minimum the six percent annual increases in the Canada Health Transfer in a second ten-year Accord.

*Recommendation 1*: that the federal government negotiate with the provinces and territories a new 10-Year Plan (Health Accord) with stable and adequate funding, including at minimum the six percent escalator. Allowing the Government of Quebec to enter into a separate agreement, the Health Accord must otherwise be one agreement applying the same terms and conditions across Canada.

*Recommendation 2*: that Health Accord funding not come at the expense of the Canada Social Transfer or equalization funding.

*Recommendation 3*: that the federal government correct the deficiencies in monitoring, reporting and enforcing the *Canada Health Act*.

*Recommendation 4*: that the Senate Standing Committee on Social Affairs, Science and Technology invite health care unions, the Canadian Health Coalition and other broad-based civil society organizations as witnesses in this review of the 10-Year Plan.

Privatization

Health care privatization has increased since 2008 at all levels: payment, administration, infrastructure, and delivery. Private for-profit clinics have expanded in number and size; user fees and extra billing are on the rise; contracting out of support services and nursing care has continued; and public private partnership have spread to long-term care. Our successes on wait times come from the public sector, yet some governments use “care guarantees” to push ahead with privatization. These trends fly in the face of evidence that privatization delivers less and costs more.

The federal government has ignored violations of the *Canada Health Act*, encouraged more for-profit delivery, and is negotiating a trade agreement that fundamentally jeopardizes current and future public health care programs.

*Recommendation 5*: that the federal government enact regulations under the *Canada Health Act* to require annual disclosure from provinces and territories on the number of private for-profit facilities, the number of services they provide, and the payments they receive; that this information be provided in the Annual Report to Parliament; and that the federal government enact a regulation under the *Canada Health Act* stipulating that federal transfers be used only for non-profit delivery.

*Recommendation 6*: that the federal government request the Auditor General of Canada immediately investigate the increased cost to taxpayers and erosion of service quality associated with public private partnerships.

*Recommendation 7*: that the federal government create an infrastructure fund to build and redevelop hospitals and long-term care facilities, stipulating public non-profit ownership, control, management, and operation of the facilities, equipment and services.

*Recommendation 8*: that the federal government encourage provincial and territorial governments to adopt public sector solutions to reduce waits that would, among other things:

- combine and better manage lists;
- fully utilize hospital operating rooms;
- expand team work and case management;
- expand primary care and continuing care; and
- address retention and recruitment problems.

*Recommendation 9*: that the federal government negotiate a new exemption, modeled on the cultural exemption in recent Canadian bilateral agreements, stipulating that nothing in CETA shall be construed to apply to measures adopted or maintained by a party with respect to health care or public health insurance.

Healthcare Associated Infections

Patient safety was one of the issues addressed in the 10-Year Plan. On healthcare associated infections (HAIs), a top patient safety concern, Canada is doing poorly. Each year, over 220,000 hospital acquired infections result in 8,000-12,000 deaths. At least 30 percent of these infections are preventable. Rising infection rates are resulting in higher levels of morbidity, mortality, length of hospital stay, health care costs, and institutionalization. Canada has the second highest HAI prevalence rate among high-income countries at 11.6 percent compared to the pooled rate of 7.6 percent.

Understaffing and contracting out are major determinants of our high HAI rates. Dr. Michael Schull from the Institute for Clinical Evaluative Sciences correctly informed this Committee that cuts to cleaning staff in the 1990s were a mistake and that reinvestment is needed. Unsafe occupancy levels significantly worsen the problem.

Contracting out contributes to HAIs through staff cuts, higher turnover, less training and rupturing of the link between clinical and support staff.

The federal government's fragmented and weak initiatives on HAIs stand in contrast to the UK government's regulatory actions, and they fail to meet our obligations under global health governance standards. Even at the level of pan-Canadian data, reporting on HAIs and other adverse events is poor, and we have virtually no federal data on health care cleaning.

*Recommendation 10*: that the federal and provincial and territorial governments implement a strategy on healthcare associated infections (HAIs) with substantial, dedicated funding for increased in-house health care cleaning, stringent infection control and microbiological cleaning standards, maximum occupancy levels in hospitals, and mandatory public reporting on HAI rates and deaths.

Continuing Care

While the 10-Year Plan represented some progress on short-term and end of life home care, the provisions were too modest, and they reinforced a growing emphasis on medical care to the detriment of health promotion and illness prevention. Residential long-term care (LTC) received no mention, despite the urgent need for access and quality improvements in that sector.

Continuing care in Canada is characterized by unequal access and quality concerns largely due to inadequate public funding and regulation, commercial involvement and its exclusion from Medicare. Care is often rushed. Access is two-tiered. Privatization at all levels - financing, ownership, management and delivery – worsens access and quality problems.

*Recommendation 11*: that the federal government extend Medicare to continuing care (home/community and residential care), with legislated standards and dedicated funding, financed through general revenue. The regulatory framework should include *Canada Health Act* provisions plus minimum staffing standards and phasing out of for-profit delivery.

Primary Care

Canada has not reached the 10-Year Plan goal of 50 percent of Canadians having 24/7 access to multidisciplinary teams by 2011, and it lags behind other developed countries on measures such as after-hours care, wait times, chronic disease management, mental health, and electronic medical records in primary care. Canadians experience economic barriers to primary care, and on social determinants of health, we also rank poorly. Community health centres are our best option for improving care and addressing the underlying inequities.

*Recommendation 12*: that the federal government establish standards and provide targeted resources for primary health care reform, including expanded access to community health centres, prioritizing individuals, families and communities with the greatest need.

Aboriginal Health

The federal government has failed to improve Aboriginal people's health as envisioned in the 10-Year Plan, and the Conservative government of Stephen Harper shelved the Kelowna Accord. The health, social and economic disparities between Aboriginal and non-Aboriginal people are huge and in some cases growing. Safe drinking water, a significant determinant of health, is out of reach of many Aboriginal communities, and the water infrastructure deficit approaches $6.6 billion. Non-Insured Health Benefits are also underfunded, making it yet more difficult for First Nations people to access basic health care services.
*Recommendation 13*: that the federal government involve Aboriginal organizations in negotiations with First Ministers on the renewal of the Health Accord; meet the goals of the Kelowna Accord; implement recommendations of The National Engineering Assessment; adopt higher water quality standards for reserves; and make new investments in the Non-Insured Health Benefits (NIHB) Program.

Prescription Drugs

The federal government has not followed through on its commitment in the 10-Year Plan to a national pharmaceutical strategy. Federal leadership is essential to ensure universal access, safe and appropriate prescribing, and value for money.

Eight million Canadians have no prescription drug coverage, and those with plans are seeing higher fees and benefit cuts. Unsafe prescribing and pharmaceutical use cause harm and in many cases death. Drug costs continue to rise steeply, in part because Canada pays 30 percent more than the international average. Industry self-regulation, direct-to-consumer advertising and off-label promotion fuels inappropriate prescribing.

Canada could save $10.7 billion with a universal public drug plan. Many countries, including France, the UK, Sweden, Australia and New Zealand have universal drug plans and, as a result, pay far less for drugs than Canada. Going in the opposite direction, the Canadian government is negotiating a trade agreement with the European Union that could increase prescription drug costs by $2.8 billion a year.

*Recommendation 14*: that the federal government begin immediately to work with the other governments in Canada to implement the National Pharmaceutical Strategy as agreed to in the 2004 Health Accord.

*Recommendation 15*: that the federal government establish a national pharmacare program that provides equal access to safe and effective drugs while keeping rising costs in check. The program should include first-dollar coverage for essential drugs on a

national formulary, bulk purchasing, more rigorous safety standards, evidence-based prescribing, and stricter controls on drug company marketing.

*Recommendation 16*: that the federal government reject the demand by the European Union in CETA negotiations to change intellectual property laws to increase patent protection for brand-name drugs as this will add significant costs to Canada's public health care system and increase the financial barriers to medically necessary medicines for millions of Canadians.

Health Human Resources

While there has been some progress on health human resources in the 10-Year Plan, the federal government has all but ignored workers outside of the category of doctors, nurses and allied health professionals. For example, the federal government has supported much-needed credential recognition and integration of internationally educated providers, but at the same time expanded the Temporary Foreign Workers Program which exploits migrant workers who provide hands-on care and support services at the bottom end of the pay scale. The wage and benefits gap between continuing-care and hospitals persists and is worst for support staff.

*Recommendation 17*: that the federal government develop and implement a pan-Canadian health human resources strategy that achieves better working conditions, training and upgrading programs, and wage parity to improve retention and recruitment across the health sector; that this strategy advance employment equity, including Aboriginal “representative workforce” strategies.

*Recommendation 18*: that the federal government adopt and promote recruitment policies consistent with the World Health Organization Global Code of Practice on the Ethical Recruitment of Health Personnel; establish a Migrant Worker Commission as an independent regulatory body that has enforcement power; and develop a national policy framework to regulate labour brokers and recruiters.

## 1. Accountability and Funding

Our first and foremost concern with the 10-Year Plan implementation has been the lack of accountability and the government’s refusal to uphold Medicare standards. The federal government placed few conditions on the transfers contained in the 10-Year Plan, and – not surprisingly – there has been very little accountability for that funding.

In 2008, CUPE observed that “every year, the *Canada Health Act* annual report falls short, ignoring entirely the transfer of Medicare to for-profits in certain provinces, or giving paltry details for others. And every year, the federal government does next to nothing about user fees, extra billing and other violations of Medicare rights.”[4] The situation has deteriorated since then with the continued tacit approval by the federal government of increased for-profit delivery and violations of the *Act*.

According to reports of the Auditor General of Canada, the Minister of Health is unable to tell Parliament the extent to which health care delivery in each province and territory complies with the criteria and conditions of the *Canada Health Act*.[5] Further, the federal/provincial/territorial Advisory Committee on Governance and Accountability has been disbanded.[6] Information on how governments spend targeted funds is either patchy or not available at all. Parliament should hold the Minister of Health to account and should not approve the transfer of health care funds to provinces unless they demonstrate compliance with the *Act*.

There is a broad consensus that the federal government has an essential role in coordinating health policy among the provinces and territories and promoting better access and quality across the health care system. Yet the federal government has refused to play a leadership role in defending and improving Medicare. Dr. Jack Kitts, CEO of the Health Council of Canada, identified this problem in recent testimony before this committee. In response to Senator Braley asking if there was a leader in charge of the health accord, Dr. Kitts could only reply "we are without a leader."[7]

The federal government's commitment to Medicare is also called into question by recent suggestions that the Canada Health Transfer be dismantled. At least one Conservative MP and a former advisor are publicly calling for the federal government to get out of funding health care entirely – to eliminate the transfers and equalization payments and instead turn over the monies collected from the federal Goods and Services Tax to the provinces.[8] Without the clout of federal cash transfers, the federal government will be unable to uphold the *Canada Health Act* or achieve necessary improvements in access and quality across the health care system.

We are also concerned about the security of non-health transfers. The federal Conservatives have made no commitments regarding the Canada Social Transfer (CST), equalization or territorial formula financing.[9] Post-secondary education, social assistance and social services, and early childhood development and early learning and childcare, which fall under the CST, are already under-resourced. The federal government should be investing in public services rather than cutting taxes; $1 billion of public investment in health care and education creates two to three times as many jobs as the same amount in personal income tax cuts. The boost to the economy (measured as GDP increase) is also stronger.[10]

We find it disturbing that this Committee has chosen to deny the majority of health care workers (through their elected organizations, trade unions) and many public interest advocates the opportunity to speak as witnesses in this Senate review. Our organizations represent hundreds of thousands of Canadians with direct experience as providers and care recipients. You risk losing the opportunity to dialogue with frontline workers and patient advocates with a unique perspective on the 10-Year Plan and ways forward.

Recommendation 1

that the federal government negotiate with the provinces and territories a new 10-Year Plan (Health Accord) with stable and adequate funding, including at minimum the six percent escalator. Allowing the Government of Quebec to enter into a separate agreement, the Health Accord must otherwise be one agreement applying the same terms and conditions across Canada.

Recommendation 2

that Health Accord funding not come at the expense of the Canada Social Transfer or equalization funding.

Recommendation 3

that the federal government correct the deficiencies in monitoring, reporting and enforcing the *Canada Health Act*.

Recommendation 4

that the Senate Standing Committee on Social Affairs, Science and Technology invite health care unions, the Canadian Health Coalition and other broad-based civil society organizations as witnesses in this review of the 10-Year Plan.

## 2. Privatization

Health care privatization has increased since 2008 at all levels: payment, administration, infrastructure, and delivery. The federal government has ignored violations of the *Canada Health Act*, encouraged more for-profit delivery (sometimes couching it in the euphemistic phrase “alternate service delivery”), and is negotiating a trade agreement that fundamentally jeopardizes current and future public health care programs.

For-profit clinics

Since our portrait of privatization in 2008, private for-profit clinics have expanded considerably. In 2008, the Ontario Health Coalition identified 42 for-profit MRI/CT clinics, 72 for-profit surgical hospitals (clinics) and 16 boutique physician clinics operating in Canada providing medically necessarily care.[11]

There is no federal process in place for monitoring the growth in the private for-profit delivery of health care, notwithstanding the requirements of the *Canadian Health Act*. It is however possible to piece together a picture since 2008 that illustrates the considerable growth in private clinics, the vast majority of which are for-profit:

- A recent article in the *Canadian Medical Association Journal* estimates that there are 300 private clinics in Quebec, and that clinics are growing in size, becoming mini-hospitals.[12]

- A recent investigation by the College of Physicians and Surgeons of Ontario regarding unsafe practices at an Ottawa endoscopy clinic revealed that there are 270 private surgical clinics in Ontario.[13]

- In March 2011, Alberta Health Services (AHS) contracted with private surgical facilities in Edmonton and Calgary to perform 2,140 cataract surgeries. A further 1,400 were contracted in May 2011, with only 100 of those to be done at a public hospital.[14] Alberta was already a leader in outsourcing hospital procedures.
- In Saskatchewan, the Regina Qu'Appelle Health Region contracted-out 570 surgeries to Omni Surgery Centre between August 2010 and July 2011; the Saskatoon Health Region contracted-out 673 surgeries to another for-profit clinic, Surgicentre, between October 2010 and July 2011.

Activity-based funding (ABF), a form of fee-for-service funding, threatens to accelerate the shift to private for-profit delivery of health care services. There is no strong evidence that activity-based funding improves health care system performance,[15] reduces waits or saves money.[16] In fact, there is evidence of negative consequences. ABF has been linked to over treatment, drawing from research on cataract surgeries.[17] Physicians in the UK say ABF tends to promote "cream skimming" by for-profit clinics, leaving publicly funded hospitals with more complex and expensive cases,[18] and that it leads to higher administration costs, fragmentation, and a destabilization of the health care system.[19]

User Fees and Extra Billing

Providers are violating the *Canada Health Act* and provincial Medicare laws with growing frequency, and the federal government does little to track the problem much less stop it.

Certain provinces – most notably, British Columbia and Quebec - are allowing private clinics to charge privately for medically necessary diagnostic and surgical services. In 2008 alone, 89 potential violations of the *Canada Health Act* were identified in five provinces.[20] Some doctors get around the ban on user fees and extra billing by charging patients for uninsured services, which leads to queue jumping and potential conflicts of interest. Other doctors charge annual block fees for so-called "incidental" services like telephone consultations, prescription renewals and document preparation - also a violation of the accessibility criterion of the *Canada Health Act*.[21] Such fees appear to be on the rise.[22] Several recent examples give rise to concern:

- A study published in the February 2011 issue of the Canadian Journal of Gastroenterology found that 31.7 percent of patients in private clinics are being charged for colonoscopy services.[23]

- Concerned patient advocates, doctors and federal health critic MPs are calling on Ottawa to take action on Copeman Healthcare Centre, a member-only primary care clinic operating in Vancouver and Calgary.[24] The provincial government's audit of Copeman relied solely on the clinic's own written policies and did not thoroughly investigate complaints of extra-billing, reinforcing the need for stronger investigation and enforcement at the federal level.[25]

- The Quebec health insurance board (the Regie de l'assurance maladie du Quebec, RAMQ) is concerned about the jump in the number of doctors and clinics trying to circumvent the law when it comes to billing patients for insured services.[26] The RAMQ ruled in September 2011, that three clinics had violated the Quebec health insurance law by charging user fees for medically necessary services. More clinics are under investigation.[27]
- The Quebec College of Physicians and Surgeons is investigating allegations that some physicians are accepting bribery payments to give patients preferential access.[28]

Contracting Out

In addition to contracting out entire blocks of diagnostic and surgical procedures, health care employers continue to outsource support services and nursing care, often as part of shared services projects. For both support services and direct care services, contracting out is associated with less training and higher turnover, which undermine continuity and quality of care.[29] We explore the problems of contracted-out cleaning in the section on healthcare associated infections. Contracting out of laundry, food, administration and other support services – increasingly to multinational corporations - also compromises quality and accountability and redirects resources from patient care to corporate profit.[30] Outsourcing of care aide and nursing work is also on the rise, despite evidence that over-reliance on nursing agency staff is linked to disrupted care and more resident distress.[31]

Privatization and Sustainability

Private health care spending and for-profit ownership, infrastructure development and delivery threaten the sustainability of Medicare. In terms of the generally accepted measure of a society's ability to pay – its GDP – health care costs generally and Medicare costs in particular have been remarkably stable since the program's introduction in the early 1970s.[32] What is unsustainable is privatization - of delivery, infrastructure, administration and financing (user charges, utilization taxes, restricted public insurance coverage and increased reliance on private insurance).

Private spending represents around 30 percent of total health care spending, one of the highest levels among OECD countries. Within that, private insurance is rising faster than other sources of finance. Between 1988 and 2009, per capita spending on private health insurance increased from $139.40 to $648.90.[33] Canada is also on the high end of the spectrum in other areas of private health care spending. Out-of-pocket expenses account for 15 percent of total health care costs in Canada, compared with 12 percent in the United States, seven percent in France and only 5.5 percent in the Netherlands.[34]

The two most important drivers of public health care spending increases are both dominated by the private sector: prescription drugs and payments to physicians. Prescription drugs have increased as a share of Medicare spending from two percent to nine percent since 1975 and by themselves account for one-quarter of the increase in health care costs as a share of GDP since 1975. Payments to physicians have increased only slightly as a share of health care costs over the past 35 years, but because they make up 20 percent of total costs, that increased share has a notable impact on health care costs.[35]

As shown later in this submission, public-private partnerships and for-profit ownership in long-term care are associated with higher overall costs. The key to controlling costs and improving quality in the health care system is to shift costs and control from the private sector to the public sector.

Recommendation 5

that the federal government enact regulations under the *Canada Health Act* to require annual disclosure from provinces and territories on the number of private for-profit facilities, the number of services they provide, and the payments they receive; that this information be provided in the Annual Report to Parliament; and that the federal government enact a regulation under the *Canada Health Act* stipulating that federal transfers be used only for non-profit delivery.

Public Private Partnerships

Public private partnerships (P3s) continue despite mounting evidence that they cost more and deliver lower quality than publicly built, financed and operated facilities.[36] There are now 48 public-private partnership (P3s) hospitals built or under construction in four provinces. Governments are also now building and renovating long-term care facilities using P3s.

P3 hospitals are more expensive, with as much as an 83 percent cost disadvantage compared to public sector financing.[37] In the UK, failed Private Financing Initiatives (PFIs, equivalent to P3s) have left taxpayers with huge burdens as costs spiral out of control, and the UK National Audit Office has warned against using PFIs for building schools and hospitals.[38] Even at a higher cost, P3 hospitals often deliver fewer beds and worse quality.[39]

P3s also weaken accountability, fragment the health care system, and open the door to two-tier health care. The secrecy of P3 deals prevents proper accounting for public health care spending and makes it difficult to monitor compliance with the *Canada Health Act*. P3 hospital contracts typically allow the companies to establish clinics and other business within the facility, significantly increasing the likelihood of cream-skimming, self-referrals, kickbacks and other conflicts of interest for health care providers working on both sides of the hallway. The opportunity for these abuses is far greater given the lack of transparency typical of these complex contractual and leasehold regimes.[40]

The federal government historically played an important and direct role in funding health care infrastructure.[41] Particularly in the current economic climate, the federal government should invest in public hospital and residential long-term care, using public financing and delivery, not P3s. Every dollar in public infrastructure provides 17 cents a year in cost savings to business, as well as other social benefits; $1 billion of public investment in infrastructure creates twice as many jobs and twice the GDP boost as the same amount in personal income tax cuts.[42]

Recommendation 6

that the federal government request the Auditor General of Canada immediately investigate the increased cost to taxpayers and erosion of service quality associated with public private partnerships.

Recommendation 7

that the federal government create an infrastructure fund to build and redevelop hospitals and long-term care facilities, stipulating public non-profit ownership, control, management, and operation of the facilities, equipment and services.

Wait Times

Wait times have been reduced in the five clinical areas targeted in the Accord (cancer, heart, diagnostic imaging, joint replacements, and sight restoration). The aggregate numbers show overall progress; eight out of 10 Canadians are treated within the pan-Canadian benchmarks set in 2005, though waits vary by procedure and by hospital.'[43]

Our concern with wait time initiatives is that several provinces have exploited the issue to justify contracting out, despite the evidence that for-profit providers lengthen waits in the public system, cost more and yield worse health outcomes.[44] For-profits rob our public system of valuable health human resources and money,[45] creating longer waits in the public system.[46] Early analysis of contracting out of surgical procedures in the Regina Q'Appelle Health Authority indicates that the total number of surgical procedures

declined by 2.9 percent after the health authority entered into the contract with a for-profit clinic.[47]

Our successes have come from expansion and improvements in the public non-profit health care system.[48] We agree with the Health Council of Canada's progress report on wait times: "continued coordinated effort and greater use of effective management tools could make wait times management one of the success stories of the health accords".[49] As the Romanow Commission concluded: "Rather than subsidize private facilities with public dollars, governments should choose to ensure that the public system has sufficient capacity and is universally accessible."[50]

Recommendation 8

that the federal government encourage provincial and territorial governments to adopt public sector solutions to reduce waits that would, among other things:

- combine and better manage lists;
- fully utilize hospital operating rooms;
- expand team work and case management;
- expand primary care and continuing care; and
- address retention and recruitment problems.

Comprehensive Economic and Trade Agreement

The Comprehensive Economic and Trade Agreement (CETA) negotiations currently underway between Canada and the European Union threaten the ability of Canadian governments to expand Medicare and protect it from further privatization.[51] In fact, current NAFTA provisions that exempt health care could be weakened by the procurement, services and investment provisions in CETA.[52] Given the current discourse in Canadian health care reform on expanding Medicare to continuing care and pharmacare, it is vital that the federal government stand up for Canadians, not corporations, and ensure that Medicare is protected in its current and future form.

Recommendation 9

that the federal government negotiate a new exemption, modeled on the cultural exemption in recent Canadian bilateral agreements, stipulating that nothing in CETA shall be construed to apply to measures adopted or maintained by a party with respect to health care or public health insurance.

## 3. Health Care Associated Infections

Patient safety was one of the issues addressed in the 10-Year Plan. On healthcare associated infections (HAIs), a top patient safety concern, Canada is doing poorly. According to a 2011 report by the World Health Organization, Canada has the second highest HAI prevalence rate among high-income countries at 11.6 percent, considerably higher than the pooled rate of 7.6 percent.[53] The only high-income country with a worse rate was New Zealand which, like Canada, has high hospital occupancy rates.

Each year in Canada, over 220,000 hospital acquired infections result in 8,000-12,000 deaths.[54] At least 30 percent of these infections are preventable.[55] Rising infection rates are resulting in higher levels of morbidity, mortality, length of hospital stay, health care costs, and institutionalization.[56] The direct costs of hospital acquired infections in Canada are estimated to be $1 billion annually. On top of that are costs borne by patients and volunteer caregivers as well as program costs for home and community care.

There is significant and robust evidence that understaffing and contracting out of health care cleaning contribute to increased infection rates,[57] [58] and in recent testimony to this committee, Dr. Michael Schull from the Institute for Clinical Evaluative Sciences acknowledged the role of cuts to cleaning staff:

> "The [funding] cuts in the 1990s certainly had something to do with the decision to cut support staff because they were not a priority and cuts had to be made. I think we now know it was a mistake and we are starting to reinvest in those basic services."[59]

Contracting out leads to cuts in staff, higher turnover rates, less training and a rift between clinical and support services.[60] The auditor general of Scotland found that hospitals with contracted-out cleaning, compared with those with in-house cleaning, had fewer cleaning hours, less monitoring and supervision, greater use of relief staff and lower scores on cleanliness.[61] The UK Department of Health found that 15 of the 20 “worst” hospital National Health Service (NHS) trusts for cleanliness had outsourced cleaning.[62] The Scottish and Welsh governments announced in 2008 plans to bring health care cleaning back in-house.[63]

Investing in rigorous cleaning programs in hospitals and ensuring that cleaners are properly viewed as part of the infection control team are two critical steps that have been shown to reduce rates of HAI.[64] In a UK study, researchers found that 90 percent of rooms that had been declared clean were shown by microbiological testing to have unacceptable levels of microorganisms.[65]

Compounding the problem is the fact that Canadian hospitals are severely overcrowded. Across Canada, hospital beds were cut 36 percent from 1998 to 2002,[66] and now Canada has one of the highest bed-occupancy rates among countries in the Organisation for Economic Co-operation and Development. Canada's hospital bed

numbers (relative to population) were two-third the OECD average in 2008: 3.3 beds per thousand compared to the OECD average of 5.1.[67] Occupancy rates in Ontario, for example, are at the undisputedly dangerous level of 97.9 percent.[68] Dr. Gardam and other infection control specialists have pointed out that “occupancy rates can climb above 100 percent, with patients occupying lounges and hallways.” [69] UK research shows that hospitals with occupancy over 90 percent have 10 percent higher MRSA rates than hospitals below 85 percent.[70]

Canada lacks robust reporting requirements. There are two major deficits in pan-Canadian data on HAIs. First, there is no standard in Canada for reporting on HAIs. The Health Council of Canada has been critical of "inconsistent reporting on adverse events” generally,[71] and leading public health experts call for mandatory reporting of HAI rates across Canada.[72]
Second, we have very little pan-Canadian data on health care cleaning. The Canadian Institute for Health Information ignores cleaning services and workers in its reports on spending and health human resources – and even in a report on HAIs.[73] Statistics Canada inadequately tracks cleaning and other ancillary health care services; in fact, it misrepresents the nature of health care cleaning by categorizing privatized cleaners under the hospitality and service section of the National Occupation Code, obscuring the significant differences between health care work and hospitality work.[74]

The federal government’s fragmented and weak initiatives on HAIs stand in contrast to the UK government’s regulatory actions,[75] and they fail to meet our obligations under global health governance standards.[76] Strong pan-Canadian standards and enforcement mechanisms must be put in place in order to turn the tide on these deadly infections.

Recommendation 10

that the federal and provincial and territorial governments implement a strategy on healthcare associated infections (HAIs) with substantial, dedicated funding for increased in-house health care cleaning, stringent infection control and microbiological cleaning standards, maximum safe occupancy levels in hospitals, and mandatory public reporting on HAI rates and deaths.

## 4. Continuing Care

While the 10-Year Plan represented some progress in extending first-dollar coverage to some short-term and end of life home care, the provisions were too modest, and they reinforced a growing emphasis on medical care to the detriment of health promotion and illness prevention. Residential long-term care (LTC) received no mention, despite the urgent need for access and quality improvements in that sector.

Continuing care has recently come to the fore with concerns about health care funding, demographic trends, and now the Health Accord renewal. Often the discussion misses

critical issues such as understaffing and privatization, and at the federal level, residential care is frequently overlooked. While Canada's aging population does not represent a "crisis" of sustainability as Medicare critics suggest,[77] it does mean that the demand for continuing care will rise. We propose three policy directions: create a pan-Canadian continuing care program, improve quality and reverse privatization.

Continuing care in Canada is characterized by unequal access and quality problems largely due to inadequate public funding and regulation, commercial involvement and its exclusion from Medicare. Programs are patchwork, with variations across provinces in the availability of services, level of public funding, eligibility criteria and out-of-pocket costs borne by residents/clients. Most provinces have cut long-term care bed capacity relative to the senior population in the past decade, without sufficiently expanding home and community care or adequately increasing staffing to reflect the higher acuity of the remaining residents. As a result, care is often rushed and underfunded, with poor working conditions leading to poor quality of care and quality of life for residents/clients. Access is two-tiered. Privatization at all levels - financing, ownership, management and delivery – are worsening quality and access problems.[78]

Commercial involvement is increasing as governments award new contracts to for-profit providers, raise caps on private fees, and subsidize assisted living and retirement or personal care homes, despite evidence of harm. A growing body of empirical evidence, including two systematic reviews,[79] has demonstrated that for-profit long-term care facilities are associated with lower quality of care and poorer resident health outcomes. Further, residents in for-profit LTC facilities in most provinces have to pay more privately (out-of-pocket or through private insurance) for services and products.[80]

Quality problems in residential LTC are a major concern for policy makers, academics, residents, workers and the general public,[81] and while there are many contributing factors, research points to staffing as the key determinant. There is a robust and extensive literature describing an association of higher staffing levels with improved care quality and health outcomes for residents. Multiple studies have shown that higher-staffed facilities perform better on a range of quality and outcome measures,[82] for example, rates of pressure ulcers,[83] weight loss,[84] nutrition and hydration,[85] restraint use[86] and violations of care standards.[87] There are no reliable Canada-level data on staffing in LTC facilities, but available provincial data indicate serious deficiencies, putting us far below safe minimums established by the landmark US Congress-commissioned study.[88]

Home care in Canada is also characterized by quality and access problems. There have been modest new investments in home and community care in all provinces,[89] but progress is uneven,[90] and unmet needs are substantial.[91] In Ontario alone, 10,000 people are on a waiting list for non-nursing home care services, with waits being as long as 262 days.[92] Working conditions are marked by job insecurity, low wages[93] and high injury rates – all of which negatively impact quality of care.

Over time, there has been a shift to more specialized, medical home health services, often as substitution for hospital care, and less and less health promotion and illness prevention.[94] Housekeeping, meal prep, and other home support services continue to be severely underfunded.

Home care is even more privatized than residential long-term care, harming clients and diverting money from direct patient care to company profits. In Ontario, for-profit providers went from 18 percent of all providers in 1995 to 58 percent in 2010[95] with competitive bidding bringing cuts in services, a chill on cooperation, and ballooning administrative costs,[96] as well as turnover approaching 60 percent.[97]
Canada needs a comprehensive strategy, not one that uses “closer to home” rhetoric to camouflage cuts or to pit “home” against “institution”. Instead of increased support for seniors and people with disabilities and chronic illnesses, health care restructuring has on the whole meant increased burdens — a shifting of responsibility and costs to underpaid workers, unpaid caregivers, and residents/clients themselves. There has been inappropriate downloading of patients from hospitals and mental health facilities to LTC facilities. With rationing of residential LTC, there has been a further downloading onto already-strained home and community health programs. At every step, the burden on unpaid caregivers increases, and the wages and working conditions of paid caregivers deteriorate.[98]

We need a federal continuing care program, and it should be funded through general tax revenue. Pooling risk widely by financing a continuing care program from general revenue is more efficient and equitable than any of the other recently proposed options: social insurance, registered savings plans, medical savings accounts and tax breaks for private insurance. General revenue–funded LTC has a number of advantages over social insurance funding, including progressivity, greater control over costs and lower administrative costs.[99] Tax-assisted private savings plans benefit those individuals who can afford to invest (a small and shrinking number), and government ends up with less revenue for population-wide programs.[100] There is extensive evidence critical of medical savings accounts[101] and private insurance.[102] We will have to pay for continuing care one way or another: the choice is whether we do so in a socially just and economically prudent way.

Expanding Medicare to continuing care is financially doable, and there is growing demand for federal action from inside and outside of parliament. In terms of financing, the federal government could make choices that would give it ample fiscal capacity for increased health transfers;[103] halting the latest round of corporate tax cuts alone would garner the public treasury $20 billion over five years.[104] A majority of Canadians are willing to pay higher taxes for health care.[105]

We can also look beyond our borders for inspiration. Canada currently lags behind much of the developed world.[106] Nordic European countries have long-standing public (comprehensive, universal and tax-financed) continuing care programs. Other countries have introduced major public initiatives in the past decade, most notably Scotland,

Germany and Japan. Relative to Canada, other developed countries have more extensive government regulation, monitoring and public reporting of LTC quality.[107]

Safe staffing levels and non-profit ownership are two of the most important determinants of quality of care and must be part of the regulatory framework. The federal government is within its rights to set these types of conditions on federal transfers. Consider Bill C-303, the *Early Learning and Child Care Act*. While voted down by the Conservatives in 2007, the *Act* had support from all three opposition parties and passed Justice lawyers' scrutiny in the committee stage. Not only would it have created a new social program, it would have tied federal funding to non-profit delivery (with grand-parenting of for-profit providers) and quality standards, including child-to-caregiver ratios.

Recommendation 11

that the federal government extend Medicare to continuing care (home/community and residential care), with legislated standards and dedicated funding, financed through general revenue. The regulatory framework should include *Canada Health Act* provisions plus minimum staffing standards and phasing out of for-profit delivery.

## 5. Primary Care

The 10-Year Plan set the objective of 50 percent of Canadians having 24/7 access to multidisciplinary teams by 2011. That objective has not been met. The Health Council reports that "Canada's primary health care system lags behind those in similar Western countries in measures such as after-hours care, wait times, chronic disease management, mental health, quality improvement, and electronic medical records."[108] In 2009, only 32 percent of Canadians reported having access to more than one primary health care provider.[109] The 2010 Commonwealth Fund International Health Policy Survey also found significant barriers to primary care, in particular after-hours care, same day appointments, and timely access to specialists.[110]

As shown in this Committee's June 2009 report,[111] health status is affected by social, economic and environmental factors; a holistic approach is required to address health disparities arising from societal inequity. The Health Council estimates that income disparities account for up to 20 percent of total health spending.[112] The Commonwealth Fund survey revealed disturbing inequity in health care utilization between low and high income Canadians:

- Nine percent of lowest-income Canadians report not consulting a doctor because of cost, compared with one percent of highest-income Canadians.
- 10 percent of lowest-income Canadians report skipping a medical test or treatment due to cost, compared with only three percent of those with the highest income.[113]

The benefits of multi-disciplinary care have been well documented, particularly for people with chronic health conditions. The community health centre model, in which physicians, nurses, physiotherapists, social workers and other providers collaborate, is uniquely positioned to deliver coordinated primary care.[114]

In order to achieve the objectives of the 10-Year Plan to improve the health status of Canadians, and to address the underlying inequities that impact on health status, we need a primary care system in which community-driven programs are part of the primary health care "system" within every Canadian community.[115]

Recommendation 12

that the federal government establish standards and provide targeted resources for primary health care reform, including expanded access to community health centres, prioritizing individuals, families and communities with the greatest need.

## 6. Aboriginal Health

The federal government committed in the 10-Year Plan to improve access to health care in the North and Aboriginal health more broadly. After meeting of First Ministers and national Aboriginal leaders in September 2004, the federal government announced a five-year $200 million Aboriginal health transition fund. Then in November 2005, after a conference in Kelowna, the federal government pledged $5 billion over five years to improve health care, housing, economic development and education, promising to use the Blueprint on Aboriginal Health. Though the Conservative government promised in its first budget in 2006 to meet the targets of the Kelowna deal, it has not carried through. None of the investments in recent federal budgets have come close to the level of funding and the type of programs envisioned by the Kelowna Accord.

The Health Council of Canada in 2008 and again in 2010 concluded that "the Federal government remains unclear about its intentions with respect to implementing the Blueprint on Aboriginal Health and the Kelowna Accord."[116] The Auditor General reported in June 2011 that "(d)espite the federal government's many efforts to implement our recommendations and improve its First Nations programs, we have seen a lack of progress in improving the lives and well-being of people living on reserves."[117]

The health, social and economic disparities between Aboriginal and non-Aboriginal people are unacceptable, significant, and in some cases growing. Aboriginal people continue to have higher levels of infant mortality, higher rates of chronic disease and lower life expectancy than non-Aboriginal people.[118] As stated by the Canadian Mental Health Association, "Aboriginal people are also more likely to face inadequate nutrition, substandard housing and sanitation conditions, unemployment and poverty, and discrimination and racism, all important factors in maintaining health and wellness."[119]

Aboriginal women experience particular barriers in accessing health care: distance and transportation costs, lack of trained health care workers, insufficient general and specialized health services in their communities, lack of consultation in program development, and lack of culturally sensitive care.[120]

Aboriginal communities endure the worst water conditions in Canada. The National Engineering Assessment released by the federal government in July 2011 concluded that 73 percent of First Nation water systems are at risk, 118 First Nations communities remain on boil water advisories, and infrastructure needs total $6.578 billion.[121] Access to clean drinking water is a universal human right, affirmed by the United Nations in 2002.[122] Associate Chief Justice Dennis O'Connor, in his Walkerton Inquiry Report, urged the federal government to work with First Nations to formally adopt water quality standards for reserves that are equal or superior to standards elsewhere, and to make those standards legally enforceable.[123]

The Non-Insured Health Benefits (NIHB) program needs immediate new investments. There will be a 9.7 percent increase in eligible beneficiaries due to recent new registrations under the *Indian Act*. In addition, the Assembly of First Nations estimates that 6.3 - 9.3 percent more money is needed in various benefit areas to deal with growth of the existing client population, inflation, and changes in health service utilization, health status, and technology. Without a resolution to this funding crisis, First Nations children, adults, and elders face growing barriers to basic health care.[124]

Health care programs for Aboriginal communities are characterized by gaps in service and a lack of predictable and stable funding. As the Health Council notes "(i)f Canada's goal is to reduce the unacceptable health disparities between Aboriginal and non-Aboriginal Canadians, a concrete way of doing this is to expand programs that work and provide stable, multi-year funding."[125]

Recommendation 13

that the federal government involve Aboriginal organizations in negotiations with First Ministers on the renewal of the Health Accord; meet the goals of the Kelowna Accord; implement recommendations of The National Engineering Assessment; adopt higher water quality standards for reserves; and make new investments in the Non-Insured Health Benefits (NIHB) Program.

## 7. Prescription Drugs

The federal government has not followed through on its commitment in the 10-Year Plan to a national pharmaceutical strategy. The impact on Canadians is dire:

- Up to eight million Canadians do not have coverage for prescription drugs,[126] and one in 10 Canadians report they have "failed to fill a prescription, or have skipped a dose, because of cost."[127]

- Inappropriate use of pharmaceuticals continues to be a leading cause of death in Canada.[128]

- Drugs are the second highest spending area in health care,[129] and drug costs continue to rise steeply.[130]

- Prescription drugs in Canada are 30 percent more expensive than the international average.[131]

- Health Canada has drafted legislation to weaken drug safety regulation and speed up drug approvals.

- The federal government fuels inappropriate prescribing by allowing illegal direct-to-consumer advertising and off-label promotion, and by continuing to allow pharmaceutical companies to regulate their own marketing.[132]

A groundbreaking study published in 2010 showed that a universal public drug plan would save Canadians up to $10.7 billion a year.[133] Many countries, including France, the UK, Sweden, Australia and New Zealand have universal drug plans and, as a result, pay far less for drugs than Canada.[134] Going in the opposite direction, the Canadian government is negotiating a trade agreement with the European Union that could increase prescription drug costs by $2.8 billion a year.[135]

Federal leadership is essential to ensure universal access, safe and appropriate prescribing, and value for money.

Recommendation 14

that the federal government begin immediately to work with the other governments in Canada to implement the National Pharmaceutical Strategy as agreed to in the 2004 Health Accord.

Recommendation 15

that the federal government establish a national pharmacare program that provides equal access to safe and effective drugs while keeping rising costs in check. The program should include first-dollar coverage for essential drugs on a national formulary, bulk purchasing, more rigorous safety standards, evidence-based prescribing, and stricter controls on drug company marketing.

Recommendation 16

that the federal government reject the demand by the European Union in CETA negotiations to change intellectual property laws to increase patent protection for brand-name drugs as this will add significant costs to Canada's public health care system and increase the financial barriers to medically necessary medicines for millions of Canadians.

## 8. Health Human Resources

The 10-Year Plan made commitments of $85 million to Health Human Resource (HHR) renewal, as well as ongoing funding of $20 million per year to develop a pan-Canadian HHR strategy that has yet to be realized. The federal government committed to: address concerns regarding the assessment and integration of internationally trained health care graduates, address the HHR deficit in Aboriginal communities, and participate in HHR planning with interested jurisdictions. Despite this investment, Canada remains far behind in ensuring an adequate supply of health care providers.[136] In fact, the federal government's endorsement of parallel private for-profit health care worsens the shortages.

The June 17, 2011 report of the House of Commons Standing Committee on Health on HHR indicates there are positive developments in areas such as developing collaborative practice programs, accelerated integration of internationally-educated health care professionals, and initiatives for Aboriginal, rural and northern communities.[137] However, we are concerned with the lack of attention paid to providers other than doctors, nurses and allied health professionals. For example, 80 percent of home care work is performed by unregulated health care workers providing both direct care and support services, yet governments have failed to address the recruitment and retention issues in this sector. As well, the Committee failed to address the international recruitment of health care workers.

Health employers continue to poach health care workers from developing countries, relying more and more on migrant workers, aided by the federal government's Temporary Foreign Workers Program (TFWP). Employers use the TFWP to drive down wages and working conditions resulting in increased precariousness of work.[138] The TFWP operates without a sufficiently rigorous regulatory framework, as evidenced in the 2009 report of the Auditor General that pointed to major problems regarding all aspects of the program.[139] Workers recruited through the TFWP are vulnerable in that they often lack English language skills, and are often subjected to exploitative recruitment fees, withholding of pay, and dismal living and working conditions, with no universal right to pursue permanent resident status in Canada.

CUPE supports upgrading, language training, and credential recognition of internationally educated health care workers, including those already in Canada and employed in health care. The federal government must do more to address the persistent barriers to training and professional certification faced by many underemployed nurses, doctors and paraprofessionals. Laddering programs, for example for care aides to become nurses, are similarly underfunded.

The federal government should also pursue employment equity strategies. We would like to know, for example, what progress has been made on recruiting and training Aboriginal health care workers since the 10-Year Plan was signed. CUPE is part of a groundbreaking "representative workforce" strategy in Saskatchewan that increased the health care workforce participation rate of Aboriginal people from one percent prior to 1995 to six percent in 2008[140] and provided Aboriginal Awareness Training to 27,000 workers.[141] We believe this is a strategy that the federal government should support and expand beyond Saskatchewan.[142]

A pan-Canadian health human resources strategy must also address the poor working conditions and wide wage gaps that characterize the health care sector, particularly for support workers.[143] One in ten support workers in Canada has income below the Statistics Canada poverty line. Two-thirds have no pension, and less than half have extended health or dental coverage.[144] In the wake of massive contracting out, health care support workers in British Columbia struggle under a two-tiered wage system to support their families.[145] In one study, 40 percent were working at least two jobs to make ends meet.[146]

The Health Committee Report on HHR makes clear that federal government leadership is critical in providing "sustained and secure funding mechanisms" to achieve HHR objectives.[147] The federal government must step up to lead and accelerate this important work.

Recommendation 17

that the federal government develop and implement a pan-Canadian health human resources strategy that achieves better working conditions, training and upgrading programs, and wage parity to improve retention and recruitment across the health sector; that this strategy advance employment equity, including Aboriginal "representative workforce" strategies.

Recommendation 18

that the federal government adopt and promote recruitment policies consistent with the World Health Organization Global Code of Practice on the Ethical Recruitment of Health Personnel; establish a Migrant Worker Commission as an independent regulatory body that has enforcement power; and develop a national policy framework to regulate labour brokers and recruiters.

## Conclusion

The future of health care in Canada can only be secured with strong federal leadership. Given the federal government's refusal to enforce the *Canada Health Act* or show leadership in tackling quality and access problems across the continuum of care, and its pursuit of a trade agreement that favours corporate interests in health care, CUPE is deeply concerned about the future of Medicare.

The 2004 Health Accord stabilized the health care system following deep cuts in the 1990s that seriously compromised access and quality of care. The Health Accord must be renewed in 2014 with at minimum six percent increases for another ten years. It must also address growing gaps and safety issues in continuing care, primary care, prescription medicines, and Aboriginal health. Privatization and contracting out must be reversed to improve quality and access and to save money. In all areas of health care, we need federal leadership to achieve pan-Canadian policy goals.

sc/cope491

## Endnotes

[1] Nanos Research in Canadian Health Coalition. 2010. *Election Primer. Put Health Care on the Ballot*. Retrieved November 6, 2011 at http://healthcoalition.ca/wp-content/themes/default/Medical%20Tabloid_EN_web.pdf
[2] Ipsos. July 21, 2011. "When it comes to Healthcare, Most Canadians (89%) Expect the Federal Government to Play a Leading Role – and Think that a First Ministers Meeting Needs to be Called as Soon as Possible to Address the Challenges Facing the Health System (92%)". Retrieved November 6, 2011 at http://www.ipsos-na.com/news-polls/pressrelease.aspx?id=5293
[3] Canadian Union of Public Employees. 2008. *Submission to the House of Commons Standing Committee on Health (Canada) in relation to its review of the 10-Year Plan to Strengthen Health Care.* Retrieved November 6, 2011 at http://cupe.ca/health-care/Moist_to_committee_h
[4] Ibid, p. 1.
[5] Office of the Auditor General. September 2002. *Status Report of the Auditor General of Canada. Chapter 3 – Health Canada – Federal Support for Health Care Delivery*. Retrieved November 6, 2011 at http://www.oag-bvg.gc.ca/internet/English/parl_oag_200209_03_e_12388.html
[6] Health Council of Canada. *2006 Annual Report: Health Care Renewal in Canada: Measuring Up*. P.9. Retrieved November 6, 2011 at http://www.healthcouncilcanada.ca/docs/rpts/2007/HCC_MeasuringUp_2007ENG.pdf
[7] Dr. Jack Kitts in the *Proceedings of the Standing Committee on Social Affairs, Science and Technology. Issue 22 – Evidence – March 9, 2011*. Retrieved November 6, 2011 at http://www.parl.gc.ca/Content/SEN/Committee/403/soci/22evb-e.htm?Language=E&Parl=40&Ses=3&comm_id=47
[8] "Bernier seeks end to $40-billion in social, health transfers to provinces." *Globe and Mail.* Oct. 13, 2010; André Picard. May 27, 2011. "Tories set to steer new course on health care funding. *Globe and Mail*.
[9] Erin Weir. "Premiers could be reaching for their wallets." *The Toronto Star*. April 25, 2011. Retrieved November 3, 2011 at http://www.thestar.com/opinion/editorialopinion/article/978840--premiers-could-be-reaching-for-their-wallets
[10] Infometrica Ltd. in Canadian Union of Public Employees. 2008. *Economic Climate for Bargaining*, Vol. 5, No. 4. Retrieved August 1, 2009 at http://cupe.ca/updir/ECB_December_2008.pdf
[11] Ontario Health Coalition. 2008. *Eroding Public Medicare: Lessons and Consequences for For-Profit Health Care Across Canada*. P. 7 Retrieved October 28, 2011 at http://www.web.net/ohc/Eroding%20Public%20Medicare.pdf
[12] CMAJ, May 17, 2011, 183(8) http://www.cmaj.ca/content/183/8/E437.full
[13] "Patients need to know." Ottawa Citizen. October 20, 2011. Retrieved November 6, 2011 at http://www.ottawacitizen.com/health/Patients+need+know/5577773/story.html
[14] Diana Gibson, Parkland Institute, e-mail communication with Irene Jansen, CUPE Research, November 3, 2011.
[15] Sutherland, Jason. 2011. *Hospital Payment Mechanisms: An Overview and Options for Canada*. CHSRF Series of Reports on Cost Drivers and Health System Efficiencies. Paper 4, p. 10. Retrieved November 6, 2011 at http://www.chsrf.ca/Libraries/Hospital_Funding_docs/CHSRF-Sutherland-HospitalFundingENG.sflb.ashx
[16] Canadian Doctors for Medicare. 2008. *Activity-Based Funding in Canadian Hospitals and Other Surgical Facilities*. P. 11. Retrieved November 6, 2011 at http://www.canadiandoctorsformedicare.ca/images/stories/ABF_Position_Paper_15OCT08.pdf
[17] Hudson, Alan. 2009. "Panel Presentation" 2009 CEO Forum: Service-based Funding and Payment for Performance: Experience, Evidence and Future Prospects. Association of Canadian Academic Healthcare Organizations, Canadian Medical Association, Canadian Health Services Research Foundation. Retrieved November 7, 2011 at http://www.chsrf.ca/NewsAndEvents/Events/CEOForum/CEOforum2009.aspx
[18] British Medical Association. 2009. *BMA Evidence to the Health Select Committee Inquiry into Commissioning*. P. 5. Retrieved November 6, 2011 at www.bma.org.uk/healthcare_policy/responses_consultations/healthcomevi.jsp

[19] National Health Service Consultants' Association. August 16, 2007. *Letter from the NHS Consultants' Association to the Canadian Medical Association.* Accessed May 2, 2008 at http://www.cupe.ca/healthcare/NHSCAletter
[20] Ontario Health Coalition. 2008. *Eroding Public Medicare: Lessons and Consequences for For-Profit Health Care Across Canada*. P. 7 Retrieved October 28, 2011 at http://www.web.net/ohc/Eroding%20Public%20Medicare.pdf
[21] Canadian Union of Public Employees based on a legal analysis by Steven Shrybman. 2008. *Defending Medicare: A Guide to Canadian Law and Regulation*. Retrieved November 6, 2011 at http://cupe.ca/updir/DefendingMedicare.pdf
[22] Roger Collier. October 21, 2008. "Aggressive billing techniques confusing Canadians." *Canadian Medical Association Journal*. Vol. 179, No. 9. Retrieved November 6, 2011 at http://www.cmaj.ca/content/179/9/888.full
[23] Canadian Doctors for Medicare. February 10, 2011. *New study finds that extra billing is back. Private clinics charge patients for medically necessary services, provide excessive care*. Retrieved November 6, 2011 at http://www.canadiandoctorsformedicare.ca/new-study-finds-that-extra-billing-is-back-private-clinics-charge-patients-for-medically-necessary-services-provide-excessive-care.html
[24] BC Health Coalition. January 31, 2011. *Medicare advocates call for Health Canada investigation into Copeman Healthcare Centre's member-only' concierge medicine' model.* Retrieved November 6, 2011 at http://www.cnw.ca/fr/story/775667/medicare-advocates-call-for-health-canada-investigation-into-copeman-healthcare-centre-s-member-only-concierge-medicine-model
[25] BC Health Coalition. June 29, 2011. *Copeman Clinic: Health Coalition questions Medical Services Commission's ability to protect patients from illegal user charges*. Retrieved November 6, 2011 at http://www.bchealthcoalition.ca/images/PDF/bchc_nr_copeman_june_2011_final.pdf
[26]*Montreal Gazette*. January 19, 2011. "'Concierge' medical services under fire; Annual fee: $975." Page: A6
[27] *Montreal Gazette*. January 20, 2011. "Private clinics under investigation: Health board launches 11 probes"; Gouvernement du Québec. September 28, 2011. Comminuque: Enquêtes sur trois coopératives de santé. Retrieved November 6, 2011 at http://communiques.gouv.qc.ca/gouvqc/communiques/GPQF/Septembre2011/28/c7417.htmlSource
[28] *Montreal Gazette*. November 27, 2010. "Want fast care? Slip an MD some cash 'It's systemic'. Privatization fosters black market, physician says."
[29] Aronson, J., M. Denton, I.U. Zeytinoglu, S. Davies and D. Hunter. 2006. "The Impact of Implementing Managed Competition on Home Care Workers' Turnover Decisions." *Canadian Public Policy* 1(4): 106–23; Bourbonniere, M., Z. Feng, O. Intrator, J. Angelelli, V. Mor and J.S. Zinn. 2006. "The Use of Contract Licensed Nursing Staff in U.S. Nursing Homes." *Medical Care Research and Review* 63(1): 88–109; Davies, S. 2010. "Fragmented Management, Hospital Contract Cleaning and Infection Control." *Policy and Politics* 38(3): 445–63(19); Stinson, J., N. Pollack and M. Cohen. 2005. *The Pains of Health Care Privatization.* Vancouver, BC: Canadian Centre for Policy Alternatives, BC Office.
[30] Canadian Union of Public Employees. 1996. *Cooking Up A Storm: Shared food services in the health care sector*. http://cupe.ca/health-care/cooking-storm-shared-food-services; Guillaume bert. 2010. *Nouveaux CHUM/CUSM: Vers la sous-traitance des services alimentaires?* - conomiques.
[31] Castle, N., Engberg J. and Men, A. 2008. "Nurse Aide Staffing and Quality of Care in Nursing Homes." *Medical Care Research and Review*, 65:232.
[32] Mackenzie, M. and M. Rachlis. 2010. *The Sustainability of Medicare.* Ottawa, ON: Canadian Federation of Nurses Unions. http://www.nursesunions.ca/report-study/the-sustainability-medicare
[33] Canadian Institute for Health Information. *National Health Expenditure Trends 1975-2011*. P. 15 http://secure.cihi.ca/cihiweb/products/nhex_trends_report_2011_en.pdf
[34] Mackenzie, M. and M. Rachlis, 2010.
[35] Ibid.
[36] Ontario Health Coalition. January 2008. *When public relations trump public accountability: The evolution of cost overruns, service cuts and cover-up in the Brampton Hospital P3*; Stuart Murray. June 2006. *Value for money? Cautionary lessons about P3s from British Columbia*. Canadian Centre for Policy Alternatives; Aiden R. Vining and Anthony E. Boardman. December

2006. *Public-Private Partnerships in Canada: Theory and Evidence*. UBC Saunder School of Business. Working Paper 2006-04; Auerbach, L. December 2002. *Issues raised by public-private partnerships in Ontario's hospital sector.*

[37] Hugh Mackenzie. 2009. *Bad Before, Worse Now: The Financial Crisis and the Skyrocketing Costs of Public Private Partnerships (P3s).* Retrieved November 1, 2011 at http://www.cupe.bc.ca/sites/default/files/Bad%20Before%20Worse%20Now%20_final_%20_2_.pdf; Canadian Union of Public Employees. 2010. *Business case for P3 hospitals" unfounded": Quebec auditor.* Retrieved November 7, 2011 at http://cupe.ca/privatization-watch-june-2010/business-p3-hospitals-unfounded-quebec.

[38] Allyson Pollock, David Price, and Moritz Leibe. 2011. "Private finance initiatives during NHS austerity." *British Medical Journal*. 9 February 2011; Polly Curtis. April 28, 2011. "PFI projects not best value for money, says watchdog." *The Guardian*. Retrieved November 6, 2011 at http://www.guardian.co.uk/politics/2011/apr/28/pfi-not-best-value-money

[39] BC Health Coalition. 2008. *Abbotsford P3 Hospital – overtime and over budget*; Ontario Health Coalition. 2008. *When Public Relations Trump Public Accountability;* Ontario Health Coalition. 2003. *P3 Hospitals – Importing a British Failure;* Allyson Pollock. 2005*. NHS plc: the privatisation of our health care*.

[40] Steven Shrybman in Loxley, John with Salim Loxley. 2010. *Public Service Private Profits: The Political Economy of Public-Private Partnerships in Canada*. Fernwood. Halifax and Winnipeg. P. 109.

[41] BC Health Coalition et al. 2005. *Re-establishing a Federal Role in Hospital Infrastructure Finance, Discussion Paper.* Retrieved November 6, 2011 at http://cupe.ca/updir/final_hospital_infrastructure.pdf

[42] Infometrica Ltd. in Canadian Union of Public Employees. 2008. *Economic Climate for Bargaining*, Vol. 5, No. 4. Retrieved August 1, 2009 at http://cupe.ca/updir/ECB_December_2008.pdf

[43] Health Council of Canada. May 2011. *Progress Report 2011: Health Renewal in Canada*. P.7. Retrieved November 6, 2011 at http://www.healthcouncilcanada.ca/docs/rpts/2011/progress/2011Progress_ENG.pdf

[44] P.J. Devereaux, et al, A systematic review and meta-analysis of studies comparing mortality rates of private for-profit and private not-for-profit hospitals, CMAJ May 28, 2002 vol. 166 no. 11, on line at http://www.cmaj.ca/content/166/11/1399.full; CUPE, Private For- Profit Clinics – Fact Sheet, Sept. 2008 http://cupe.ca/updir/Private-For-Profit-Health-Care-Clinics.pdf

[45] Canadian Union of Public Employees. 2008. *Private For- Profit Clinics Fact Sheet*. http://cupe.ca/health-care/Private-for-profit-c

[46] Tuohy, C. H., Flood, C. M., & Stabile, M. 2004. "How does private financing affect public health care systems? Marshaling the evidence from OECD nations." *Journal of Health Politics, Policy and Law*; 29(3): 359-39; Hall, J. et al, cited in S.J. Duckett. 2005. "Living in the parallel universe in Australia: public Medicare and private hospitals." *Canadian Medical Association Journal*. 173(7): 745-747; Duckett, S. J. 2005. "Private care and public waiting." *Australian Health Review* 29(1): 87-93.

[47] CUPE and SEIU. October 4, 2011. "Data show fewer surgeries in health region: Government and health region need to explain what happened." Retrieved November 6, 2011 at http://keephealthcarepublic.ca/www/updates/data-fewer-surgeries-health-region

[48] Alicia Priest, Michael Rachlis and Marcy Cohen. 2007. *Why Wait? Public Solutions to Cure Surgical Waitlists*. Canadian Centre for Policy Alternatives. Retrieved November 6, 2011 at http://www.policyalternatives.ca/sites/default/files/uploads/publications/BC_Office_Pubs/bc_2007/why_wait_surgical_waitlists.pdf

[49] Health Council of Canada. March 10, 2011. *Report to the Standing Senate Committee on Social Affairs, Science and Technology.*

[50] Romanow, R.J. 2002. *Building on Values: The Future of Health Care in Canada – Final Report.* Ottawa: National Library of Canada, p. 8.

[51] Sinclair, Scott Koivusalo, Meri Ronald Labonte. 2011. *The Proposed EU-Canada Trade Agreement Raises Health Concerns In Both Canada and European Union*. Ottawa: Canadian Centre for Policy Alternatives.

[52] Scott Sinclair. March 2011. *The CETA and Health Care Reservations: A briefing note for the Canadian Health Coalition*. Canadian Centre for Policy Alternatives. P. 2. Retrieved November 6, 2011 at http://www.policyalternatives.ca/sites/default/files/uploads/publications/National%20Office/2011/03/CETA%20and%20Health%20Care.pdf

[53] World Health Organization. 2011. *Report on the Burden of Endemic Health Care-Associated Infection Worldwide*. P. 13. Retrieved November 6, 2011 at http://whqlibdoc.who.int/publications/2011/9789241501507_eng.pdf
[54] Zoutman et al, 2003. "The state of infection surveillance and control at Canadian acute care hospitals." *American Journal of Infection Control*, 31, 266-275.
[55] Canadian Committee on Antibiotic Resistance. 2007. *Infection Prevention and Control Best Practices for Long Term Care, Home and Community Care including Health Care Offices and Ambulatory Clinics*. Retrieved August 29, 2007 at: http://www.ccar-ccra.com/english/pdfs/IPC-BestPractices-June2007.pdf
[56] Murphy, Janice M. 2007. *The importance of cleaning in the fight against rising healthcare associated infections: A review of the evidence*. Unpublished paper
[57] Canadian Union of Public Employees. 2009. *Health Care Associated Infections: A Backgrounder*. Retrieved November 6, 2011 at http://cupe.ca/health-care/health-care-associated-infections
[58] Dancer, Stephanie J. 2007. "Importance of the environment in methicillin-resistant Staphylococcus aureus acquisition: the case for hospital cleaning." *The Lancet.* Published online October 31, 2007 DOI: 10.1016/S1473-3099(07)70241-4
[59] Dr. Michael Schull speaking to the Senate Standing Senate Committee on Social Affairs, Science and Technology, September 29, 2011. http://www.parl.gc.ca/Content/SEN/Committee/411/soci/49055-e.htm?Language=E&Parl=41&Ses=1&comm_id=47
[60] Canadian Union of Public Employees. 2009. *Health Care Associated Infections: A Backgrounder*. http://cupe.ca/health-care/health-care-associated-infections
[61] Auditor General of Scotland. 2003. *Hospital Cleaning: Executive Summary.* Edinburgh, Scotland: Author.
[62] Davies, S. 2009. *Making the Connections: Contract Cleaning and Infection Control. A Report for UNISON.* Cardiff, Wales: Cardiff University.
[63] Irene Jansen. 2009. "Environmental Cleaning and Healthcare-Associated Infections. *HealthcarePapers* Vol. 9, No. 3: 38-43.
[64] Canadian Union of Public Employees. 2009. *Health Care Associated Infections: A Backgrounder*; Todd Neale. March 29, 2011. "MRSA Acquisition Tied to Better Cleaning." *MedPage Today.* Enhanced cleaning protocol halved the acquisition rate of MRSA in 10 ICUs from 3 percent to 1.5 percent. Retrieved November 6, 2011 at http://www.medpagetoday.com/CriticalCare/InfectionControl/25595; Kelly M. Pyrek. July 14, 2011. "Communicating the Importance of Environmental Hygiene to Healthcare Workers." *Infection Control Today*. Retrieved November 6, 2011 at http://www.infectioncontroltoday.com/articles/2011/07/communicating-the-importance-of-environmental-hygiene-to-healthcare-workers.aspx
[65] Malik, R.E., Cooper, R.A. and Griffith, C.J. (2003) "Use of audit tools to evaluate the efficacy of cleaning systems in hospitals." American Journal of Infection Control Vol. 31(3):181-187.
[66] Canadian Institute for Health Information. 2005. *Hospital Trends in Canada*. Ottawa, ON: Author.
[67] Organization for Economic Co-operation and Development. June 2011. *OECD Health Data 2011*. http://www.oecd.org/document/16/0,3746,en_2649_34631_2085200_1_1_1_1,00.html
[68] Ontario Health Coalition (July 21, 2011) No Vacancy: Hospital Overcrowding in Ontario, Impact on Patient Safety and Access to Care p. 8 http://www.web.net/ohc/hospitalbedsreport.pdf
[69] Dr. Michael A. Gardam et al. 2009. « Healthcare-Associated Infections as Patient Safety Indicators." *HealthcarePapers* Vol. 9, No. 3, p. 20.
[70] British Medication Association. June 2009. *Tackling healthcare associated infections through effective policy action*. P. 21. Retrieved November 6, 2011 at http://www.bma.org.uk/images/Tackling%20healthcare%20associated%20infections%20through%20effective%20policy%20action_tcm41-188116.pdf
[71] Health Council of Canada. June 8, 2010. *Presentation to National Health Care Leadership Conference.* Retrieved November 7, 2011 at *http://www.healthcouncilcanada.ca/docs/speeches/2010/Notes%20NHLC%20Breakfast_JGA_June%208_2010.pdf*
[72] HealthcarePapers Vol. 9, No. 3 2009.
[73] Canadian Institute for Health Information. 2008. *Patient Safety in Ontario Acute Care Hospitals: A*

*Snapshot of Hospital Acquired Infection Control Practices.* Retrieved November 5, 2011 at https://secure.cihi.ca/estore/productFamily.htm?pf=PFC1089&lang=fr&media=0

[74] Marjorie G. Cohen. 2001. *Do comparisons between hospital support workers and hospitality workers make sense?* Prepared for Hospital Employees' Union. Retrieved November 6, 2011 at http://www.heu.org/~DOCUMENTS/research_reports/Comparison_Hospital_Support_Workers_1.pdf

[75] Steve Davies. 2009. *Making the Connections: Contract Cleaning and Infection Control.* A Report for UNISON. Cardiff, Wales: Cardiff University.

[76] Kumanan, W. and H. Lazar. 2005. *Planning for the Next Pandemic Threat: Defining the Federal Role in Public Health Emergencies.* Montreal, QC: Institute for Research on Public Policy

[77] Mackenzie, M. and M. Rachlis. 2010. *The Sustainability of Medicare.* Ottawa, ON: Canadian Federation of Nurses Unions.

[78] Irene Jansen. 2011. "Residential Long-Term Care: Public Solutions to Access and Quality Problems." HealthcarePapers. Vol. 10 No. 4.

[79] Comondore, V.R., P.J. Devereaux, Q. Zhou, S.B. Stone, J.W. Busse, N.C. Ravindran et al. 2009. "Quality of Care in For-Profit and Not-for-Profit Nursing Homes: Systematic Review and Meta- Analysis." *BMJ* 339: b2732; Hillmer, M.P., W.P. Wodchis, S.S. Gill, G.M. Anderson and P.A.Rochon. 2005. "NursingHome Profit Status and Quality of Care: Is There Any Evidence of An Association?" *Medical Care Research and Review* 62(2): 139–66.

[80] Irene Jansen 2011.

[81] McGregor, M.J. and L. Ronald. 2011. *Residential Long-Term Care for Canada's Seniors*: *Non-Profit, For-Profit or Does It Matter?* Montreal, QC: Institute for Research on Public Policy. Retrieved January 25, 2011 at http://www.irpp.org/summary.php?id=359

[82] Canadian Union of Public Employees. 2009. *Residential Long-Term Care in Canada: Our Vision for Better Seniors' Care*. Retrieved November 6, 2011 at http://cupe.ca/updir/CUPE-long-term-care-seniors-care-vision.pdf; McGregor and Ronald 2011; Murphy, J.M. 2006. *Residential Care Quality: A Review of the Literature on Nurse and Personal Care Staffing and Quality of Care.* Unpublished report, prepared for the Nursing Directorate, BC Ministry of Health; Schnelle, J.F., S.F. Simmons, C. Harrington, M. Cadogon, E. Garcia and B.M. Bates-Jensen. 2004. "Relationship of Nursing Home Staffing to Quality of Care." *Health Services Research* 39(2): 225–50.

[83] Horn, S.D., P. Buerhaus, N. Bergstrom and R.J. Smout. 2005. "RN Staffing Time and Outcomes of Long-Stay Nursing Home Residents." *American Journal of Nursing* 105: 58–70.

[84] Dyck, M.J. 2007. "Nursing Staffing and Resident Outcomes in Nursing Homes: Weight Loss and Dehydration." *Journal of Nursing Care Quality* 22(1): 59–65.

[85] Kayser-Jones, J. and E.S. Schell. 1997. "Staffing and the Mealtime Experience of Nursing Home Residents on a Special Care Unit." *American Journal of Alzheimer's Disease* 12(2): 67–72.

[86] Castle, N.G. and J. Engberg. 2008. "Further Examination of the Influence of Caregiver Staffing Levels on Nursing Home Quality." *Gerontologist* 48(4): 464–76.

[87] Castle, N.G. 2002. "Nursing Homes with Persistent Deficiency Citations for Physical Restraint Use." *Medical Care* 40(10): 868–78.

[88] Jansen 2011.

[89] Canadian Institute for Health Information. 2007. *Public-Sector Expenditures and Utilization of Home Care Services in Canada: Exploring the Data.* Ottawa, ON: Author.

[90] Health Council of Canada. 2008. *Fixing the Foundation: An Update on Primary Health Care and Home Care Renewal in Canada.* Ottawa, ON: Author.

[91] Senate Special Committee on Aging. 2009. Final Report. *Canada's Aging Population*: *Seizing the Opportunity.* Ottawa, ON: Parliament of Canada. Retrieved December 10, 2010 at http://www.parl.gc.ca/40/2/parlbus/commbus/senate/com-e/agei-e/ subsite-e/Aging_Report_Home-e.htm

[92] Office of the Auditor General of Ontario. 2010 Annual Report. Section 3.04, P. 22. Retrieved November 10, 2011 at http://www.auditor.on.ca/en/reports_2010_en.htm

[93] For example, the legislated hourly rate is $12.50 in Ontario and $11.50 in New Brunswick.

[94] McGrail, K., A. Broemeling, M.J. McGregor, K. Salomons, L.A. Ronald and R. McKendry. 2008. *Home Health Services in British Columbia: A Portrait of Users and Trends over Time.* Vancouver, BC: UBC Centre for Health Services and Policy Research.

[95] Ontario Health Coalition. 2011. Still Waiting: An Assessment of Ontario's Home Care System After Two

Decades of Restructuring. Retrieved November 6, 2011 at http://www.web.net/~ohc/homecare2011finalreport.pdf

[96] Ontario Health Coalition. 2005. *Market Competition in Ontario's Homecare*: *Lessons and Consequence*. Retrieved November 6, 2011 at http://www.web.net/ohc/Homecare2005/homecare%20summary3.pdf; Ross Sutherland. 2001.*The Costs of Contracting Out Home Care: A Behind the Scenes Look at Home Care in Ontario.* Unpublished paper. Retrieved November 6, 2011 at http://cupe.ca/downloads/CostsofContractingout.pdf

[97] Caplan, E. 2005. *Realizing the Potential of Home Care: Competing for Excellence by Rewarding Results*. P.23.

[98] Canadian Union of Public Employees. 2009. *Residential Long-Term Care in Canada: Our Vision for Better Seniors' Care*. Retrieved November 6, 2011 at http://cupe.ca/updir/CUPE-long-term-care-seniors-care-vision.pdf

[99] Jost, T.S. 2008. "Funding Health Care Services: The Optimal Balance." In C. Flood, M. Stabile and C.H. Tuohy, eds., *Exploring Social Insurance: Can a Dose of Europe Cure Canadian Health Care Finance?* Kingston, ON: School of Policy Studies, Queen's University.

[100] Townson, M. 2009. *A Stronger Foundation: Pension Reform and Old Age Security.* Ottawa, ON: Canadian Centre for Policy Alternatives.

[101] Hurley, J. 2002. "Medical Savings Accounts Will Not Advance Canadian Health Care Objectives." *Canadian Medical Association Journal* 167(2): 152–53.

[102] Brown, J.R. and A. Finkelstein. 2007. "Why Is the Market for Long-Term Care Insurance So Small?" *Journal of Public Economics* 91: 1967–92; CUPE 2009; Jost 2008; Royal Commission on Long Term Care. 1999. *With Respect to Old Age: Long Term Care – Rights and Responsibilities.* London: The Stationary Office.

[103] Canadian Centre for Policy Alternatives. 2011. *Alternative Federal Budget*.

[104] Campbell, B. 2010. "Canadians Are Finally Starting to Rethink Tax Cuts." straight.com. Retrieved April 8, 2011 at http://www. straight.com/article-302219/vancouver/bruce-camp- bell-canadians-are-finally-starting-rethink-tax-cuts

[105] Vector Research and Development Inc. 2010. *The Vector Poll on Public Opinion in Canada.* Unpublished document prepared for the National Union of Public and General Employees.

[106] Jansen 2011.

[107] Du Moulin, M.F.M.T., J.C.M. van Haastregt and J.P.H. Hamers. 2010. "Monitoring Quality of Care in Nursing Homes and Making Information Available to the General Public: State of the Art." *Patient Education and Counseling* 78: 288–96.

[108] Health Council of Canada. *At the Tipping Point: Health leaders share ideas to speed primary health.* Retrieved November 6, 2011 at http://www.healthcouncilcanada.ca/docs/rpts/2010/HCC_Commentary_pages2_052510.pdf

[109] Health Council of Canada. 2009. *Teams in Action: Primary Health Care Teams for Canadians*. P. 18. Retrieved November 6, 2011 at http://www.healthcouncilcanada.ca/teamsinaction.pdf

[110] Health Council of Canada. 2010. *How Do Canadians Rate the Health Care System? Results from the 2010 Commonwealth Fund international Health Policy Survey.* Retrieved November 6, 2011 at http://www.healthcouncilcanada.ca/docs/rpts/2010/comm/Commonwealth_FINAL_E_Nov2010.pdf

[111] Senate Standing Committee on Social Affairs, Science and Technology Sub-Committee on Population Health. June 2009. *A Health Productive Canada: A Determinant of Health Approach*. Final Report. Retrieved November 6, 2011 at http://www.parl.gc.ca/Content/SEN/Committee/402/popu/rep/rephealth1jun09-e.pdf

[112] Health Council of Canada. 2010. *Stepping It Up: Moving the Focus from Health Care in Canada to a Healthier Canada*. P. 28. Retrieved November 6, 2011 at http://www.healthcouncilcanada.ca/docs/rpts/2010/promo/HCCpromoDec2010.pdf

[113] Health Council of Canada. *How Do Canadians Rate the Health Care System? Results from the 2010 Commonwealth Fund international Health Policy Survey.* Retrieved November 6, 2011 at http://www.healthcouncilcanada.ca/docs/rpts/2010/comm/Commonwealth_FINAL_E_Nov2010.pdf

[114] Canadian Alliance of Community Health Centre Associations. 2011. *Improve Health and Health Care For All Canadians*: *Background to online petitions in Canada's Provinces and Territories*. Retrieved

November 6, 2011 at http://www.cachca.ca/news/documents/Improve%20Health%20and%20Health%20Care%20for%20All%20Canadians%20-%20Aug%202011%20backgrounder.pdf
[115] Ibid.
[116] Health Council of Canada. 2008. *Fixing the Foundation: An Update on Primary Health Care and Home Care Renewal in Canada*. P. 6.
[117] Office of the Auditor General of Canada. June 2011. *Status Report of the Auditor General of Canada, Chapter 4: Programs for First Nations on Reserves*. Retrieved November 6, 2011 at http://www.oag-bvg.gc.ca/internet/English/parl_oag_201106_04_e_35372.html
[118] Mikkonen, J., & Raphael, D. 2010. *Social Determinants of Health: The Canadian Facts.* Toronto: York University School of Health Policy and Management. P. 42. Retrieved November 6, 2011 at http://www.thecanadianfacts.org/The_Canadian_Facts.pdf
[119] Canadian Mental Health Association. *Aboriginal People/First Nations*. Retrieved November 7, 2011 at http://www.ontario.cmha.ca/about_mental_health.asp?cID=23053; Colonization as a determinant of health is also addressed by Larry N. Chartrand. 2007. *Maskikiwenow: The Métis Right to Health.* Retrieved November 7, 2011 at http://www.naho.ca/library/maskikiwenow-the-metis-right-to-health/
[120] Health Council of Canada. 2011. *Understanding and Improving Aboriginal Maternal and Child Health in Canada Conversations about Promising Practices across Canada*. P.11. Retrieved November 6, 2011 at http://www.healthcouncilcanada.ca/docs/rpts/2011/abhealth/HCC_AboriginalHealth_FINAL1.pdf
[121] Assembly of First Nations. 2011. *Federal Pre-Budget Submission*. Retrieved November 6, 2011 at http://www.afn.ca/uploads/files/2011-pre-budget-submission.pdf
[122] Polaris Institute. 2008. *Boiling Point: Six community profiles of the water crisis facing First Nations within Canada*. P. 5. Retrieved November 6, 2011 at http://www.polarisinstitute.org/files/Boiling%20Point.pdf
[123] The Honourable Dennis R. O'Connor. 2002. *Report of the Walkerton Inquiry: The Events of May 2000 and Related Issues*. Chapter One, Part Two, Recommendation 89. Toronto: Ontario Ministry of the Attorney General.
[124] Assembly of First Nations, "Structural Transformation & Critical Investments in First Nations on the Path to Shared Prosperity", Pre-Budget Submission, 2011 to the House of Commons Standing Committee on Finance, August 12, 2011. http://www.afn.ca/uploads/files/2011-pre-budget-submission.pdf
[125] Ibid, p. 13.
[126] Marc-André Gagnon. 2010. *The Economic Case for Universal Pharmacare: Costs and Benefits of Publicly Funded Drug Coverage for all Canadians*. Canadian Centre for Policy Alternatives & Institut de recherché et d'informations socio-économiques. Retrieved November 8, 2011 at https://s3.amazonaws.com/policyalternatives.ca/sites/default/files/uploads/publications/National%20Office/2010/09/Universal_Pharmacare.pdf
[127] Health Council of Canada. *Health Care Renewal In Canada: Progress Report 2011*. P. 13. Retrieved November 8, 2011 at http://www.healthcouncilcanada.ca/docs/rpts/2011/progress/2011Progress_ENG.pdf
[128] Canadian Health Coalition. 2011. *Secure the Future of Medicare: A Call to Care.* Brief to the Senate Standing Committee on Social Affairs, Science and Technology on its Review of the Progress in Implementing the 2004 Health Accord; World Health Organization. 2008. *Medicines: safety of medicines – adverse drug reactions*. Retrieved November 7, 2011 at http://www.who.int/mediacentre/factsheets/fs293/en/
[129] Health Council of Canada. *Health Care Renewal In Canada: Progress Report 2011*. P. 12. Retrieved November 6, 2011 at http://www.healthcouncilcanada.ca/docs/rpts/2011/progress/2011Progress_ENG.pdf
[130] Marc-André Gagnon. 2010. *The Economic Case for Pharmacare.* Ottawa: Canadian Centre for Policy Alternatives. Retrieved November 6, 2011 at http://pharmacarenow.ca/wp-content/uploads/2010/09/Universal-Pharmacare-Report-e.pdf
[131] Ibid, p. 7.
[132] The Canadian Health Coalition. 2007. *More for Less: Pharmacare – A National Drug Plan*. Retrieved November 6, 2011 at http://pharmacarenow.ca/wp-content/uploads/2010/01/moreforless2.pdf

[133] Marc-André Gagnon, 2010.
[134] Ibid.
[135] Grootendorst P, Hollis A. 2011. *The Canada-European Union comprehensive economic and trade agreement. An economic impact assessment of proposed pharmaceutical intellectual property provisions*. Retrieved November 6, 2011 at http://www.canadiangenerics.ca/en/news/docs/02.07.11CETAEconomicImpactAssessment-FinalEnglish.pdf
[136] John G. Abbott. Health Council of Canada. 2009. *Speaking Notes for Appearance before the House of Commons Standing Committee on Health in its Study of Health Human Resources in Canada*. Retrieved November 6, 2011 at http://www.healthcouncilcanada.ca/docs/speeches/2009/HCC%20Submission%20to%20HESA%20JGA%20March%2024%202009%20_2_.pdf
[137] House of Commons Standing Committee on Health. 2010. *Promoting Innovative Solutions To Health Human Resources Challenges*. http://www.parl.gc.ca/content/hoc/Committee/403/HESA/Reports/RP4631326/hesarp06/hesarp06-e.pdf
[138] Karl Flecker. 2011. *Temporary Foreign Workers Program: Model Program or Mistake.* P. 18. Retrieved November 6, 2011 at http://documents.clc-ctc.ca/HR-EQ/Model-Program-or-Mistake-2011-InDesign-EN.pdf
[139] Auditor General of Canada. 2009. *Report to the House of Commons. Chapter 2: Selecting Foreign Workers Under the Immigration Program*. Retrieved November 6, 2011 at http://www.oag-bvg.gc.ca/internet/English/osh_20091126_e_33492.html
[140] Saskatchewan Association of Healthcare Organizations. *2008/09 Annual Report.* Retrieved November 7, 2011 at http://www.saho.org/portal.jsp?y3uQUnbK9L2RmSZs02CjVy0w7ZkI/ks6pQWxlAIN+Jc=
[141] Saskatchewan Association of Healthcare Organizations. 2010. *Representative Workforce Program*. Retrieved November 7, 2011 at http://www.saho.org/portal.jsp?y3uQUnbK9L2RmSZs02CjV9A3BZ1Tvj1H9cZ4PmbJGZA=
[142] Canadian Union of Public Employees. April 2011. *Creating a Representative Workforce: An Overview of Partnership Agreements and Equity Plans in CUPE Workplaces in Saskatchewan*. Retrieved November 7, 2011 at http://cupe.ca/updir/Creating_Representative_Workplaces_Brief_(Updated_April_13_2011).pdf; Canadian Union of Public Employees. 2008. *Representative Workforce Strategy.* Retrieved November 6, 2011 at http://cupe.ca/aboriginal/Representative-Workf
[143] Salimah Valiani. 2011.*Valuing the Invaluable: Rethinking and respecting caring work in Canada.* Ontario: the Ontario Nurses' Association. Retrieved November 6, 2011 at http://www.ona.org/documents/File/pdf/ONAResearchSeries_ValuetheInvaluable_05052011.pdf
[144] Pat Armstrong, Hugh Armstrong and Krista Scott-Dixon. 2006. *Critical to Care: Women and Ancillary Work in Health Care*, p. 35*.* National Network on Environments and Women's Health. Retrieved May 5, 2008 at: http://www.womenandhealthcarereform.ca/publications/criticaltocarereport.pdf
[145] Hospital Employees' Union Living Wage Campaign http://www.heu.org/campaigns-issues/living-wage-campaign
**[146]** Jane Stinson, Nancy Pollak and Marcy Cohen. 2005. *Pains of Privatization: How Contracting Out Hurts Health Support Workers, Their Families, and Health Care*. CCPA-BC Office. P. 3. Retrieved November 6, 2011 at http://www.heu.org/sites/default/files/uploads/2008_MemberResources/pains_privatization.pdf
[147] House of Commons Standing Committee on Health. 2009. *Promoting Innovative Solutions To Health Human Resources Challenges.* P. 63. Retrieved November 6, 2011 at http://www.parl.gc.ca/content/hoc/Committee/403/HESA/Reports/RP4631326/hesarp06/hesarp06-e.pdf