A 10 – YEAR PLAN TO STRENGTHEN HEALTH CARE?

A CRITICAL LOOK AT THE FIRST MINISTERS' DEAL

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Research Branch

Federal, provincial and territorial first ministers met in Ottawa from September 13 – 16, 2004 in an attempt to reach yet another agreement to resolve health care funding and delivery woes. Paul Martin and the federal Liberals election promised that it would be a deal to "fix health care for a generation." Here is what happened.

REACHING THE DEAL

After two days of public meetings where the federal and provincial governments were able to engage in public relations pitches to their respective electorates, the First Ministers reverted to traditional federal/provincial deal making to try to reach an agreement on health care.

On day one there were positive developments as the federal government met with aboriginal leaders and came to an agreement to provide $700 million over 5 years to improve aboriginal health care. This is welcome new money to assist aboriginal communities in their efforts to deal with some very critical health issues.

Day two saw the Premiers continue their individual, but coordinated, pitches for more money citing the need for stable funding to provide long-term programming. The provinces made a compelling case that federal transfers should be increased to 25% of total provincial/territorial health expenditures. The federal government stuck to its contention that their proposal met that standard. The issue of accountability appeared to be still on the agenda, but just below the surface.

By the end of day two it was clear that the battle lines were drawn around funding and accountability measures. The televised meeting adjourned and the First Ministers went behind closed doors in the evening to try to work out the funding differences.

On day three the First Ministers never emerged from the closed - door negotiations and the hard bargaining was on. The outstanding issues were reported to be (1) funding, (2) how the deal would apply to Quebec, (3) conditionality – what the accountability measures and mechanisms would be, and (4) equalization payments.

The equalization issue was an on-again, off again, on-again and finally off-again item at these meetings. The provinces initially placed the matter on the table in conjunction with the health care funding issue. It was later shunted aside in order to focus on the real questions of the costs of health care programming in the provinces. It re-appeared on day three probably at the insistence of the "have not" provinces, but did not show up in the final deal. It has since been announced that a First Ministers' meeting on equalization will be held on October 26, 2004.

When the smoke cleared the First Ministers announced a deal in the early morning of day four, Thursday September 16. The deal was what we expected but not what we wanted. Money was the major item and the deal was structured around an additional $41 billion transfer from the federal government over the next ten years.

Accountability and conditionality for the transfers came a sad second in the list of priorities. It is hard to think of how the First Ministers could have done less on these matters.

The issue of privatization and for – profit care never made it to the table - truly remarkable given that Canadians are passionate about keeping health care publicly funded and delivered. Even more remarkable was that the First Ministers continued to keep their heads in the sand on for-profit care even as three physicians in Quebec announced they were opting out of the public system to provide for – profit services.

Not surprisingly, the ink is barely dry on the agreement and the provinces are already musing about more money being necessary to meet targets. Money is the issue for governments, but money with accountability and conditions are the issues for Canadians. The governments have failed to meet our expectations.

KEY FEATURES OF THE DEAL

Funding, But Few Conditions

Significant amounts of new money will be infused into the health care system bridging the so-called "Romanow gap" and bringing federal transfers to approximately 25% of total provincial/territorial health spending. The new federal spending amounts to $41 billion over 10 years.

The federal commitment to increased funding is substantial and the 6 percent escalator provision goes a long way to providing stable, long term funding for the provinces.

The details on the funding are:

- $1 billion in 2004-05 and $2 billion in 2005-06 applied to the base of the Canada Health Transfer;
- $500 million in 2005 – 06 to be applied to commitments on home care and catastrophic drug coverage;
- Base funding in the Canada Health Transfer to increase to $19 billion in 2005 – 06;
- A 6 percent escalator clause to be applied in 2006 – 07;
- $4.5 billion will be allocated to a "Wait Times Reduction Fund" between 2004 –05 and 2009 – 10;
- In 2010 – 11, $250 million per year will be added for health human resources;
- $500 million will be allocated to medical equipment in 2004 – 05;
- $700 million over 5 years to improve the health of aboriginal peoples.

See appendix A for full details on the 10-year funding commitment plan.

In spite of the new funding the federal government was unable to wrest any meaningful commitments from the provinces on accountability and unable to establish any conditions that the provinces/territories must meet in order to receive federal funding.

"Stemming the tide of privatization" as promised by Health Minister Dosanjh and halting for – profit delivery of health care services were never put on the table. Federal government election promises to strengthen public health never went beyond providing additional money.

The federal government missed a golden opportunity to seek commitments to the public delivery of health care in exchange for the significant increase in federal investment. The provinces descended to a lowest common denominator hiding behind provincial jurisdictional rights to deliver health care services and allowing the pro-privatization provinces to keep the public delivery question off the table.

Accountability and Reporting to Citizens

Over the next 10 years (2004 – 05 to 2013 – 14) the federal government will transfer $239.5 billion to the provinces and territories, barring any further changes. What level of accountability should the federal government expect as the *quid pro quo* in this bargain? Very little, apparently.

The federal government has placed few conditions on the use of the funds and no real enforcement mechanisms should the provinces not use the funds as intended. Prime Minister Martin is on record as saying that the provincial governments will have to face their electorate if they don't. That is not good enough. Canadians have a right to demand accountability from the provinces for federal transfers for health care.

Instead, the First Ministers wrapped this key element of the agreement up in five short sentences that boil down to this - the provinces must report to their residents through their respective health councils and the Canada Health Council must issue a report. However, since Alberta and Quebec do not participate in the Canada Health Council, the Council's report will be incomplete. Alberta and Quebec escape this level of scrutiny on health spending.

The First Ministers formalized a disputes resolution mechanism (initially proposed in 2002) whereby a federal/provincial arbitration panel will explore the dispute and issue a recommendation for resolution to the federal government. This dispute mechanism will be nothing more than a continuation of behind closed doors deal making between the federal government and the provinces. The panel will have no formal legal process, will not be open to public scrutiny or intervention, and will not operate on the basis of established law and precedents.

Wait Times and Improving Access

The provinces agreed to reduce wait times by March 31, 2007 in the following areas: cancer, heart, diagnostic imaging, joint replacements, and sight restorations. A Wait Times Reduction Fund ($44.5 billion over 5 years) is allocated to assist the province in reaching their goals.

Each jurisdiction will establish their own indicators for access and benchmark targets for wait times. The territories and provinces will report progress to their own citizens. The Canadian Institute for Health Information (CIHI) will produce a pan-Canadian report by compiling information from each report.

On the surface, it may seem that progress has been made. A process is to be developed by the respective Ministers of Health to establish benchmarks. The indicators and benchmarks are to be "comparable" but there is no guarantee that they will be.

The only reporting requirement is that they report to their own citizens – they are not compelled to report to the federal government for spending related to wait time reductions.

<u>The real issue for wait times</u>

The real issue to reduce wait lists and wait times is how it will be done. Better management and coordination of the lists, investment in health human resources, and capital infrastructure will each have a positive impact on the size of wait lists and the length of time people are on the lists. These approaches require long term funding and planning but they are indeed essential elements of a "fix for a generation." Provinces that follow this approach will be closer to a permanent solution.

However, it is likely that those provincial governments who are already predisposed to for-profit care and have been promoting for-profit care will follow a different path – a path that is not cost effective and will never alleviate wait lists or wait times. They will choose to contract health services to for – profit providers and to jump at the opportunity to license for-profit facilities. The services that are most likely to be contracted are joint replacement surgeries, cataract surgeries and diagnostic imaging. These services coincidentally fall squarely with the First Ministers' list of priority areas to reduce wait lists and times. Some provinces have been privatizing already and others have just been waiting for additional funding to boost their opportunity to do it.

The inevitable consequence is not reduced wait lists and wait times but a flourishing parallel for-profit system of providers who become dependent upon government contracts. Profit – seeking and self-interested, they will have no desire to see wait lists or times shrink. Similarly, physicians who are investors in for-profit clinics and who undoubtedly will be working in both the public and for-profit systems, will have no

motivation to shrink wait lists or times either. Their incomes will be dependent upon the wait list and wait times "crises" (real or manufactured.)

Money used to fund the contracting out approach to wait list and wait time reduction is almost guaranteed to increase rather than reduce problems. Aside from the incentives of investors the tendency is to place more patients on wait lists if there is a belief that they will be seen or treated – whether they need to be or not.

The answer to long wait lists and times is not private, for – profit health services. Good practice involving wait list management, an effective human resource strategy, and appropriate capital investment in infrastructure e.g., MRI machines, will be a more effective solution over the medium and long term.

Home Care

The First Ministers agreed to take some modest steps on home are with first dollar coverage for

- Two weeks short term acute home care;
- Two weeks short term community mental health home care;
- End of life care – case management, nursing, and the cost of palliative specific pharmaceuticals.

The agreement is a long way from our demand that a national home care program be established under the Canada Health Act with guidelines and standards for all regardless of province of residence.

National Pharmaceuticals Strategy

The Ministers agreed to establish a Ministerial Task Force to develop a pharmaceuticals strategy for implementation by June 30, 2006.

The strategy will include:

- Options for catastrophic pharmaceutical coverage;
- A common National Drug Formulary;
- Acceleration of access to breakthrough drugs;
- Purchasing strategies to obtain the best prices;
- Actions to influence prescribing behaviours of health care professionals;
- Access to non-patented drugs;
- Enhanced analysis of cost drivers and cost-effectiveness.

Quebec will have its own pharmacare program.

It is encouraging that the First Ministers have put the National Pharmaceuticals strategy on the agenda for future discussions at a Ministerial Task Force to report in 18 months, but it is equally discouraging that more progress was not made on immediate implementation measures to address this fastest growing cost – driver in the health care system. At the July meeting of the Council of the Federation, the Premiers identified national pharmacare as their priority for federal action. It has now slipped significantly down the list of priorities, probably at the insistence of the federal government who have been reluctant to commit to anything more than catastrophic coverage.

The Task Force will focus on several issues including: cost options for catastrophic coverage, a national formulary, drug safety, purchasing strategies, prescribing behaviour of physicians, electronic prescribing, access to breakthrough drugs, and access to non-patented drugs.

It is unclear what some of the items on this list mean e.g., "access to non-patented drugs," but others show potential for addressing real issues e.g., purchasing strategies and a national formulary. Still others such as "accelerate access to breakthrough drugs" speak to a dangerous practice of speeding up drug approvals so that the brand name drugs can reach the market faster. This practice, advocated by the brand name pharmaceutical corporations to increase profits, also puts the safety of Canadians at risk. Clinical trials and evaluation of all drugs must be free from self-interested corporate influence.

Aboriginal Health

The federal government met with leaders of the Assembly of First Nations, the Inuit Tapiriit Kanatami, the Métis National Council, the Congress of Aboriginal Peoples and the Native Women's Association of Canada in advance of the formal start of the First Ministers' meeting. The Aboriginal leaders and the government agreed to a $700 million plan over five years to implement "specific measures to close the gap between the health status of Aboriginal Peoples and the Canadian public."

The plan includes:

- $200 million for an Aboriginal Health Transition Fund to integrate and adapt existing health services;
- $100 million for an Aboriginal Health Human Resources Initiative to improve recruitment and retention of aboriginal health care workers;
- $400 million for programs of health promotion and disease prevention focusing on suicide prevention, diabetes, maternal and child health and early childhood development.

CUPE has been working to implement health human resources strategies to increase the numbers of aboriginal health care workers in CUPE workplaces by signing partnership agreements with employers. These agreements are starting to have some

positive results as more aboriginal workers are being recruited into the health sector. The creation of a representative workforce means that aboriginal workers can use their own expertise and knowledge to improve the health status of aboriginal communities.

The $700 million plan, while a good start, is only a fraction of the funding that is necessary to address health care issues within aboriginal communities. Additional funds and federal cooperation will be necessary to make major gains.

Health Human Resources

The new money is intended to spur solutions to shortages of health professionals and to stimulate action on implementing the appropriate mix of health personnel.

The First Ministers specifically reference accelerating and expanding the integration of internationally trained health care graduates. This approach implies a reliance on foreign trained health professionals. We would caution that any reliance on this approach should not contribute to a "poaching" of health professionals from developing countries and should only be done as a partnership with developing countries such that both may benefit. Such agreements are currently in place in other jurisdictions.

Recruitment and training of health personnel for aboriginal communities and Official Languages Minority Communities is a welcome addition to any human resources strategy. The task will be to ensure that adequate monies are devoted to this program. It is time for the federal government to review, support and emulate recruitment and training strategies that are already in place e.g., a groundbreaking partnership agreement signed in 2001 by the CUPE Saskatchewan Health Care Council, Saskatchewan Intergovernmental and Aboriginal Affairs, and the Saskatchewan Association of Health Organizations. The intention of the partnership is to facilitate recruitment and training of an aboriginal health care workforce.

The agreement includes a reference to "measures to reduce the financial burden in specific health education programs." No details are provided. We would urge that the federal government re-consider a labour proposal for a pilot project for health care workers to be re-trained and/or upgraded through an Employment Insurance training program. This program would allow for significant mobility of personnel already working in the system into areas where there are shortages e.g., upgrading of care aides to practical nurses or practical nurse to registered nurse positions. Over the last several years, labour has introduced this proposal to Ministers of Human Resources Development Canada (HRDC) several times. It is time for the current Minister of the new Human Resources and Skills Development Canada (HRSD) to take up the proposal in consultation with the Minister of Health and Health Canada.

Finally, it is time for federal and provincial governments to review and take seriously the studies and recommendations of health human resources studies already on-going or recently completed. The Home Care Sector Study, funded by HRDC (approximately

$1 million) and in which CUPE was a partner, is sitting on the shelf with ten recommendations on how to deal with home care human resources issues. The Advisory Council of Health Delivery and Human Resources (a federal/provincial/ territorial body) has assiduously ignored this study and done nothing to deal with recruitment and retention issues in home care – placing the expansion of home care and the quality of home care in jeopardy.

A Nursing Sector Study, also funded by HRSD (approximately $2 million) and in which CUPE is a partner, is nearing completion. We fear that without some direction from the federal government this study too, will be relegated to the dusty shelves of government reports. An HRSD funded physicians' study (in excess of $4 million) is being conducted and may find a similar fate in spite of a more powerful lobby from the physicians themselves.

It is time that the federal government started a dialogue with the provincial governments about the results of these studies conducted with the participation and support of employers, professional associations, labour, and advocacy groups. It is time that the Departments of Health and Human Resources and Skills Development started to talk to one another about the policy implications of these studies. Why spend over $7 million in funding health human resources studies for no measurable gain?

Long Term Care

Almost shocking is the complete absence of any mention of long term care. As the population ages and the demand for nursing home care increases the First ministers failed to allocate any support to address the issues of care for the elderly into the next decade. Sadly, this probably signals a continued trend to download the cost of this care onto individuals and their families. Transfers that do flow through to long term care will do so without any pan-Canadian and long term plan.

Primary Care Reform

The First Ministers seem to be satisfied that they are making significant progress on primary care reform, and that all they need to do now is to share information on best practices. This view is not shared by millions of Canadians who are in need of family physicians and are awaiting anxiously some meaningful reform that establishes access to primary care on a 24/7 basis with interdisciplinary teams of caregivers. The Community Health Centre model has proven to be successful in delivery primary care in this way. Yet, the governments have taken no concerted steps to promote this model. On the contrary, the Quebec government has taken steps to dismantle the highly successful CLSCs where care was delivered according to the principles that the governments now say they are closer to achieving.

Electronic Health Records

The First Ministers have put electronic health records squarely on the agenda as a prerequisite to health system renewal. However, the First Ministers and the federal government in particular are to be faulted for not providing any assurances that such programs will be secure to ensure privacy and confidentiality. Our confidence in any electronic health record is rocked by the revelation that health records B.C. have been contracted to a large US corporation that must follow U.S. law (U.S. Patriot Act) in terms of release of information to the FBI. This does not inspire confidence and the blame for this should surely be squarely on the shoulders of the federal government for not demanding accountability from the provinces for the privacy of their health information.

Access to Care in the North

A Territorial Health Access Fund of $150 million over five years will provide direct funding for transportation costs and will fund a working group to facilitate long term reforms in the North. This money is welcome and serves as recognition of the specific needs of our northern communities. This should be only the beginning of a process to ensure these health needs are adequately funded and met.

Prevention, Promotion and Public Health

In spite of the critical importance of health promotion and disease prevention the First Ministers could find nothing more than rhetoric and self – congratulatory words to characterize their position. It is unfortunate that they weren't more directive in their approach.

Health Innovation

Investment in science, technology and research, while gratuitously mentioned, was ignored.

Asymmetrical Federalism for Quebec

A separate statement regarding Quebec's jurisdiction accompanied the health care deal. The statement affirms that Quebec supports the objectives and general principles of the deal and that Quebec support is contingent upon Quebec applying its plans own plans re: wait list reduction, home care, community mental health, palliative care, drug access strategies, and health promotion and prevention. In reporting terms the Quebec government will report to Quebecers, the Quebec Health Commissioner will report to the government of Quebec, and will cooperate with CIHI for any further reporting at the pan-Canadian level.

Transfers to Quebec are to be used to implement Quebec's own plan for reform and Quebec will report to Quebecers for the use of those funds.

We are confident that Quebecers understand the principles of publicly funded and delivered health care and wish to have health care delivered in terms that parallel the principles embodied in the *Canada Health Act.* We are not so confident that the Quebec government shares those same values.

However, in the end the entire health care deal contains an element of "flexible federalism" not only for Quebec but also for all other provinces – where the concept makes less sense. While asymmetrical federalism is appropriate to maintain Quebec's unique status within Canada, its implicit extension to all provinces and territories weakens the pan-Canadian approach to publicly funded and delivered health care.

CONCLUSION

Will this agreement ensure that health care in Canada is publicly funded and publicly delivered with all governments held accountable for spending under the principles and criteria of the *Canada Health Act*? The answer is "no." The First Ministers have failed to meet the fundamental expectations of Canadians.

Additional federal transfers will ensure a greater federal role in funding provincial and territorial health expenditures and will facilitate the expansion of some health services, but the lack of political will on the First Ministers part to establish conditions and accountability means that health care in Canada is still open to private, for-profit delivery and the threat of two-tier health care remains real.

Appendix A

FMM 2004 Investments for Health and New Funding Levels (10-Year)

Current Track

($ million)	2004-05	2005-06	2006-07	2007-08	2008-09	2009-10	6-Year Total	2010-11	2011-12	2012-13	2013-14	10-Year Total
Canada Health Transfer (CHT)	12,650	13,000	13,400	13,750								
Health Reform Transfer (HRT)	1,500	3,500	4,500	5,500								
Transfer Levels	**14,150**	**16,500**	**17,900**	**19,250**	**20,200**	**21,200**		**22,250**	**22,250**	**22,250**	**22,250**	

FMM 2004 Investments

($ million)	2004-05	2005-06	2006-07	2007-08	2008-09	2009-10		2010-11	2011-12	2012-13	2013-14	
Romanow Short-term gap (includes home care and catastrophic drug coverage)	1,000	2,000					3,000					3,000
Addition to CHT base in 2005-06 for home care and catastrophic drug coverage[1]		500					500					500
New CHT base in 2005-06[2]		19,000										
Amount to achieve 6% escalator of the $19B after 2005-06[3]			2,240	2,098	2,429	2,787	9,555	3,176	4,702	6,319	8,033	31,785
New CHT Levels		**19,000**	**20,140**	**21,348**	**22,629**	**23,987**		**25,426**	**26,952**	**28,569**	**30,283**	
Wait Times Reduction[4]	625	625	1,200	1,200	600	250	4,500	250	250	250	250	5,500
Medical Equipment	500						500					500
Total New Funding	**2,125**	**3,125**	**3,440**	**3,298**	**3,029**	**3,037**	**18,055**	**3,426**	**4,952**	**6,569**	**8,283**	**41,285**
Total New Funding Levels	**16,275**	**19,625**	**21,340**	**22,548**	**23,229**	**24,237**		**25,676**	**27,202**	**28,819**	**30,533**	

[1] Additional funding of $500 million in the CHT base in 2005-06 for home care and catastrophic drug coverage and escalated at 6% as of 2006-07.

[2] The new 2005-06 CHT base of $19.0 billion includes existing CHT and HRT legislated levels for 2005-06, plus the proposed $2 billion increase to close the short-term Romanow gap and an additional $500 million for home care and catastrophic drug coverage. The new CHT base in 2005-06 corresponds to 25% of estimated provincial-territorial costs for services currently covered under the Canada Health Act, as well as amounts in respect of home care and catastrophic drug coverage, consistent with the Romanow Report. An escalator of 6% will also be applied to the $19 billion base starting in 2006-07.

[3] Impact shows new funding required beyond current funding track to achieve 6% escalator.

[4] Extension of wait times funding starting in 2010-11 primarily for health human resources.

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