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*

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Introduction

The Canadian Union of Public Employees represents approximately 570,000 workers in public sector employment across Canada. 170,000 of our members are healthcare workers in hospitals, nursing homes, home support agencies and other healthcare settings. They are dietary workers, registered practical nurses, cleaners, operating engineers, secretaries, ward clerks, porters, carpenters, cooks, personal support workers, lab assistants, and many others providing essential healthcare services on a daily basis. From this direct experience, we believe that we have valuable input for the Health Committee's review of the 10-Year Plan.

This brief will address the federal government's lack of leadership on healthcare and its failure to ensure that transfers to the provinces under the 10-Year Plan are spent in accordance with the principles and conditions of the *Canada Health Act*. It will also recommend public solutions that would strengthen medicare and demonstrate federal government leadership.

Canada Health Act

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.

The Canada Health Council was mandated to report on progress under the 10-year plan, but its capacity to do so is hampered by a number of factors, as illustrated in the largely anecdotal reports issued to date. Alberta and Quebec do not even participate in the Canada Health Council, leaving two provinces entirely outside of the 10-Year Plan accounting.

Quoting from the last Canada Health Council annual report, released in February 2007:

> "We are unable to specify where the provinces and territories are investing funds from the federal healthcare agreements because no financial breakdowns are provided."[1]

The 10-Year Plan funding falls under the *Canada Health Act*, and yet Parliament and Canadians have seen patchy monitoring and reporting under the Act, and enforcement continues to be lax.

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.

Below are some concrete examples of where healthcare is being transferred to for-profits, how this impacts patients, and how it relates to the *Canada Health Act*.

Private clinics, illegal fees, and queue-jumping

Since the 10-Year Plan was signed almost four years ago, the number of for-profit clinics delivering medically necessary services in Canada has likely doubled. There is no firm data on private clinics; the federal government refuses to collect this data, in contravention of the *Canada Health Act*.

Entrepreneurs are setting up surgical and diagnostic clinics at an ever-increasing pace, many of them subsidized by the public purse, and complaints about user fees and extra billing are increasing. All the while, the federal government turns a blind eye or tacitly endorses the illegal practices.

Because the government was failing in its duty to monitor, report and enforce the *Canada Health Act*, last February, CUPE published a citizens' guide to medicare laws[2] and joined the Canadian Federation of Nurses' Unions in launching a website (yourmedicarerights.ca) that encourages patients to report *Canada Health Act* violations. Since February, we've distributed over four thousand guides and had close to five thousand people visit our website.

People are shocked to see how far our public system has been eroded. Some have written to us with disturbing accounts of being charged user fees or offered faster access for a price. For example:

- A Quebec man was told that he could pay $1,000 to get a CT scan immediately, or wait eight months.
- Another Quebec man was charged a $20 "professional services" fee for each appointment with his ophthalmologist.
- An Ontario woman was charged an annual block fee of $250 for so-called "incidentals".
- A mother in British Columbia told us that she couldn't afford the $440 that the podiatrist would charge to remove her son's two ingrown toe nails. In her words: "I am a working single mom and I do not have this kind of money … This is unfair."
- Several people, from different provinces, wrote to us about family doctors screening them out after an initial interview.[3]

What we hear is just the tip of the iceberg. Most people are, understandably, reluctant to report violations. As one person told us "I do not wish to complain about it publicly because I may need to find a new doctor some day and do not want to alienate any doctors as there is such a shortage here."

Certain provinces – most notably, British Columbia and Quebec - are allowing private clinics to charge privately for diagnostic and surgical services which are clearly necessary

hospital services within the definitions of the *Canada Health Act*. The federal government is doing virtually nothing to challenge these increasingly common user fees. In fact, it refuses to even thoroughly track the problem.

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.[4] For example, a full body MRI scan may not be considered a "necessary" service for someone suffering pain in the hip. However, by purchasing such a scan, that patient might get diagnosed for a hip replacement and be in the queue sooner for a publicly insured hip replacement.

Other doctors charge annual block fees – ranging from $100 to several thousand dollars - for so-called "incidental" services like telephone consultations, prescription renewals and document preparation. These fees are a significant financial barrier for patients seeking medical care – patients who are in a vulnerable situation due to their health and the difficulty finding a doctor. Block fees are clearly a violation of the accessibility criterion of the *Canada Health Act*, which requires that insured health services to be provided on "uniform terms and conditions". Yet the federal government does nothing to challenge the practice, and transfers under the 10-Year Plan continue to flow unimpeded.

All of the examples above are variations on a theme: queue jumping. The Romanow Commission described the problem this way:

> The growth of private advanced diagnostic facilities has permitted individuals to purchase faster service by paying for these services out of their own pocket and using the test results to "jump the queue" back into the public system for treatment … Canadians made it clear to the Commission that they are deeply concerned about the prospect of this becoming routine.[5]

With new for-profit MRI and CT scan clinics popping up across the country, and with medical tourism growing, queue jumping has certainly become more common. Will this Health Committee help prevent it from becoming routine?

One recent news story suggests that this federal government plans to foster rather than curtail queue jumping and for-profit clinics. This month, a federally sponsored trade mission will go to the Caribbean to support private clinics that are marketing surgeries to Canadians.[6] Why is this government encouraging queue jumping rather than investing in public solutions?

Commercialization linked to "wait time guarantees"

The 10-Year Plan approach to wait times and the federal government's model of "care guarantees" has, in some provinces, hastened the commercialization of medicare and distorted health planning. Further, there is no requirement that provinces substantially report to the federal government on how the Wait Times Transition Fund was spent or what outcomes it achieved.

Health Minister Tony Clement has praised the Quebec "care guarantee" – a model that was formalized in Bill 33, which legalized private insurance for some medically necessary procedures. Bill 33, which came into effect January 1, 2008, represents a sea change in medicare policy and a violation of the *Canada Health Act* criteria of *accessibility* and *universality*. In addition to legalizing elite access to insured services, Bill 33 sets the stage for contracting out those services.

In the first such contract, Sacré-Coeur Hospital is renting space, equipment and nursing staff at the private Rockland MD Clinic. As reported in the *Canadian Medical Association Journal* last month:

> "In the very first surgery at the clinic, a nurse mistakenly administered a potentially lethal dose of painkiller intravenously, rather than as an intramuscular injection. The patient suffered a massive decrease in blood pressure and had to be taken by ambulance back to Sacré-Coeur for emergency treatment. Despite this incident, the Quebec government said that at least five other hospitals in the province are negotiating similar contracts to access operating theatres and staff at private clinics."[7]

Offloading complications onto the public system is just one of the many problems with for-profit clinics. There is irrefutable evidence that for-profit delivery lengthens wait times, increases administration costs, and provides lower quality of care.[8]

Federally-funded wait time strategies in Ontario and British Columbia have introduced another form of commercialization: "fee-for-service" funding and internal markets for hospitals. Fee-for-service funding and market-based competition in acute care is a model that doctors in the United Kingdom tell us leads to higher administration costs, fragmentation, and a destabilization of the healthcare system.[9] Many Canadians will be concerned that the model particularly disadvantages small and rural hospitals. Even proponents acknowledge that stamping a price tag on patients is a stepping stone to more for-profit hospitals.[10]

Public-private partnerships

Beyond commercial clinics, insurance and funding models, another area where for-profits are making inroads in Canada's healthcare system - with damaging repercussions for patient care and access - is public-private partnerships (P3s). P3s are multi-decade contracts for the private operation of hospitals. There are 38 P3 hospitals planned or underway in four provinces: British Columbia, Ontario, Quebec, and New Brunswick. P3 nursing homes are even more widespread.

There is a substantial and growing body of evidence that P3s cost more and provide lower-quality service than do public hospitals.[11] CUPE believes that this erosion of quality and waste of money with P3 schemes should be a top concern for the federal government and this parliamentary committee, and together with other unions and

community coalitions, we have proposed a renewed role for the federal government in public hospital infrastructure financing.[12]

P3 hospitals open the door to two-tier healthcare in a number of ways. First, these contracts typically allow the companies to establish clinics and other business within the hospital. Co-location significantly increases the likelihood of cream-skimming, self-referrals, kickbacks and other conflicts of interest for healthcare 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.

The complexity and secrecy of P3 schemes presents another risk to single-tier healthcare. Locked into long term lease arrangements and service contracts, hospital boards, and in turn provincial governments, have very little leverage to ensure that the private sector counterparts operate in accordance with medicare laws. Many don't even know entirely what is in the contracts. For instance, the Brampton P3 hospital contractual scheme is more than two thousand pages, with key provisions kept secret and even the provincial Ministry of Health prevented from revealing important details.

If the federal government were to start taking its *Canada Health Act* responsibilities seriously, it might find that the bifurcated management structures and complex legal arrangements in these P3 schemes make it difficult to even know what is happening in those sites. What type of accountability is this?

How is it that the federal government is letting hospitals be carved up and contracted out, with apparently no thought to *Canada Health Act* compliance, and certainly with no public consultation? In fact, through P3 Canada Inc. and other initiatives, the federal government is actively pushing the P3 model in other sectors. We believe that P3 hospitals deserve immediate investigation and action by this Health Committee, by the Auditor General of Canada, and by the current Parliament.

Cleaning and superbugs

One area of hospital services that is increasingly being privatized, both through P3 schemes and stand-alone contracts, is hospital cleaning. This should be a concern for the Health Committee for two reasons. First, for-profit delivery of hospital support services contravenes the "public administration" criterion of the *Canada Health Act*. Second, privatized cleaning presents a major risk to patient safety, one of the issues addressed in the 10-Year Plan.

Each year in Canada, over 220,000 hospital-acquired infections result in 8,000-12,000 deaths.[13] At least thirty percent of these infections are preventable.[14] Rising infection rates are resulting in higher levels of morbidity, mortality, length of hospital stay, healthcare costs, and institutionalization.[15]

There is a growing body of evidence that understaffing and contracting out of hospital cleaning services have contributed to increased infection rates.[16] Unsafe occupancy levels are a related factor.[17]

To take just one example, the coroner's inquest into deaths at the Honoré-Mercier Hospital from C. Difficile concluded last year that a key factor in the deaths was the hospital's decision to skimp on appropriate hygiene measures in a bid to cut costs.[18] We see this even more when for-profit companies handle healthcare cleaning. Evidence clearly shows increased risks of healthcare-acquired infections with the contracting out of cleaning services.[19]

Public health measures in the 10-Year Plan have fallen short in combating healthcare-acquired infections. The federal government's efforts to even track these infections are reportedly crumbling due to lack of investment.[20]

Continuing care

The 10-Year Plan represented modest advances on home care, with the goal of first dollar coverage for some short-term and end-of-life care, but it fell far short of what is needed. The problem is three-fold.

First, there is no reliable evaluation of progress on the agreed-to goals and no likelihood of this changing, judging from the Health Council of Canada's reports on home care and the weak reporting requirements in the 10-Year Plan.[21] In its January report, the Council squarely states that:

> "As with primary healthcare, there are insufficient efforts to monitor and publicly report on the progress of home care renewal."[22]

Second, the Plan did not include home support services, such as housework and meal preparation – services that the Council's recent survey and the Special Senate Committee on Aging both find to be in high demand[23], that are essential to supporting people at home, and that are severely underfunded in every jurisdiction.

Third, the 10-Year Plan failed to require provinces to spend home care funding on non-profit home care providers. Competitive bidding is harming patients and diverting money from direct patient care to company profits. In Ontario alone, the handover from longstanding community-based agencies like the Victoria Order of Nurses to for-profit agencies, some of them investor-owned multinationals, has meant cuts in services, a chill on cooperation, and ballooning administrative costs.[24] Turnover rates in that province now approach 60 percent.[25]

Completely absent from the 10-Year Plan, and an equally urgent issue for Canadians, is long term facility care. Despite the obvious and growing need for nursing home care and its connection to wait times in the acute care sector, the First Ministers failed to address the issue four years ago, and the federal government has done nothing since to address the gap. Thousands of Canadian seniors are waiting on nursing home lists, and thousands more are anxiously approaching that day, knowing how difficult it is to find accessible long term care.

CUPE represents approximately 56,000 long term care workers across the country, and those members are at once saddened and outraged by the deplorable conditions in long term care, particularly in the for-profit homes.[26] Our members do their utmost for residents, but they have to constantly fight for things like adequate diapers, time to bathe residents, decent living conditions - things that should be fundamental rights for our seniors.

Primary healthcare

In the 10-Year Plan, First Ministers agreed only to share information on best practices and to advance electronic health records, with no strings attached and no vision for primary healthcare reform. The Health Council of Canada has reported some progress, but primary healthcare continues to be a patchwork across the country.[27] In terms of 24/7 access, more patients can now call telephone help lines, but there is rarely any connection back to the primary care practitioner.[28] There are more primary care teams, but few of these are full-fledged multidisciplinary teams, and only a handful are geared to health promotion, disease prevention, and individual/community empowerment as called for in the 2005 PAHO/WHO Montevideo Declaration, to which Canada is a signatory.[29]

Meanwhile, with a couple of exceptions, government support for community health centres has either remained static or slipped backwards. The only two provinces that seem to be moving ahead with community health centres are Ontario and New Brunswick; even there, community health centres remain on the periphery. The Quebec government has dismantled the community-based governance of CLSCs, undermining their ability to achieve the broader goals of health equity and social inclusion that are fundamental to primary healthcare reform.

Health human resources

There were measures in the 10-Year Plan to address health human resources problems, but there remains no comprehensive pan-Canadian strategy. In fact, the federal government's endorsement of parallel private healthcare worsens the shortages.

The 10-Year Plan called for increased recruitment of internationally trained healthcare professionals. CUPE supports upgrading, language training, and credential recognition for internationally-educated healthcare workers, including those already in Canada and employed in healthcare; in fact, many nurses, doctors and paraprofessionals who are

underemployed in Canada are in our union and face constant barriers to training and professional certification. Laddering programs, for example for care aides to become nurses, are similarly underfunded.

Meanwhile, health employers are poaching healthcare workers from developing countries and relying more and more on migrant workers. In fact, the federal government has, without public debate, expanded the Temporary Foreign Worker Program – a program in which workers are subjected to exploitative recruitment fees, withholding of pay, and often dismal living and working conditions, with no universal right to pursue permanent resident status in Canada.[30]

Instead of poaching from other countries and creating a larger underclass of migrant workers, the federal government should support and implement a World Health Organization ethical recruitment policy, and it should suspend the Temporary Foreign Worker Program and address the widespread abuses occurring in this program.

The government should also pursue employment equity strategies. We would like to know, for example, what progress has been made on recruiting and training aboriginal healthcare workers since the 10-Year Plan was signed. CUPE is part of a groundbreaking "representative workforce" strategy in Saskatchewan that has increased the healthcare workforce participation rate of First Nations' peoples from less than one percent to over six percent, representing 2,100 new hires since 2003. The strategy has also trained 75 percent of the existing healthcare workforce, or 21,000 workers, preparing them for a more diverse workforce. Through these and other measures, retention went from four percent to 96 percent.[31] We believe this is a strategy that the federal government should support and expand beyond Saskatchewan.

A pan-Canadian health human resources strategy must also address the poor working conditions and wide wage gaps that characterize the healthcare sector. 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.[32] In the wake of contracting out, the wages of healthcare support workers in British Columbia are now the equivalent of what was paid in 1968.[33]

Wages and working conditions as a factor in retention and recruitment have featured in federally-commissioned health human resource sector studies. What has been done to implement the recommendations of those studies, in particular the home care sector study which seems to have been shelved despite acute and worsening recruitment and retention problems in this sector.

First Nations

The federal government committed in the 10-Year Plan to improve access to healthcare in the North. A special meeting of First Ministers and national Aboriginal leaders in September 2004 announced a five-year $200 million Aboriginal health transition fund. Then in November 2005, the federal government pledged $5 billion over five years to

improve healthcare, housing and education for Aboriginal people, promising to use the *Blueprint on Aboriginal Health* in creating Aboriginal health programs.

As the Health Council of Canada reported in February of last year, "There is no clear direction with respect to the future of the *Blueprint on Aboriginal Health* and the Kelowna Accord."[34]

Federal funding announced in the 2008 budget fell far short of the Kelowna Accord commitments, and without a doubt, the federal government continues to seriously underfund healthcare for First Nations.[35] It also fails to adequately support the programs and infrastructure that would improve First Nations people's health, for example decent housing, clean water, and community economic development.

As stated by the President of the Association of the Faculties of Medicine of Canada, Dr. Nick Busing:

> "The Government of Canada must take a more systematic approach to the health and wellness of First Nations, Inuit and Metis communities in Canada, both on and off reserves. The problems that these communities face are inexcusable in a country as prosperous as Canada in the twenty-first century."[36]

Aboriginal women and Metis were not even mentioned in the last federal budget.[37]

Pharmacare

The First Ministers agreed in September 2004 to develop and implement a national pharmaceuticals strategy, and a Task Force of representatives from federal, provincial and territorial governments was established. The First Ministers released a progress report on the National Pharmaceutical Strategy (NPS) in September 2006. There has been no progress on expanding drug coverage, and the overall pharmaceutical strategy appears to be stalled due to lack of federal financial commitment or even a willingness to convene meetings.

Meanwhile, pharmaceutical companies continue to violate the ban on direct-to-consumer advertising with impunity, and the government is proposing changes to the *Food and Drug Act* that would exacerbate drug safety problems by formalizing in law the speed-up of drug approvals.

Conclusion and recommendations

CUPE and other unions and social justice groups fought for medicare decades ago, and we are outraged that our federal government is letting the country slip back to a time when wealth determined access to healthcare. To add insult to injury, public money that should go to direct patient care is being siphoned off to profits for investors in private

clinics, P3 schemes, service contractors, continuing care firms, and the private insurance industry.

CUPE takes great pride in our long-standing tradition of fighting for high-quality, universal, accessible, comprehensive, publicly funded and publicly delivered healthcare. We call on members of the Standing Committee on Health to press the federal government to implement the following public solutions:

Enforce the *Canada Health Act* and turn back the privatization of our healthcare system. Members of the Health Committee should ask the government what it will do to ensure that people aren't paying twice for medicare and that provincial governments are meeting the *Canada Health Act* requirements - starting with handing over details about for-profit clinics and hospitals. Further, federal transfers should be used only for non-profit delivery.

Establish a national long term care program that includes targeted funding and national standards for home and residential long term care, including minimum staffing standards. All new funding and contracts should go to non-profits, and sales to for-profits should be disallowed.

Implement a wait time strategy that guarantees public sector improvements and not private insurance or outsourcing to for-profit clinics.[38] The strategy should:

- 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.

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.[39]

Create a national infrastructure fund to build and redevelop hospitals and long term care facilities. All healthcare infrastructure funding must be tied to public non-profit ownership, control, management, and operation of the facilities, equipment and services.[40]

Follow through on commitments made in the Kelowna Accord and the *Blueprint on Aboriginal Health*. CUPE and many other organizations, including the Assembly of First Nations, endorsed the Canadian Centre for Policy Alternatives 2008 Alternative Federal Budget which would direct $4.2 billion to First Nations communities for housing, healthcare and education and a further $800 million to support Aboriginal people living in urban centres.[41]

Establish a national strategy to combat healthcare acquired infections. The federal government should create a federal-provincial task force to:

- establish mandatory public reporting of healthcare acquired infections;
- create stringent infection control, cleaning, sterilization, and disinfection standards;
- establish improved healthcare housekeeping and nursing staffing levels;
- establish maximum occupancy levels in hospitals; and
- increase staffing levels and end contracting out of healthcare cleaning services.

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. Support the expansion of First Nations "representative workforce" strategies beyond Saskatchewan. Stop the unethical poaching of internationally trained healthcare workers and the exploitation of temporary migrant workers.

Support primary healthcare reform that achieves genuine progress on illness prevention, health promotion, social equity, and personal/community empowerment goals, as exemplified in the community health centre model. Start by including these goals in data collection, monitoring and evaluation of progress on the 10-Year Plan and other federal government primary healthcare initiatives.

ENDNOTES

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