

## 1.5 Health Care

In its latest *Speech from the Throne*, the Conservative government made no commitment to improve or maintain the provision of health care. In fact, the speech did not include the word Medicare. But Prime Minister Harper did promise to “introduce legislation to place formal limits on the use of the federal spending power for new shared-cost programs in areas of exclusive provincial jurisdiction.” Such legislation could severely compromise Medicare, in combination with other actions and inactions of this government.

Most significant in the “failure to act” category is the silence on how to deal with existing and accelerating labour shortages in health care and the rising cost of pharmaceuticals. These two issues threaten to undermine Medicare: labour shortages inflame the desire for two-tiered health care, and spending on prescription drugs relentlessly drive up public costs. For the federal government, the issue is not just spending more, but helping better manage what we have.

All federal political parties have said they are committed to the Canada Health Act and its core principles. Nonetheless privatization is accelerating, and recent federal governments have cho-

sen not to enforce the principles of the Canada Health Act or prepare Medicare for future challenges. Governments can take action to reverse the troubling trends, which, left unchecked, will have a devastating impact on Canadians’ health and economic security.

Medicare was not developed as a gender-specific program, but the benefits of a well-functioning Medicare system are perhaps disproportionately advantageous to women. Due to women’s reproductive roles and their higher incidence of chronic disease, women are the major users of health services. As well, because 43% of all children in a low-income family live with a single parent,<sup>1</sup> universal, accessible and quality health care and Pharmacare is essential. Rising rates of chronic disease in the overall population and continuing shortages of hospital beds results in the transfer of more unpaid caregiving work to women. These necessary and often non-negotiable “jobs” often compromise labour force participation and put many women, and their families, in precarious financial situations. When federal transfers to the provinces support delivery of not-for-profit health care, the impact on Canadian women is meaningful.

The federal government plays a significant role in both improving access to health care and better managing and controlling the rising costs. This chapter of the AFB shows how.

### Dealing with labour shortages in public health care

The labour shortage among health professionals — doctors, nurses, radiologists, diagnosticians, lab technicians — already is a cause for concern. It threatens to become much more severe in the next decade. Thus far there is no pan-Canadian plan to deal with this situation, short of ratcheting up wages in the hopes of attracting people from place to place, or actively recruiting people from overseas.

Canadians want health care to be available when they need it. They are willing to pay taxes to publicly fund health care for all, when needed, without financial sting when people are most vulnerable.

The commitment to universal access has been overshadowed by the discussion around wait times for some procedures and tests. The more urgent problem is that one in 10 Canadians do not have a family doctor or equivalent point of access (through nursing, counseling, or physical supports) to primary care.

That means their only guarantee of help in physical and mental health matters is through the most expensive element of the health care system: the hospital emergency room. Waiting until health issues become acute or life-threatening is a more costly and a senselessly inhumane public policy option. The AFB strongly advocates for primary care reform, long-term care and mental health strategies that foster the use of all the skill competencies of all health workers.

That puts the emphasis on labour strategies, not wait time strategies.

Expanding the supply of health care providers is at the heart of ensuring the efficiency and sustainability of publicly-funded health care. The

AFB accordingly sets out a 10-year plan to move towards the objective of having enough health care providers, in the right place, providing the right care, at the right time.

This requires training more people to join the ranks of health care workers in the entire range of jobs that provide care. It also means upgrading skills and better utilizing the skills of existing health care workers. The following proposals are made to address this issue at the federal level, with a fully-phased-in cost of \$600 million per year, for the next 10 years.

1. The AFB will directly fund the expansion of seats in medical and nursing schools, as well as other health professional programs. In addition, the AFB designates a medical and nursing school specific grant based on financial need, which will provide 50% of tuition fees, up to \$5,000, per year of study, to ensure health professionals come from every socio-economic background. Finally, the AFB will implement a student debt-reduction program for graduates of medical and nursing and health professional programs in return for service to designated under-served areas. This return of service program will be developed in collaboration with the provinces and student groups, and will be flexible, comprehensive, sustainable, and non-coercive. The option chosen by the AFB this year allocates \$20,000 to graduates for student debt-reduction in return for two years of service for this purpose. Another proposed option is that all graduates of medical and nursing schools provide return of service in designated under-served areas, in acknowledgment of the sizeable public investment made in their professional development, and to serve the public interest. The AFB proposes a mandatory review of both the student grant and student debt-reduction programs in three years.

2. The existing skills shortages in the health care sector requires immediate action. The AFB commits \$200 million each year over three years for a pilot program in skills upgrading for existing health care workers. This pilot program would

eventually be funded by the Employment Insurance fund, but initial funding will come from Human Resources and Social Development Canada. The program will combine on-the-job practical experience and formal training for health care workers to upgrade their skills to develop greater competencies and advancements in certification. After assessing the pilot programs in these job areas, short- and long-term courses could be developed in other areas. The AFB believes the program could eventually include 5% of the total health care workforce annually (excluding doctors). Given the high proportion of immigrants in the health care sector working below their skill levels, this program will help in the recognition of international credentials.

While there is much more that AFB partners recommend with respect to health human resource issues, these two priority investments in the labour force of the publicly-funded health care system will set the stage for Canadians to feel more secure about the accessibility, availability, quality, and appropriateness of care. This is what is currently missing in federal investments designed to “fix” health care for the next generation.

#### Public Pharmacare Program — More For Less

With the exception of the United States, Canada is the only advanced industrial nation that does not have a national approach to pharmacare in its provision of publicly-funded health care. Everyone else, including most Canadians, knows that access to prescription drugs is part of what is medically necessary treatment.

Employers, provincial governments, hospitals, and individuals all agree that spending on pharmaceuticals is out of control. Most recent figures show that in 2006 total spending on prescription drugs in Canada was \$21 billion, more than double the amount spent on prescription drugs in 1999.<sup>2</sup>

Canadians’ out-of-pocket expenses for prescription drug purchases have averaged 8% annual growth since 2000.<sup>3</sup> Pharmaceuticals have become the second largest category of health care expenditure for provincial and territorial budgets, after hospital care.<sup>4</sup> Meanwhile, employers cite the increasing costs of pharmaceuticals in group benefits plans as the reason they plan to shift the costs and risks to workers and cut the level of benefits to workers and retirees.

Canadians continue to pay more and more despite public and private insurance plans for drugs. An estimated 11% of the population remains uninsured or underinsured, leaving at least 3.4 million people in Canada exposed to potentially catastrophic costs associated with the need for prescription drugs.

Canada’s patchwork of approaches bears a high price, financially and in human terms.

Since the 2004 Health Accord Health Ministers have been working towards a National Pharmaceuticals Strategy. In the summer of 2006, their task force made a series of recommendations envisioning a common national formulary; coverage for expensive drugs for rare diseases; lower generic drug prices; coordinated purchasing; streamlined drug approval; enhanced drug safety; and limited role for the state to ensure catastrophic drug coverage.<sup>5</sup> The federal government has yet to respond to these proposals.

The AFB will take immediate steps to establish the national Pharmacare program, implementing the recommendations of the task force, with the twin goals of providing greater equality of access to major prescription drugs across the country in a cost-effective manner, and to keep the rising costs of prescription drugs in check.

As we have seen in Australia and New Zealand, a public single-payer pharmacare system reduces administrative costs, increases access, and promotes social equality.<sup>6</sup> For this to happen in Canada, bulk purchasing arrangements will be negotiated, price controls will be imposed on both

patented and generic pharmaceutical products, and progressive patent reforms introduced.

The starting point of this approach would be establishing a national formulary for essential drugs that would provide minimum standards for drug programs across the country. It would be funded on a 50/50 cost shared basis with the provinces. Provinces would reimburse the federal government for bulk purchased drugs on the formulary.

AFB partners are seeking a comprehensive approach that goes beyond better provincial programs. Our objective is a first-dollar, universal program, providing equal access to prescription drugs through publicly funded and controlled systems. Essential drugs should be covered in the way that Medicare now covers hospitals and physicians.<sup>7</sup>

We believe this would lead to better value for money for Canadians, stretching our dollars through bulk purchasing, getting better management of costs, and providing greater public safety. Employers, some of whom now co-finance drug benefits for their workers and retirees, and all of whom benefit from a healthy work force, would also help finance this program, through general corporate taxation or other revenue measures.

In the short-term, however, this year's AFB proposal commits federal funds so that the federal government can spur the process of better managing the spiraling costs of public pharmacare programs, reduce unequal access to drugs across the country, and lead the way in promoting the use of non-drug therapies for the treatment of illness and injury.

The AFB will allocate \$900 million in 2008–09 to the national Pharmacare program. We anticipate the combination of increasing efficiencies and increasing coverage will result in reaching \$3.0 billion in 2010–11.

The additional spending moves Canadians towards roughly equivalent standards of access across the country, and moves Canada's approach to health care firmly into the 21st century. This

#### GENDER ANALYSIS Health Care

Due to their reproductive roles and their higher incidence of chronic disease, women are the major users of health services. As well, because 43% of all children in a low-income family live with a single parent,<sup>9</sup> universal, accessible and quality health care and Pharmacare is essential. Ensuring that federal transfers to the provinces support the delivery of strictly not-for-profit health care will have a great impact on the health of Canadian women and their families.

Increasing rates of chronic disease and continuing closures of hospital beds result in the transfer of more unpaid caregiving work to women, thereby compromising their labour force participation and putting many women in precarious financial situations.

is one government initiative that indisputably helps Canadians get more for less.

#### The Health of the First Nations Peoples

The AFB seeks a negotiated agreement between Ottawa and the First Nations that sets out an action plan to deal with the dismal state of health of the peoples of the First Nations.

The Assembly of First Nations has called for the 3% cap on the Non-Insured Health Benefits (NIHB) program to be abolished. They believe that, for prescription drugs, a 14% escalator is needed to take into account aging, inflation, population increases, and the rising costs of drugs.

Even though the AFB will work to limit the costs of drug increases, and invests substantially in the determinants of health, it allocates \$200 million in 2008–09, \$463 million in 2009–10 and \$527 million in 2010–11 to this purpose.

#### Privatization and Conditionality of Federal Funding

The federal government is using the issue of wait times to fuel support for two-tier medicine. In

a direct contravention of the spirit and principles of Medicare, the Conservative government promised to “allow for a mix of public and private health care delivery, as long as health care remains publicly-funded and universally accessible”. Prime Minister Harper’s endorsement of the Quebec model reveals what is meant: introducing private insurance for medically-necessary services; increasing publicly-funded contracts to for-profit clinics (both of which contravene the Canada Health Act as well as provincial medicare laws); and promoting the use of P3s (public-private partnerships) to finance, build, and service critical health care infrastructure.

As well as steadily eroding the broader “public” character of the health care system, this multi-pronged emphasis on greater use of for-profit businesses costs more, compromises quality, and results in higher mortality rates than a not-for-profit health care system.<sup>8</sup>

The AFB believes there should be firm conditions attached to the transfer of all federal money to the provinces for health care, and that the Canada Health Act should be rigorously enforced. Further, there should be no increase in tax points as a share of total federal health transfers to the provinces, as a mechanism to address wait time guarantees, emerging demands on provincial health care systems, or the “fiscal imbalance”.

The conditions placed on the transfer of money to the provinces for health care should include a) a requirement that federal funds be used for not-for-profit delivery of medically necessary health care, and b) reporting requirements to show how public funds for health care are allocated, specifically between for-profit and non-profit service providers.

The goal of the Canadian Health Transfer (CHT) should conform with the Canada Health Act (CHA): to support provincial and territorial capacity to deliver medically-necessary and publicly-administered health care in a universally-accessible and comprehensive basis. Whereas not-

for-profit delivery is not specified in the CHA, it is implicit in the view that governments should not waste taxpayers’ money nor lose the capacity to oversee and audit services funded by the public purse. The cloak of corporate confidentiality shrouds business operations, a serious impediment to the transparency and accountability required for the audit of public service. For these reasons, the AFB would direct public funds for health care to non-profit public or private service providers.

## Notes

1 <http://www.statcan.ca/bsolc/english/bsolc?catno=89-503-X>

2 *Drug Expenditure in Canada Data Tables*, (Ottawa: CIHI, 2007) Expenditure on Drugs by Type, by Source of Finance and as a Share of Public, Private and Total Health Expenditure, Canada, 1985 to 2006 ([http://secure.cihi.ca/cihiweb/dispPage.jsp?cw\\_page=AR\\_8o\\_data\\_e](http://secure.cihi.ca/cihiweb/dispPage.jsp?cw_page=AR_8o_data_e))

3 Figure derived from Canadian Institute for Health Information, *National Drug Expenditure Overview Table A.2 — Part 1* “Expenditure on Drugs Per Capita by Type, by Source of Finance, and Public, Private and Total Health Expenditures, Canada 1985–2005”.

4 Health Canada, “National Pharmaceutical Strategy Progress Report: Executive Summary”, September 21, 2006.

5 Federal/provincial/territorial Ministerial Task Force, “National Pharmaceuticals Strategy Progress Report”, Government of Canada: June 2006. pp. 1–48.

6 A 1995 study showed that Australia’s national drug plan kept drug costs 30% below OECD average while Canada’s costs were 30% higher. Organization for Economic Co-operation and Development, “Purchasing Power Parities and Real Expenditures”, 1993: EKS results, Volume 1, Paris: OECD 1995. As cited in Joel Lexchin, “A National Pharmacare Plan: Combining Efficiency and Equity”, *CCPA Monitor*, March 2001, p.7–8.

7 Canadian Health Coalition, *More for Less: A National Pharmacare Strategy*, May 2006

8 Himmelstein, David U., et al (1999), "Quality of Care in Investor-Owned vs. Not-for-Profit HMOs", *The Journal of the American Medical Association*, 282(2), 159–163; Garg, Pushkal P., et al (1999), "Effect of the Ownership of Dialysis Facilities on Patients Survival and Referral for Transplantation", *New England Journal of Medicine*, 341(2), 1653–60; Rosenau, P.V., and Linder, S.H. (2003), "A comparison of the performance of for-profit and nonprofit health provider performance in the United States", *Psychiatric Services*,

Feb. 2003, Vol. 54, No. 2, pp.183–187; Rosenau, P. V., and Linder, S.H. (2003), "Two decades of research comparing for-profit health provider performance in the United States", *Social Science Quarterly*, 84(2), 219–241; Schneider, Eric C., Zaslavsky, Alan M., and Epstein, Arnold M. (2005), "Quality of care in for-profit and not-for-profit health plans enrolling Medicare beneficiaries", *American Journal of Medicine*, 118, 1392–1400.

9 <http://www.statcan.ca/bsolc/english/bsolc?catno=89-503-X>