

Health Care

Since October 2008, 486,000 jobs have been lost across Canada and there are now almost 1.6 million unemployed people across the country.¹ The loss of good jobs has been devastating for families and communities, especially coming on the heels of an already precarious situation for many people in Canada.

In its 2009 Report Card on Child Poverty, Campaign 2000 reports that 637,000 children (about one in ten) and their families were living in poverty in 2007. In First Nations families, one in four children is living in poverty.² A recent report from the Canadian Institute for Health Information found, not surprisingly, that people in more disadvantaged urban areas face higher rates of hospitalization.³ They were more likely to be smokers and less likely to enjoy good health than people in more privileged communities. Low-income people are less likely to find ways out of poverty in the midst of an economic crisis.

In the midst of the current economic crisis, food insecurity has grown. Food banks across Canada responded to 794,738 separate individuals in March 2009. This was an increase of 17.6%, or almost 120,000 people, compared to

March 2008.⁴ Mental health issues are exploding. A gathering of mental health experts convened by Canada's Mental Health Commission in August 2009 concluded that we may expect increased levels of depression, anxiety and suicide over the next year, as unemployment, or the threat of unemployment, takes its toll. The report from the Round Table suggested that the social and economic effects of the recession are likely to increase and be felt for at least a decade.⁵

A deep social crisis is in full swing for those people who cannot find decent work. More than ever, people are depending upon public services to help them cope with the tremendous pressure they are under. Our public health care system is a fundamental pillar of our society, and it must be strengthened, especially in the wake of the devastation caused by the economic crisis. Public health care remains one of our most valued public services. A recent Health Canada report confirmed that over 85% of Canadians are very satisfied or somewhat satisfied with the way health services are delivered.⁶ These results were confirmed in October 2009 by Nanos Research, which found that 90% of Canadians support universal health care.⁷

When it comes to the experience of economically marginalized peoples, whether Aboriginal, recent-immigrant, unemployed or low-income communities, this recession will not be over for a long time. It will continue to have devastating impacts on human health and will require strategic thinking about how to best deliver health services in an equitable manner. As a result, the AFB will respond to these needs.

What we need

The current federal government allocation of the Canada Health Transfer was \$24 billion in 2009–10. Under the terms of the 2004 First Ministers' Agreement, this amount will grow at 6% per year to 2013–14. The tax transfer was \$13.9 billion in 2009–10 and will grow in line with the economy.⁸ We know the federal governments will be facing a deficit but this in no way should lead to cuts in health transfers, and the Alternative Federal Budget will maintain the terms of the agreement. The AFB will strengthen and expand the public system to ensure that everyone has access to quality health care, regardless of their ability to pay.

Given the impact of the economic crisis on individuals, families, and communities across the country, we must affirm this commitment in the federal budget now more than ever. We will not let this economic crisis be used as an excuse for proponents of privatization to “not let a good crisis go to waste.” We stand against those who would discard the Canada Health Act. We reject privatization, whether in the form of private hospitals, public-private partnerships in hospitals, or in any other way.

Pharmacare: A universal public drug plan

The massive job losses experienced across the country have reduced access by hundreds of thousands of families to prescription drugs. Not just individuals, but entire communities have seen

their benefits cut off. As well, the attack on retirement security has meant that thousands of pensioners also have more difficulty getting the drugs they need. Since 2004, when manufacturing job losses started to soar, per capita out-of-pocket spending on prescription drugs has increased almost 30%.⁹ Between 2004 and 2009, one in seven manufacturing workers became unemployed, with many losing their drug insurance coverage along with their jobs.¹⁰

In Canada, we spent over \$25 billion on prescribed drugs in 2008. We spent 17.4 % of total health expenditure on drugs. Given that total prescription drug costs have increased 51% over inflation since 2000, on a per capita basis, rising drug costs are an unsustainable aspect of our health care system. A public program is needed, one that will provide universal public drug insurance, a national formulary for essential drugs, independent drug evaluation, and bulk-purchasing.¹¹ The public program will ban direct-to-consumer advertising. Brand-name companies will not be allowed to restrict generic drugs by extending patents. Pharmacare will ensure the safe and appropriate use of drugs, and cover essential drug costs just as Medicare covers hospital and physician costs.¹²

The 2010 AFB will end years of federal government inaction by launching serious discussions with the provinces and territories to cost-share Pharmacare between the federal and provincial governments and employers at a proposed rate of 50-25-25%. The AFB will allocate \$20 million over two years to set up a Royal Commission on the Establishment and Financing of a Public Drug Plan. As a first step toward a universal program, the AFB will allocate \$900 million in the first year and \$1.2 billion in the second to extend coverage for low-income people as part of a cost-shared program with provinces and employers. Funding will come with cost-cutting conditions attached.

Long term care and community care

The Alternative Federal Budget will restore federal cash payments for “extended health services,” defined in the *Canada Health Act* as nursing home intermediate care services, adult residential care services, home care services, and ambulatory (outpatient) health care services.¹³

Designated federal contributions to provincial extended health services ended in 1995, when the federal government introduced the *Canada Health and Social Transfer* (CHST). David Dingwall, then the minister of health, reported to Parliament that the CHST necessitated nine consequential amendments to the CHA, which “did not affect any of the criteria or conditions of the Act nor any of the provisions for their enforcement.”¹⁴

Unfortunately, this was not the case. Amendments to the *Canada Health Act* included the repeal of Section 6, which authorized the federal Minister of Health to allocate discretionary cash payments for extended health services. In 1995, approximately 10% of Health Canada’s total health contribution was allocated to nursing homes, residential care, home care, and outpatient services such as physiotherapy, at an estimated rate of \$51.32 per capita. In return for the cash, the provinces were required to report to the federal Minister of Health about their activities in this increasingly important area of health services delivery.¹⁵ The 1995 repeal of Section 6 removed any obligation on the part of the federal government to provide funds specifically for extended health services, and also removed any requirement that the provinces disclose information about public funding for and access to this sector of the health care system.¹⁶

As Canada’s population ages, there is a growing need for extended health services across the country. In July 2009, Statistics Canada estimated that the population in the 45-to-64 age group accounted for 40.4% of the nation’s working-age population, while those above the age of 65 accounted for 13.9% of the population.

The reduction in the number of days spent in hospital for patients undergoing surgery has increased the need for rehabilitative outpatient services. In most provinces, however, limits are imposed by both public and private insurers on access to ambulatory health care services such as physiotherapy. The demand for rehabilitation services after joint replacement surgery is increasing, but access is restricted by a growing number of financial barriers.

As the need for home, long-term, and residential care rises, it places additional strains on those on low and fixed incomes. Many people who are actively engaged in the workforce are supporting parents who require health care services that are not included in provincial health insurance plans. We need federal leadership to expand coverage and access through legislation and build a stable home care workforce.¹⁷

We need to extend Medicare to residential long-term care, with increased federal funding tied to legislated standards, including *Canada Health Act* criteria and conditions. We must phase out public funding to for-profit providers and end contracting-out. We need legislated minimum staffing levels to ensure that the ratio between staff and patients/residents meet safety and quality standards that would apply across the country.¹⁸

The AFB will restore cash transfers to 1995 levels. This will cost \$65.34 per capita or \$2.2 billion. Such an allocation will reduce the stress on the health care system by providing access to needed services for the elderly, people with disabilities, and those who require community-based services such as physiotherapy.

Health human resources

We see the longer wait times as a labour issue. Wait times will not be reduced by creating a parallel private health care system. Instead, public resources should be used to strengthen the public system. We need good wages and working

conditions for health care workers so that they are attracted to — and remain in — the health professions.

In the wake of the prolonged economic crisis, the AFB will support public health care and maintain sufficient transfers to provinces and territories so that workers do not bear the brunt of declining tax-revenues. We see in health human resource policy an opportunity for health care workers to work in safe and healthy environments that support high quality care.¹⁹ Workers have the right to maintain a balance between work and personal life.

We recognize the need for reform that would expand the skill utilization of health care workers such that no profession is diminished, but all are enhanced. We reject cost-cutting measures that would pit worker against worker in a competitive working environment. We encourage healthy work environments where organizational practice encourages high levels of job satisfaction and cooperation. We will seek broad discussion on reforms that could make better use of health care dollars through reform of primary care and other innovations within the public system.

The AFB appreciates the skills of thousands of resident internationally-trained health care workers who would contribute to public health care across the country if they were given the opportunity to be employed in good jobs. These workers should have access to ongoing education and professional development, and have a clear path toward recognition of their international credentials. The AFB will allocate \$10 million over two years for the federal government to work with professional regulatory bodies, health care unions, and immigrant rights organizations to facilitate the recognition of international education.

The AFB will allocate a further \$10 million per year for a Health Human Resources Innovation Fund to test, evaluate, and replicate effective retentions strategies. These funds will be made available for pilot projects for partnerships by

health care authorities, health care worker unions, and provincial, territorial, and First Nation governments. The results of these pilot projects will be disseminated widely.

The AFB will dedicate \$200 million each year for the next three years to pilot a job-laddering program for health care workers who are already working, but who need either training or upgrading to develop their skills and gain access to other professions within the health care system. This pilot program will develop the potential of the health care labour force and ease the shortage of health care workers within the public system.

The AFB will commit additional funds to expand seats in medical, nursing, and other health care education programs. The AFB will pay 50% of tuition fees, up to \$5,000 per year, based on financial need. We will also support institutions committed to reducing student fees with a fund of \$100 million in each of the next two years.

The health needs of Aboriginal communities are not being met in large part because of a shortage of health care workers. Aboriginal peoples are underrepresented in health care fields. In recent years, post-secondary institutions have begun to incorporate issues of cultural safety within their programs, but these efforts need to be advanced and supported to meet the health needs of Aboriginal peoples and increase their representation in health education programs. In each of the next two years, the AFB will allocate \$50 million to post-secondary institutions to support Aboriginal students in health education programs who choose to work with Aboriginal communities. This education support will be tied to employment equity programs like the Representative Workforce Strategy in Saskatchewan.²⁰

Migrant workers' health agenda

The AFB commits \$20 million for each of the next two years to improve the access of migrant workers to health care. As part of the dismantling of the Temporary Foreign Workers' Program and

TABLE 9 Health Care Investments (\$millions)

	2010-11	2011-12
Royal Commission on the Establishment and Financing of a Public Drug Plan	10	10
Pharmacare	900	1,200
Extended Health Services	1,500	2,200
Credential Recognition	5	5
Health Human Resources Innovation Fund	10	10
Extend EI for Retraining Health Care workers	200	200
Tuition Debt, Seat Expansion for Health Education Programs	100	100
Seat Expansion for Aboriginal Health Care Workers	50	50
Funding for Migrant Workers' Health Agenda	20	20

the transition to a more just immigration system, the federal government will establish a program to ensure access to health services by migrant workers. This program will be designed in consultation with migrant workers, advocates, and community health researchers.²¹ Such a program will extend health outreach services to migrant workers through clinics at locations and during hours that are most convenient, as well as through a “telehealth line.” Translation will be available. The program will ensure that workers will not be vulnerable to repatriation or loss of future employment if they fall ill or become injured. Workers will have access to information in their own languages and will have the means to appeal decisions concerning workers’ compensation. The program will ensure pan-Canadian standards.

Notes

¹ Canadian Labour Congress, *Recession Watch Bulletin*, Issue 3: Fall 2009

² Campaign 2000, “Annual Report Card on Child and Family Poverty”, November 24, 2009. (Retrieved November 24, 2009) <http://www.campaign2000.ca/reportCards/national/2009EnglishC2000NationalReportCard.pdf>

³ Canadian Population Health Initiative, “Reducing Gaps in Health: A Focus on Socio-Economic Status in Urban Canada” Canadian Institute for Health Information, November 24, 2008. www.cihi.ca/cphi (Retrieved November 24, 2009)

⁴ Food Bank’s Canada, “Food Banks Canada’s Hunger Count study shows largest year-over-year increase in food bank use on record” News Release, November 17, 2009. www.food-bankscanada.ca (Retrieved November 21, 2009)

⁵ Mental Health Commission of Canada, “International Round Table: Impact of the Recession on the Mental Health of Workers and Their Families Summary Report”, August 16 & 17, 2009 Ottawa. www.mentalhealthcommission.ca (Retrieved November 21, 2009)

⁶ Health Canada, “Healthy Canadians: A federal report on comparable health indicators 2008” Ottawa: Government of Canada, 2009. <http://www.hc-sc.gc.ca/hcs-sss/pubs/system-regime/index-eng.php>

⁷ Nanos Research Poll was conducted for *Policy Options* in October 2009 and is available at www.irpp.org

⁸ Finance Canada, Canada Health Transfer, <http://www.fin.gc.ca/fedprov/cht-eng.asp>

⁹ Canadian Institute for Health Information *Drug Expenditure in Canada, 1985-2008*, “Table A Canada—Per Capita : Expenditure on Drugs Per Capita by Type, by Source of Finance and Public, Private and Total Health Expenditures, Canada 1985 to 2008, Annual Percentage Change”, CIHI, 2009, p.62

¹⁰ Andre Bernard, “Trends in Manufacturing Employment” *Perspectives on Labour and Income*, February 2009. Statistics Canada—Catalogue no. 75-001-X 13pp.

¹¹ Canadian Health Coalition, “Appendix B: 10 Elements of a National Strategy for Pharmacare”, *More for Less: Pharmacare a National Drug Plan*, September 2007. pp.29 <http://www.healthcoalition.ca/mfl2007.pdf>

¹² Canadian Health Coalition, *More for Less: Pharmacare a National Drug Plan*, September 2007. pp.29 <http://www.healthcoalition.ca/mfl2007.pdf>

- 13 Section 2: Definitions. *Canada Health Act* (R.S. 1985, c. C-6)
- 14 *Canada Health Act* Annual Report 1996–97, p.13 (Ottawa: Minister of Public Works and Government Services Canada, 1997)
- 15 *Canada Health Act* Annual Report 1995–96 (Ottawa: Minister of Public Works and Government Services Canada, 1996), p.13
- 16 Fuller, C, What we have, What we need, Canadian Health Coalition, May 2001
- 17 Canadian Federation of Nurses Unions, “Home Care Fact Sheet” July 2009 www.cfnu.ca
- 18 Canadian Union of Public Employees, “Residential Long-Term Care in Canada: Our Vision for Better Seniors’ Care”, October 2009 www.cupe.ca
- 19 CUPE, “Residential Long-term Care in Canada”, pp. 10–14
- 20 CUPE, “Representative Workforce Strategy” <http://cupe.ca/aboriginal/Representative-Workf> and CUPE, “Representative Workforce (Employment Equity) Guidelines” <http://cupe.ca/aboriginal/a49f88949b28ae>
- 21 Janet McLaughlin, “Migration and Health: Implications for Development — A case study of Mexican and Jamaican Migrants in Canada’s Seasonal Agricultural Workers’ Program” Canadian Foundation for the Americas, Policy Paper, October 2009.