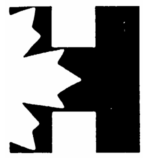


Canadian Healthcare Association

Analysis of the 2004 Health Care Plan

Preamble

The 2004 Health Care Plan commits to significant progress in a number of key areas such as: wait times, health human resources, an expanded continuum of care, and increased funding that is on-going and predictable.

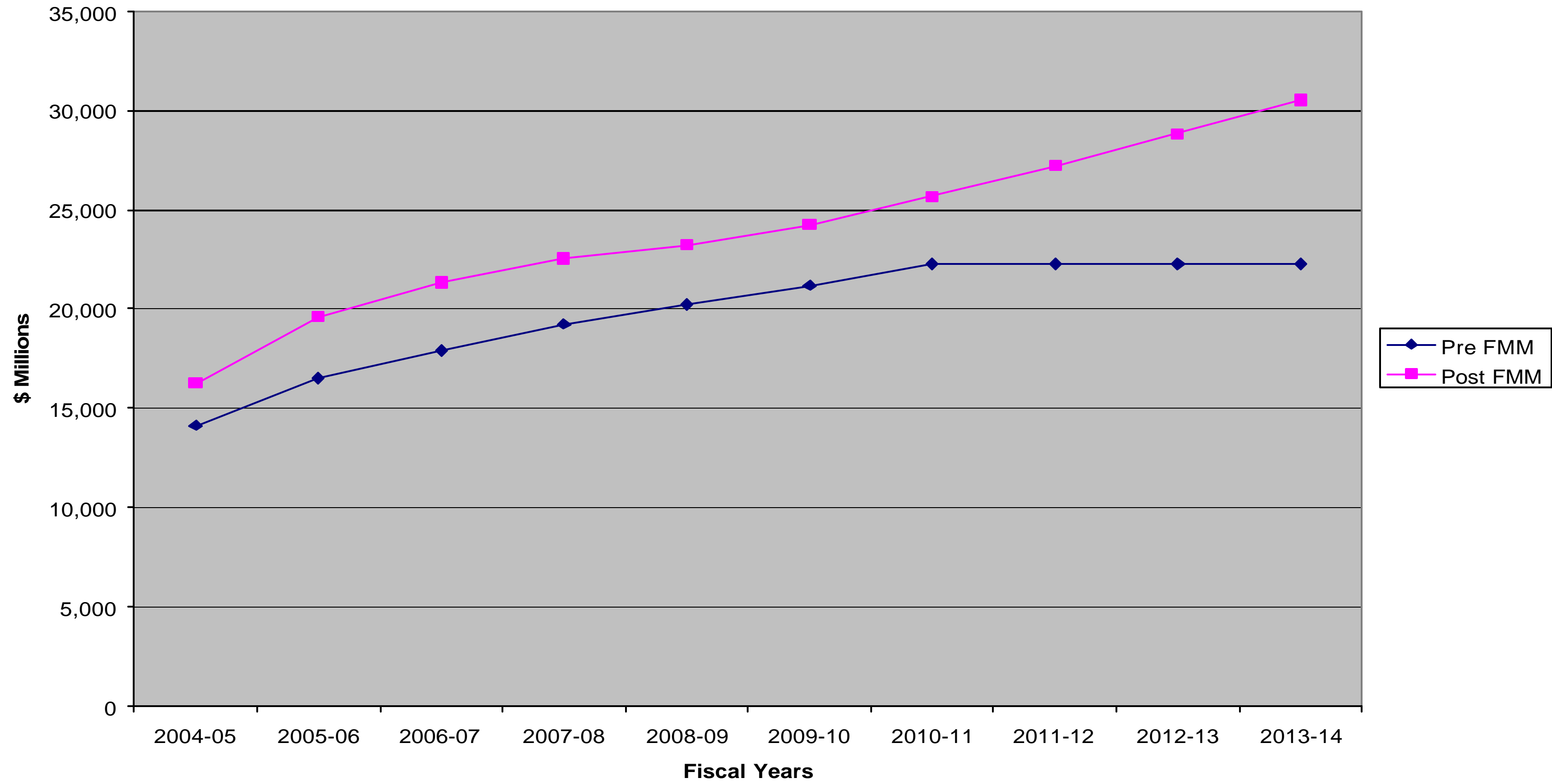
CHA and its provincial and territorial members will need to monitor whether provincial/territorial governments direct the new federal funding appropriately for those areas highlighted in the agreement. The only conditions attached to the funds are as follows: "All funding arrangements require that jurisdictions comply with the reporting provisions of this communiqué".

Additional communiqués addressed a separate arrangement for Quebec, and the issue of Aboriginal health. Governments committed to working with Aboriginal leaders to convene a First Ministers' Meeting dedicated to Aboriginal issues including the critical determinants of health.

Another First Ministers' Meeting will take place on October 26, 2004 to discuss Equalization, Territorial Formula Financing (TFF) and to provide an opportunity for a discussion of other financial pressures facing provinces and territories.

Funding

The First Ministers' 2004 Health Care Plan provides significant federal reinvestment to the health care system - $18 B over 6 years, rising to $41.285 B over 10 years. Moreover, because the majority of the funding is ongoing, added to the CHT base, and then escalated at 6% as of fiscal year (FY) 2006-07, the need for long-term predictable funding is addressed. The financial improvements are illustrated in the graph on pg. 2.


Pre and Post FMM Comparison
35,000
30,000
25,000
20,000
15,000
10,000
5,000
0
$ Millions
2004-05
2005-06
2006-07
2007-08
2008-09
2009-10
2010-11
2011-12
2012-13
2013-14
Fiscal Years
Pre FMM
Post FMM

New Investments to the CHT Base to Sustain Medicare Services

CHA had been advocating for at least $3B in new money to be added to the base to sustain existing medicare services. In FY 2005-06, there is a total of $3.125 B in new funding, including $2 B to close the Romanow Gap, an additional $.5 B in the base for home care and catastrophic drug coverage, and $.625 B to address wait times. (The Wait Times Reduction Fund will be used for jurisdictional priorities including hiring more health professionals, and tools to manage wait times.) This approaches the CHA goal of $3B in additional funds to support existing medicare services.

Long-term, Predictable Funding

CHA has always advocated for long-term, predictable funding rather than short-term, stop and go funding. The new federal funds that resulted from the 2004 Health Care Plan are ongoing, the only exception being a one time $.5 B commitment in FY 2004-05 for medical equipment. Further, the Health Care Plan guarantees that by FY 2010-11, the Wait Times Reduction Fund will be replaced with an additional $.25 B to the CHT base, primarily for health human resources.

Explicit Escalator

CHA had been advocating for an explicit escalator in the range of a 5% annual increase to the CHT base, to reflect increases in inflation and health system cost drivers. By FY 2006-07, $2.5B of the additional funds provided by the 2004 Health Care Plan in FY 2005-06, (Romanow Gap funds of $2 B, and homecare and catastrophic drug funds of $.5B) are added to the CHT base and escalated at 6% annually, an enhancement of 1% over what CHA was advocating.

Conclusion

While the overall increase to the CHT base in FY 2005-06 is somewhat less than what CHA was advocating for ($2.5 B plus portion Wait Times Funds rather than $3 B), by 2007-08, the difference is minimal ($21.49 B under the CHA proposal compared to $21.34 B under the 2004 Health Care Plan), and by FY 2010-11, the amount under the 2004 Health Care Plan exceeds the amount that was provided for under the CHA proposal ($25.42 B under the 2004 Health Care Plan compared to $24.88 B under the original CHA proposal). That is to say that within six years, the reinvestment exceeds the CHA proposal due to the compounding effect of the higher escalator (6 rather than 5%) on the base. Moreover, this positive compounding benefit continues to accrue with each subsequent year. The attached chart summarizes the funding investments.

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]	1,000	2,000					**3,000**					**3,000**
Addition to CHT base in 2005-06[1]		500					**500**					**500**
New CHT base in 2005-06[2]		19,000										
6% Escalator			1,140	1,208	1,281	1,358	**4,987**	1,439	1,520	1,617	1,714	**6,295**
(New CHT Level – Old Level)			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[3]	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 legislative 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]Extension of wait times funding starting on 2010-11 primarily for health human resources.

Wait times/Access

♦ **The Facts (selected quotes)**

To reduce wait times, the federal government will invest $4.5 billion over the next six years, beginning in 2004-05, in the Wait Times Fund which will primarily be used for jurisdictional priorities such as training and hiring more health professionals, clearing backlogs, building capacity for regional centres of excellence, expanding ambulatory and community care programs and/or tools to manage wait times. In 2010-11, $250 million ongoing will be added to the CHT base primarily for health human resources. The First Ministers have committed to achieving meaningful reductions in wait times in priority areas such as cancer, heart, diagnostic imaging, joint replacements, and sight restoration by March 31, 2007, while recognizing the different starting points, priorities, and strategies across jurisdictions.

First Ministers have agreed to collect and provide meaningful information to Canadians as follows:

- Each jurisdiction agrees to establish comparable indicators of access to health care professionals, diagnostic and treatment procedures, with a report to their citizens to be developed by December 31, 2005.
- Evidence-based benchmarks for medically acceptable wait times starting with cancer, heart, diagnostic imaging procedures, joint replacements, and sight restoration will be established by December 31, 2005 through a process to be developed by Federal, Provincial and Territorial Ministers of Health.
- Multi-year targets to achieve priority benchmarks will be established by each jurisdiction by December 31, 2007.
- The Canadian Institute for Health Information will report on progress on wait times across jurisdictions.

♦ **CHA Commentary**

CHA has called for benchmarks for appropriate waiting times which must be met. Canadians will not support a health system unless it provides them with timely access to the services they need. The issue is one of adequate levels of funding and human resources, as well as a standardized approach to establishing clinically appropriate waiting times.

Advocacy opportunity: Advocacy may be required in regard to wait times in emergency rooms, as this issue is not addressed in the new Health Care Plan, and could suffer if resources are redirected to other areas.

Health Human Resources

- **The Facts (selected quotes)**

First Ministers agreed to continue and accelerate their work on health human resources action plans and/or initiatives to ensure an adequate supply and appropriate mix of health professionals. These plans are to build on current work in health labour relations, interdisciplinary training, investments in post-secondary education, and credentialing of health professionals.

F/P/T governments agreed to increase the supply of health professionals (based on their assessment of the gaps) and make their action plans public, including targets for training recruitment, and retention of professionals by December 31, 2005.

The federal government will:

- Accelerate the assessment and integration of internationally trained health care graduates,
- Target efforts on HHR to Aboriginal and Official Languages Minority Communities,
- Reduce the financial burden on students in specific health education programs, and
- Participate in HHR planning with interested jurisdictions.

In 2010-11, $250 million (ongoing) will be added to the base primarily for health human resources through the Wait Times Reduction Fund.

- **CHA Commentary**

CHA supports a pan-Canadian health human resource framework and strategy that will address scopes of practice issues, deal effectively with labour relation issues (including remuneration levels, benefit packages, service contracts, and payment mechanisms for physicians, nurses, and other providers), and ensure that health organizations are an employer of choice.

CHA is pleased that the challenges of recruitment and retention, labour relations, and other key reforms are now being addressed. However, these initiatives do not seem to be co-coordinated at a pan-Canadian level.

Advocacy opportunity: CHA will explore whether there is any coordination at a pan-Canadian level and will continue to advocate for this.

CHA's position is that any pan-Canadian health human resource framework or strategy should be developed collaboratively with F/P/T government representatives, employer representatives from health facilities and agencies, and employee representatives, in the consultation and decision making process.

First Ministers have acknowledged that they will commit to working with health care providers and the “health, post-secondary education, and labour market sectors”.

Advocacy opportunity: CHA and its members will need to ensure their involvement in the development and implementation of plans along with health care providers.

Home Care

- **The Facts (selected quotes)**

First Ministers agreed to provide first dollar coverage by 2006 for certain home care services, based on assessed need. Specifically, this will include: short-term acute home care (2 weeks of case management, IV medications related to discharge diagnosis, and nursing and personal care) short-term acute community mental health (2 weeks of case management and crisis response services), as well as end-of-life care (case management, nursing, palliative-specific pharmaceuticals, and personal care at the end of life).

Each jurisdiction is to develop a plan for staged implementation of these services and report annually to citizens. Health Ministers are tasked to explore next steps to fulfill the home care commitment and report to First Ministers by December 31, 2006.

Home Care funding is included in the Romanow Gap funds and then added to the CHT base.

- **CHA Commentary**

CHA has long advocated for a home and community care program supported by a legislative framework that addresses both acute care replacement home care and ongoing continuing/chronic care services. Certainly, the First Ministers' agreement addresses acute care replacement services, short-term community mental health, and end-of-life care with first-dollar coverage. You will recall that these goals were previously outlined in the 2003 Health Accord, with these services to become available by 2006.

While there is a commitment to provide the above three components on a short-term basis, there is no commitment to continuing/chronic care in the community. Furthermore, there is no assurance that the plans each jurisdiction 'explores' and 'develops' will ensure Canadians comparable services no matter where they live. A lack of a legislative framework means that as long as First Ministers can report on some progress, they are not required to meet pan-Canadian objectives on home care.

Advocacy opportunity: CHA and its members must continue to express to governments that, while recognizing that jurisdictions are at differing stages of reform for home care, all governments must strive to meet a set of pan-Canadian objectives that ensure access to both acute care replacement <u>and</u> on-going continuing/chronic home care services.

CHA and its members will need to monitor these developments closely, as previous target dates have been missed and, with no legislative framework, there are no strong consequences if a province or territory falls short on progress.

Primary Health Care Reform

- **The Facts (selected quotes)**

In order to meet a previous objective of 50% of Canadians having 24/7 access to multidisciplinary teams by 2011, First Ministers agreed to establish a "best practices network" to share information and find solutions to barriers to progress in primary health care reform such as scope of practice issues, and to regularly report on progress.

First Ministers also agreed to accelerate the development and implementation of the electronic health record, including e-prescribing. To this end, First Ministers agreed to work with *Canada Health Infoway*. First Ministers have also asked for acceleration of efforts on telehealth to improve access for remote and rural communities.

- **CHA Commentary**

CHA supports primary health care reform and encourages the identification of "champions" from a variety of groups, organizations and perspectives. CHA also supports training that fosters team approaches; facilitating communication and community development processes that engage the public, physicians, nurses, all health providers and health organizations; and working to ensure client and consumer acceptance, satisfaction and confidence.

Advocacy opportunity: CHA will continue to advocate for an explicit plan with interim benchmarks for primary health care reform.

Access to Care in the North

- **The Facts (selected quotes)**

The federal government will increase funding to the Territories totaling $150 million over 5 years through a Territorial Health Access Fund, targeted at facilitating long-term health reforms, and including direct funds for medical transportation costs. A federal/territorial working group will be established to support the management of the fund.

- **CHA Commentary**

CHA and its members will monitor the development of the Territorial Health Access Fund.

Pharmaceuticals

♦ **The Facts (selected quotes)**

Health Ministers are directed to establish a Ministerial Task Force to develop, implement, and report on a national pharmaceuticals strategy by June 30, 2006. The strategy includes the following actions:

- Develop, assess, and cost options for catastrophic pharmaceutical coverage,
- Establish a common national drug formulary,
- Accelerate access to breakthrough drugs by improvements to the drug approval process,
- Strengthen evaluation of drug safety and effectiveness,
- Pursue purchasing strategies,
- Support action to influence prescribing behaviour,
- Broaden the practice of e-prescribing through efforts on the electronic health record,
- Improve access to non-patented drugs and achieve international parity on prices of non-patented drugs, and
- Enhance the analysis of cost drivers and cost-effectiveness, including best practices in drug plan policies.

Catastrophic drug funding is included in the Romanow Gap funds and then added to the CHT base.

Quebec will maintain its own pharmacare program.

♦ **CHA Commentary**

CHA is pleased to see the development of a common National Drug Formulary, and that utilization issues such as costs and appropriate prescribing will be included in a national pharmaceuticals strategy. CHA was looking for the strategy to link pharmaceuticals to a home care program, and recognizes the inclusion of IV medications and palliative-specific medications linked to the current commitments to home care. That said, both the 2003 Health Accord and the 2004 Health Care Plan did not envisage a legislative framework for pharmacare. Moreover, while First Ministers have committed to action on catastrophic drugs, what is not included in the national pharmaceuticals strategy is proposed coverage for uninsured and under-insured Canadians.

Advocacy opportunity: CHA and its members will continue to advocate for a legislative framework to support the national pharmaceuticals strategy. As well, CHA and members will need to advocate for drug coverage for under/uninsured Canadians.

Prevention, Promotion, Public Health

- **The Facts (selected quotes)**

The First Ministers committed to further collaboration and cooperation in developing coordinated responses to infectious disease outbreaks and other public health emergencies through the new Public Health Network. They also committed to accelerating work on a pan-Canadian Public Health Strategy. For the first time, governments will set goals and targets for improving the health status of Canadians. The Strategy will include efforts to address common risk factors, such as physical inactivity, and integrated disease strategies.

The federal government also commits to ongoing investments for needed vaccines, through the National Immunization Strategy.

- **CHA Commentary**

CHA supports efforts to ensure adequate health system capacity and response to public health emergencies and infectious disease outbreaks. CHA has also advocated for more resources for wellness initiatives, and is committed to the inclusion of health promotion programs and healthy lifestyle initiatives within the health system as well as investments in the determinants of health and healthy public policy. CHA has also advocated for a Public Health Agency to address disease surveillance and disease prevention.

Advocacy opportunity: CHA will monitor these developments as a member of the Canadian Coalition for Public Health in the 21st Century.

Health Innovation

- **The Facts (selected quotes)**

First Ministers recognized that investments in health system innovation through science, technology and research help to strengthen health care as well as our competitiveness and productivity. Investments are necessary to develop new, more cost-effective approaches and to facilitate and accelerate adoption and evaluation of new models of health protection and chronic disease management.

The federal government commits to ‘continued investments to sustain activities in support of health innovation’.

- **CHA Commentary**

CHA has long advocated for adequate levels of funding for health research and is pleased to see a commitment to ongoing investments in support of health innovation.

Advocacy opportunity: CHA and its members will need to determine whether the investments in health research are sufficient to support leading edge health research across the continuum of care.

Accountability and Reporting to Citizens

♦ **The Facts (selected quotes)**

All governments agreed to report to their residents on health system performance including the elements set out in the 2004 Health Care Plan. Governments agreed to seek advice from experts and health providers on the most appropriate indicators to measure health system performance. **All funding arrangements require that jurisdictions comply with the reporting provisions** of the Health Care Plan.

First Ministers of jurisdictions participating in the Health Council agreed that the Council will prepare an annual report to all Canadians, on the health status of Canadians and health outcomes. The Council will report on progress of elements set out in the Health Care Plan.

♦ **CHA Commentary**

CHA supports appropriate performance indicators for the health system as well as a pan-Canadian evaluation and monitoring system which would include appropriate indicators, a minimum data set that is comparable across the country, and harmonized reporting mechanisms.

We are pleased to see the commitment to ensuring that indicators and measures are appropriate and that advice will be sought by experts and health providers. An annual report prepared by the Health Council is a positive step in ensuring transparency to the Canadian public.

CHA also believes that the role of the federal government is to ensure that a broad range of comparable health services are available to Canadians. This means asserting the Canada Health Act and any other legislative frameworks that are put in place. The federal government cannot write a blank cheque without being assured of compliance with pan-Canadian objectives and agreed-upon performance outcomes. At the same time, the federal government needs to recognize that the delivery of health services is a provincial/territorial responsibility and some flexibility will be needed to address regional realities.

Although the new Health Care Plan requires that jurisdictions comply with reporting provisions, there are no real "teeth" that will ensure commitments are held. So long as Premiers report publicly, there are no guarantees that each will strive to meet a pan-Canadian objective or standard of care or spend the federal dollars appropriately. The federal government is relying on the court of public opinion instead of using legislative or financial penalties for jurisdictions that do not meet pan-Canadian objectives.

Advocacy opportunity: CHA and its members must continue to advocate that the federal government introduce legislative changes to tie future transfers to compliance. CHA members will need to continue to hold their governments accountable for ensuring that the new health money will be used for the areas committed to in the 2004 Health Care Plan.

Dispute Avoidance and Resolution

- **The Facts (selected quotes)**

Federal, Provincial, and Territorial governments formalized the agreement reached on dispute avoidance and resolution with regard to the Canada Health Act in an exchange of letters in April 2002.

- **CHA Commentary**

One component of the 1999 Social Union Framework Agreement (SUFA) was to create a mechanism for resolving disputes between the federal government and the provincial and territorial governments in areas of intergovernmental initiatives. In April 2002, Minister McLellan proposed a Dispute Avoidance and Resolution Process to apply to the interpretation of the principles of the *Canada Health Act*. Premier Klein accepted the proposal on behalf of all provincial and territorial governments, except Quebec.

The agreement encourages the governments to engage in discussions to avoid disputes that require formal resolution proceedings. This includes ad hoc F/P/T committees and government-to-government information sharing. As well, Health Canada committed to provide advance assessments to any province or territory upon request.

When a dispute cannot be resolved through discussion, either of the two health ministers involved in the dispute can request that the dispute resolution process be initiated. The first step in the formal process is fact-finding and negotiation. If no agreement on the facts or a solution is reached, either health minister may refer the matter to a third party panel. The panel will be composed of one representative appointed by the federal government, one representative appointed by the province or territory, and a chairperson that the two representatives select. The panel will have the ability to provide non-binding advice and recommendations. The federal Minister of Health has the final authority to interpret and enforce the *Canada Health Act*. In deciding whether to invoke the non-compliance provisions of the Act, the Minister will take the panel's report into consideration.

To ensure an open process, the governments will report on any dispute avoidance and resolution activities, including panel reports.

For more information, see: http://www.hc-sc.gc.ca/medicare/DAR.htm#3

Note: It does not seem as if this agreement is an integral part of the 2004 Health Care Plan. Rather, the 2004 Health Care Plan formally recognizes the dispute process agreed to in the April 2002 letters.

Quebec

♦ **The Facts (selected quotes)**

Quebec will apply its own wait time reduction plan, in accordance with the objectives, standards and criteria established by the relevant Quebec authorities, including health human resources management, family and community care reform, home care, drug access strategies, and health promotion and chronic illness prevention strategies. With respect to wait times, evidence-based benchmarks established by December 31, 2005, will help Quebec have a more effective action plan. Quebec will pursue its objective of providing more first dollar coverage for short-term acute home care, short-term acute community mental health home care and palliative care, in accordance with its financial capacity.

The government of Quebec will report to Quebecers on progress in achieving its objectives, and will use comparable indicators, mutually agreed to with other governments. In this respect, Quebec will continue to work with other governments to develop new comparable indicators. Quebec plans to continue to work closely with the provincial and territorial governments and with the federal government, on sharing information and best practices.

Quebec's Health Commissioner is responsible for reporting to the Government of Quebec on Quebec's health system. He will cooperate with the Canadian Institute of Health Information.

Funding made available by the Government of Canada will be used by the Government of Quebec to implement its own plan for renewing Quebec's health system.

The Government of Quebec will continue to report to Quebecers on the use of all health funding.

♦ **CHA Commentary**

The agreement with Quebec is similar to the agreement with other provincial/territorial governments while 'fully respecting its jurisdiction'. Please see CHA Commentary and Advocacy Opportunities under the "Accountability and Reporting to Citizens" section of this analysis, as they apply to Quebec's agreement as well.

Aboriginal Health

- **The Facts (selected quotes)**

First Ministers and Aboriginal leaders reached agreement to work together to develop a blueprint to improve both the health status of Aboriginal peoples, and the heath services provided to Aboriginal peoples through concrete initiatives for:

- Improved delivery of and access to health services to meet the needs of all Aboriginal peoples through better integration and adaptation of all health systems;
- Measures that will ensure that Aboriginal peoples benefit fully from improvements to Canadian health systems; and
- A forward looking agenda of prevention, health promotion and other upstream investments for Aboriginal peoples.

Federal/Provincial/Territorial Ministers responsible for Health and Aboriginal Affairs have been tasked to work in partnership with Aboriginal leaders to develop a blueprint and report back in one year.

The federal government announced that it would commit $700 million over 5 years for:

- An Aboriginal Health Transition Fund to enable federal/provincial/territorial and First Nations governments to devise new ways to integrate and adapt existing health services;
- An Aboriginal Health Human Resource initiative; and
- Programs on health promotion and disease prevention.

Governments committed to working with Aboriginal leaders to convene a First Ministers' Meeting dedicated to Aboriginal issues including the critical determinants of health.

- **CHA Commentary**

CHA believes that this was a significant development because all levels of government are committing to work together to resolve long-standing jurisdictional disputes over responsibility for Aboriginal health services. It is also significant that for the first time, the Métis Nation is being included in initiative as the federal government has not traditionally extended Aboriginal benefits to Métis peoples.