

**CANADA'S PUBLICLY FUNDED HEALTH SYSTEM:
THE KEY TO ECONOMIC GROWTH, PROSPERITY
AND CARING FOR CANADIANS**

Brief Submitted to the
House of Commons
Standing Committee on Finance



By the Canadian Healthcare Association

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1.0 INTRODUCTION

The Canadian Healthcare Association (CHA) is the federation of provincial and territorial hospital and health organizations across Canada. Through our members, CHA represents a broad continuum of care, including acute care, home and community care, long term care, public health, mental health, palliative care, addiction services, children, youth and family services, housing services, and professional and licensing bodies. These services are provided through regional health authorities, hospitals and other facilities and agencies that serve all Canadians and are governed by trustees who act in the public interest

The Canadian Healthcare Association was founded in 1931 and historically represented provincial and territorial hospital associations at the national level. In 1995, our name was changed from the Canadian Hospital Association to the Canadian Healthcare Association to reflect the broadening scope of our association's membership.

CHA's mission is to improve the delivery of health services in Canada through policy development, advocacy and leadership. CHA's distance education programs, conferences and publishing services contribute to this national leadership. CHA and our members are committed to realizing the vision of a publicly funded health system that provides access to a broad range of comparable health services across Canada.

CHA appreciates this important opportunity to contribute to the deliberations of the House of Commons Standing Committee on Finance concerning the 2004 federal budget and thanks members of the Committee for their consideration of this brief.

The Committee has asked three questions of those wishing to have input into its report regarding the 2004 federal budget, specifically:

- What taxation, spending and other measures should be taken to ensure economic growth and job creation, balanced federal budgets and any needed changes in addressing the net-debt-to GDP ratio?
- What taxation, spending and other measures should be taken to ensure progress in investing in, and caring for, all members of Canadian society?
- What taxation, spending and other measures should be taken to ensure that urban, rural and remote communities are desirable places in which to live and work, and maximize their contribution to Canada's prosperity?

CHA and our members believe that a sustainable, responsive and accountable publicly funded health system provides the answer to all three questions. CHA and our member organizations are committed to realizing this system in partnership with governments, health stakeholders, business and labour, other sectoral organizations and the public.

Two factors are essential to ensuring sustainability for our publicly funded health system:

- stabilizing the existing hospital and physician-based medicare system; and

- supporting appropriate system change to ensure a responsive system for the future in which Canadians have access to a broad range of comparable health services across Canada.

In recent years, the federal government has pursued measures toward ensuring these goals, most recently the 2003 First Ministers Health Accord and the subsequent federal budget. When the First Ministers Accord was announced, CHA recognized that some progress had been made toward these goals, and when the federal budget was released, CHA supported the wide range of investments contained in it that impact on the health and well-being of Canadians.

However, while the 2003 Accord and the subsequent federal budget contain some positive measures, CHA remains deeply concerned that:

- The Accord provides neither a comprehensive plan nor sufficient federal funding over five years to both stabilize the existing system and facilitate real change to improve access to needed services across the broader continuum of care.
- Despite the Romanow Commission's recommendation for a federal funding increase of \$15 billion to our publicly funded health system over three years, the Accord and federal budget provide only \$12 billion over the same time period.
- A one-time funding provision within the Accord of \$2 billion for this fiscal year which is contingent on the federal surplus being sufficient to accommodate this transfer is now potentially in doubt because of lower than anticipated economic growth, which has been exacerbated by the impact of Severe Acute Respiratory Syndrome (SARS), Bovine Spongiform Encephalopathy (BSE or mad cow disease), the recent fires in the British Columbia interior, the increase in the value of the Canadian dollar and the uneven economic recovery in the United States. However, a number of provinces have already factored this money into their health planning for this year. This is a good illustration of why health funding must be stable, predictable and adequate as opposed to ad hoc and one-time.
- The lack of sufficient funds to support and stabilize the existing hospital/physician medicare system threatens to cannibalize the health reform fund which is supposed to be used to facilitate real change, an aspect of the Accord and federal budget about which Commissioner Romanow has expressed concern. CHA has taken the position that sufficient funds need to be transferred to the provinces and territories for Canada Health Act services, that is, we must "shore the core", while at the same time ensure that the other funds are used for health reform. After all, Canadians have expressed repeated concern about waiting lists for services, which cannot be enhanced without funds to pay for them.
- The Accord has not alleviated the political acrimony between the federal, provincial and territorial governments concerning our health system which impedes opportunities for reform.

In the wake of the Romanow and Kirby reports, the First Ministers Health Accord and the federal budget, there has been the temptation to argue that our health system has had its day and we cannot afford further investments in our health system. In contrast, CHA

would argue that we cannot afford ? either in terms of our economic competitiveness or our quality of life — not to address the deficiencies within the Accord.

2.0 SUSTAINABLE, PUBLICLY FUNDED HEALTHCARE IS KEY TO ECONOMIC GROWTH, PROSPERITY, AND CARING FOR CANADIANS

In the face of repeated prognostications by some concerning the supposed unsustainability, inefficiency, ineffectiveness and consequent need to replace our publicly funded health system, the idea that this system provides the key to economic growth, prosperity and caring for Canadians may seem incongruous. In response, we should remember a key paragraph in Commissioner Romanow's "A Message to Canadians" which precedes the body of his final report:

I am pleased to report to Canadians that the often overheated rhetoric about medicare's costs, effectiveness and viability does not stand up to scrutiny. Our health outcomes, with a few exceptions, are among the best in the world, and a strong majority of Canadians who use the system are highly satisfied with the quality and standard of care they receive. Medicare has consistently delivered affordable, timely, accessible and high quality care to the overwhelming majority of Canadians on the basis of need, not income. It has contributed to our international competitiveness, to the extraordinary standard of living we enjoy, and to the quality and productivity of our work force.¹

2.1 PUBLICLY FUNDED HEALTHCARE AS A CORE CANADIAN VALUE

CHA and our members have continually upheld the core Canadian value that access to health services be provided on the basis of health need, not on the ability to pay. For example, as noted in CHA's *Ten Point Plan*, developed in 2002 to identify what is required to ensure that Canada's publicly funded health system is responsive, sustainable and better positioned to achieve true health reform, this value is characteristic of what is known as the "shared risk approach" as opposed to the "individual risk approach"² that more typically characterizes the provision of health services in countries such as the United States.

While the Romanow report did not deny the need for change within the system to ensure that it be truly national, comprehensive and accountable, it fundamentally rejected any approach such as user fees, medical savings accounts, de-listing services, greater privatization, a parallel private system, co-payments, or other suggestions that would effectively degrade the core Canadian value of access based on need, not on ability to pay.

¹ Commissioner Roy J. Romanow, Q.C., *Building on Values: The Future of Health Care in Canada ? Final Report*, 2002, p. xvi.

² CHA, *A Responsive, Sustainable, Publicly Funded Health System in Canada: The Art of the Possible*, February 2002, p. 4, www.cha.ca.

There is no evidence these solutions will deliver better or cheaper care, or improve access (except, perhaps, for those who can afford to pay for care out of their own pockets). More to the point, the principles upon which these solutions rest cannot be reconciled with the values at the heart of medicare or with the tenets of the Canada Health Act that Canadians overwhelmingly support.³

Where CHA does have difficulty with the Romanow report is that it focuses almost exclusively on the acute care system and does not provide a blueprint for creating access for Canadians to ongoing care, continuing care or chronic care. This brief will say more about this issue later.

2.2 PUBLICLY FUNDED HEALTHCARE AS A SOUND ECONOMIC INVESTMENT

CHA and our members have also long maintained that investment in our publicly funded health system contributes not only to our individual and collective well-being, but also to our economic performance. For example, as noted in the CHA 2001 pre-budget submission to the Standing Committee on Finance, "publicly funded healthcare contributes to a healthy workforce, increased productivity, economic development (through research and innovation), quality of life related to business decisions to locate in Canada, and increased global competitiveness."⁴

2.2.1 Publicly Funded Healthcare as a Competitive Advantage

It is well recognized that our publicly funded health system affords businesses based in Canada a distinct competitive advantage due to significant administrative cost differences between Canada's single-insurer (government) system for hospital and physician services and the American multi-payer (private companies) system. For example, a recent study in the *New England Journal of Medicine* (NEJM) has drawn the following conclusions after analyzing data for 1999:

- Total administrative costs within the U.S. system are US\$294 billion per year compared to about US\$9 billion in Canada; this represents a difference of over 300 percent.
- On a per capita level, administrative costs were estimated to be US\$1059 in the United States, compared to US\$307 in Canada.
- Administration accounts for 31 percent of health care expenditures in the U.S. but only 16.7 percent in Canada. Interestingly, the overhead amongst Canada's private insurers was higher than that in the U.S. (13.2 percent versus 11.7 percent). In contrast, Canada's national health insurance had overhead costs of 1.3 percent. Providers' administrative costs were far lower in Canada.

³ *Building on Values*, p. xx.

⁴ See for example CHA, *Canada's Publicly Funded Health System: the Foundation for Global Competition, Fiscal Opportunities and Quality of Life*, Brief submitted to the House of Commons Standing Committee on Finance, August 2001, website op.cit.

- The study's authors concluded that \$209 billion may be saved in the US "if administrative costs could be trimmed by implementing a Canadian-style health care system."⁵

The study's lead author, Dr. Steffie Woolhandler, an associate professor of medicine at Harvard University, concluded in an interview that difficulties with the Canadian health system such as waiting lists for treatment emanate from inadequate funding for medical care. "From our point of view, your funding is too low but your system is very good." In contrast, in the United States, "we have a systemic problem here. There is lots of money sloshing around, yet we have 41 million people with no health insurance, seniors who can't afford medications, and multiple other problems."⁶

In a related commentary in the *NEJM*, economist Henry Aaron of the Brookings Institution stated that "I look at the U.S. health care system and see an administrative monstrosity, a truly bizarre mélange of thousands of payers with payment systems that differ for no socially beneficial reason." While Mr. Aaron had a different estimate on the precise amount of money that could be saved by adopting a Canadian-style health system for the United States, his estimate of US\$159 billion⁷ is almost twice the total forecast expenditure (public and private constant dollars) for the entire Canadian health system for the year 2002 of just under CN\$102 billion.⁸

The impact of this difference in costs on business is dramatic. For example:

- General Motors spends more on health care for its pensioned employees than it does on the steel that goes into its automobiles; the corporation estimates US\$1,300 per car go toward medical care for its former employees, making it one of the largest healthcare providers in the world. This cost burden is a motivation behind the corporation's strategy of cutting prices in order to increase sales, thereby spreading the cost across more vehicles. Health care benefits to retired workers added almost US\$4.1 billion to the corporation's costs in 2002 and are expected to cost US\$4.5 billion this year, almost double its forecasted profits "It's one of the biggest issues in investors minds when they think about GM," according to Rod Lache, auto analyst with Deutsche Bank.⁹ "On the competitive side, that's [publicly funded healthcare in Canada] part of the competitive advantage," according to General Motors Canada spokesperson Stewart Low.¹⁰

⁵ Steffie Woolhandler, M.D., M.P.H., Terry Campbell, M.H.A., David U. Himmelstein, M.D., "Costs of Health Care Administration in the United States and Canada," Online Abstract, *New England Journal of Medicine*, Vol. 349: 768-775, No. 8, August 21, 2003, www.nejm.org; "U.S. health administration costs 300% higher than in Canada," *National Post*, August 21, 2003, www.nationalpost.com; "Canada-U.S. gap in health care grows," *Globe and Mail*, August 21, 2003, www.theglobeandmail.com.

⁶ Woolhandler quoted in the *National Post*, August 21, 2003.

⁷ Aaron's article cited in the *National Post*, August 21, 2003.

⁸ *Total Health Expenditure, Canada, 1975 to 2002 - Summary*, Canadian Institute for Health Information, www.cihi.ca.

⁹ "GM pensioner care biggest cost in vehicle," *National Post*, August 20, 2003.

¹⁰ "US health care carriers big price for taxpayers: Canada's medicare offers competitive advantage in business," *National Post*, February 9, 2001, p. A13; cited in CHA, 2001, p. 5.

- This cost burden is not unique to General Motors or only to the auto manufacturing sector. For example, General Electric was forced to back down this year after workers went on strike to protest plans to have them pay more for healthcare, although pay raises were moderated in exchange.¹¹

2.2.2 Public Health: Essential to Our Economy and Our Health System

CHA and our members advocate that all components of the health system must be strengthened to meet the needs of Canadians by providing access to a broad range of comparable services across Canada, including emergency medical care, acute care, palliative care, home, community and long term care, and mental health. Given the recent outbreak of SARS and its significant and negative impact on our economy and on our health system, this brief will discuss measures which are urgently needed to rectify inadequacies within our public health system.

As an important part of our publicly funded health system, a strong public health system is crucial to the successful prevention, surveillance and control of infectious diseases such as SARS and to respond to other public health emergencies due to bioterrorism, accidents, environmental disasters, etc.; in other words, an all-hazards approach. There is no question that the SARS outbreak demonstrated the professionalism and commitment of countless public health officials. The SARS outbreak has also exposed gaps in Canada's public health capacity and emergency preparedness.

The federal government should not presuppose that the professionalism and dedication of health care providers and managers will suffice in the wake of another extraordinary health event in the absence of the leadership necessary to address these deficits. Unless these gaps are closed, the economic and health impacts of potential future emergency public health situations could be even more significant. **CHA recommends that the federal government demonstrate strong leadership for a pan-Canadian approach to respond to public health issues.**

CHA and our members have long stressed the need for improvements in our public health system. In section 2.3 of CHA's *Ten Point Plan*, prepared several years ago, a prescient paragraph on the need to improve public health states that, "greater investments in health promotion and disease prevention are needed now. Deaths due to contaminated water, mad cow disease, and the recent terrorist attacks demonstrate just how vulnerable our current public health system is."¹²

CHA was invited to submit its initial observations regarding the "lessons learned" from SARS for the purposes of informing the examination of long-term approaches to public health in Canada to Dr. David Naylor, Chair of the National Advisory Committee on SARS and Public Health.

¹¹ National Post, August 20, 2003.

¹² CHA, op.cit, 2002, p. 9.

CHA made four specific recommendations to the Committee:

- Federal legislation to accommodate public health programs and services;
- The creation of a Canadian Centre for Disease Control;
- The establishment of a Chief Medical Officer of Health for Canada; and
- That the health system receive appropriate investment for the health delivery system (in both the acute and community health systems) to accommodate surge capacity.

Details related to these recommendations were included in our submission to Dr. Naylor, which we append for your review (Appendix 1).

CHA was pleased, therefore, with the September 4, 2003 agreement by federal, provincial and territorial Ministers of Health to collaborate to develop an enhanced public health system which would include:

- clarification of roles and responsibilities for preventing and responding effectively to public health threats, responding effectively to public health threats, respecting federal, provincial and territorial jurisdictions;
- creation of a national network of centres of public health science;
- strengthened public health human resources, including the need for more robust regional and national public health emergency response capacity; and
- enhanced national surveillance and information infrastructure.¹³

We believe that this announcement reflects the federal government's commitment to a strong public health system. However, this commitment must be supported by funding that not only accommodates this enhanced federal role in public health, but also transfers to the provinces and territories sufficient funds for both public health infrastructure and surge capacity in the health delivery system. We believe that this will require in excess of \$1 billion from the federal government over the next five years.

2.3 PUBLICLY FUNDED HEALTHCARE VERSUS OTHER INITIATIVES AND PRIORITIES

In response to a number of federal funding initiatives for health over the past few years (for example, the 1999 "health budget", the 2000 Health Accord, and the 2003 Accord and federal budget), there has been the perception that our publicly funded health system is receiving more than its fair share of public money and is somehow a drain on our economy as opposed to an investment in it. (See section 4.) As both leaders in the business community as well as the federal government itself have recognized, this is untrue.

2.3.1 Federal Investment in the Broad Determinants of Health and Other Social Investments

CHA has never advocated investing in health to the exclusion of other important areas of Canadian life. Indeed, CHA and our members recognize federal efforts to support the

¹³ Conference of Federal/Provincial/Territorial Ministers of Health Halifax, Nova Scotia– September 4, 2003, Press Release, Health Canada.

broader determinants of health and other worthy social investments. When the federal budget this year was announced, "CHA praised the 2003 federal budget investments that impact on the health and well-being of Canadians. These include: the environment, measures directed to children; health research and innovation; national health information, the health of First Nations and Inuit communities; patient safety and quality care; health human resources planning; a national immunization program; and greater accountability for the performance of our publicly funded health system."¹⁴

CHA would like to draw special attention to the commitment by federal, provincial and territorial First Ministers under the 2003 Health Accord to a national strategy to improve patient safety and to the federal government's undertaking to fund the Canadian Patient Safety Institute. We are pleased therefore by the recent announcement by federal, provincial and territorial Ministers of Health to open a Canadian Patient Safety Institute by the end of 2003 "designed to facilitate collaboration among initiatives being undertaken by governments and stakeholders to enhance patient safety."¹⁵

2.3.2 Federal Economic Initiatives: Tax Cuts

In a June 25 speech to the Economic Club of Toronto, Deputy Prime Minister and Minister of Finance John Manley noted the \$100 billion tax reduction over five years in the 2000 federal budget.¹⁶

As has been stated in previous CHA pre-budget briefs, our association is not opposed to tax cuts. However, the benefits to individuals of tax cuts versus increased personal/private investment in health must be examined; this is particularly important since private spending on health increased at a greater rate than public spending on health in 2001 and 2002.¹⁷ And since inequities in income is a powerful determinant of health, care must be taken to ensure that tax cuts narrow, not widen income inequities in Canadian society.

It should be kept in mind that the \$100 billion in tax cuts over five years is three times the federal money for health announced in the 2003 Health Accord of \$34.8 billion over five years. Remember, Canadians have repeatedly said that health is their number one priority. Furthermore, part of the federal money announced in the 2003 Health Accord is simply a re-announcement of federal funding initiatives in the 2000 Health Accord (see section 3). As well, the \$34.8 billion includes increases in direct spending at the federal level in addition to transfers to the provinces and territories. It also includes cumulative amounts as well as some one-time funding.

¹⁴ CHA, "CHA supports Federal budget direction but remains concerned about health system funding," *Press Release*, February 18, 2003, www.cha.ca.

¹⁵ Press Release, Health Canada, September 4, 2003, *op.cit.*

¹⁶ Speech by the Honourable John Manley, P.C., M.P., Deputy Prime Minister and Minister of Finance, to the Economic Club of Canada, June 25, 2003, Department of Finance Canada, www.fin.gc.ca.

¹⁷ CIHI, *Tables on Public and Private Health Expenditures, by Province and Territory 1975 to 2002 - Current Dollars*, www.cihi.ca.

2.3.3 Federal Economic Initiatives: Debt Reduction

In his June 25 speech, Minister Manley also pointed out the reduction in the federal debt by approximately \$50 billion since 1997-98 due to federal surpluses since that time. Noting the potential for a lower than predicted surplus for 2003, the Minister stated that "Once the books are closed, I expect the surplus for 2002-03 will be about equal to the \$3-billion Contingency Reserve that was incorporated in the 2003 budget. ***This surplus will reduce federal debt.***"¹⁸ (Emphasis added.)

In contrast, the federal 2003 budget outlines "a federal government commitment to provide up to an additional \$2.0 billion for health for the provinces and territories at the end of fiscal year 2003-04, ***if the Minister of Finance determines during the month of January 2004 that there will be a sufficient surplus above the normal Contingency Reserve to permit such an investment.***"¹⁹ (Emphasis added.)

CHA acknowledges the importance of debt reduction to Canada's economy. However, we do not believe that debt reduction should be pursued at any price and remind the federal government that the 1999 "health budget" provided a precedent for part of the anticipated federal surplus, which was supposed to be directed toward debt reduction, being used instead to provide immediate funds to the provinces and territories for health.²⁰ Given both that the funding provisions within the Health Accord fall short of what the Romanow report recommended and the risk of further exacerbating federal-provincial-territorial tensions on health, **CHA recommends that \$2.0 billion of the anticipated \$3 billion surplus for 2003 now directed toward debt reduction be instead directed to the provinces and territories for health.** This makes sense in light of recent reports that Canada's debt to GDP ratio compares favourably with that of other countries.

2.3.4 Health Research

The federal government's commitment to health research was demonstrated by the creation of the Canadian Institutes of Health Research with an enhanced budget. Particularly important is its mandate which covers biomedical research, clinical research, health systems research and population health research. Investments in health research contribute significantly to economic growth and development in Canada and help to reverse the brain drain. CHA supports further federal investments in health research and recommends that these investments be increased so that they are 1% of total health spending.

¹⁸ Manley, op.cit.

¹⁹ *The Budget Plan*, 2003. Tabled in the House of Commons by the Honourable John Manley, P.C., M.P., Deputy Prime Minister of Canada and Minister of Finance, February 18, 2003, p. 69.

²⁰ "The 1999 Budget: Strengthening Health Care for Canadians," *Fact Sheet*, Office of the Prime Minister of Canada, February 16, 1999, www.pm.gc.ca.

3.0 THE 2003 HEALTH ACCORD AND THE FEDERAL BUDGET: A CRITIQUE

In the wake of Commissioner Romanow and Senator Kirby's final reports in the fall of 2002 and the announcement of the First Ministers Health Accord and federal budget in 2003, there was much anticipation that the federal-provincial-territorial discussions on health would culminate in an agreement which contained a comprehensive plan with sufficient federal funds over five years to stabilize the existing medicare system and facilitate real change to improve access to needed health services across a broader continuum of care. There was also the expectation that governments would report on progress toward achieving national objectives linked to federal money for health, and that based on comparable indicators, all governments would be accountable to Canadians regarding the performance of the health system and the health status of our population.

Did the Health Accord and the 2003 federal budget meet these challenges? While both contain some positive measures, unfortunately, the answer is no. While the federal commitment to our publicly funded health system under these initiatives appears generous at first blush, on closer examination, it is lacking. The Health Accord is less than what Commissioner Romanow had recommended, and provisions to stabilize the existing medicare system are inadequate. This continued instability threatens to jeopardize the successful implementation of needed health renewal such as primary health reform, home care and catastrophic drug coverage. Funds intended to achieve health reform will inevitably have to be used to support existing medicare services. As noted by Dr. David Naylor, Dean of Medicine at the University of Toronto and Dr. Allan Detsky, Chief of Internal Medicine at Toronto's Mount Sinai Hospital, "the Health Accord represents a welcome reinfusion of previously withdrawn federal funds and contains many useful reform initiatives. However, we also believe that the latest federal-provincial-territorial agreement is best interpreted as yet another temporizing compromise."²¹

The federal government states that the 2003 Health Accord commits it to \$34.8 billion for health over five years. While this seems impressive, it is important to note the following (see also appendices 2, 3 and 4):

- The federal investments noted for the first three years of the 2003 Health Accord (2003-04 to 2005-06) are re-announcements of the commitments previously made in the 2000 Health Accord. Thus, the 2003 Health Accord simply extends the federal government's commitment to funding core services by another two years. The total cumulative figure of \$9.5 billion includes \$3.9 billion (0.7 + 1.3 + 1.9) previously announced in the 2000 Health Accord.
- The 2003 Health Accord does not provide an increase to the cash floor of the CHST. This will have serious consequences in terms of trying to stabilize the existing hospital and physician-based medicare system or establishing a base for the new health-specific transfer, the Canada Health Transfer. If there is not enough money today, there will not be enough money for the base in the future. **CHA recommends**

²¹ "Canada's Health Care System ? Reform Delayed," *New England Journal of Medicine*, op.cit: 804-810; cited in "Canada-US gap in health care grows," op.cit.

an increase to the CHST cash floor of \$3 billion in order to help stabilize the existing medicare system

- An inadequate and implicit annual escalator is provided. At a maximum of 3.1 percent in current, not real terms, in 2003-04 and only 2.8 percent in years four and five, this implicit escalator will not cover labour settlements, meet increased demands due to a growing population, nor reflect growth in the GDP. **CHA recommends an appropriate escalator for the proposed Canada Health Transfer which accurately reflects these realities.**
- On a related issue, one must also ask if there is to be a Canada Social Transfer as well and, if so, what will be the base for this transfer and will there be an escalator. If the federal contribution for a possible CST is not sufficient (and this covers important determinants of health such as post secondary education and social services), then there will be less money in the Consolidated Revenue Funds of the provinces and territories to finance these services, which will not be helpful. **CHA recommends a corresponding Canada Social Transfer with an adequate base and a sufficient escalator.**
- The figures quoted by the federal government with respect to their investments in "core" services are cumulative figures. While they are arithmetically correct, they can also be misleading because what is important to the health system is the annual increase in funding. It is this increase that allows new needs to be met, innovation to take hold, and increases in ongoing expenses to be funded. And what about waiting lists?
- The \$2.5 billion allocated in 2002-03 is one-time funding to be used immediately or to be drawn down by the provinces and territories over three years ; it is not added to the CHST cash floor.
- As previously noted, the potential one-time allocation of \$2.0 billion for 2003-04 is dependant on the federal surplus and unresolved questions concerning this allocation are serving to aggravate intergovernmental tensions which were supposed to be resolved by the Accord.
- The one-time funding provisions within the Accord place the provinces and territories in a precarious position: do you establish a program or service one year and then cancel it the following year due to the lack of ongoing, adequate funding?
- The lack of sufficient funds devoted to stabilizing the existing medicare system threatens the use of the federal reform fund for primary health care reform, home care and catastrophic drug coverage, which are in danger of being "cannibalized" in favour of shoring up the existing system. This should not be an "either/or" situation, but rather a "both/and" requirement.
- The amounts for these three important initiatives are a good beginning. As the programs become fully implemented we will have a better idea of funding requirements.
- While the 2003 Health Accord refers to a broader home care program, the focus will be on acute care substitution, with some additional services for acute mental health services and palliative care. CHA sees this as the first step in the development of a more comprehensive home care program which necessarily must deal with ongoing continuing care and chronic care needs. However, it is not clear when such a program will be developed, nor is there a commitment to examine this in the future. CHA has

advocated for a *Canada Home, Community and Long Term Care Act* to address continuing care needs as opposed to acute care needs. Not all of the services in this package will involve first dollar coverage, but clearly national principles and funding for non-acute services are required. These services are needed by a growing older population, by persons with disabilities, by children with special needs and by persons with mental illnesses. Also it is not clear whether there will be a permanent home care program or permanent catastrophic pharmacare in the absence of federal legislation establishing them. While there will be eventual reports based on agreed-upon indicators, these reports are not a substitute for a program. **CHA recommends a *Canada Home, Community and Long Term Care Act* to establish permanent national programs to enhance access to home, community and long-term care services that address ongoing continuing/chronic care needs. In addition, CHA recommends federal legislation to ensure a catastrophic pharmacare program for the future.**

- As outlined earlier, accessible publicly funded health care is essential not only to our well-being but also to our economic competitiveness. The challenges of rural and remote communities concerning both health and economic opportunities are unique. Access to both comparable health services and economic and employment opportunities are often less assured and more difficult in these areas. It is essential that primary health care reform recognize the needs of each kind of community, including not only urban, but also rural, remote and northern communities. While the Accord states that the goal of primary health care reform under the agreement is to have 50 percent of Canadians with access 24 hours, seven days a week to an appropriate healthcare provider within eight years, it does not discuss the unique challenges that achieving this goal in rural and remote communities will entail or how they will be addressed.
- The Health Accord commits First Ministers to the establishment of a Health Council designed to “monitor and make annual public reports on the implementation of the Accord, particularly its accountability and transparency provisions.” CHA acknowledges that some progress has been made by federal, provincial and territorial Ministers of Health to move forward on this matter through their agreement to expedite work during the fall of 2003 on the Health Council. This would include recommendations for a Chair, non-governmental representatives, the naming of government representatives, development of an appropriate mandate and structure, and funding requirements.²² However, CHA is concerned about the ongoing procedural issues that are delaying the Council’s implementation. As the national association of health system managers and trustees, CHA supports initiatives towards greater accountability and transparency for our health system. We trust that those who manage and govern this system will play a role in the development of proposed indicators to be used by the Council for “national comparable information on the themes of access, quality, and system efficiency and effectiveness.”²³

The 2003 Health Accord seems only to have heightened rancour between the federal, provincial and territorial governments. Premiers and Territorial Leaders indicated that

²² Health Canada, Press Release, September 4, 2003, op.cit.

²³ 2003 First Ministers’ Accord on Health Care Renewal, p. 4.

they would ask for more money next year or the year after, complaining of the "Romanow gap", that is, the shortfall between what Romanow recommended and what the Accord offered and also about the fact that even with the funding provisions in the Accord, federal funding will not cover the minimum 25 percent of provincial health spending by 2005-06 they are requesting. The lack of resolution of the additional \$2.0 for 2003-04 has further chilled intergovernmental discussions on health. As put by Manitoba Premier Gary Doer: "We are a minimum of \$3-billion short in three years; we are short the 25 per cent recommendation that is part of the Romanow report and we also have a situation where the \$2-billion is in a state of suspended animation."²⁴

4.0 CONCLUSION

CHA and our members acknowledge the steps taken by all levels of government to address previous massive cuts to health. Despite this, our health system continues to face challenges. Why? Let's review the facts:

- During most of the 1990s, real per capita public spending on health increased, on average, only one percent per year.
- In 1997, public spending on health started to increase. But this increase only partially addressed previous cuts and did not match labour settlements or infrastructure and equipment needs.
- As noted earlier, in 2001 and 2002, private spending increased at a higher rate than public spending.
- Public spending on health has stayed at about six percent of GDP over the last few years, making Canada one of the lowest, not highest, public spenders on health.²⁵
- While federal spending has risen 11 percent from 1997, it is still 12 percent below the 1992 high. In particular, transfers to the provinces, which have risen by 15 percent from the low, remain 18 percent from the peak. Ottawa's spending on its own programs has climbed 10 percent from the low point but is still 11 percent below the 1992 high.²⁶

The 2003 Health Accord could have been and should have been an historic opportunity to support and stabilize the existing medicare system, ensure a sustainable, responsive and accountable system for the future, and finally put to rest the pervasive bickering which has marred intergovernmental discussions concerning health for the past several years.

This did not happen. An historic opportunity was squandered. That is unacceptable for all Canadians.

Given the importance of our publicly funded health system, we cannot afford, either in terms of our economic competitiveness or our quality of life, not to address the deficiencies within the Accord.

²⁴ "Premiers put creation of health council on hold," *The Globe and Mail*, July 11, 2003, website op.cit.

²⁵ CHA, *Open Letter to the Prime Minister*, January 29, 2003 website op.cit.

²⁶ "The ups and downs of government spending," *The Globe and Mail*, July 14, 2003, website op.cit.

For the sake of our much-envied publicly funded health system, our economic competitiveness, our prosperity, our ability to care for each other, and our quality of life, CHA and our members urge all governments to work together to sustain our health system for the future.

5.0 SUMMARY OF RECOMMENDATIONS

- CHA recommends that the federal government demonstrate strong leadership for a pan-Canadian approach to respond to significant public health issues.
- CHA recommends that the federal government introduce specific legislation to accommodate public health programs and services.
- CHA recommends that the federal government create a Canadian Centre for Disease Control (CCDC) or similar organization, whatever its nomenclature.
- CHA recommends that the federal government establish the position of Chief Medical Officer for Canada to head this agency.
- CHA recommends that the federal government support the building of surge capacity in the health system through significant investments in both the acute and community health delivery systems.
- CHA recommends the development of a new framework for appropriate federal response and support when there are extraordinary health events or public health emergencies.
- CHA recommends that \$2.0 billion of the anticipated \$3 billion surplus for 2003 now planned to be directed toward debt reduction be instead directed to the provinces and territories for health.
- CHA recommends an increase to the CHST cash floor of \$3 billion in order to support and stabilize the existing medicare system.
- CHA recommends an appropriate base for the proposed Canada Health Transfer.
- CHA recommends an appropriate escalator for the proposed Canada Health Transfer which accurately reflects the costs of labour settlements, increased demands due to a growing population, and growth in the GDP.
- CHA recommends a corresponding Canada Social Transfer with an adequate base and a sufficient escalator
- CHA recommends a Canada Home, Community and Long Term Care Act to establish a permanent national program to enhance access to home, community and long-term

- care services that address ongoing continuing/chronic care needs, not all necessarily with first dollar coverage.
- CHA recommends federal legislation to ensure access to catastrophic pharmacare.
 - CHA recommends that federal investments in health research be increased to 1% of the total health spending in this country.

7.0 APPENDICES

7.1 CHA LETTER TO DR. DAVID NAYLOR, CHAIR, NATIONAL ADVISORY COMMITTEE ON SARS AND PUBLIC HEALTH

July 4, 2003

Dr. David Naylor
Chair, National Advisory Committee on SARS and Public Health
c/o Ms. Sylvie Ladouceur
Executive Assistant
Assistant Deputy Minister's Office – HPCB
Health Canada
Tunney's Pasture, PL 0911B
Ottawa, ON
K1A 0K9

Dear Dr. Naylor:

I would like to thank you for giving the Canadian Healthcare Association (CHA) the opportunity to contribute to your assessment of the "lessons learned" from the current public health situation in relation to SARS and to explore long-term approaches on how best to prepare Canada to respond effectively to future infectious disease challenges.

The CHA is the federation of Provincial and Territorial hospital and health organizations across Canada. Through its members, CHA represents a broad continuum of care, including acute care, home and community care, long-term care, public health, mental health, palliative care, addiction services, children, youth and family services, housing services and professional and licensing bodies. These services are provided through regional health authorities, hospitals and other facilities and agencies that serve all Canadians and are governed by trustees who act in the public interest.

CHA's mission is to improve the delivery of health services in Canada through policy development, advocacy and leadership. CHA and our members are committed to realizing the vision of a publicly-funded health system that provides access to a broad range of comparable health services across Canada.

In February, 2002, CHA developed its "*Ten Point Plan*" to identify what was required to ensure that Canada's publicly-funded health system was responsive, sustainable and better positioned to achieve true health reform. Section 2.3 of the *Plan* recommended that all components of the system, including public health, should be strengthened. This recommendation is not new; in fact, CHA has been calling for enhancements to public health for many years.

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The problem with taking action on public health has always been the perceived lack of immediate impact that public health investments have. Health promotion and disease prevention initiatives have a substantial impact on health outcomes, but they take time to realize and so are not as attractive, politically-speaking, to invest in, as are the traditional avenues for health investment – facilities and providers. The lesson of SARS is that we need both.

It seemed that in the wake of the Walkerton e-coli tragedy, the need for increased investment in a public health system would have some resonance and result in funding enhancements for public health. Regrettably, this did not happen and the situation is exacerbated by the constitutional division of powers such that provinces and territories are responsible for the delivery of health services, including public health programs. What has evolved is a significant variation in public health programs (and resources for them) across Canada, a system which actually supports the spread of serious infectious disease across the country rather than what a responsible public health system should do – surveillance, prevention and containment.

There is a Federal role in public health, dating back to the *Quarantine Act* of the 19th century, but that role has not necessarily been clear, nor has it been appropriately utilized. Without going into the details of constitutional law and politics in this country, it is sufficient to say that there is a Federal role in public health – surveillance, health protection, product safety, etcetera. There is also a pivotal Provincial role and a municipal role as well and this is all part of the patchwork quilt. How to address problems in a more coordinated manner is the essential challenge.

CHA offers four specific recommendations for responding to infectious disease challenges. These recommendations correspond, in broad terms, to building capacity in public health without forgetting the need to incorporate flexibility and surge capacity in the health delivery system.

Building Capacity for Public Health

1. Introduce specific legislation to accommodate public health programs and services.

The absence of national standards for public health delivery only facilitates the current patchwork quilt of public health programs and services that currently exist across Canada. If public health programs and services were entrenched in a *Canada Public Health Act*, and appropriately funded (including transfers to the provinces and territories for this purpose), as is the case for hospital and physician services in the *Canada Health Act*, a province or territory would have financial incentives to implement them, or face a financial penalty for not doing so. Most importantly, this would be a vehicle whereby the Federal Government would provide much-needed resources for public health infrastructure across the country.

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The scope of what is provided under public health programs and services would need to be negotiated and Federal/Provincial/Territorial agreement is not always easily achieved; however, those aspects of public health dealing with disease prevention and health protection would have to be included.

2. To create a Canadian Centre for Disease Control (CCDC)

In the wake of the SARS outbreak, many prominent epidemiologists, microbiologists and clinicians from across Canada pointed to the “Centre for Disease Control and Prevention” (CDCP) in the United States as a credible Federal agency for protecting the health and safety of the public. The former Laboratory Centre for Disease Control (LCDC) used to provide many of the functions the CDCP; however, in one of the more recent Health Canada reorganizations, LCDC’s component parts were separated and shifted to different branches across Health Canada. This lack of centralization and control of key elements of disease prevention and control, environmental health and health promotion and education has not served the people of Canada well.

These various services must be re-grouped under one agency, operating in the public interest but at arms length from Government, thereby ensuring its credibility. In addition to any of its surveillance, prevention and control activities, the CCDC would also be responsible for research related to these activities.

3. To establish the position of Chief Medical Officer of Health for Canada.

The scrambling to respond to the SARS outbreak at the national level served only to underscore the palpable lack of appreciation for the leadership required in responding to an extraordinary event like the outbreak of an infectious disease. The obvious communication gaps between Health Canada and the Ministry of Health and Long-term Care in Ontario, the numbers of “experts” trying to explain the various facets of the issue (from the World Health Organization travel advisory about Toronto to the varying definitions for what actually constituted a case of SARS) suggested that nobody was really “in charge” and working to respond to issues on behalf of all Canadians.

It is crucial, therefore, to establish a Chief Medical Officer of Health for Canada who would serve as the head of the Canadian Centre for Disease Control and in that capacity be responsible for implementing policy and standards for pan-Canadian public health practices developed in conjunction with the Chief Medical Officers of Health in the provinces and territories. The person in this position would also be the major spokesperson for the Federal Government on all public health matters.

4. To build surge capacity in the health system through significant investment in both the acute and community health systems

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One of the CHA's own members, the Ontario Hospital Association (OHA), is in the process of finalizing the costs of the SARS outbreak in Ontario alone. The estimate is in the vicinity of \$1.2 billion. This cost is reflective of extra acute care health delivery costs due to SARS and includes foregone hospital income (for example, parking lot revenues).

Building surge capacity in the acute care system means capital investment in hospitals and long-term care facilities to ensure that they are appropriately retrofitted to accommodate isolation and other step-down units for infectious disease. It also means the establishment of new "standard operating procedures" for patient in-take and re-direct, infection control, equipment, communication mechanisms with external agencies (including public health units) etcetera, all of which have cost components.

CHA is not in a position to comment on the investment required to upgrade and accommodate surge capacity in the community public health system. However, the investment in a health system that effectively captures the inter-relationship between acute care and community public health initiatives will be significant. A "total" figure cannot be identified in the absence of more comprehensive evaluation of the same costs across all provinces and territories.

An appropriate public health system, together with a flexible, responsive health services delivery system, is essential for the health of Canadians. CHA believes that the Federal government must exercise leadership and accountability in this regard and can do so by putting in place the mechanisms we suggest, through which a coordinated and integrated approach to public health can be ensured. Enacting these measures will require more funding for the health care system; we cannot reasonably expect existing funds to accommodate the costs associated with building surge capacity and implementing a new infrastructure.

The time to proceed is now. Not proceeding with substantive changes in public health and corresponding investments in the existing public health delivery system in the wake of SARS and other similar health challenges could have tragic consequences for Canadians.

Sincerely,



Sharon Sholzberg-Gray
President and CEO

Attachment

cc.: CHA Board of Directors
CEOs of Provincial and Territorial Health and Hospital Organizations
CHA's Policy and Public Affairs Staff

7.2 INCREASES TO CORE FUNDING UNDER THE 2003 HEALTH ACCORD: ANNUAL AND CUMULATIVE INCREASES TO CORE FUNDING

TABLE 1 2003 Health Accord: Transfers to the Provinces and Territories Annual and Cumulative Increases to Core Funding								
2003 Accord Increase to Core Services (\$ Billions)	Year 0 2002-03	Year 1 2003-04	Year 2 2004-05	Year 3 2005-06	Year 4 2006-07	Year 5 2007-08	TOTAL Annual	TOTAL Cumulative
Base Funding								
Starting Point CHST Cash Floor	19.1							
Annual Increase to CHST Base (Implicit Escalator) Previously Committed in 2000 Accord		0.7	0.6	0.6				
Annual Increase to CHST Base (Implicit Escalator) New Money Announced in 2003 Agreement					0.6	0.6	1.2	1.8
Cumulative Annual Increase to the Base		0.7	1.3	1.9	2.5	3.1		9.5
CHST Base		19.8	20.4	21.0	21.6	22.2		

Notes:

- The Federal investments noted for the first three years of the 2003 Health Accord (2003-04 to 2005-06) are re-announcements of the commitments previously made in the 2000 Health Accord. Thus, the 2003 Health Accord simply extends the federal government's commitment to funding core services by another two years. The total cumulative figure of \$9.5 billion includes \$3.9 billion (0.7 + 1.3 + 1.9) previously announced in the 2000 Health Accord.
- The 2003 Health Accord does not provide an increase to the cash floor of the CHST. This will have serious consequences in terms of trying to stabilize the existing hospital and physician-based medicare system or establishing a base for the new health-specific transfer, the Canada Health Transfer. If there is not enough money today, there will not be enough money for the base in the future.
- An inadequate and implicit annual escalator is provided. At a maximum of 3.1 percent in current, not real terms, in 2003-04 and only 2.8 percent in years four and five, this implicit escalator will not cover labour settlements, meet increased demands due to a growing population, nor reflect growth in the GDP.
- The figures quoted by the federal government with respect to their investments in "core" services are cumulative figures. While they are arithmetically correct, they can also be misleading because what is important to the health system is the annual increase in funding. It is this increase that allows new needs to be met, innovation to take hold, and increases in ongoing expenses to be funded.

7.3 INCREASES TO CORE FUNDING UNDER THE 2003 HEALTH ACCORD: ONE-TIME FUNDING FOR CORE SERVICES

TABLE 2								
2003 Health Accord: Transfers to the Provinces and Territories								
One-time Funding for Core Services								
2003 Accord Increase to Core Services (\$ Billions)	Year 0 2002-03	Year 1 2003-04	Year 2 2004-05	Year 3 2005-06	Year 4 2006-07	Year 5 2007-08	TOTAL Annual	TOTAL Cumulative
CHST Supplement ¹	2.5							2.5
Potential Increase if Sufficient Surplus ²		2.0?						2.0?
Diagnostic and Medical Equipment ³		1.5						1.5
Capital Infrastructure								0

Notes:

1. The CHST supplement can be drawn down by the provinces and territories until 2005-06. The federal government is accounting for this money in 2003-04.
2. Sufficiency of the surplus will not be determined until January 2004.
3. Details of this fund are provided in the chart concerning Health Renewal investments in the 2003 Health Accord. This commitment is noted in the renewal fund chart so that comparisons can be made with figures from the Romanow report which include funding for diagnostic equipment.

7.4 HEALTH RENEWAL UNDER THE 2003 HEALTH ACCORD

TABLE 3									
2003 Health Accord Transfers to the Provinces and Territories									
Health Renewal									
	Year 1 2003-04	Year 2 2004-05	Year 3 2005-06	Year 4 2006-07	Year 5 2007-08	Total Y1 - Y3 Cumulative	Total Y1 - Y3 Annual New Money	Total Y1 - Y5 Cumulative	Total Y1 - Y5 Annual New Money
2003 Health Accord									
Health Reform Fund: for Primary Health Care, Home Care and Catastrophic Drug Coverage Available Each Year (Cumulative) ¹	1.0	1.5	3.5	4.5	5.5	6.0		16.0	
Annual Increase ²	1.0	0.5	2.0	1.0	1.0		3.5		5.5
Diagnostic and Medical Equipment Available Each Year (Not Cumulative) ³									
<i>Subtotal — Health Reform and DME</i>	0.5	0.5	0.5	0.0	0.0		1.5		1.5
	1.5	2.0	4.0	4.5	5.5	7.5	5.0	17.5	7.0
Romanow Commission									
Primary Health Care Reform ⁴	1.0	1.5				2.5	1.5		
Home Care	1.0	1.0				2.0	1.0		
Catastrophic Drug Coverage		1.0				1.0	1.0		
Diagnostic and Medical Equipment	1.5					1.5	1.5		
<i>Romanow Subtotal</i> ⁵	3.5	3.5				7.0	5.0		
Other ? Rural and Remote	1.5					1.5	1.5		
Romanow Total	5.0					8.5	6.5		

Notes:

1. Some totals in Y1-3 and Y1-5 are reported in the Health 2003 Accord cumulatively (e.g., Health Reform Fund) and others are a simple addition, or a lump sum divided evenly over three years (e.g., the Diagnostic and Medical Equipment Fund is \$1.5 billion over three years, which equals \$0.5 billion each year). It is technically correct that the federal government will contribute the cumulative figure to the health system. However, this figure can also be misleading

since the public may expect all of the challenges facing the health system to be addressed immediately, given the large federal contribution. However, the incremental amount of new money available to the health system each year, after the initial investment, is the amount that matters over time, in terms of being able to support new demands, growth and innovation.

2. The Health Reform Fund is intended to support new initiatives in primary health care , home care and catastrophic drug coverage. If a province or territory meets the objectives of the Fund, residual funding can be used for other health priorities.
3. The Medical and Diagnostic Equipment Fund will be funded by 2002-03 surpluses. Therefore all the funds were available to the provinces and territories by June 2003. The \$0.5 allocation this year is notional; provinces and territories can draw down the money at any time and in any amounts until they have reached their position based on a per capita allocation. This line item appears both in the Renewal Chart and in the Core Funding Chart because funding for diagnostic equipment was included in the Romanow figures. Therefore, for comparison with Romanow, it is listed as part of the Renewal funds, though the 2003 Health Accord recognizes this Fund as part of the renewal investment.
4. Romanow Primary Health Care Reform states \$1.5 billion in Y2 on p. 70, but it is clearer that it is only \$0.5 billion more on p. 255.
5. The total amounts for the Health Reform initiatives (e.g., Primary Health Care Reform, Home Care and Catastrophic Drug Coverage) as outlined in the Romanow Report and the 2003 Health Accord are very similar. The problem is insufficient funds allocated to the existing Canada Health Act services and thus the funds available for health reform may be in jeopardy of being used to "shore the core".