The federal Conservatives are cutting $ 36 billion dollars from health care funding to the provinces, instead of protecting and expanding our public health care system.

The Conservatives are taking health care in the wrong direction.

saveourhealthcare.ca

Here's what you can do...

Tell your Member of Parliament to protect, strengthen and expand health care services, not cut them.

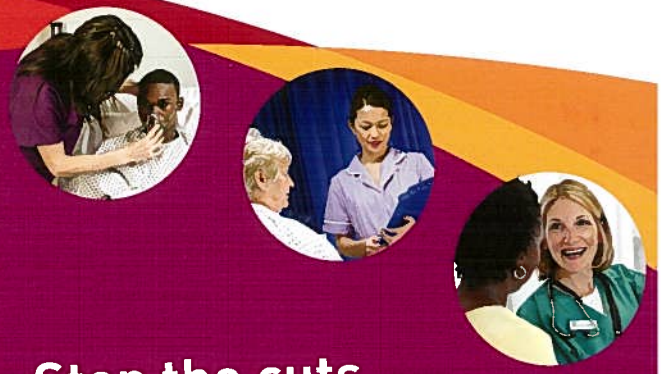
Visit saveourhealthcare.ca to write your MP and find out more.

Brought to you by the *Campaign to Protect, Strengthen, and Expand Medicare*.

The federal Conservatives are cutting $36 billion from health care over the next ten years.

What is your Member of Parliament doing to stand up for you and your family?

KEEP HEALTH CARE PUBLIC!



Stop the cuts to health care.

It's time to protect, strengthen and expand health care services.

The federal Conservatives are abandoning our public health care system by:

- Cutting $36 billion from health transfers to the provinces and starving the system, making it impossible to provide the services Canadians need.
- Encouraging for-profit corporations to deliver health services

The result: one health system for the rich and a broken system for the rest of us.

What will these cuts mean for your health care services?

$36 billion in cuts to health care is like losing:

- 90,000 hospital beds over 10 years;
- 60,000 nursing positions per year; or
- 2.4 million joint replacement operations.

How much will your province lose?

British Columbia	$ 5 billion
Alberta	$ 4.1 billion
Saskatchewan	$ 1.1 billion
Manitoba	$ 1.3 billion
Ontario	$ 14 billion
Quebec	$ 8 billion
New Brunswick	$ 715 million
Nova Scotia	$ 902 million
Prince Edward Island	$ 144 million
Newfoundland & Labrador	$ 491 million
Canada total	$ 36 billion

Total cuts over 10 years.
Source: Report of the Council of the Federation Working Group on Fiscal Arrangements, July 2012

What is the Health Accord?

The Health Accord is an agreement between the federal government, provinces, and territories which provides stable funding and national standards for health care services.

Canada's Health Accord expired on March 31, 2014 and the federal Conservatives have refused to sign a new one.

Why is a new Health Accord important?

It's the best way we can:

- Stop gouging through extra-billing and illegal fees;
- Expand health coverage to prescription drugs, and long-term care and home care;
- Ensure quality seniors' care and mental health services;
- Guarantee stable and fair health care funding (increase federal share to 25 per cent); and
- Enforce national benchmarks so everyone gets high quality care.

What will happen if we don't get a new Health Accord?

Federal funding will fall to 18 per cent, from its original 50 per cent share. Patients will suffer from longer wait times, hospital closures and the privatization of hospitals and seniors' care.

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NOTES

CUPE HEALTH ACCORD FACT SHEETS

Full citations on the Fact Sheet References page at **cupe.ca/health-care/public-solutions**

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CUPE IN HEALTH CARE

The **Canadian Union of Public Employees** is **Canada's largest union**, with more than **627,000 members**, in sectors like municipalities, post-secondary education, energy, child care, libraries, media and airlines.

CUPE is also **Canada's largest health care union**, with **more than 190,000 members** in the **health care** sector.

We **represent more** health care workers in Canada than **any other union**.

CUPE members work in all areas of the health care system – hospitals, long-term care facilities, emergency medical services, outpatient clinics, medical labs, homes and community agencies – providing both direct and non-direct care services.

We help people at all stages of health, from illness prevention to surgery recovery to palliative care and points in between. We help physicians and other providers do their jobs, often working behind the scenes.

We work in hundreds of classifications in areas like nursing, therapy, cleaning, dietary, emergency care, administrative and support services, trades, maintenance, diagnostics and many other parts of the health care workforce.

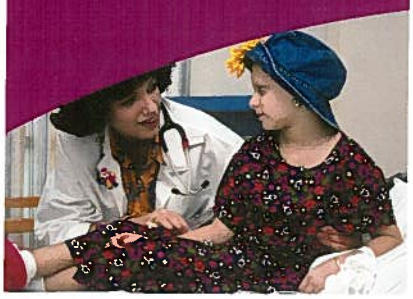
We book appointments and handle medical records. We provide hands-on nursing care and personal support. We help patients rehabilitate. We clean health care facilities and homes, preventing deadly infections. We plan, prepare and serve meals. We do laundry and sterilize equipment. We help residents bathe, dress and eat. We maintain buildings and everything in them, including advanced medical equipment. We provide security. We answer 911 calls and provide emergency medical care. We do these jobs and many more.

Our jobs are too numerous to list in one place, and they vary by province. Put simply, CUPE members are the backbone of our health care system.

Our jobs go beyond the title. We help people through some of their hardest moments. Whether we're cleaning a room, changing a dressing, delivering food or providing another service, we offer a kind word and a helping hand. These personal interactions help people heal from injury and illness, live to their fullest, and die with dignity. This is why we care deeply about our work – and why we want federal leadership to protect, strengthen and expand Medicare.

"We are nurses and personal support workers providing bedside care. We cook and deliver the food that nourishes patients. We run tests and other diagnostics. We provide a social connection for patients every day. We keep homes and health care facilities clean, safe and well-maintained. We are the organizational backbone of hospitals, admitting patients and handling medical records. We are the first responders in our communities. We perform these and other essential roles.

We are concerned about health care as workers, and as members of families and communities who rely on our public health care system."



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HEALTH ACCORD ESSENTIALS

What is the Health Accord?

The Health Accord is a legal agreement between the federal and provincial/territorial[1] governments on health care funding. Running from 2004 to 2014, this 10-year plan recommitted leaders to the *Canada Health Act*, set wait time and other goals, and increased health care funding by 6 per cent each year.

Why is the Health Accord important?

The accord provided stable funding after deep cuts in the 1990s. It has brought the federal government's cash share of provincial health spending up to 20 per cent, which is not the 50 per cent it covered at the start of Medicare, but better than the 10 per cent of 1998, before the first health accord.

The accord is also important because it promoted national standards. The Prime Minister and Premiers recommitted to the *Canada Health Act* and its requirements: public administration, universal access, comprehensive coverage, accessibility without extra charges or discrimination, and portability across provinces. It committed the federal and provincial governments to a set of common goals around wait times, home care, prescription drugs, and team-based primary care.

On wait times, the accord has been successful: eight out of 10 Canadians are getting treatment within the timelines set in 2005, for the five chosen procedures. We need to do more, but progress has been made.

In the other areas (home care, drugs, and primary care), progress has been poor because the governments set only loose goals, with no financial strings attached.

Now, Prime Minister Stephen Harper doesn't want even loose goals — in fact, he's refusing to negotiate another accord.

What is Harper's plan for health care?

The Harper government will cut health care funding and let provinces go their own way, with no national goals or commitment to uphold national standards. This will lead to 13 different health care systems and more privatization.

Without notice, without discussion, the federal government announced a take it or leave it health care funding plan in December 2011.

That plan will keep federal health care funding on its current track until 2017, at which point cuts will kick in. Instead of increasing at 6 per cent a year, the health transfer will be tied to economic growth, with a 3 per cent floor.

The federal government is also changing how it divides the health transfer between provinces, leaving some worse off. Starting in 2014, the transfer will be cash only (still based on population), instead of being a mix of tax and cash points, adjusted for each province's wealth. Backtracking on an earlier promise, the federal government will not fully protect provinces that lose funding.

Together, these two changes to the Canada Health Transfer mean $36 billion (8.3 per cent) less in federal funding for health care over 10 years. Over time, the federal government's share of health care spending will shrink to a small fraction of its original 50 per cent contribution – down to 18.6 per cent by 2024 alone.

Many federal Conservatives would like to get out of funding health care altogether. Some prominent Conservatives propose eliminating transfers and equalization payments, instead turning over revenues from the federal Goods and Services Tax to the

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[1] In this backgrounder, for brevity, we use "provinces" to mean "provinces and territories."

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provinces. Without the clout of federal cash transfers, the federal government would be unable to uphold the *Canada Health Act* and national standards. As University of Ottawa law professor Errol Mendes put it: cash transfers from the federal government "are the only potential carrot and stick available … to encourage nation-wide social development and promote equity between the provinces."

Stephen Harper has already encouraged provinces to rely more on the for-profit sector to deliver health care, stating for example: "We also support the exploration of alternative ways to deliver health care. Moving toward alternatives, including those provided by the private sector, is a natural development of our health care system."

Already, the federal government is ignoring violations of the *Canada Health Act*, allowing for-profit health care to grow and doing next to nothing about user fees, extra billing and other violations of Medicare rights.

The federal government is also pursuing a trade agreement with the European Union that would increase prescription drug costs by $2.8 billion a year and open Medicare up to trade challenges by multinational corporations.

Unchallenged, the Harper Conservatives will further weaken Medicare. Their plans would lead to:

- Increased for-profit delivery, meaning higher costs and worse quality;
- Continued high inflation in drug and seniors' care costs;
- No plan to give community care the boost it urgently needs;
- Cuts to Medicare, meaning two-tier care; and,
- Further weakening of the *Canada Health Act* and national standards.

What are the privatizers doing?

Groups that profit from health care have laid the groundwork over the last few years by framing Medicare as unsustainable and outmoded. Corporate-backed think tanks push privatization as the solution.

- The Fraser Institute calls for a five-year moratorium on the *Canada Health Act* to "give provinces freedom and encourage experimentation with alternative financing schemes."
- The Macdonald-Laurier Institute says the federal government should cut the Canada Health Transfer and allow provinces "the maximum amount of flexibility to design, regulate and provide health care."
- The Frontier Centre for Public Policy wants more private sector involvement in health care financing and delivery.
- Among the major backers of a new Conference Board program, the Canadian Alliance for Sustainable Health Care, are insurance companies, banks, big pharma, and medical products manufacturers — all of whom want a bigger share of the health care market.

What does CUPE propose?

CUPE is calling on the federal government to:

- Negotiate with the provinces and territories a new 10-year Health Accord with stable and adequate funding, including at minimum the 6 per cent escalator;
- Enforce the *Canada Health Act*, including the ban on user fees and extra billing, and correct gaps in monitoring and reporting under the Act;
- Implement a national strategy to reduce healthcare associated infections, with dedicated funding for microbiological cleaning standards, more in-house cleaning staff, lower hospital occupancy, and mandatory public reporting;
- Promote access to effective primary health care with funding for new and expanded Community Health Centres;
- Create a national continuing care program (residential and home/community care), with dedicated transfers financed from general revenue and *Canada Health Act* standards plus minimum staffing and phasing out of for-profit delivery; and
- Establish a national pharmacare program, and exempt health care from trade agreements, starting with CETA.

For more on these changes and why they are needed, see: **cupe.ca/health-care/public-solutions**

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LET'S PROTECT, STRENGTHEN AND EXPAND OUR PUBLIC HEALTH CARE SYSTEM – FOR ALL CANADIANS

WE NEED PUBLIC SOLUTIONS AND FEDERAL LEADERSHIP

The federal-provincial plan for Medicare, the Health Accord, expires in spring 2014. The federal government has refused to sit down with the provinces and negotiate a new Accord, sticking with its plan to cut federal funding which could lead to further privatization.

Canadians cherish our public health care system. It represents bedrock values of equality, fairness and democracy. It delivers the best care at the lowest cost. Canadians want Medicare expanded, not dismantled.

Recent national polls show that:

- 87 per cent of Canadians support public solutions to make health care stronger, across party lines[1];
- Canadians expect their federal government to take the lead in health care reform[2]; and,
- Canadians want their federal politicians to make Medicare improvements the top priority.[3]

The Canadian Union of Public Employees represents more than 627,000 Canadians, including 190,000 health care workers. We call on the federal government to protect, strengthen and expand Medicare.

The federal government must protect Medicare through:

- Stable and sufficient funding: Negotiate with the provinces and territories a new 10-year Health Accord with stable and adequate funding, including at minimum the 6 per cent escalator.
- National standards: Enforce the *Canada Health Act*, including the ban on user fees and extra billing, and correct gaps in monitoring and reporting under the Act.

The federal government must strengthen Medicare through:

- Safe health care: Implement a national strategy to reduce health-care associated infections, with dedicated funding for microbiological cleaning standards, more in-house cleaning staff, lower hospital occupancy, and mandatory public reporting.
- Better frontline care: Promote access to effective primary health care with funding for new and expanded Community Health Centres.

The federal government must expand Medicare through:

- Better continuing care: Create a national continuing care program, covering long-term care facilities, home and community care, with dedicated transfers financed from general revenue and Canada Health Act standards, plus minimum staffing and phasing out of for-profit delivery.
- Safe and affordable drugs: Establish a national pharmacare program, and exempt health care from trade agreements, starting with CETA.

For more information, see:
www.cupe.ca/health-care/public-solutions

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PUBLIC WORKS BEST:

PUBLIC HEALTH CARE COSTS LESS, DELIVERS MORE

Public health care is sustainable – in fact, it's a far better deal than private for-profit health care. It also gives Canadians better quality and more accountability.

Public health care spending remains 8 per cent of our national income (gross domestic product),[1] and it is slowing – up only 3.3 per cent in 2011 and 2.9 per cent in 2012, compared to seven per cent annual increases over the previous decade.[2] Spending on Medicare (hospital and physician services) has been even more stable at 4 to 5 per cent of GDP over the last 35 years.[3]

Most peer countries spend more on health care through the public sector; 10 OECD countries spend more than 80 per cent publicly compared to our 70 per cent. Canada is among the bottom third.[4]

Major cost drivers are on the private side: drugs, physicians, medical products, public-private partnerships, and for-profit providers of diagnostics, surgeries, dental care, physiotherapy, continuing care, eye care and other services.

- Private sector health spending as a share of total health spending increased from 25 to 30 per cent between 1989 and 2010.[5]
- Prescription drugs have increased as a share of Medicare spending from 1.7 per cent to 8.5 per cent since 1975.[6]
- Physician payment has risen faster than inflation and is now the fastest growing category of health spending,[7] largely due to fee increases.[8]
- Between 1988 and 2009, per capita spending on private health insurance increased from $139.40 to $664.10.[9]
- Ontario paid 75 per cent more to for-profit labs than it had to non-profit community labs over the previous 30 years, for the same tests.[10]
- Public-private partnerships are 83 per cent costlier to finance than public projects.[11]

Seniors, hospitals and workers are not driving costs through the roof, as some claim.

- Cost increases related to population aging are manageable – roughly 1 per cent per year over the next 25 years.[12]
- Hospitals declined from 55 per cent of public health care costs in 1975 to 36 per cent in 2009.[13]
- Wages, salaries and benefits have declined as a share of hospital operating costs from a high of 75 per cent in the late 1970s to just over 60 per cent in 2008.[14]

Governments spend a larger budget share on health care because they slashed revenues and other spending. Between the mid-1990s and late-2000s, Canadian governments cut taxes by 6 per cent of GDP and Medicare costs increased by 1.5 per cent of GDP.[15]

Our public health care system provides better care at lower costs. We spend roughly half of what the private US system spends per person,[16] and we get better coverage and outcomes.

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per capita spending on health care:

 $4,445  $8,233

life expectancy:

 81  78

- We cover everyone, where the US system leaves 49 million uninsured[17] and another 25 million underinsured.[18]
- More than 26,000 Americans die each year because of lack of health insurance.[19]
- Medical problems are the leading cause of personal bankruptcy in the US.[20]
- Studies comparing US and Canadian outcomes for heart attacks, cancer, surgical procedures and chronic conditions show that Canada does at least as well, often better.[21]

Public health care costs less than private health care.

- Administration costs 16.7 per cent in Canada (1.3 per cent for Medicare), compared to 31 per cent in the United States.[22]
- Private for-profit hospitals cost 19 per cent more than not-for-profit hospitals in the US.[23]
- A recent Canadian study found that expedited knee surgery in a for-profit clinic costs $3,222 compared to $959 in a public hospital (with worse return-to-work outcomes).[24]

"Private for-profit facilities typically have to generate 10 to 15 per cent profits to satisfy shareholders. Not-for-profit facilities can spend that money on patient care."[25]
— P.J. Devereaux, Physician and Professor in Clinical Epidemiology, McMaster University

Public health care is safer than private health care.

- Patients treated in for-profit compared to non-profit dialysis clinics in the U.S. had an 8 per cent higher risk of dying. Fewer and less well trained staff and shorter treatments are likely the principal factors.[26]
- Adults had 2 per cent higher death rates in for-profit hospitals, while the infant mortality rate was 10 per cent higher. Switching to a for-profit hospital system in Canada would mean 2,200 more deaths each year – more than deaths from suicide, colon cancer or car accidents.[27]
- For-profit nursing homes have higher rates of ulcers, dehydration, malnutrition, hospitalization and other quality problems.[28]

Publicly funded and delivered health care makes sense financially, covers everyone, and delivers better care.

Find citations in fact sheet notes and fact sheet references documents online at **cupe.ca/health-care/public-solutions**

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PROTECT MEDICARE:

STABLE AND SUFFICIENT FEDERAL FUNDING

Provinces and territories need stable and adequate funding from the federal government to protect public health care. Canadians want national standards and equal access to health care no matter their income or region. To get us there, the federal government must sit down with the provinces and territories and negotiate a new 10-year agreement with at least 6 per cent annual increases in the Canada Health Transfer.

The funding

The federal government covers only one fifth of provincial health spending, where it used to cover half – and it wants to scale back further. The 2004–2014 Health Accord provided stable funding after deep cuts in the 1990s. It has brought the federal government's cash share of provincial health spending up to 20 per cent[1] from a low of 10 per cent in 1998[2] and part way to its original 50 per cent share. The current federal government wants to reverse this progress.

The federal government plans to cut $36 billion in health care funding to the provinces* – without consulting them. Instead of increasing at 6 per cent a year, the health transfer will be tied to economic growth, with a 3 per cent floor. No discussion, no agreement, no national vision.

The federal government is also changing how it divides the health transfer between provinces, leaving most of them worse off. Starting in 2014, the transfer will be cash only and based on population, instead of a mix of cash and tax points adjusted for each province's wealth. Backtracking on an earlier promise, the federal government will not fully protect provinces that lose funding.

CUPE calls on the federal government to:

Negotiate with the provinces and territories a new 10-year Health Accord with stable and adequate funding, including at minimum the 6 per cent escalator.

Together, these changes to the Canada Health Transfer mean $36 billion (8.3 per cent) less in federal funding for health care over 10 years. Over time, the federal government's share of health care spending will shrink to a small fraction of its original 50 per cent contribution – down to 18.6 per cent by 2024 alone.[3]

$36 billion less means:

- The federal government will have a harder time upholding the *Canada Health Act* and national standards, with less financial clout.
- Provinces will cut services and privatize, as they did when federal health transfers shrank in the 1990s, bringing: higher costs for families and more unpaid work for women; longer waits and two-tier care; more hospital overcrowding and avoidable deaths from medical errors and health care associated infections; and worse quality and higher costs for services delivered by the private sector.

* In this fact sheet, for brevity, we use "provinces" to mean "provinces and territories."

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The federal government has choices. The Parliamentary Budget Officer has shown that, instead of downloading financial problems onto other levels of government, Ottawa can increase program spending and transfers by $25 billion in 2012 alone – and more over time – while maintaining fiscal sustainability.[4] Fair tax measures at the federal level would garner the public treasury an additional $29 billion per year.[5]

The process

The prime minister should sit down with premiers and work out a long-range vision and concrete plan. Health care is complex and important; previous health accords involved many first ministers meetings. Most premiers want those discussions. Canadians deserve them.

Medicare is a national program, and Canadians expect a national plan. Allowing for an asymmetrical agreement with Quebec, the Health Accord must otherwise be one agreement applying the same terms and conditions across Canada.

Instead, the federal government is meeting with provinces separately, disadvantaging those with fewer resources and greater needs. Stephen Harper has not hosted a first ministers meeting on health since elected in 2006, and there is no meeting in sight even as the Health Accord nears an end.

The solution

Canadians want the federal government to protect Medicare with sufficient long term funding and a vision for the country. A renewed 10-year accord with at minimum 6 per cent annual increases in the Canada Health Transfer will bring the federal government closer to its original 50 cents on the dollar commitment and a leadership role on national standards. And a joint agreement, not 13 separate plans, is essential.

No. 1 in a series of fact sheets on CUPE's health accord proposals

Find citations in fact sheet notes and fact sheet references documents online at **cupe.ca/health-care/public-solutions**

NO.2

PROTECT. STRENGTHEN. EXPAND.

PROTECT MEDICARE:
NATIONAL STANDARDS

Canadians want equal access to health care, not two-tier care. For-profit health care providers are growing, working around and sometimes in direct violation of the law. User fees, extra billing and other *Canada Health Act* violations are on the rise. The federal government is failing to enforce the *Act* or even properly monitor. To protect universality and other *Canada Health Act* standards, the federal government must actively identify and penalize law-breakers.

CUPE calls on the federal government to:

Enforce the *Canada Health Act*, including the ban on user fees and extra billing, and correct gaps in monitoring and reporting under the *Act*.

We need the federal government to uphold health care rights

Anywhere in Canada, medically necessary services – whether at a doctor's office, a hospital, a surgical centre or a diagnostic clinic – are 100 per cent paid for by government. Patients cannot be charged user fees or extra billed for government-paid care. These and other rights – public administration, comprehensiveness, universality, accessibility and portability – are protected under the *Canada Health Act*.[1] The federal government is responsible for safeguarding these rights.

Patients across the country are denied their Medicare rights, and the federal government does next to nothing.

- In 2008 alone, 89 suspected violations of the *Canada Health Act* were identified in five provinces.[2] Since that time, private clinics have expanded in number and size.[3]
- Illegal health care billing is on the rise, creating financial barriers to health care and more inequality.[4] Recent examples:
- Quebec private clinics are charging patients for "nursing accompaniment" during an operation, "teaching services" and post-op phone calls.[5] Some have separate waiting rooms and phone lines for elite clients who pay membership fees of $1,000 or more a year.[6] In 2010 alone, the Quebec government identified $829,607 in illegal fees – double the previous year.[7]
- Two Vancouver clinics, the BC government ruled, have charged patients illegally "on a frequent and recurring basis,"[8] and the owners have still not been penalized or stopped.
- Many more patients are billed illegally, but are afraid to come forward.
- Provinces* continue to delist, underfund and cut services, failing to provide comprehensive, universal, accessible and portable health care. Quebec's failure to adequately provide ultrasounds and medical imaging in the public system is a case in point.[9]
- Doctors are double-dipping (billing the patient and government for the same procedure),[10] giving private clinic patients preferential access[11] and accepting bribes for faster care.[12]
- The federal government has imposed only minor penalties. Between 2006 and 2010, it deducted $361,174 from transfers to the provinces.[13] During that same period, public spending exceeded $858 billion.[14]

* In this fact sheet, for brevity, we use "provinces" to mean "provinces and territories."

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The current government goes further by encouraging the for-profit industry – what Stephen Harper euphemistically calls "experimenting with alternative service delivery."[15]

The erosion of Medicare rights hurts some more than others. Canadians marginalized by income, geography, gender, sexual orientation, race, ethnicity, language and disabilities suffer most when national standards are weakened.[16]

We need stronger monitoring and reporting

To uphold our health care rights, the federal government needs information on what patients are paying, to whom and for what – and how provinces spend federal health dollars. Currently, that information is patchy.

The federal government must strengthen the *Canada Health Act* by requiring provinces to report the number of private for-profit facilities, the services they provide, and the payments they receive – and making that information public.

Every year, the *Canada Health Act* annual report falls short, ignoring entirely the transfer of Medicare to for-profits in certain provinces, or giving paltry details for others.

According to reports of the Auditor General of Canada, the Minister of Health is unable to tell Parliament the extent to which health care delivery in each province and territory complies with the *Canada Health Act*.[17] Parliament should not approve the transfer of health care funds without evidence that Canadians' health care rights are secure.

We need public solutions

We want a federal government that defends Canadians' hard won health care rights, not one that sides with for-profits. Before Medicare, access to health care was dictated by geography and wealth. Canadians do not want to return there.

No. 2 in a series of fact sheets on CUPE's health accord proposals

Find citations in fact sheet notes and fact sheet references documents online at **cupe.ca/health-care/public-solutions**

NO.3

PROTECT.
STRENGTHEN.
EXPAND.

STRENGTHEN MEDICARE:

SAFE HEALTH CARE

Canada needs a national strategy to combat healthcare associated infections (HAIs). Canada has the second highest rate of HAIs among high-income countries, and we have no national strategy. Hospital overcrowding, contracting out and understaffing hamper infection prevention and control efforts. Public reporting on HAIs and federal oversight are weak.

Thousands of Canadians are injured and die unnecessarily from healthcare associated infections each year.

- Over one in 10 patients suffer from an infection they acquired in hospital.[1]
- By the last estimate, in 2002, up to 12,000 die from these infections each year.[2]
- Canada has the second highest HAI prevalence rate among high-income countries at 11.6 per cent, considerably higher than the pooled rate of 7.6 per cent.[3]
- At least 30 per cent of these infections are preventable.[4]

Beyond causing avoidable suffering and deaths, failure to prevent HAIs costs our hospitals dearly – between $1 billion[5] and $4.5 billion[6] annually. On top of that are costs borne by patients, unpaid caregivers, home and community care programs as well as litigation costs, lost work time and other economic impacts.[7]

There is robust evidence that understaffing and contracting out of health care cleaning contribute to our high infection rates.[8]

CUPE calls on the federal government to:

Implement a national strategy to reduce healthcare associated infections, with dedicated funding for microbiological cleaning standards, more in-house cleaning and infection control staff, lower hospital occupancy and mandatory public reporting.

- Contracting out leads to cuts in staff, higher turnover rates, less training and a rift between clinical and support services.[9]
- The auditor general of Scotland found that hospitals with contracted-out cleaning, compared with those with in-house cleaning, had fewer cleaning hours, less monitoring and supervision, greater use of relief staff and lower scores on cleanliness.[10]
- The UK Department of Health found that 15 of the 20 "worst" National Health Service hospital trusts for cleanliness had outsourced cleaning.[11]

Compounding the problem, Canadian hospitals are overcrowded. Eighty five per cent occupancy is recognized as a minimum standard for safety; above that, hospitals cannot effectively isolate patients, ensure hand-hygiene and clean.[12] UK research shows that hospitals with occupancy over 90 per cent have 10 per cent higher MRSA rates than hospitals below 85 per cent.[13]

Across Canada, hospital beds were cut 36 per cent from 1998 to 2002,[14] and now Canada has one of the lowest bed-to-population ratios and highest occupancy rates among countries in the Organisation for Economic Co-operation and Development (OECD).

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- Canada's hospital bed numbers (relative to population) are less than two-thirds the OECD average: 3.2 beds per 1,000 compared to the OECD average of 4.9.[15]
- Hospital occupancy in Canada was 93 per cent on average in 2008 – the second highest of 26 OECD countries, the average being 76 per cent.[16]
- Occupancy rates in Ontario and British Columbia are at the dangerous level of 97.9 per cent[17] and 96.8 per cent[18] respectively. Alberta Health Services reports that Calgary and Edmonton hospitals have run above 100 per cent occupancy for a decade;[19] the Health Quality Council of Alberta recommends 85 to 90 per cent.[20]

Understaffing and overcrowding will worsen with federal health funding cuts, as happened in the 1990s.

Even at the level of monitoring HAIs and contributing factors, Canada does poorly. The Health Council of Canada has been critical of inconsistent reporting on adverse events,[21] and leading public health experts call for mandatory reporting of HAI rates across Canada.[22] We also have poor pan-Canadian data on hospital occupancy, health care cleaning, and contracting out. The Canadian Institute for Health Information ignores cleaning services and workers in its reports on spending and health human resources – and even in a report on HAIs.[23] Health Canada tackles only a sliver of HAIs in its health indicators reports and doesn't even mention environmental contamination.[24] Statistics Canada inadequately tracks cleaning and other ancillary health care services; it counts privatized cleaners as hospitality and service workers, undervaluing the complexity of health care cleaning.[25]

The Canadian government's fragmented and weak HAI initiatives stand in contrast to federal responses in England,[26] Scotland and the Netherlands,[27] and they fail to meet our obligations under global health governance standards.[28] Strong pan-Canadian standards and enforcement mechanisms must be put in place to turn the tide on these deadly infections.

No. 3 in a series of fact sheets on CUPE's health accord proposals

Find citations in fact sheet notes and fact sheet references documents online at **cupe.ca/health-care/public-solutions**

NO.4

PROTECT.
STRENGTHEN.
EXPAND.

STRENGTHEN MEDICARE:

BETTER FRONTLINE CARE

Canadians need better access to primary health care.* Millions of Canadians lack a primary care provider and have to rely on walk-in clinics. Few primary care programs are integrated with social services and community development. Community Health Centres (CHCs) best address clinical care needs and the social determinants of health, yet are under-resourced in every province.

Canada lags behind many developed countries in coordination, after-hours care, wait times, chronic disease management, mental health, quality improvement, and electronic medical records,[1] as well as measurement and accountability.[2] Team-based care is under-developed, despite evidence that it improves health outcomes and saves money.[3]

Community Health Centres, which combine medical care with health promotion, social services and community development,[4] are the best way to meet these challenges.

- CHCs deliver better care for people with diabetes, heart disease and other chronic conditions.[5]
- Communities engaged in decisions about their health and local services have better health outcomes.[6]
- In the US, where the federal government is doubling the national CHC network, CHCs compare favourably on national measures of clinical quality and patient satisfaction.[7]

CHCs are a better way to meet health provider shortages than physician-dominated private practice, even with changes to physician reimbursement and other reforms.

CUPE calls on the federal government to:

Promote access to effective primary health care with funding for new and expanded Community Health Centres.

- Health policy experts have shown that we have enough doctors; they aren't working in the right places, in the right ways.[8]

"We talk about five million Canadians not having access to a family doctor, but they should have access to an integrated health care team where the first point of care would not necessarily be a physician."

Dr. Paul Armstrong,
founding president of the Canadian Academy of Health Sciences[9]

- Health providers are drawn to underserviced communities when they can be part of a CHC team, with mutual support, working to their full scope of practice. Ontario has expanded CHCs into rural and northern communities that had difficulty retaining physicians in solo practice.[10]
- Many provinces are changing how they pay and regulate doctors, with mixed results. Community Health Centres care for disadvantaged populations with more complex needs and still have better outcomes than physician-led models.[11]

* Primary care refers to medical, nursing and other clinical services; primary health care includes a broader group of providers focused on health promotion and early intervention, prevention and mitigation of illness.

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- An Ontario-wide study found that CHCs served high-needs clients and had lower than expected emergency department visits than any other model.[12]
- CHCs are non-profit and usually governed by locally elected boards accountable to clients, funders and the community. Physician-dominated primary care clinics operate as private businesses, with less transparency, accountability or even connection to the local community.
- CHCs respond effectively to the social determinants of health such as income, housing and the environment.[13] Combined, social determinants are more important to health than biomedical and lifestyle factors.[14]
- CHCs are the only model that meets all of the World Health Organization's criteria for a high performing primary health care system: community participation, intersectoral coordination and a focus on the social determinants of health.[15]

The potential is huge. Currently, only 300 communities – mainly in Ontario and Quebec – have a CHC.[16]

CHCs are rooted in Tommy Douglas' vision and the Saskatchewan birth of Medicare, and many federal reviews and reports since have recommended a major expansion of CHCs.[17] Most recently:

- The Health Council of Canada recommends that CHCs "be pursued aggressively."[18]
- The Wellesley Institute, a leading health equity think tank, recommends that the federal government earmark $360 million to kickstart 140 new CHCs to serve over a million Canadians.[19]

The federal government has a role. The federal $800 million Primary Health Care Transition Fund (2000–2006) kickstarted new programs across the country, with conditions tied to the funding. We need a new fund, this time tied to Community Health Centres.

Primary health care based on the CHC model means better and more equitable health outcomes for Canadians. It also means more transparent, accountable and cost-effective health care, compared to the dominant clinical care and private practice physician models. A new health accord can achieve this public solution to strengthen Medicare.

No. 4 in a series of fact sheets on CUPE's health accord proposals

Find citations in fact sheet notes and fact sheet references documents online at **cupe.ca/health-care/public-solutions**

NO.5

PROTECT.
STRENGTHEN.
EXPAND.




EXPAND MEDICARE:

LONG-TERM CARE AND HOME/ COMMUNITY CARE

Canadians need a national program, with dedicated transfers tied to *Canada Health Act* standards, minimum staffing levels, and more public and non-profit delivery. In the absence of federal standards, continuing care (home/community and residential) is a patchwork of programs. Access is two-tiered, waits are long, and quality is uneven. Continuing care services are poorly funded and regulated, offered in many places by for-profits, and fall outside of Medicare. Privatization at all levels – financing, ownership, management and delivery – worsens access and quality problems.

Continuing care varies across provinces* in the availability of services, level of public funding, eligibility criteria and out-of-pocket costs borne by residents/clients. Most provinces have cut long-term care bed capacity relative to the senior population in the past decade, without sufficiently expanding home and community care or adequately increasing staffing to reflect the higher acuity of the remaining residents.[1] There have been new investments in home and community care, but progress is uneven, and unmet needs are substantial.[2] As a result, care is often rushed and underfunded, with poor working conditions leading to poor quality of care and quality of life for residents/clients.

While Canada's aging population does not represent a "crisis" of sustainability as Medicare critics suggest,[3] it does mean that the demand for continuing care will rise.

Canada currently lags behind much of the developed world. For all meaningful purposes, continuing care is excluded from the *Canada Health Act*, and we have no national strategy. Even at the level of information, the federal system is weak. By contrast, Nordic European countries have long-standing public (comprehensive, universal and tax-financed) continuing care programs. Other countries have introduced major public initiatives in the past decade, most notably the United Kingdom, Germany and Japan.

CUPE calls on the federal government to:

Create a national continuing care program, covering long-term care facilities, home and community care, with dedicated transfers financed from general revenue and tied to *Canada Health Act* standards, plus minimum staffing and phasing out of for-profit delivery.

Government committees and a number of national organizations have recently called for federal action on continuing care.[4] Among the most recent, the Parliamentary Committee on Palliative and Compassionate Care recommended that the federal government "implement a right to home care, long term care and palliative care, for all residents of Canada, equal to the current rights in the *Canada Health Act*."[5]

Canadians need a federal continuing care program,† one that is:

- Funded through general tax revenue. Pooling risk widely is more efficient and equitable than any of the other recently proposed options: social insurance, registered savings plans, medical savings accounts and tax breaks for private insurance.[6]

* In this fact sheet, for brevity, we use "provinces" to mean "provinces and territories."
† Allowing for an asymmetrical agreement with Quebec, the program would otherwise fall under one federal transfer and law.

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- Established through stand-alone legislation, with *Canada Health Act* standards, minimum staffing standards and a program to phase out for-profit delivery.

New federal continuing care legislation should incorporate the criteria and conditions in the *Canada Health Act*, namely: public administration, universality, comprehensiveness, accessibility, portability and no extra billing or user charges.

Safe staffing levels and non-profit ownership are two of the most important determinants of quality of care and must be part of the regulatory framework.

- More non-profit delivery will improve quality and access and reduce costs. A growing body of empirical evidence, including two systematic reviews, has demonstrated that for-profit long-term care facilities are associated with lower quality of care and poorer resident health outcomes.[7] They also bring higher costs and two-tier access. Home care is even more privatized in Canada, with similar results.
- Staffing is the key determinant of quality, and national standards must include a minimum level. Higher-staffed facilities perform better on a range of quality and outcome measures, for example, rates of pressure ulcers, weight loss, nutrition and hydration, restraint use and violations of care standards.[8] U.S. experience shows that staffing and care will only improve with legislation requiring facilities to employ staff at specified levels.[9]

Canadians should have access to medically necessary services free of charge at the point of use, whether the setting is a hospital, LTC facility, home or community agency. Care should be safe and of high quality. To achieve this, the federal government needs to substantially increase funding transfers to the provinces for continuing care and make those transfers conditional on compliance with legislated standards.

No. 5 in a series of fact sheets on CUPE's health accord proposals

Find citations in fact sheet notes and fact sheet references documents online at **cupe.ca/health-care/public-solutions**

NO.6

PROTECT. STRENGTHEN. EXPAND.




EXPAND MEDICARE:

PHARMACARE

Canadians need a national pharmacare program to ensure universal access, safe and appropriate prescribing, and value for money. Prescription drugs are largely excluded from Medicare. We have a patchwork of programs that are costly, leave millions uninsured, and expose all Canadians to unsafe regulation and prescribing.

A national pharmacare program must provide universal, public first-dollar coverage for essential drugs on a national formulary, bulk purchasing, evidence-based drug evaluation and prescribing, and stricter controls on drug company marketing. In the near term, the federal government must reject the EU demand for increased patent protection, which would increase drug costs by $2.8 billion a year.

Many Canadians cannot afford essential medicines, and access is unequal.

- Up to eight million Canadians do not have coverage for prescription drugs,[1] and nearly one in 10 Canadians cannot afford to fill, renew or follow a prescription.[2]
- Canadians have differential access to drugs, depending on their location and income[3] as well as age, gender, health and employment status.[4]

Unsafe prescribing is widespread, and drug safety regulation is weak.[5] Adverse drug reactions continue to be a leading cause of death in Canada.[6]

The federal government contributes by ignoring post-market drug safety concerns,[7] keeping important research and drug approvals information secret,[8] and by letting pharmaceutical companies:

- Market to doctors and influence researchers, with few restrictions;[9]
- Conduct unethical clinical trials;[10]
- Ghost-write articles and hide negative results;[11]
- Advertise direct-to-consumer;[12]
- Expand the boundaries of illnesses and lower the threshold for treatment;[13] and,
- Unduly influence the drug regulatory system.[14]

CUPE calls on the federal government to:

Establish a national pharmacare program, and exempt health care from trade agreements, starting with CETA.

Health Canada wants to weaken drug safety regulation and speed up drug approvals.[15] The Auditor General reports that Health Canada already fails to give timely safety warnings, disclose information on drug trials and address conflicts of interest.[16]

Canadians spend far more than necessary for prescription drugs.

- Drugs are the second highest spending area in health care, and public spending on prescription drugs has risen on average 9.4 per cent a year since 1985.[17]
- Patent expiry on blockbuster drugs and new provincial purchasing policies have slowed the rate of increase, but a new era of specialized medicine and niche drugs is driving unprecedented prices, and Canadians continue to pay dearly for prescription drugs. Prescription drugs in Canada are 30 per cent more expensive than the international average.[18]

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A national pharmacare program would improve safety and access, and it would save us a lot of money.

- In our vision, pharmacare would provide first-dollar coverage for necessary drugs and promote safe and effective drug use. Catastrophic coverage helps Canadians with huge drug bills, but this is not enough; we need full public insurance for essential medicines together with bulk buying, evidence-based prescribing and drug evaluation, and stricter controls on drug company marketing.
- A universal public drug plan would save Canadians up to $10.7 billion a year, or 43 per cent of our prescription drug bill.[20]

Canada is the only country with a universal health insurance system that excludes universal coverage of prescription drugs.[21] Many countries, including France, Germany, the Netherlands, Norway, Sweden, Denmark, Switzerland, Australia, New Zealand and the UK have universal drug plans. They pay less than Canada and provide better, more equitable access.[22]

Instead of catching up, the Canadian government is negotiating a trade agreement with the European Union (CETA) that would increase our prescription drug costs by $2.8 billion a year.[23] The large drug companies argue that longer monopolies will boost innovation, but they spend twice as much on marketing than on research and development,[24] and half of their R&D spending is tax subsidies.[25] A strong majority of Canadians (69 per cent) oppose the drug patent provisions in CETA.[26]

Prescription drug coverage was originally envisioned as part of Medicare, and a series of government commissions and experts over the years have called for pharmacare reform.[27] Provinces and territories are now cooperating to bulk-buy several drugs,[28] but we need a more ambitious program and federal leadership to make prescription drugs affordable and safe for Canadians.

No. 6 in a series of fact sheets on CUPE's health accord proposals

Find citations in fact sheet notes and fact sheet references documents online at **cupe.ca/health-care/public-solutions**