

**FIRST MINISTERS ACCORD ON HEALTH CARE —
IT'S A START
BUT THERE IS STILL A LONG WAY TO GO!**

The efforts of the Canadian labour movement and its allies were extraordinarily successful in shaping the conclusions and recommendations of the Romanow Commission.

The First Ministers Accord falls short in implementing many of Romanow's major recommendations. However, the establishment of a separate Canada Health Transfer is something the CLC has repeatedly asked for.

Our call to expand the public medicare system to include home care and prescription drugs, and primary care reform, are key components of the accord.

They represent the first steps to expanding the public system which was an important part of our campaign.

There is also significant new money in the system, although it falls short of Romanow's recommendations of what is needed to properly fund the system as we discuss below.

The ability of the labour movement to articulate the priorities and aspirations of Canadians, and to expose the huge divide between Canadians and much of our political leadership, is also a significant accomplishment.

Although a first step, the agreement between the federal and provincial governments will not completely secure the future of medicare as a national, public healthcare system in which access to care is based on need, not on the ability to pay. We will need to remain alert and committed.

Preserving medicare as a national public health system in which access to health care is guaranteed to every Canadian on an equal basis was the fundamental premise underlying the recommendations of the Romanow *Royal Commission on the Future of Health Care in Canada*. Commissioner Romanow's report made it clear beyond any doubt that public financing was not enough on its own to sustain medicare. Delivering health services on a not-for-profit basis is the twin pillar to public payment for health care services. This was a key conclusion reached by the Commission.

The Accord, ignored the very issue at the heart of public debate about the future of medicare –the for-profit delivery of health care. Romanow issued a challenge to the for-profit sector to show that the private system was more effective, more efficient and more cost effective in delivering health services. As he stated in his report, “the evidence was not forthcoming”. The for-profit delivery of health services was rejected by the Commission because there was no evidence to show that it could improve medicare, and because “*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 which Canadians overwhelmingly support*”.

Overall, Commissioner Romanow has many of the same reservations as the CLC does, as reflected in his comment, “It [the Accord] puts Canadians firmly on the road toward progressive reform, a road, however, which still has to be travelled.”

FIRST NATIONS HEALTH

From this Accord, you would never know the dire health circumstances of First Nations citizens. It does not lay the groundwork for closing the gap between the health and economic status of Aboriginal Peoples and other Canadians. That may have been different had the leaders of the First Nations been at the table with the rest of Canada’s leaders, but they were left out in the cold, literally, again. The Accord contains no provisions for a full partnership with Aboriginal peoples in order to develop accountable and relevant health care delivery in Aboriginal communities.

In addition, the leaders of the territorial governments refused to sign the Accord because there was nothing in it to address the specific health needs of northern and remote communities and the minimal attention paid to Aboriginal issues.

ACCOUNTABILITY

One of the ways that the Romanow Commission endeavoured to limit and narrow the opportunities for a further proliferation of for-profit health services was a series of accountability measures. The accountability measures in the Accord are extraordinarily weak and undeveloped. The proposed Health Council will not report directly to Canadians. Instead it will report through ministers of health, leaving it without the critical factor of autonomy. There is no mention as to how public participation will be achieved. There is no requirement for the Chair of the Council to be nominated from the Council members.

There is no requirement for a national reporting mechanism allowing full comparability of how public health care funds are spent in every province. It will be difficult, if not impossible to track how federal funds are spent in the provinces. It will not be possible to track public funds spent on the for-profit delivery of care, and thus impossible to even make comparisons in terms of value for money and access to care where care is delivered on a for-profit basis. There is nothing in the Accord which would require the release of information to the public on contracts with

investor-owned care facilities.

The Accord is silent on for-profit diagnostic clinics. The Romanow Commission made an explicit recommendation to clarify that diagnostic tests for medically necessary services come under the provisions of the Canada Health Act. The goal was to ensure that the existence of for-profit diagnostic clinics did not lead to queue jumping based on the ability to pay extra for such tests.

Roy Romanow expressed concern himself while commenting on the Accord, “I think if you say here’s public money for the provincial governments, you can also say—you must ensure—that if there are private, for-profit MRI’s, they’ve got to be on the same footing as the publicly funded ones. You can’t have extra billing and you can’t have queue jumping.”

The Accord does commit to the establishment of a Canada Health Transfer (CHT) by March 2004, so it will be possible to track the level of federal transfers to the provinces/territories for health care. This is something the Canadian Labour Congress (CLC) has called for repeatedly. The Accord states that through the CHT, the federal government will ensure predictable annual increases in health transfers.

HEALTH CARE SERVICES REFORM —THE HEALTH REFORM FUND

A Health Reform Fund will be established for additional investments in primary health care, home care, and catastrophic drug coverage.

Primary Health Care

The Accord identifies that the ultimate goal of primary health care is to provide all Canadians with access to appropriate health care providers, twenty-four hours a day, seven days a week. It was agreed that provinces and territories will ensure that a minimum of 50% of their residents will have access to that kind of primary care within eight years. The only progressive element of primary care reform mentioned was the delivery of care by multi-disciplinary teams or health care organizations. What is meant by health care organizations is unknown.

Nothing is mentioned of community-based primary health care, enhanced scope of practice for health care providers, better linkages throughout the system or health promotion and illness prevention. This signals that there will be no national vision developed for the provision of primary care. Without such an approach and common understandings as to the goals and building blocks for reform, it’s unlikely that such issues as doctors as the gatekeepers, fee-for-service and service integration will be addressed.

Home Care

The Health Reform Fund will be used to provide first-dollar coverage for short-term acute home care (just out of hospital), acute community mental health, and end-of-life care. By 2006 (!), services 'could' include nursing/professional services, prescription drugs, medical supplies, support for personal care and assessment of client needs, and case management.

The federal government will pursue a 'compassionate care benefit' through the Employment Insurance program and job protection through the Canada Labour Code.

Since there is nothing in the Accord limiting the for-profit delivery of health care services, and since such a large portion of home care services are delivered on a for-profit basis, a large share of these public funds will go to for-profit providers of home care. Since the eligible home care services will be comprised mainly of sub-acute care (formerly provided in hospitals), it is fair to say that the Accord actually provides for the privatization of hospital services.

Prescription Drugs

By the end of 2005/06, provinces agree to ensure that Canadians, no matter where they live, have 'reasonable' access to catastrophic drug coverage. Reasonable is left undefined. Important recommendations from the Romanow Commission were not included such as, the establishment of a National Drug Agency to control drug costs, among other things, and a National Drug Formulary to help control costs. The pressing issue of drug patent protection went unaddressed. The Accord only calls for further collaboration to promote optimal drug use, best prescribing practices and better drug safety.

THE MONEY DEAL

The money deal can be explained in two words: 'funny money'. The numbers provided on the deal are very confusing in that they don't add up, they're contradictory, and insufficient detail is provided to make sense of it at this point. Below are the broad figures released. We will follow up with a further analysis next week once we've had a chance to ask some questions and get some answers.

- \$17.3 billion increase over the next three years, of which \$13.2 billion is money owed from the September 2000 Accord.
- \$34.8 billion over five years.
- \$16 billion of this money is tied to the Health Reform Fund for primary care, home care, and catastrophic drug coverage.
- \$2.5 billion under the CHST to relieve existing pressures.
- \$1.5 billion for a Diagnostic/Medical Equipment Fund.

- \$600 million for the development of electronic patient records.
- \$500 million for research hospitals.
- \$2 billion additional at the end of 2003-04 if the surplus permits.
- \$1.8 billion to extend transfers to 2007-08.
- \$1.6 billion in federal only initiatives —Canadian Office for Health Technology Assessment, Employment Insurance compassionate care, GST rebate for health institutions, a national immunization strategy and governance and accountability.
- \$1.3 billion over the next five years in a series of federal health priorities to be set out in the next Budget.
- \$1.3 billion for Aboriginal health.

On a positive note, the federal government will remove the Equalization ceiling on a going-forward basis which will be of help to the provinces with fewer financial resources (fiscal capacity).

CONCLUSION

The 2003 First Ministers Accord on Health Care is not an agreement to implement the recommendations of the Romanow Commission. However, the focus on primary care, home care, and catastrophic coverage is a good start. It remains to be seen whether the accountability and transparency measures are sufficient enough to track the spending of federal dollars at the provincial level or to establish minimum standards of health services across the country.

We made progress over the past couple of years but we still need to be vigilant to ensure the federal government upholds the principles and conditions of the Canada Health Act. We will also need to continue the campaign at the provincial and territorial level.

As Tommy Douglas frequently told us, we will have to be ever vigilant if we are to keep medicare intact generation after generation.