# This is Us!

NUPGE/40

CONVENTION 2016

# Negotiating a New Health Accord:

## Protecting the Health of Canadians

The **National Union of Public and General Employees (NUPGE)** represents 360,000 members who are employed in virtually every segment of our country's provincial public sector. We also have a growing membership among workers in the private sector.

Among the public sector members of our union are more than 100,000 women and men who work in Canada's health care system. They work ensuring that our health care facilities are clean and well maintained, providing diagnostic, therapeutic and pharmaceutical services, and work as licensed practical and registered nurses.

Our members have a wealth of experience and knowledge and an important perspective on the current state of Canada's public health care system.

Furthermore, they are eminently qualified to offer recommendations for the future of our health care system and the negotiations for a new Health Accord.

We offer these comments and recommendations in the spirit of helping to improve and expand upon Canada's crown jewel of public programs—Medicare. Our members firmly believe our Medicare system is a triumph of Canadian values and economic wisdom.

The **Canadian Health Professionals Secretariat (CHPS)** is a national non-profit advocacy body that represents more than 100,000 unionized health science professionals who deliver the diagnostic, clinical, rehabilitation, and preventive services that are essential to timely and quality health care. Some of the highly trained professionals represented by CHPS include occupational therapists, respiratory therapists, physiotherapists, pharmacists, medical lab technologists, social workers, medical radiation technologists, dietitians, and psychologists.

## Canada needs to secure our health care future

The first half of this decade has seen more than its share of global health crises. The Zika virus in South America. Ebola in Africa. Avian flu outbreaks in Asia.

This is in addition to many of those diseases that continue to afflict millions of people around the world—HIV/AIDS, typhoid, tuberculosis, and cholera and on and on. Even a disease such as polio that has been eradicated in many regions continues to harm people around the world.

Discussing global outbreaks of diseases might seem like an unusual way to start a brief on Canada's public health care system. However, they serve as an important reminder of the role that an accessible and modern health care system plays in protecting the lives and health of a nation's citizens.

> It has been shown that all of these global health outbreaks were made worse by societal poverty and the weak and inaccessible health care systems of the countries involved:

The connection between poverty and the Zika virus outbreak has been well established. As Amy Vittor, professor of medicine, wrote in the New York Times:

> Indeed, the outbreak is a symptom of a larger problem that has gone unaddressed for the world's poor. Lack of running water and waste management, in conjunction with urban crowding and poor housing, has given rise to the perfect set of conditions for the transmission of such mosquito-borne viruses.[1]

The World Health Organization, with regard to the Ebola crisis in West Africa, cites shortages of health professionals, poor equipment, overwhelmed hospitals and clinics, and inadequate public health education as all factors that contributed to the crisis.[2]

Raymond Williamson summed it up best when he wrote that

> the primary tragedy is that Ebola has overwhelmed health care systems that were already failing the poor. The people of Guinea, Liberia and Sierra Leone needed adequate health care services before this outbreak happened. Of course, a health care system that cannot cope with more prevalent diseases cannot cope with an extraordinary outbreak like this, either.[3]

This should be a warning for Canada. Many of the conditions that have fostered these epidemics and tragedies are present in our country, albeit not as severe. There are growing levels of poverty within some communities, primarily Aboriginal and remote communities, experiencing living conditions similar to those in the developing world.

In health care, a history of cutbacks and poor funding has created serious shortages in health professionals, laboratory services, longer and longer times spent waiting for health care services, and poorer access to hospitals and clinics. Obviously, the situation is not as dire here, for the most part, as in Africa or some countries of South America. But the trend lines in all of these things suggest that, without intervention, our health care system will continue to decline.

Canadians remain very proud of their public health care system. It remains the single most popular public service in the country. Currently, approximately 70% of all health care services in Canada are funded through our taxes from both provincial, territorial, and federal sources.

For the overwhelming majority of Canadians, this is an excellent bargain. Access to necessary medical services based on need instead of ability to pay is guaranteed. In addition, the value received for these taxes is equal to or better than what was contributed. As the Canadian Institute of Health Information notes,

> when we look at the relationship over a lifetime, only the most affluent (the top 20%) contribute significantly more to health care than they receive. For other income groups, the value received from publicly funded health care is approximately the same as or more than the value of taxes paid to fund those services. The redistributive effect of publicly funded health care in Canada is a 16% reduction in the income gap between the highest- and lowest-income groups. Without the publicly financed health system, the lowest-income Canadians would be at risk of going without needed health care or of being impoverished by paying for it.[4]

Indeed, on this basis, the publicly funded health care system is one of the most important programs promoting equality in Canada.

However, the cracks are starting to appear. Changes in our population will undoubtedly have an impact on how health care is delivered in this country. Many of the most significant health challenges facing Canada are not the acute, episodic

infectious diseases, but rather the chronic diseases that are becoming more prevalent—obesity, hypertension, diabetes, kidney failure, heart disease and dementia—all of which are also associated with an aging population.

Now is the time to secure the future of our health care system in order to protect Canadian's health well into the future.

## A short history of Canada's Medicare system

The history of Canada's Medicare program is a fascinating topic but, unfortunately, a detailed review is beyond the scope of this paper. However, some basic details are required as part of this discussion.

While most people have some familiarity with the role that Saskatchewan's Tommy Douglas played in the creation of our current health care system, the program's roots go further back in time.[5]

Calls for a national health insurance system gained considerable popularity in the early part of the 20th century. Germany was the first to introduce a national health program in 1883, to then be followed by the United Kingdom in 1911 and then Russia in 1912. Many people in Canada in the early 20th century felt that it was time for our young country to move forward similarly.

As the Great Depression brought widespread misery for many, the demand for a public health system become even more prominent. Even many physicians, who had historically opposed what they felt was an intrusion into their practice, when confronted with reduced income as a consequence of the depression, gradually shifted to supporting government financing as a means to provide stability to the system.

There were some initial steps towards provincial health insurance programs in 1935 in Alberta, and in 1936 in British Columbia; however, both initiatives suffered setbacks. Prime Minister Mackenzie King promised to create a national program but never did.

The next major step forward was in 1946 when Saskatchewan introduced a near-universal health-coverage program. There had been a history of government involvement in Saskatchewan health care, and a large component of delivery in the

province was at that time already controlled and paid for by the government. The provincial government, led by the Co-operative Commonwealth Federation, passed the *Saskatchewan Hospitalization Act*, providing for free hospital care for much of the population. While the premier, Tommy Douglas, wanted to provide universal health care, the province's fiscal situation did not allow it.

In 1957, the St. Laurent federal government passed the *Hospital Insurance and Diagnostic Services Act (HIDS)*, which committed to funding 50% of the cost of health care programs for any provincial government that adopted them. The HIDS Act, a precursor to the *Canada Health Act*, set out five conditions: public administration, comprehensiveness, universality, portability, and accessibility.

In short order, all ten provinces agreed to start HIDS Act programs. Saskatchewan used the increased funding to extend the health coverage to include physicians. Though this resulted in a dispute with the College of Physicians and Surgeons of Saskatchewan, and to the Saskatchewan Doctors' Strike, the situation was eventually resolved in the province's favour.

The success of these programs led the federal government to introduce the *Medical Care Act* in 1966 that extended the HIDS Act cost-sharing to allow each province to establish a universal health care plan. The *Canada Health Act* was passed in 1984 and included the principles of the HIDS Act but also prohibited user fees and extra billing by doctors. The pillars of the *Canada Health Act* where reaffirmed in the 1999 Social Union Framework Agreement.

The responsibility for providing health care is considered primarily that of the provinces. While the 1867 *Constitution Act* (formerly called the *British North America Act*, 1867) did not mandate health care to either the federal or provincial governments, it did give the provinces responsibility for regulating hospitals. Furthermore, the provinces have argued that, under the Constitution, their general responsibility for local and private matters encompasses health care.

However, the federal government has argued that the health of the population falls under the Peace, Order, and Good Government provisions of the *Constitution Act*. This dispute wasn't resolved until the 1930s, when the Judicial Committee of the Privy Council decided that the administration and delivery of health care was a provincial concern, but that the federal government also had the responsibility of protecting the health and well-being of the population.

As a result, the large costs associated with delivering health care have been partially funded by the federal government. By covering 50% of health costs the federal government was able to play a significant role in how a province delivered services to its citizens.

The cost-sharing agreement started with the HIDS Act, and extended by the *Medical Care Act*, was replaced in 1977 by Established Programs Financing. This represented a shift to a bloc transfer to the provinces from targeted funding, which gave the provinces greater flexibility but diminished the federal government's ability to influence health care delivery.

## Crisis, solution, and then more crisis!

The 1995 federal budget, following years of reduced federal funding to health care, proved to be a deep blow to health care in Canada. In that budget, the Finance Minister, Paul Martin, introduced massive cuts to federal transfer payments for health, social services, and education.

Under the newly created block fund, the Canada Health and Social Transfer (CHST), federal transfers to the provinces was cut by $4 billion in two years—from $16.6 billion in 1995, to $12.6 billion in 1997. Between 1994 and 2002, more than $25 billion was removed from the CHST.

While the funding may have been cut, the demand on provinces to provide health care continued unabated. Provinces confronted with serious shortfalls in funding responded by laying off health professionals and cutting health services.

Canadians quickly started to feel the brunt of the cuts: wait-lists lengthened, hospital beds grew scarce, and many health professionals sought other opportunities.

The World Health Organization report in 2000 ranked the performance of Canada's health care system an embarrassing 30th in the world—below Morocco but above Finland. While the merits of WHO's ranking system can be debated, it was clear that our health care system was ailing.

With the growing recognition that the cuts had gone too far in 2002, the federal government created the Commission on the Future of Health Care in Canada, more commonly referred to as the Romanow Commission.[6]

Canadians came out to present to the Romanow Commission in unprecedented numbers. Ultimately, the commission concluded that Medicare must be protected and expanded upon and provided recommendations to achieve this goal.

After a period of negotiations, the federal, provincial, and territorial governments agreed on a 10-year Health Accord in the fall of 2004. The federal government's funding commitments to the provincial and territorial health care systems provided what was a desperately needed degree of stability. Evidence suggests that significant improvements have been made in some areas of the health care system.

As the provinces were preparing for negotiations with the federal government to renew the Health Accord, Jim Flaherty, the federal finance minister, at a 2011 Finance Ministers meeting, unilaterally dictated the terms for the two federal transfer agreements—the Canada Health Transfer (CHT) and the Canada Social Transfer (CST).

What the Finance Minister announced was that the federal government would continue the 6% escalator clause, part of the 2004 Health Accord, for the CHT only until the 2016/17 fiscal year. After that, until at least 2024, annual increases in the CHT will be tied to the growth in the Gross Domestic Product (the GDP adjusted for inflation). The Finance Minister also guaranteed that annual increases would not drop below 3%.

The announcement also confirmed the federal government's plan to allocate CHT payments on a strictly per capita basis between jurisdictions, thus eliminating the existing formula that considers the taxation capacity of individual provinces. The impact of the move to per capita funding will not be felt evenly by all the provinces.[7] Most likely the poorer provinces will find it more difficult to meet the health care needs of their population.[8]

According to a paper prepared for the Council of the Federation, presented at its meeting in July 2012, the premiers estimated that the proposed changes to the CHT would cost their jurisdictions $36 billion over 10 years.

The paper, prepared by the Council of the Federation's Working Group on Fiscal Arrangements, found that changing from a 6% escalator to an increase tied to economic growth will cost the provinces and territories an accumulated total of $25 billion by 2023/24. Furthermore, the limited protection plan to cushion provinces and territories from the allocation change will cost an additional accumulated total of $11 billion.[9]

## The federal funding conundrum

There is probably no more hotly contested policy issue in Canada than how to fund health care. The issue is tied to discussions of federal-provincial-territorial powers as well as to the role that private for-profit interests should play in health care delivery.

As we have seen, the federal government, through the HIDS Act, extended by the *Medical Care Act*, and then replaced in 1977 by Established Programs Financing, played a significant role in the establishment of the current Medicare system. The provision of 50% of the cost of delivering health care allowed provinces to develop and expand programs that responded to the needs of their citizens. It also gave the federal government a strong central role in directing how that health care was delivered.

The shift to bloc funding provided more flexibility to the provinces, but it also reduced the ability of the federal government to intervene. However, the size of the federal contribution still ensured that they maintained a powerful voice in health care policy.

As the real federal contribution declined, the power of the government in Ottawa to place conditions or demands on the provinces was diminished. Some of this was the intention of various federal governments.

The ability of the federal government to hold the provinces accountable for how their share of the health funding was spent was also compounded by the complexity of the funding formula. By including targeted funding to achieve wait-time targets, as well as an equalization component, the ability of the federal government to

evaluate the impact of their funds became diminished. In many ways, the move to a per capita transfer could strengthen the ability of the federal government to hold provinces accountable.[10]

At this point it is worth mentioning that the aftermath of the 2008 global financial crisis, and the decline in oil prices, which began in mid-2014, have had a significant impact on the fiscal capacity of many provinces. Following decades where tax cuts were the primary fiscal tool used by almost all governments in Canada, the ability to respond to the economic downturn was severely hampered. A number of provinces turned to austerity policies, cutting funding to public services and privatizing others, as a means to balance the budgets.

With provincial spending on health care being either frozen or cut, there are growing reports from across Canada of a decline in the quality of the health care system. It is also the case that the proportion of funding that is being provided by the federal government became a greater component of total health expenditures.

The question is, ultimately, what is the best role that the federal government can play in the funding of health care? As we have seen, provincial health care systems underwent the greatest period of expansion and development when the federal government stepped forward and played a larger role in both funding services and in placing conditions on how that money was spent.

It can also be argued that federal health care funding should also take into consideration the demographic diversity of the country. Over the next decade, Canada will be confronted with a shift in the age composition of its population, the degree of which will vary by province. It has been demonstrated that the age composition of a population can have a significant impact on a jurisdiction's health expenditures. Similarly, the regional distribution of the population can strongly influence a province's health expenditures.[11]

During the 2015 federal election, the now governing Liberal Party made a number of promises related to health care:

- Prime Minister will sit down with provincial and territorial Premiers;
- negotiate a new Health Accord with provinces and territories, including a long-term agreement on funding;
- invest $3 billion, over the next four years, in home care services;

- pan-Canadian collaboration on health innovation, and improve access to necessary prescription medications—join with provincial and territorial governments to buy drugs in bulk;
- high-quality mental health services made more available to "Canadians who need them, including our veterans and first responders";
- introduce a National Disabilities Act.[12]

The total costs of Canada's Medicare system are in line with those of most wealthy countries in the world and substantially lower than those of the United States. In a 2014 report from the Organisation for Economic Co-operation and Development (OECD),[13]

> Health spending accounted for 10.9% of GDP in Canada in 2012, 1½ percentage point higher than the OECD average of 9.3%. However, health spending as a share of GDP is much lower in Canada than in the United States (which spent 16.9% of its GDP on health in 2012), and is also lower than in certain European countries such as the Netherlands (11.8%), France (11.6%) and Germany (11.3%).[14]

On a global level, the overall health of Canadians ranks well. However, there is room for improvement. The Conference Board of Canada compared Canada with 16 other developed nations on 11 health performance indicators and found that our health care system placed 10th out of the 17 countries.[15] This earned the country a solid B grade.

It must be remembered, though, that population health indicators are not exclusively the result of health care systems. As the Conference Board notes,

> Canadians have universal access to health care services, highly skilled and committed health care professionals, and internationally recognized health care and research institutions. But the Canadian health care system also has challenges. These include limited availability of comprehensive health information systems, wait times for some health care diagnostics and treatments, and management systems that don't focus enough on the quality of health outcomes.

> What's more, health care is just one of several contributors to the health of Canadians; other factors also come into play, such as the age of the population and lifestyle choices including tobacco use, alcohol consumption, physical activity, and eating habits. These factors are, for the most part, independent of the formal health care system.[16]

Fundamentally, as was said in the final report from the Romanow Commission, our Medicare is as sustainable as we want it to be.[17] How governments spend the taxes they collect from us—and how much they collect—are choices that we, as citizens, direct them to make.

The fact is that Canadians have repeatedly said they support our Medicare and want more tax dollars invested in it—not less! Opponents of Medicare are spreading myths about health care spending being out of control. Total public health care spending, as a percentage of our Gross Domestic Product (GDP), is currently at 10.9% compared to its previous peak of 9.8% in 1992.[18] It must be added that health spending as a share of GDP has been declining since the 2008 recession.

> It is anticipated that, overall, health expenditure will represent 10.9% of Canada's GDP in 2015, a share that has fallen gradually in the past few years, following the recession in 2009. The current trend, viewed in the context of the last 40 years, appears similar to that experienced in the mid-1990s.[19]

It is true that public health care has slightly increased its share of provincial government program spending since the late 1990s. Total provincial government health spending has been remarkably stable as a share of GDP in the past 20 years, showing an increase from just under 6% in 1989, to just over 7% in 2009. The reason it looks like provincial health spending is soaring out of control actually has nothing to do with health care spending. It looks this way because of cuts in other program spending and dramatic tax cuts. That is to say, the health care slice of the total provincial pie looks bigger because other slices, and the total pie, have been getting smaller, while the health care slice has remained about the same.[20]

Canada does not have a spending problem. Total government spending as a share of our GDP has decreased every year since 1992.[21] But we do have a revenue problem. Since the mid-1990s, all levels of government (municipal, provincial, and federal) have cut taxes so drastically that they've reduced their revenue by 6% of GDP—that's a loss of $90 billion in revenue every year. That's more than enough money to not only strengthen our current Medicare system but to also expand it.

This point was well presented in a report from the Public Services Foundation of Canada entitled *The sky is not falling*.[22] In an extensive look at the data, the report concludes that “empirical data clearly reveals as false the popular argument that public spending is out of control.” In particular, the Public Services Foundation dedicates a chapter to debunking the argument that health care spending is unsustainable. They point out that “total health care costs, and public spending in particular, have been remarkably stable over the last 25 years as a share of GDP and fall comfortably in the mainstream among other wealthy nations.”

At the end of the day, it’s all about priorities and choices. Instead of spending billions of dollars on fighter jets, federal mega-prisons and more corporate tax cuts, we can fund those services that Canadians actually want. There’s more than enough money to protect and strengthen our Medicare—the federal government just has to make it a priority.

Establishing a stable and progressive mechanism for federal health funding is an important challenge facing the new federal government. When it comes to negotiating a new Health Accord the federal government should have three priorities:

1. Ensure that the health care system has stable and sufficient funds to provide all Canadians, regardless of their income or where they live, access to high quality publicly provided medical services well into the future. This is what Canadians want and deserve. It is the fundamental promise the founders of Medicare system made when they strove to implement universal health care coverage.
2. Provide enough funding to have a say in how the provinces and territories deliver and administer their health care services. As we have seen, in the past the federal government was able to use its financial clout to convince provincial and territorial governments to implement and expand core medical services. The federal government must be able to play a role in guiding and shaping the future of Medicare.
3. Introduce national standards, in addition to the principles of the *Canada Health Act*, to accompany increased funding, with the ability to withhold the funds should provincial or territorial governments fail to meet the national standards.

## RECOMMENDATION 1

**Promised health program initiatives should receive additional funding**

The promise of $3 billion in home care should not come at the expense of total federal funding to health care. This should be additional new monies from what is contained in the CHT.

## RECOMMENDATION 2

**Negotiate with provincial and territorial governments using the 3 priorities**

The federal government must continue the process of fair and open negotiations with their provincial and territorial counterparts to achieve a new Health Accord. The federal government is urged to adopt three priorities in their negotiations:

1. stable and sufficient funding for health care;
2. sufficient federal funds to have a meaningful voice in provincial and territorial health care delivery;
3. adoption of national standards, in addition to the principles of the *Canada Health Act*, to increased funding, and ensure that they are followed.

## The *Canada Health Act* must be enforced

The 1984 *Canada Health Act* (CHA) is an important piece of federal legislation in the delivery of health care in Canada. The act sees "the primary objective of Canadian health care policy is to protect, promote and restore the physical and mental well-being of residents of Canada and to facilitate reasonable access to health services without financial or other barriers."[23]

The legislation sets out the conditions and criteria that provincial and territorial health insurance programs must conform to in order to receive federal transfer payments under the Canada Health Transfer.

The five main principles in the *Canada Health Act* are as follows:

- **Public Administration**: All administration of provincial health insurance must be carried out by a public authority on a non-profit basis. It must also be accountable to the province or territory, and their records and accounts are subject to audits.
- **Comprehensiveness**: All necessary health services, including hospitals, physicians and surgical dentists, must be insured.
- **Universality**: All insured residents are entitled to the same level of health care.
- **Portability**: A resident that moves to a different province or territory is still entitled to coverage from their home province during a minimum waiting period. This also applies to residents that leave the country.
- **Accessibility**: All insured persons have reasonable access to health care facilities. In addition, all physicians, hospitals, etc., must be provided reasonable compensation for the services they provide.[24]

The CHA principally deals with how the health care system is financed. As a consequence of the constitutional division of powers between the federal, provincial and territorial governments, adherence to these CHA conditions is voluntary. However, the federal government has been able to use its role as a major funder of health care to ensure the provinces and territories comply with the principles contained in the CHA.

Unfortunately, for far too long the federal government has been lax in its enforcement of the CHA.[25] Roy Romanow told an audience that "in most recent years, Ottawa has become more reluctant to involve itself in the shaping of new national reforms." And that "they've forgotten to enforce the *Canada Health Act* at all."[26]

Sharon Sholzberg-Gray, former CEO of the Canadian Healthcare Association, noted that the previous federal government "does not appear to have the inclination to monitor compliance with the principles of the *Canada Health Act* as a condition for receiving federal money."[27]

As a consequence of the withdrawal of the federal role in the coordinating and enforcement of national health policy, we are seeing increasing fragmentation among provincial and territorial systems. This ultimately violates the core principles of the *Canada Health Act*, especially comprehensive coverage and portability between provinces and territories.

Weakened accountability measures have served to increase the pace of privatization in provincial and territorial health care systems. The proponents of privatization in health care are opposed to increased accountability for public health care funding. This makes the public administration and review of health care spending all the more important.

We know that there are violations of the *Canada Health Act* taking place in provinces and territories. A 2008 report found that there were at least 89 suspected violations of the *Canada Health Act* in private clinics in 5 provinces.[28] Since this report, the number of private clinics and services has expanded in number and size.

The extent of privatization in health care in Canada will be discussed in the next section of this paper. However, the point is that the lack of enforcement of the principles of the *Canada Health Act* has allowed privatization in health care to grow.

The Auditor General of Canada reports that the Minister of Health is unable to inform Parliament of the extent to which provincial and territorial health care delivery complies with the *Canada Health Act*. Parliament must insist that the Minister of Health enforce the *Canada Health Act*.

## RECOMMENDATION 3

### Develop accountability mechanisms

An independent public accountability system would track public funds in health care in order to monitor how much is going to investor-owned private for-profit health care, home care, and long-term care, as well as track health outcomes to assess the financial cost or benefit to Canadians.

## RECOMMENDATION 4

### Minister of health must monitor and enforce the Canada Health Act

The federal minister of health must correct the deficiencies in monitoring, reporting, and enforcing the *Canada Health Act*. In particular, the ban on queue-jumping, user fees and extra-billing by doctors, other health providers, and corporate entities

must be strictly enforced. Violations must result in financial penalties. There needs to be a sufficient number of federal inspectors to monitor and report on provincial health care services.

### RECOMMENDATION 5

**Enact *Whistleblower* legislation**

The federal government should enact legislation to protect whistleblowers who report violations of the *Canada Health Act*. This legislation would need to be accompanied by an administrative process for individuals to make these reports, in a safe manner, to *Canada Health Act* inspectors.

## Privatization is harming health care delivery

After more than 30 years of governments privatizing health care services, presumably there should be ample and compelling evidence to assess the results, a demonstrated track record of whether the introduction of for-profit providers has been a cost-effective and equitable means to deliver health care.

The truth is that the privatization of health care services has been shown, time and time again, not to improve the system but rather to harm it. Indeed, sometimes disastrously so. This has been shown in countries around the world.

Unfortunately, there is decades of evidence that privatization does not improve Canada's health care system has done little to dissuade governments from pursuing it. This is despite the fact that Canadians have repeatedly demonstrated their commitment to a health care system where access is based on need rather than wealth.

As a report from the Canadian Centre for Policy Alternatives points out,

> indeed, when confronted with the privatization failures of the past, many politicians will assure us that they have "learned from past mistakes" and will apply extra caution "this time." What is maddening about the "this time it will be different" rhetoric is that it never seems to be.[29]

In a study of for-profit diagnostic, surgical, and "boutique" physician clinics across Canada, the author found that

> the majority of for-profit clinics are maximizing their profits by charging public plans and charging patients out-of-pocket or through third-party insurance as well. The evidence shows that for-profit delivery erodes the public health system by taking financial and human resources out of the public system and by promoting two-tier health care. In many cases, the drive of clinics to maximize revenues by billing all available sources—governments, patients and third party insurers—is jeopardizing the equality and fairness of the public system which is supposed to assure equal access to medically necessary hospital and physician services regardless of wealth.[30]

For those lacking the wealth to pursue private health care options, the impact is immediately obvious. There are a finite number of health care providers in Canada with well-documented shortages for many health professionals in many regions. This problem is exacerbated by the lower number of health professionals working in remote and rural areas. Wait times for many procedures in the public system would increase as staff are lured away to the private sector by the promise of higher pay.

> There is little evidence to support the contention that for-profit ownership bears any relation to reducing wait times. In fact, in demonstrable cases, for-profit clinics have forced reductions in local public and non-profit hospitals' services by taking staff out of local hospitals, worsening shortages in the public health system.[31]

So, contrary to what the proponents of privatization claim, private health care delivery harms the public system in a number of ways:

- Wait times in the public system increase as a parallel private system drains scarce health professionals out of the public system.[32 33]
- The quality of care declines as private health insurance companies deny coverage and for-profit providers cut corners to save money and increase profits.[34]
- Health care dollars are diverted from patient care into high executive pay and benefits packages and advertising campaigns.[35]

On the flip side, in some jurisdictions, private care is usually associated with an over-abundance of some specialized procedures. Profitability of health services and not patient needs can lead to a situation where there are too many tests, too many appointments, and unnecessary treatments.

Our neighbours in the United States would recognize this issue. People with private health insurance find themselves subjected to the risks of unwarranted tests and procedures. In the United States, for example, we see the highest rate of invasive cardiac procedures in the world—45% more than the next highest country. And yet, this has not brought Americans better heart health.

Private clinics focus on those health conditions and services that realize the greatest profit. These tend to be the more easily treated conditions, in patients who do not suffer from complicating comorbidities, so that they do not require long-term intensive therapies. This results in the more difficult cases being left to the public system, a practice often referred to as *cream-skimming.*

Even the wealthy will occasionally require the services of the public health care system. Emergency and trauma care, for example, are unlikely to be provided by private clinics in Canada. Private clinics tend to focus on the more profitable and less expensive health care services. The public system is already confronted by shortages of health professionals and is lacking resources. If health professionals are recruited away from the public system, the emergency and trauma services provided by hospitals are weakened.[36]

Even the economic arguments for health care privatization have been shown to be flawed. Examples of privatization initiatives being financial flops and foul-ups in Canada abound. The poor performance of Public-Private Partnerships (P3s) in health care has been well documented. Provincial auditors have highlighted these problems on a number of occasions:

- Ontario Auditor General found that P3s cost $8.2 billion more than public procurement.[37]
- Ontario Auditor General found that the Brampton Civic Hospital, built by a P3, cost $394 million more than a public-only option would have.[38]
- Quebec Auditor General showed that the P3 option was more expensive for McGill University Health Centre and Centre de recherche du Centre hospitalier de l'Université de Montréal (report is in French).[39]
- BC Auditor General's report on Vancouver General Hospital Academic Ambulatory Care Centre found that the P3 project cost 29% more than promised.[40]

As Globe and Mail health policy columnist André Picard noted,

> taxpayers deserve more than P3 boosterism. And they deserve more justification than a fallacious premise that governments are incapable of efficiency.
>
> Our much-needed public works projects, from hospitals to bridges, should be built and operated as efficiently and cost-effectively as possible and, so far, P3s have not proven their mettle.[41]

Perhaps less reported is the potential for fraud and illegal billing in privatization schemes. In the example of the McGill University Hospital P3, at least 9 people were involved in a $22.5 million dollar fraud investigation—considered one of the largest fraud cases in Canadian history.[42]

In British Columbia, a 2012 audit of the private for-profit Cambie Surgery Centre and its affiliated Specialist Referral Clinic found that they had billed patients for publicly insured medical services in contravention of the *Medicare Protection Act*. The province has said that there is evidence that these doctors illegally billed both their patients and the provincial health system.[43]

The research has consistently demonstrated the advantages the public health care system provides. A public Medicare system provides better coverage for Canadians, better quality of services, and better accountability for less money than for-profit health care does.

In addition, public Medicare gives Canadian businesses a competitive advantage by ensuring reduced health care costs to employers. It is vital to attracting more new investment into Canada's economy. A private system will erode this competitive advantage.

Charles Baillie, a former CEO of TD Bank, said a few years ago: "I choose to talk about health care as a banker—as a corporate leader—because I believe it's high time that we in the private sector went on record to make the case that Canada's health-care system is an economic asset, not a burden, one that today, more than ever, our country dare not lose."[44]

The path to ensure that Medicare is available for all Canadians in the future is to be found in a reinvestment in the public system. However, increased funding is not, in and of itself, the only way to ensure this future. Reforms must, and can, be done within the public system.

## RECOMMENDATION 6

### Public administration must also mean public delivery

It seems incongruent that the *Canada Health Act* would mandate that federal monies allocated for health care be publicly administered but not necessarily publicly delivered. The federal government needs to interpret the *Canada Health Act* so as to prohibit the private for-profit delivery of health care.

## RECOMMENDATION 7

### Remove the P3 screen for federal funding and close PPP Canada

Public-Private Partnerships have been shown to be a poor option for governments when delivering important health and social services. The previous federal government introduced an expectation that federal funds for some projects must use the P3 model. This screen should be removed from all federal funding initiatives. Furthermore, the agency PPP Canada, established by the previous federal government to facilitate the adoption of P3s, should be closed and its funding reallocated.

## Develop a human resources strategy for health professionals for Canada

Too many Canadians are waiting too long for the critical services they need. One cause of long wait times is obvious enough: a shortage of health professionals.

Some of these shortages are regionally specific. While Canada's urban areas may experience shortages in some professions, this problem is heightened when it comes to rural and remote communities.

The shortages include doctors, licensed practical nurses, and all the highly skilled health science professionals who deliver life-saving diagnostic, clinical, rehabilitation, pharmaceutical and emergency services. It must be noted that these shortages are more acute in some specializations and are getting worse.

For example, it is well recognized that the Canadian population, as a whole, is aging. As the population ages, there will be an increased demand for health professionals that work with the elderly. But the number of health professionals, for example physicians, working with seniors is considerably less than those working with some other populations:

> Currently there are 129 active Ontario physicians holding subspecialty training in geriatric medicine serving a population of 2.0 million seniors. This yields a ratio of 0.65 geriatricians per 10,000 older Ontarians. By contrast, there are 1641 pediatricians serving a population of 2.2 million children, yielding a ratio of 7.5 pediatricians per 10,000 Ontario children. This discrepancy is more alarming considering that by 2016 Ontario seniors will outnumber Ontario children.[45]

Dr. Roger Wong, clinical professor in the Division of Geriatric Medicine at the University of British Columbia and past president of the Canadian Geriatrics Society, worries that Canada's shortage of geriatricians puts seniors at risk of functional decline. "We are not just talking about looking after those seniors who are frail, but also those active seniors, who want to stay active."[46]

Shortages of health professionals exist across the country, but in some regions these shortages are more acutely felt. A 2014 story by CBC Halifax highlighted how an aging and retiring health care workforce in Nova Scotia is leading to staff shortages.

> "Professions requiring close monitoring include physicians, registered nurses, licensed practical nurses, continuing care assistants and lab and diagnostic imaging staff to name a few."[47]

The story further points out that "department figures also say that 39 per cent of the province's nearly 4,000 licensed practical nurses and 37 per cent of 851 medical laboratory technologists are over the age of 50. Of the 574 medical radiation technologists currently working, 129 plan to retire within the next five years, which amounts to 22 per cent."[48]

> The average age of those working in health professions in Canada was 43 in 2011—two years older than the average age of the general Canadian workforce. According to the 2011 LFS (Labour Force Survey), the "younger age" professionals (younger than 40) included ambulance attendants, dental assistants, respiratory therapists, dental hygienists and dental therapists, and occupational therapists. Some of the "older age" professionals (older than 45) included psychologists, dentists and physicians as a group (both general practitioners and specialists).[49]

The long hours and stressful working conditions take a toll on workers in the sector. Most health professionals retire younger than the Canadian average.

> But health professionals often retire before age 65. In fact, about half (49%) did so between 1997 and 2000. Projections assuming a retirement age of 55 estimate even greater losses by 2006: 64,248 RNs aged 50 or older, or 28% of the 2001 nursing workforce. Under this model, losses would range from 22% of RNs in the Atlantic region to 32% in British Columbia.[50]

It also is likely true that decades of cuts in the sector have also made many health professions a much less desirable career choice for many young people.

> The profession's difficult working conditions—long hours, shift work, understaffing, and low availability of full-time positions—may be a factor in the declining enrolments in college and university nursing programs.[51]

However, the decline in enrolment in educational programs for health professionals may be more a factor of cost and enrolment caps.

There's a brisk migration of health professionals across the country, and provinces often attract their health professionals at the expense of neighbouring provinces. To succeed, we must work together, on a national level.

While accrediting and integrating foreign-trained professionals could be part of the solution, it is not the magic bullet. To begin with, the path to having foreign credentials recognized is often so onerous that many highly trained professionals never resume the careers for which they were trained, leaving them underemployed in supporting roles, or forcing them to leave the health system altogether. Those who do achieve recognition often lose several years of their career to do so. Even if mi-

grants could enter our system seamlessly, health professional shortages are a global problem and Canada's lack of planning must not be an excuse to poach health professionals from other countries struggling with their own shortages.

There are other important reasons for the establishment of a national human resources strategy for health professionals in addition to the need to address shortages and gaps.

The most basic might be that compensation of health care workers is the bulk of the cost of the system. Indeed, it is actually quite remarkable that so little time and so few resources are dedicated to human resources planning in the sector:

> It may be surprising to the public, as it was to me, to find out how little Canadian governments plan for the number and type of health worker we need now and in the future—from the medical specialists for an aging population with multiple chronic conditions, to the number of physiotherapists, occupational therapists and personal support workers to enable older adults to remain independent in their own homes.[52]

While there are a number of organizations that do look at human resources issues in the health care sector, they tend to be focused either provincially or regionally. There is no national coordination or planning of health human resources.

A strong argument can be made for the creation of a national agency to oversee the health workforce.

> But here's the kicker: pretty much every country in the world has an agency or organization dedicated to knowing as much as it can about their health workforce so they are best able to meet the needs of patients and the broader population. Rich countries and poor countries alike have these organizations. Such agencies are especially critical for poor countries because they have to make the most out of the few health workers they have.[53]

In one of its last reports, the Health Council of Canada said that

> despite the increase in the supply of health care professionals in Canada from 2006 to 2010, more work is needed both to achieve the optimal mix of providers and to support various health care professionals to work to their full scopes of practice. Most jurisdictions have health human resources strategies and are taking some action in planning for future resources.

> However, health human resources, including doctors, nurses, and other health care professionals, are not always integrated into broader health system plans and continue to be cost drivers for core services as reflected by increases in physician remuneration. Managing costs and strengthening the performance of Canada's health workforce require further attention in order to ensure the sustainability of the Canadian health care system.[54]

### RECOMMENDATION 8

**National strategy for more health professionals**

Our public health care system is confronted by a serious shortage of health professionals. We need a pan-Canadian strategy to recruit, train, and retain more health professionals.

### RECOMMENDATION 9

**Create a pan-Canadian Health Human Resources Agency**

The development of a pan-Canadian strategy for health human resources will require a review of the research, insights, and precedents—from both local and international sources. There is a lot that can be learned from international examples of innovative approaches to health workforce planning and deployment. A pan-Canadian Health Human Resources Agency, operating with the cooperation of provincial and territorial health systems, could play a considerable role in conducting research and liaising with other such agencies around the world.

## We need a national drug program

There are a multitude of life-saving medications available to us today. Many people who have conditions that were untreatable in the past now lead normal and productive lives as a result of new research and medications. But all too often these life-preserving medications are out of reach for many Canadians. Many of these medications are quite simply too expensive to be readily used!

As a result, many people with illnesses rely on hospitals or other facilities for treatment. People who, with the proper medication, could be living at home comfortably are instead in hospital in order to ensure their access to medication.

The cost of medications is an important issue for our health care system. According to a joint report from the provincial governments called "Pan Canadian Drug Negotiations Report," the medications are a significant expense in health care.

> Drugs are an important component of a healthcare system. In Canada, total drug expenditure reached $32.0 billion in 2011 and $33.0 billion in 2012, representing annual growth rates of 4.0% and 3.3%, respectively. Drugs' share of total health expenditure remained constant at 15.9% in both 2011 and 2012.[55]

There is an uneven patchwork of public and private coverage of drug costs for Canadians. The majority, about 66% of Canadians, are covered by private, primarily workplace, plans.[56] These plans tend to be funded by employees and employers through workplace insurance plans.

Private plans usually extend coverage to spouses and dependent children. Job loss, retirement or spousal separation can result in a sudden loss of coverage for prescription medications—often at a time when this coverage is most needed.

But being covered under a private plan is not necessarily a guarantee against high, out-of-pocket, drug expenses. Approximately 60% of private plans provide 100% coverage of prescription drug costs on their formularies to their members. Many plans range between covering 60%–80% of drug costs, and many provide no reimbursement for medications not on their formularies, or which may be prescribed but are available "over the counter."[57]

A further 29% of Canadians are covered under a mishmash of federal, provincial, and territorial plans.

> In some provinces, only seniors, those on social assistance and people suffering from certain illnesses are covered, while in others people pay for drugs based on an income assessment. The federal government covers specific groups under its jurisdiction, including First Nations and Inuit,

> refugees, the military and veterans, the RCMP and federal prison inmates. It is important to bear in mind that those included in public drug plans are not necessarily receiving their drugs free of charge. Often part of the cost must still be paid by the individual which may create a barrier to obtaining prescription drugs.[58]

And then there are the more than 3.5 million Canadians with no coverage at all for prescription drugs.[59] These are those individuals not covered by a workplace plan (i.e., self-employed, part-time, casual or employed in workplaces with no benefit plans, likely to be low-wage workplaces in the first place) or not eligible for a public drug plan. Far too often, the cost of prescription medications is out of reach for these individuals.

Canadians, individually, are paying approximately 22% of all drug expenses out of their own pockets.[60] This does not take into account the money that employees and employers are putting into workplace drug plans. As a result, many Canadians are unable to afford the medications that their doctor prescribes for them.

> The problems with this patchwork of coverage and non-coverage are predictable and disturbing. In any one year 10 percent of Canadians are unable to obtain the drugs prescribed by their doctors because they cannot afford them, and this figure increases to 36 percent for those with no insurance and low incomes.[61]

A 2015 poll conducted by Angus Reid found that in 2014 almost one-quarter of Canadians (23%) "did not take medicines as prescribed because of cost," meaning that they either did not fill their prescriptions, cut the dosage, or did not renew a prescription.[62]

Drug coverage varies considerably by the age of the individual.

> Unsurprisingly, older Canadians have more comprehensive drug coverage: about three-in-four (74%) Canadians over age 55 have public or private coverage for half or more of their household drug costs. Younger Canadians have less coverage: just over half of Canadians under age 24 have most or all of their drug costs covered by government or an insurance plan.[63]

The inescapable conclusion is that the current manner in which Canadians access prescription medications is highly flawed. Indeed, most Canadians know this, as demonstrated by the Angus Reid poll:

> Most Canadians think this country's current system of drug coverage has flaws. Almost seven-in-ten (69%) disagree with the statement: "overall the current system is working well enough and doesn't need to be changed."
>
> An overwhelming majority of Canadians (91%) express support for the concept of a national "pharmacare" program that would provide universal access to prescription drugs—and similarly large numbers support more detailed descriptions of such a plan.[64]

Canada is one of the few developed nations without a national prescription drug program. Among countries with national public health systems, Canada is the only one without a national public drug plan.[65]

Universal access to prescription medications is, in itself, a strong argument in favour of a national public drug program. Ensuring that every Canadian has access to the prescriptions they need, regardless of their ability to pay, is a goal that an overwhelming majority of Canadians support. Furthermore, research has shown that there is a strong economic case to be made for the creation of such a program in Canada.

Marc-André Gagnon, assistant professor at the School of Public Policy and Administration at Carleton University, has extensively researched the impact on Canada's health expenditures that a national public drug program would have. He has shown that the introduction of such a program would ultimately bring an astounding 41% savings in total drug costs. For example, in 2013, Canadians paid $27.7 billion in prescription drugs. With a national public drug program, that figure drops to approximately $16.3 billion.[66]

These cost savings would be achieved by eliminating various subsidies, using competitive purchasing, a more rigorous assessment of new drugs, and improved prescribing practices.

> In Canada, the most serious waste of money is in the high prices paid for drugs. This is a combination of setting high prices for new drugs and the lack of competitive pricing for drugs. We pay an additional $9.9 billion per

> year, because we do not have population-wide bargaining and competitive prices.[67]

It must be noted that a majority of these new medications—the more expensive drugs— being brought on the market may not be any better than already existing medications.

> In an attempt to shortcut drug development, there is an increasing trend among pharmaceutical companies to bring to market new formulations of existing drugs or newer versions of previously marketed drugs… Changes such as these add value if they can demonstrably be shown to improve safety, effectiveness, or adherence to treatment. However, the timing of the introduction of such changes in formulation has suggested that this is often little more than an attempt to extend patent life of the drug in the face of new competition from generic drug manufacturers.[68]

Those countries with national public drug plans are able to use their purchasing power to negotiate lower prices for both brand name and generic drugs. Because they are purchasing these medications for their entire population, they can bargain the price for bulk purchasing, establish budgets, require companies to present competitive bids, bundle the purchase of multiple drugs and so on. The evidence is clear. Those countries with national public drug plans have considerably lower prices than Canada and are far more successful at keeping price increases within reasonable levels.[69]

There are also a wide range of savings to be found in the money going into private plans and pharmacy dispensing fees. The ability of a national government to negotiate lower drug prices and address inequities in dispensing these medications would result in significantly lower health care costs for all Canadians.

When we consider that the companies that manufacture and sell pharmaceuticals are among the largest in the world and represent a multi-trillion dollar industry with global reach, the ability of these companies to influence national regulators, as well as local doctors and pharmacists, is immense. Research has shown that this influence can lead to the overuse and misuse of drugs.

A pharmaceutical company's goal of increased profits does not necessarily go hand in hand with the goals of public health. It is essential that Canada assert real control of drug approval and gain access to information from the pharmaceutical industry.

This would mean a system for independent and transparent assessment and approval of drugs. This would increase the availability of independent information and education for doctors that is based on research rather than sales quotas.

> Pharmacare is not a fake fix; it represents major reform with the potential to positively influence pharmaceutical manufacturers by forcing them to provide stronger evidence of the therapeutic value of their products relative to existing ones. But absent fundamental changes in the way pharmaceutical research is rewarded, shared, and scrutinized, any new formulary will be a half measure.[70]

A national drug plan has been promised by successive governments. And yet, Canada remains one of the few industrialized countries without one. Instead, there is a hodgepodge of provincial and territorial programs providing at best inconsistent coverage. Some provinces have relatively good programs while others do not. Where you live, or where you work, should not be a factor in whether you get the medications you need. Canadians want and need a national public drug plan.

**RECOMMENDATION 10**

### A national public drug plan

Pharmaceuticals are an important part of health care and can often reduce demand for surgeries. Universal first dollar coverage for cost-effective, safe prescription drugs will save money and lives.

## Canadians want to age with dignity

The composition of Canada's population is changing. As has been noted earlier, the population of Canada is becoming older. The impact this will have on our health care system remains to be seen.

In 2010, 14% of Canada's population was 65 or older. As the baby boom generation ages, it is estimated that this proportion will rise to about 25% in 2036.[71]

Suggestions that the trend towards an older population will overwhelm health care are unfounded and somewhat exaggerated. Yes, changes to how we deliver health care will be required. But to suggest that those Canadians who have contributed their whole lives to building this country should expect a lower standard of care as they age is unacceptable.

Aging does not necessarily mean ill health or disability. There are many Canadian seniors who are living healthy and active lives. However, the risk of ill health or disability does increase with age.

> In 2006, 33% of Canadians aged 65 or older had a disability; the proportion climbed to 44% among people aged 75 or older. Nearly three-quarters of Canadians over 65 have at least one chronic health condition.[72]

With the increasing rates of disability and chronic illness, it is expected that the demand for health services will increase as Canada's population ages.

Currently, Canadians over 65 consume roughly 44% of provincial and territorial health care budgets, and governments are concerned about the health care system's capacity to provide quality services in the future.[73]

A study in Ontario found that 5% of the province's patients accounted for almost two-thirds of health spending. Of that group, 1% accounted for almost one-third of health costs. These high-cost users tended to be concentrated in the youngest and oldest patients.[74]

But the costs are less concentrated among the oldest age group. David Henry of the Dalla Lana School of Public Health at the University of Toronto notes that the "majority of over 65s don't cost the health-care system very much. As long as we keep ourselves in good and health, and many people try very hard to do that, then it will work."[75]

The high-cost users of the health care system are primarily those that require hospitalization. An investment in those programs that reduce the need for hospital stays, such as home care and long-term care, as well as a national pharmacare program (see above), can go a long way towards containing health care costs.

Unfortunately, many of the services required by seniors, in particular, home care and long-term care, are not covered by the *Canada Health Act*. As a result, the level of funding and access to services vary widely from province to province.

Home care

Home care has become an important component of the modern health care system. For some, it is help with basic household tasks (this is not health care, but can be the difference between a senior remaining in their home or being institutionalized); for others, it is complicated medical procedures offered in the home; for still others, it is various physical and emotional therapies—and more.

Most Canadians strongly feel that, whenever possible, looking after sick people in their own homes is preferable to institutional care. It's better socially; it's better for the patient's emotional and spiritual health; and it makes good economic sense.

Home care services in Canada are widely used, but the need for in-home support continues to outstrip the availability of services.

- In 2012, there were 2.2 million individuals, or 8% of Canadians 15 years of age and older, who received help or care at home because of a long-term health condition, a disability, or problems related to aging.
- In 2012, nearly half a million Canadians, or 461,000 individuals 15 years and older, needed help or care in the 12 previous months for a chronic health condition, but did not receive it. They are referred to as persons with "unmet" home care needs.
- Of the 2.2 million Canadians who received home care in 2012, 15% (331,000) did not receive all the help needed. They are referred to as persons with "partially met" home care needs.
- Home care recipients with a physical disability were more likely to have partially met needs (18%) than care receivers without a disability (10%).
- Persons with unmet or partially met needs reported higher levels of stress and negative feelings. For example, 62% of care recipients with partially met needs experienced loneliness, compared with 31% of those whose needs were met.[76]

The good news is that home care tends to be a more cost-effective means to deal with Canadian's health care needs than more facility-based interventions:

> The central finding of this study was that, on average, the overall health care costs to government for clients in home care are about one half to three quarters of the costs for clients in facility care, by level of care. A related finding was that costs differ by the type of client. The lowest home care costs were for individuals who were stable in their type and level of care. For clients who died the costs for home care were higher, compared to cli-

> ents in long term care facilities. It was also found that some one half of the overall health care costs for home care clients were attributable to their use of acute care hospital services and that a significant portion of the health costs for home care clients occur at transition points, that is, when there is a change in the client's type, and/or level, of care.[77]

It is undoubtedly true that the low wages and few supports provided to home care workers contribute to some of the cost difference between home care and residential forms of care. However, it appears that home-based health care supports are a cost-effective means of delivering services.

Home care is not an insured service under the *Canada Health Act*. It is considered an extended service (i.e., not medically necessary), and as such, governments are not obliged to provide a minimum basket of services. This also creates confusion about how home care services are funded.

> Funding home care services is challenging for two reasons. The first is location. Home care involves both medical and social care in a home or community setting. When the location of care moves out of the hospital, non-physician services that would have been covered in the hospital no longer need to be—even though they may be deemed "medically necessary." The *Canada Health Act* defines these services in terms of who delivers them (primarily physicians) and where the services are delivered (hospitals).
>
> This traditional view of health delivery becomes problematic, as care is delivered in varied locations. The second reason is that home care encompasses both social and medical services. Home care clients obtain such care for three reasons: acute care substitution, long-term care substitution, and prevention and maintenance. Home care includes care that is not "medical," although it can be valuable—and even essential. This raises the question of which services should or should not be publicly covered.[78]

All of the above results in a hodgepodge of home care services both between provinces and even within a province. Where you live can determine what services are available, how they are funded or underfunded, and differences in service delivery models.

In the 2004 Health Accord, there was an agreement to publicly fund:

- short-term acute home care for a two-week provision of case management, for intravenous medications related to the discharge, diagnosis, nursing, and personal care;
- short-term acute community home care for mental health for a two-week provision of case management and crisis response services; and
- end-of-life care for case management, nursing, palliative specific pharmaceuticals, and personal care at the end of life.[79]

In March 2012, in its review of the 2004 Health Accord, the Standing Senate Committee on Social Affairs, Science and Technology reported that progress had been made in some areas of home care delivery in Canada. However, the focus on acute care, in particular, had sometimes come at the expense of services being provided to those who required chronic care.

Furthermore, the emphasis on a narrow range of home care services did not facilitate the development of those programs that would have been of considerable benefit to many Canadians. The committee found that there is a greater need for the integration of home care services into the broader health care system to better provide a continuum of care.

> In addition, the committee heard that home care needs to be considered an integral part of health-care systems and better integrated with the acute- and primary-care sectors, as well as the full range of continuing care services that includes palliative care and facility-based long-term care. Similarly, the committee found that there is a need to integrate the provision of home care and mental-health services. Finally, the committee agrees with witnesses that governments need to take further action to promote access to high-quality palliative and end-of-life care in Canada in a broad range of settings, as well as raise awareness among Canadians regarding the importance of planning end-of-life care.[80]

Long-term care

Similar to home care, the non-inclusion of long-term care (LTC) under the *Canada Health Act* has created a wide range of services, the availability and cost of which vary considerably between and within provinces and territories.

Of the close to 310,000 people who live in health care and related institutions in Canada, excluding Quebec, approximately 143,000 live in nursing homes. Of these 143,000 residents, the overwhelming majority (more than 90%) are over the age of 65, and there are approximately twice as many women as men.[81]

There are approximately 1,360 nursing homes across Canada, with the exclusion of Quebec. These homes employ around 126,000 full-time employees who provide a wide range of services. "Regulated professionals, including registered nurses, licensed practical nurses or therapists, made up less than half the total hours worked by all staff responsible for providing health services."[82]

There has been a considerable growth in private-for-profit facilities in Canada. In 2012, approximately 44% of all nursing homes were private for-profit agencies. Compare this to the 29% of homes that are operated by non-profits and the 27% of homes that are publicly provided.[83]

The source of funding for these homes is a mix of public and private payment, resulting in a confusing array of different services, prices, and levels of quality available. This is not only between and within provinces but often within a community.

This means that many elderly, in particular, face an uncertain future. For those seniors who are financially secure, there is a range of very good, though expensive, options for long-term care. Others will be faced with a more limited range of residential options.

Where long-term care beds are unavailable, individuals will often face lengthy hospital stays until there is an opening in a long-term care residence. This comes at an enormous expense to the health care system and to the well-being of the individual who needs long-term care; further, it impairs access to hospital services when beds are occupied by those waiting for LTC.

In 2007–2008, 1.7 million hospital bed days were occupied by individuals waiting for long-term care. When you consider that a hospital bed costs approximately $842 a day, while a long-term care bed costs about 20% less than acute care, the financial impact of a lack of long-term care options for Canadians becomes clear. Moving these patients from hospital to long-term care would save about $1.4 billion a year.[84]

However, costs saving is only one rationale for moving people into appropriate long-term care. Hospitals are not intended or suited to provide for the social, emotional, and spiritual health of those who do not need acute care. Quality long-term care facilities are designed, and are best able, to provide for all the needs of an individual requiring that level of care.

> Although commitments to short-term home care have largely been met, this has meant that long-term home care needs, particularly the needs of seniors with multiple chronic conditions, have not received the same degree of attention. Family caregivers' needs also need to be addressed.[85]

It is expected that the demand for home care and long-term care options for older Canadians will increase.

Medicare must be expanded to cover all home care.

What is needed is fundamental change. What is needed is a coherent national strategy that is publicly administered and sufficiently funded to provide an adequate number and mix of staff to offer necessary home care and long-term care services.

## RECOMMENDATION 11

### A national public home care program

Most people want to receive quality care to enable them to remain in their own home for as long as possible. Home care is cost-effective and can ease the stress on acute hospital beds and long-term care facilities. With a national public home care program, people will need fewer hospitalizations or readmissions, require shorter hospital stays, and will be able to delay admission to long-term care.

## RECOMMENDATION 12

### A national public long-term care program

There needs to be a continuum of quality public long-term care residences available to Canadians, depending on their needs. These long-term care residences should

be available in the communities that Canadians live. These residences should be available to Canadians regardless of their ability to pay and at no personal expense.

## Canadians need better access to mental health services

Access to services and supports for Canadians with mental health problems is among the most serious social policy issues confronting the nation. Virtually every Canadian feels the effects of this problem.[86]

The terms *mental illness and addiction* cover a diverse range of disorders that affect an individual's mood, thinking, and behaviour. These can include more common disorders, such as depression, anxiety disorders, schizophrenia, as well as substance abuse, and problem gambling. Symptoms vary from mild to severe, as does the impact on an individual's ability to deal with their environment.

It is estimated that 1 in 5 Canadians will experience a mental health or addiction problem.[87] This means that approximately 7 million Canadians will likely experience a mental health or addiction problem in their lifetime. In the overwhelming majority of cases, the problem will be of a mild nature.

In May of 2012, the Mental Health Commission of Canada, as mandated by the federal government, released the long-awaited *Mental Health Strategy for Canada.* To date, no government in Canada has taken the necessary steps to fully implement the strategy.

Mental health has often been described as one of the "orphan children" of Canada's health care system. It is, for the most part, outside of mainstream health care. The result is a patchwork of programs and services. Government cutbacks and privatization have resulted in many Canadians with mental illnesses feeling abandoned, ignored, and swept under the carpet. There is a crisis in those services that provide support to people suffering with mental health problems. The services are underfunded and overwhelmed.

Without adequate treatment options, many people with mental health problems end up "falling through the cracks." All too often people with mental illnesses come into conflict with the law and find themselves in correctional facilities when appropriate treatment is what they need.

Inadequate access to mental health services means that more people must resort to relying on emergency rooms and hospitals—often when another form of intervention would be better. Not only is this often not in the best interests of the person experiencing a mental health problem, it also means that wait times for other patients become longer.

The national *Mental Health Strategy*, as drafted by the Mental Health Commission of Canada, must be implemented with particular emphasis on the creation of community-based services, staffed by mental health professionals and available at all hours—from coast to coast.

The federal government, working with the provinces, needs to step forward with funding targeted to expanding upon and creating new mental health programs across the country.

### RECOMMENDATION 13

**Implement the *Mental Health Strategy* for Canada**

The ongoing human and economic costs of the lack of supports to people with mental health and addictions problems is a national shame. The 2012 *Mental Health Strategy* for Canada provides positive initial steps towards incorporating mental health fully into Canada's health care system. There needs to be federal investment in helping provinces reach the goals established in the mental health strategy.

## Improving health care for Indigenous peoples in Canada

Addressing the historical wrongs committed against Aboriginal peoples[88] in Canada is one of the priority issues of our times. The landmark report of the Truth and Reconciliation Commission on the creation and operation of residential schools in Canada is but the most recent of a long list of reports and studies. Canadians must support efforts to remedy these historical injustices.

As part of this process, it is vital that the voices and perspectives of Aboriginal peoples be heard and acted upon. Our union's intention is to amplify that voice and the calls to action being expressed by the Aboriginal communities and organizations

that know these issues best. We support immediate action to improve the health care options and outcomes for Aboriginal peoples. What follows is but a brief overview of a large body of important literature.

Any discussion of the health care needs of Aboriginal peoples alone ought to include a review of the social determinants of health. Indeed, there is considerable overlap in how socio-economic status and related factors lead to serious health inequities for Aboriginal peoples and communities in Canada. The fact is, many Aboriginal peoples and communities would be ranked as being among the lowest strata for almost all the factors considered as social determinants of health. However, it would be a mistake to point only to the social determinants of health when discussing the health inequities Aboriginal people and their communities face: it is essential that we also consider the harms wrought by centuries of colonization and racism.

While Aboriginal people in Canada can and do share in experiences of racism similar to other racialized communities, the impact of colonization must also be factored into the discussion. Indeed, lands now considered as Canadian territory are the traditional homelands of these peoples, yet most of them were either outright stolen or inappropriately acquired by European settlers. Underwriting Canada's entire history are government policies that both directly and indirectly promoted the marginalization and oppression of Aboriginal communities.

The role that governments have played in this process cannot be understated. The health inequities between Aboriginal and non-Aboriginal people in Canada are a direct consequence of historical government policies promoting the forced assimilation of Indigenous peoples into white settler society.

> These policies and their enabling laws engendered massive human rights violations through varying means such as segregation, theft of lands, removal of children, and restriction of economic and civic participation. Racism not only justified historic colonization but compounds its contemporary effects contributing to, for example, the obstruction of Indigenous self-determination and failure to recognize treaty and land rights, the lack of access to services and resources, and over-surveillance by criminal justice and child welfare systems.[89]

When considering the well-being of Aboriginal peoples, it is important to remember the manner in which colonization has undermined and disrupted traditional health practices. Prior to European contact, Aboriginal people from all communities had an extensive tradition of healing practices. With contact came a host of diseases

and illnesses previously unknown to Aboriginal peoples. The introduction of these diseases, in conjunction with conflict and violence, resulted in the devastation of many Aboriginal communities.

Many of the experienced practitioners of traditional healing methods died during this period. In addition, government policies of assimilation tried to prevent traditional healers from passing on their knowledge. Only in recent decades has there been some progress made in the recovery of this knowledge and in a restoration of traditional health practices in many Aboriginal communities.

Note that we are not referring to a single group of people with a common history or culture. There are many distinct cultural groups, each with its own history and practices. While it is possible to point to a number of shared or similar beliefs and issues, we must not forget the great diversity that exists among and even within the some 60 Indigenous cultures found in this part of the world. Furthermore, they constitute a large and growing group of peoples. Their economic contribution and impact are essential for everyone's shared future.

According to Statistics Canada, in 2011 there were 1,400,685 people in Canada who self-identified as Aboriginal, approximately 4.3% of the total population.[90] However, population growth of Aboriginal peoples is projected to be higher than for non-Aboriginal people over the next several decades. It is estimated that by 2036, the Aboriginal population will be between 1,965,000 and 2,633,000.[91] Also, according to projections, the overall Aboriginal population will be younger than the non-Aboriginal population by 2036. The median age of Aboriginal people, which was 27.7 years in 2011, would be between 34.7 years and 36.6 years in 2036.[92]

A growing proportion of the Aboriginal population resides in urban areas. According to 2011 Census data, Aboriginal people who do not live on reserve constitute the fastest-growing segment of Canadian society. In 2011, 56% of Aboriginal people lived in urban areas, up from 49% in 1996.[93]

Despite some gains, a substantial gap persists between Aboriginal people and non-Aboriginal people in a wide range of socio-economic factors in Canada. However, there are some important internal differences we must keep in mind too: the differences in socio-economic circumstances and living conditions among First Nations, Inuit, and Métis peoples; the socio-economic differences between Status and Non-status First Nations people, between those living on a reserve and those living off a reserve; and the socio-economic differences between rural and urban.[94]

While it is easy to look at Aboriginal peoples in Canada and see impoverishment and deprivation, one must also look to the examples of resistance and struggle. Many communities have made remarkable achievements when confronted by the force of racism and policies of colonization. There have been strong community leaders and activists who have managed to chart unique paths for many Aboriginal people. The cultural contributions of Aboriginal artists and performers have been incredible.

Still, many of the statistics pertaining to the social determinants of poor health for Aboriginal peoples are disturbing, for example:

- Fewer Aboriginal people between the ages of 25 and 34 obtained high school diplomas (68.1%) than non-Aboriginal people (90.0%).
- The 2005 median income for Aboriginal people was almost $10,000 lower ($16,752) than for non-Aboriginal people ($25,955).
- Despite a 10% increase in Aboriginal employment between 1996 and 2000 (compared to a 4.1% increase in non-Aboriginal employment during the same time period), the unemployment rate for Aboriginal people in 2006 was still more than twice that for non-Aboriginal people (13.0% compared to 5.2%).
- The First Nations Regional Health Survey (RHS) in 2008/10 showed no improvements in household income from 2002/03, and in fact observed an increase in low-income levels for First Nations communities.
- In 2006, 11% of Aboriginal people lived in homes with more than one person per room, a decline of 6% since 1996. Overcrowding is particularly acute for First Nations people on a reserve, where approximately 26% live in crowded homes; and for Inuit, where 36% of the population reported living in crowded homes. Almost half (49%) of Inuit in Nunavik reported lived in crowded dwellings.[95]
- Aboriginal people were three times as likely as non-Aboriginal people to live in houses in need of major repair, and over 22% of dwellings in Aboriginal communities in 2 provinces and 3 territories (Saskatchewan, Manitoba, Northwest Territories, Yukon, and Nunavut) were in need of major repair in 2006, compared with an average of 7.0% in non-Aboriginal communities in Canada.

As a result of conditions such as these, Aboriginal peoples experience major health problems at rates much higher than non-Aboriginal populations. The National Collaborating Centre for Aboriginal Health (NCCAH) summarized the situation of Aboriginal peoples well in their 2012 report *The State of Knowledge of Aboriginal Health: A Review of Aboriginal Public Health in Canada*:

> High infant and young child mortality; high maternal morbidity and mortality; heavy infectious disease burdens; malnutrition and stunted growth; shortened life expectancy; diseases and death associated with cigarette smoking; social problems, illnesses and deaths linked to misuse of alcohol and other drugs; accidents, poisonings, interpersonal violence, homicide and suicide; obesity, diabetes, hypertension, cardiovascular, and chronic renal disease (lifestyle diseases); and diseases caused by environmental contamination (for example, heavy metals, industrial gases and effluent wastes).[96]

The NCCAH lists some of these chronic and urgent health concerns:

- In Canada, Aboriginal people remain disproportionately affected by HIV, with it being estimated that Aboriginal people are close to 12.2% of new HIV infections and 8.9% of those living with HIV.
- Disproportionate rates of tuberculosis: 26.4 times the rate of Canadian-born non-Aboriginal people.
- Type 2 diabetes is now considered to have reached "epidemic" levels in First Nations communities, where adults are 4 times more likely to have Type 2 diabetes than non-Aboriginal people.
- In some communities, youth suicides occur at a rate 800 times the national average; the suicide rate among Inuit communities in Arctic Canada is 10 times that of the non-Aboriginal Canadian population.
- Violence against Aboriginal women is also considered to have reached epidemic proportions in many parts of the country, with Aboriginal women 3.5 times more likely to experience violence than non-Aboriginal women.
- The RCMP reports that between 1980 and 2012, at least 1,017 women and girls identified as Aboriginal people were murdered—a homicide rate approximately 4.5 times higher than that of all other women in Canada.
- Aboriginal peoples in Canada are also disproportionately affected by environmental contamination, particularly in Arctic regions where the traditional food sources of Inuit populations have accumulated environmental toxins, leading to a variety of health problems.[97]

Again, it should be noted that there are those within the Aboriginal population who are more vulnerable to health concerns than others. In particular, Aboriginal seniors are frequently poorer and live in more remote and impoverished conditions than the young. The Health Council of Canada noted that

> the health needs of Aboriginal seniors are magnified by determinants of health such as poverty, poor housing, racism, language barriers, and cultural differences . . . . The result is that Aboriginal seniors have more complex health needs but are often living in regions where it is more challenging and expensive to provide care.[98]

Aboriginal people in Canada access health care services through a variety of means. This includes the standard mainstream Medicare system. In addition, there are a range of clinics and practitioners funded through both the federal and the provincial-territorial governments. In addition, Status First Nations and Inuit people can access a number of health supports (i.e., medications, dental, and vision care) through the Non-insured Health Benefits (NIHB) program as well as through provincial and work-based plans.

However, the NIHB is not a comprehensive program and many face barriers when trying to access benefits.

The NIHB program provides medical goods and services for Status First Nations and Inuit people. The NIHB excludes Métis and Non-Status First Nations. It also presents barriers to those who are eligible by requiring residency on a reserve for some services, continually curtailing approved medications and treatments, and limiting access due to changes in onerous approval processes. Moreover, the delivery of NIHB poses challenges to equitable access to health services, particularly in northern and remote communities, in comparison to delivery and access experienced by non-Aboriginal people.[99]

We must not shy away from the fact that racism in the health care system is a barrier to Aboriginal people receiving timely and appropriate care. In a series of meetings conducted by the Health Council of Canada in the spring of 2012, the need to create culturally competent care and culturally safe environments for Aboriginal people in urban health care services was apparent.

> [As] participants discussed at our meetings, one of the barriers to good health lies squarely in the lap of the health care system itself. They told us that many Aboriginal people don’t trust—and therefore don’t use—main-

> stream health care services because they don't feel safe from stereotyping and racism, and because the Western approach to health care can feel alienating and intimidating.[100]

As we have seen, there are considerable challenges facing various levels of government when it comes to setting right the relationship with Aboriginal peoples in Canada and then moving forward to improve health outcomes for these communities. It is not as straightforward as improving the delivery of health care services. It must also take into consideration a wide range of political, cultural, socio-economic and health policies. Among these will be finding ways in which traditional health practices of Aboriginal peoples can be integrated into the contemporary medical system. This will require a cultural shift within the traditional health care system.

## RECOMMENDATION 14

### Indigenous communities must be consulted on new Health Accord

The scope and breadth of the health crisis confronting Aboriginal peoples in Canada makes simple fixes impossible. The first step must be to engage these communities in the discussions around a new Health Accord. This must include consultations with community leaders and experts, as well as public gatherings within the affected communities.

## RECOMMENDATION 15

### Not just hospitals and clinics

Improving access to basic health care services is an essential step in addressing the health crisis that exists in Indigenous communities. However, there also needs to be steps taken to deal with the discrimination and racism directed at Indigenous people within Canada, as well as at the poverty and living conditions in urban, rural, and remote communities.

## Social determinants of health

The link between individual behaviours and health is well known. The role that diet and exercise play in maintaining health has been well established. Few would deny the negative effects on their health of cigarette smoking or excessive drinking of alcohol.

However, it is becoming more and more apparent to researchers that there is a wide range of socio-economic factors that play a considerable role in an individual's health. Factors such as income level, race, gender, and geographic location can have a significant impact on people's lifespan and health outcomes. These are usually referred to as the social determinants of health (SDH).

The role that social and economic factors play in population health cannot be understated.

Research suggests that 15% of the population's health is determined by biology and genetics, 10% by physical environments, 25% by the actions of the health care system, with 50% being determined by our social and economic environment.[101]

Possibly one of the most dramatic examples of the impact that the social determinants can have on health is found in the work of epidemiologists at McMaster University's Department of Medicine as part of the *Code Red* research project.

When comparing 135 neighbourhoods in Hamilton, Ontario, a shocking 21 years' difference in lifespan was found between poor and rich neighbourhoods. In the city's poorest neighbourhood, residents died at an average of 65.5 years of age. A mere 5 kilometres away, wealthier Hamiltonians tended to live beyond 86 years. This is a 21-year difference in lifespan, between rich and poor, within one Ontario city.[102]

Similarly, *Code Red* found that in the poorest neighbourhoods of Sudbury, Ontario, instances of teenage pregnancy were 205 per cent higher; infant mortality, 139 per cent higher; and premature death, 86 per cent higher.[103]

The Saskatoon Health Region also looked at health disparities in the city. When comparing 6 low-income neighbourhoods with their wealthier cohorts the health region found that the rate of infant mortality was 448 per cent higher; teenage pregnancy 1,549 per cent higher; and suicide attempts 1,458 higher.[104]

These staggering figures challenge many of the long-held beliefs in fairness and equality held by the majority of Canadians. In the 2010 paper *Social Determinants of Health: The Canadian Facts*, the authors noted that

> Canadians are largely unaware that our health is shaped by how income and wealth is distributed, whether or not we are employed, and if so, the working conditions we experience. Furthermore, our wellbeing is also determined by the health and social services we receive, and our ability to obtain quality education, food and housing, among other factors.[105]

These findings have been replicated in neighbourhoods across Canada (with various levels of difference) on a wide range of issues. The research is conclusive that income disparities play a significant role in population health.

However, income is but one of the social determinants of health that has received attention. It is true that income disparity and poverty are strongly related to most of the other issues studied.

Examples of other social determinants of health that are directly related to income level are education, unemployment, job security, working conditions, food insecurity, and housing. The research has shown a strong connection between disparities in these factors and health outcomes.

There are also a number of social determinants that cannot be solely connected to disparities in income because the relationship is more complicated. These would include health disparities identified as related to the racial identity of people, their gender or sexual orientation, disability or geographic location.

The impact on the health care system of disparities in the social determinants of health is considerable. Research indicates that there is an increased incidence of major illnesses among those in the lowest socio-economic groups.[106]

For example, research suggests that diabetes is much more prevalent in poor and visible minority communities.[107] According to a 2009 report from the Canadian Diabetes Association

> the economic burden of diabetes in Canada is expected to be about $12.2 billion in 2010, measured in inflation adjusted 2005 dollars. This is an increase of $5.9 billion or nearly double its level in 2000. The cost of the disease is expected to rise by another $4.7 billion by 2020. The direct cost

of diabetes now accounts for about 3.5% of public healthcare spending in Canada and this share is likely to continue rising given the expected increase in the number of people living with diabetes in Canada.[108]

Research further indicates that those in the lower socio-economic status visit their general practitioner more often and are higher users of mental health and hospital services. In addition, those in the lowest-income groups were almost twice as likely as those in the higher-income groups to visit the emergency department.[109]

The increased rate of visiting hospital emergency is probably a consequence of the barriers faced by lower-income people in accessing many medical services. People in the lowest socio-economic status are less likely to see a specialist, more likely to wait longer to see a physician, likely to make fewer visits to the dentist, and are more likely to not fill their prescriptions.[110]

As a result, the cost of providing health services to lower-income Canadians is disproportionate when compared with their wealthier neighbours. A 1994 report from Manitoba showed that health expenditures for those in the lowest 10% of income earners were more than twice the cost of the 10% with the highest incomes. A 2011 report from a Saskatoon anti-poverty organization found that an additional $179 million in health spending was for lower-income earners compared to middle-income earners.[111]

Where the social determinants of health differ from other health-related issues is that they are overwhelmingly connected to Canadian social policy. While one may argue that many individual health behaviours can be changed through choosing different lifestyle options (though with regard to diet and some other factors this might be debated), this is not true for most social determinants of health.

And contrary to the assumption that Canadians have personal control over these factors, in most cases these living conditions are—for better or worse—imposed upon us by the quality of the communities, housing situations, our work settings, health and social service agencies, and educational institutions with which we interact.[112]

The role that public services and social policy play in mitigating many of the social determinants of health is important to remember.

One example of how progressive social policy can lead to positive outcomes in the social determinants of health is in the implementation of family-focused policies that include publicly provided child care and early childhood education programs.

Accessible and affordable public child care programs can play a significant role in improving maternal employment rates, thus alleviating child poverty, and in establishing healthy work-life balances for parents.

The example of Quebec's family policy is notable.

It includes an integrated child allowance, enhanced maternity and parental leave, extended benefits for self-employed women, and subsidized early childhood education and child care services. Through this policy, the province has been able to establish a network of child care centres for children aged four years and younger from existing non-profit daycare centres and home agencies. The centres offer low-cost care and are no cost for parents on social assistance. Elementary schools in the public system also provide low-cost before- and after-school care and full-day kindergarten is provided to all five-year-olds. In addition, some school boards offer full-day kindergarten to four-year-olds from low-income families.[113]

The successes of the program for women's employment have been well established.

Women's labour force participation in Quebec has increased at a faster rate than in the rest of Canada (since 1997). Several economic studies have found that a significant portion of this increase in employment levels is directly attributable to the affordability and accessibility of childcare in Quebec. Women's employment rates also held steady during and after the 2008 recession in Quebec, in contrast to women's employment in Ontario, for example. This suggests that consistent access to affordable childcare played an important role in lessening the impact of the economic downturn on families in Quebec.[114]

The Quebec program has also contributed to a decline in maternal and child poverty rates in the province.

Single mothers of young children in Quebec have seen their employment rates increase from 38% in 1996, the year prior to the introduction of the program, to 68% in 2014. Single female parent households have also seen their poverty rates decline from 52% in 1996 to 31% by 2011—moving 104,000 single mothers and their children out of poverty.[115]

The work-life balance of many Quebec families has improved. This includes an increase in fathers' taking parental leave under the program.[116]

Universal child care promotes the work/life balance of couples, benefiting their employment and income generation and associated family welfare.[117]

There is evidence that poor work-life balance is associated with higher stress levels for women and families.

The impacts of this are being seen in higher rates of absenteeism due to illness and stress, and a strong decline in levels of life satisfaction; with only 23% of workers feeling high levels of satisfaction. (Compared with 45% in 1991.)[118]

Reduced poverty and the reduction of stress associated with improved work life balance is most likely to lead to improved health outcomes for families.

Unfortunately, most of Canada does not have as progressive a set of child and family policies as Quebec does. Indeed, the 2006 report *Starting Strong* from the Organisation for Economic Co-operation and Development (OECD) looking at early child care and learning programs found that, of the 20 developed countries studied, Canada ranked lowest in both access to services and public investment.

Most European countries provide all children with at least two years of free, publicly funded provision before they begin primary school… other than Quebec, there has been no significant expansion of the [early care and learning] system in Canada over the past decade. Less than 20% of [Canadian] children aged 0–6 years find a place in a regulated service.[119]

Clearly, a federally mandated set of policies for assisting families, including universal public child care, would be of considerable benefit by increasing women's employment, decreasing child poverty, and improving the work-life balance for many parents.

Governmental social policies have a direct impact on the social determinants of health. How a government—either municipal, provincial, territorial, or federal—decides to focus its regulatory legislation and funding can influence health across the country. For example, implementing employment laws that provide employment security and benefits for the duration of jobs, or if these jobs end, deciding whether to fund early child development programs or supports to seniors, foster care programs, or continuing education can have very different health impacts upon different segments of the population. Those whose SDH needs are left to the whims of the employment market may suffer negative health consequences as a result.[120]

The Canadian Medical Association (CMA) agrees that the social determinants of health can have a larger impact on individual and population health than the health care system. The CMA also believes that any actions to improve health and tackle health inequity must address the social determinants and their impact on daily life.[121]

In many ways this is not new information to Canadians. The great strides that took place in Canada's public health in the 19th and 20th centuries were primarily from public infrastructure and sanitation services. Clean water, garbage removal, and improved housing are a few obvious examples of how changes in public living conditions have improved the health of Canadians. Past governments, recognizing the need for these measures, acted to ensure their implementation.

But how best to proceed? There is a question of how much the negotiations for a new Health Accord should take these issues into consideration. The Health Accord is primarily an agreement between the federal government and its provincial and territorial counterparts for funding the delivery of formal health care services. Many measures to address the social determinants of health would more properly be funded under the Canada Social Transfer (CST).

One aspect of this is that health policy experts and health professionals are not necessarily the most knowledgeable people on many of these matters. Poverty or inadequate housing are social policy issues for which there are advocates and researchers who are better able to propose progressive public options.

Furthermore, as we have discussed, there is a large number of social programs, not covered under health, that play a significant role in the health outcomes of Canadians. These include social assistance, education, child care, and community services to name just a few.

The National Union has written extensively on these issues and has developed a number of proposals for the expansion and improvement of Community Services that we believe would go a long way towards addressing many of the disparities in the social determinants of health.[122]

It seems appropriate here to include a brief summary of the proposals from the National Union aimed at rebuilding a strong, enforceable role of the federal government in the provision of social services across Canada. Those who wish more information, please consult the above referenced document (i.e., in note 105).

- Guaranteed Annual Income Program

Canada spends approximately $75.8 billion annually on a complex system of income support, consisting of a wide range of national and provincial means-tested income programs and complex web of tax credits. However, unlike community services, this wide array of income support programs at the federal and provincial levels to help people living in poverty have not played an effective role at eliminating poverty.

The fact is that most of Canada's income support system is largely based on a short-term spending model that has not been able to bring down poverty rates, has a mixed record of improving well-being, and greatly contributes to indirect poverty costs.

It's time to put the concept of a guaranteed annual income (GAI) back on Canada's public policy agenda. GAI is basically a cash transfer from government to citizens designed to provide income at a level sufficient to meet basic needs and live with dignity, regardless of work status. It is based on the vision of universal income security through ensuring that everyone receives a modest, but adequate income.

This is not a new idea for Canada and in fact has gained increased popularity in recent years with support from across the ideological spectrum.

- Divide the current CST into three separate transfers to clarify what funds are for:

* *Canada Education Transfer* (CET)—to cover a portion of the cost of providing post-secondary education in the provinces and territories.

* *Federal Income Support Transfer* (FIST)—to cover a portion of the costs of provincial and territorial social assistance programs, equal to the percentage amount (69.2%) of the current CST that the federal Department of Finance has calculated is spent on social assistance programs.

* *Canada Community Services Transfer* (CCST)—to provide dedicated federal funding towards the cost of the provinces and territories providing social assistance and a range of community services to support their citizens.

* NUPGE proposes that, at a minimum, the amount of the new CCST annual funding be equal to (in 2015 dollars) the amount that the federal government last transferred to the provinces and territories in 1996 under the Canada Assistance Plan (CAP).

- Creation of a Canada Community Services Act (CCSA):

  * The CCSA would be dedicated solely to federal funding of provincial–based social assistance programs and community services in which the authority and responsibility of the federal, provincial, and territorial governments are set out with respect to the new expanded CCST. The CCSA would establish conditions attached to the new CCST funding, as well as procedures and mechanisms for holding federal, provincial, and territorial governments accountable for expenditures and adherence to national standards.

- Establishment of a Canadian Community Services Council

  * The Council would ensure monitoring, compliance, and enforcement of the objectives, purposes, national standards, and conditions outlined in the CCSA.

## Need for equity in health care

The Canadian population is remarkably diverse. This is true for the racial, ethnic, and religious backgrounds making up the Canadian mosaic. That diversity is further enriched by the growing public expressions of differences in sexual orientation and gender identification. There are also those Canadians with physical and intellectual disabilities that are calling out for greater inclusion in our society.

While not without difficulties, the public acceptance of this diversity is a testament to the progressive values of Canadians. However, there remains a considerable gap between acceptance of diversity and societal changes to accommodate it.

Looking at the data from the 2006 World Values Survey, the Conference Board of Canada reported that

> Canadian organizations that participated in the survey stated a strong commitment to diversity, but their performance on diversity-related measures (such as representation rates, integrated strategic plans, and diversity-related investments, activities and initiatives) is mediocre. There is a gap between policy and performance, with many organizations failing to follow through on their stated commitment to diversity with initiatives and practices that foster and sustain diverse and inclusive work environments.[123]

While it is likely that the situation is somewhat improved from 2006, there is more that needs to be done. This is especially true when it comes to accommodating these equity-seeking groups in the health care system.

This is obviously a topic that requires extensive research and discussion. As such it is beyond the scope of this paper. What this paper seeks to do is identify why special consideration of the health care needs of equity-seeking groups is necessary.

The topic is made all the more complicated as people belong to multiple social identities. There is a huge way in which people's race, gender, and gender identification, sexual orientation, ability, immigration status, socio-economic status can all intersect. Within all communities there is a breathtaking range of diversity.

> Intersectionality is the study of intersecting social identities and related systems of oppression, domination or discrimination. Complementing health equity, this approach seeks to examine how various biological, social and cultural categories, such as gender, race, class, ability, sexual orientation, religion, age, and other axes of identity interact on multiple and simultaneous levels.[124]

There is also the risk in these discussions of dedicating insufficient attention and discussion to a particular equity-seeking group or to over simplify what are complex and important differences.

While there is some overlap between discussions of the social determinants of health and of those inequities that arise out of issues of race, ethnicity, gender and gender identification, sexual orientation, immigration status, and disability, there are also significant differences. As we have seen, the social determinants of health do lead to large disparities in health within the Canadian population.

However, there are disparities in access to health services and in health outcomes that are more to be found in social expressions of racism, sexism, homophobia, transphobia, and ableism than in differences in economic status.

With regards to racism, in a literature review by the Wellesley Institute, they indicate that

> a significant cohort of researchers in the area of health inequities has argued that while race and socio-economic status are indeed correlated, they nonetheless constitute discrete predictors of health status.[125]

Similarly, a joint submission by the Association of Ontario Health Centres and Rainbow Health Ontario stated that

> like other marginalized groups, LGBT people experience specific health disparities compared with the general population as a result of specific needs that may be different and also as a consequence of discrimination and social isolation. This extends to the health system itself.[126]

The lack of health services for LGBT people is reflected in the amount of training health professionals receive to work with these individuals. A study of North American medical schools found that, on average, only 5 hours total was spent on training for LGBT health issues.[127]

One particularly glaring example of the lack of access to health care services is for Canada's transgender population.

> Trans people tend to experience the greatest difficulty in obtaining respectful and appropriate health care due to their specific needs and the high levels of discrimination in society at large.[128]

A fire at Centre Métropolitain de Chirurgie, Canada's only clinic providing gender reassignment surgery, highlights the lack of services for this population.[129] While most provincial health insurance plans cover the cost of the surgery not all procedures are necessarily included and this does periodically change.[130] However, travel related costs are rarely covered.

Of course, women are the largest equity-seeking group in Canada. While women make up slightly more than half of the population there remain significant differences in women's incomes and in access to a range of public services.

> Women in Canada experience more adverse social determinants of health than men. The main reason for this is that women carry more responsibilities for raising children and taking care of housework. Women are also less likely to be working full-time and are less likely to be eligible for unemployment benefits. In addition, women are employed in lower paying occupations and experience more discrimination in the workplace than men. For these reasons, almost every public policy decision that weakens the social safety net has a greater impact on women than on men.[131]

These social determinants of health play a significant role in women's health outcomes.

> In Canada, women with less than a high school education and those whose household income was in the lowest income quintile were much more likely to report being a smoker, obese, diagnosed with high blood pressure, diabetes or a mood disorder, compared with women with a bachelor's degree or whose household income was in the highest quintile.[132]

While on average women live longer than men, this does not indicate overall better health than men.

> However, the higher mortality rate and lower life expectancy of men does not mean that women enjoy superior health. Women have more episodes of long-term disability and chronic diseases than men. On the other hand, men are more prone to accidents and extreme forms of social exclusion which reduce their overall life expectancy.[133]

There is also evidence that for some health conditions, medical professionals frequently misdiagnose and undertreat women.

> Across Canada, vast numbers of women are misdiagnosed and undertreated because they and many of the health-care professionals around them don't recognize the symptoms of heart disease in women or understand the risks.[134]

It is unfortunate that historically concerns about women's specific health issues has not been given the importance they merited. The low priority that many governments have placed on research and measures for health equality for women can be demonstrated in the 2013 cutting of federal funding to Health Canada's Women's Health Contribution Program (WHCP). Ultimately this cut in funding led to the closure of the Canadian Women's Health Network, as well as the Centres of Excellence for Women's Health across Canada, and of four other organizations researching issues pertaining to women's health.[135]

It is worth noting that women represent the majority of employees of the health care system.

> Women also comprised 55.2% of doctors, dentists and other health professionals in 2009, up from 43.1% in 1987. Similarly, 72.5% of professionals working in social sciences or religion in 2009 were women, compared with 61.4% in 1987.[136]

As a result, changes to the health care system affect women both as consumers of medical services and as the providers. This means that all policy discussions about health care should include a gender analysis.

For people with disabilities and the deaf, the range of health inequalities is staggering.

> A Canadian national survey found that adults with disabilities reported more than three times as many unmet health needs as the nondisabled population. Further people with one type of disability, (e.g. intellectual disabilities) are more likely to have additional disabilities (e.g. physical, mental health, communication disorders etc.) making them more vulnerable to poor health and often leading to difficulty in communicating the nature of their health issues. In addition, poverty rates are exceptionally high among people with disabilities, creating additional barriers to nutrition, medical care and other resources. A disproportionate number of women with disabilities live in congregate care living arrangements such as group homes or institutions where they experience high stress factors and are at a higher risk of infections associated with ulcers and gastric cancer.[137]

There is considerable evidence about how people with disabilities have a poorer experience with the health care system. A survey conducted by the Canadian Human Rights Commission found that people with disabilities reported poorer availability of health care services than their non-disabled counterparts. Also, despite reporting a greater need for health information and ongoing care, most had difficulty acquiring the supports they required.[138]

Again, this is not intended as an extensive look at the research on inequality in access to health care or health inequities for equity-seeking groups. However, the paper is suggesting that it is clear that greater attention need to be paid to these issues. Further research needs to be conducted on a broad range of issues concerning equity-seeking groups and access to health care.

## RECOMMENDATION 16

### Restore funding to research on women's health

Health Canada should restore funding to the Women's Health Contribution Program (WHCP). This renewed funding should then be used to reopen the Canadian Women's Health Network, as well as the Centres of Excellence for Women's Health across Canada. Funding should also go to organizations researching issues pertaining to women's health.

## RECOMMENDATION 17

### Health supports for transgender people

The federal government should provide ongoing funding to the provinces and territories to enable them to provide high quality, publicly delivered health care services and supports to transgender people. This should include gender reassignment surgery and procedures, as well as the costs associated with accessing these services.

# Conclusion

Canadians remain deeply committed to their national public health care program. Indeed, polls that have been conducted on Canadians' attitudes towards Medicare have consistently shown that they want it improved and expanded upon. It is also true that they do not want people's ability to pay, or where they live, to have an impact on the accessibility or quality of health care available.

Canada's health care system stands at a crossroads. The effects of the 1995 federal budget are still being felt. While the 10-year Health Accord reached in 2004 contributed towards restoring the system, the lack of a successor accord and the failure to address significant needs, including mental health and the health inequities faced by Aboriginal peoples, mean much more remains to be done.

It is also true that the health care needs of Canadians in 2016 are not necessarily the same as those of our grandparents. Demographic changes have shifted the demand for services. While predictions that the aging "boomer" generation will make public health care unsustainable are exaggerated, there do need to be changes in how services are delivered.

Finally, there have been dramatic advances in the science of medicine. New diagnostic technologies, advances in treatment options, and improved medications have changed the capabilities and the expectations of our health care system and the ways in which Canadians' health concerns are addressed.

A Health Accord between the federal government and provinces and territories is primarily a funding agreement. But it can also be a blueprint for the future. The federal government can— and MUST— use its ability to provide resources to provincial and territorial health systems to defend and expand these services for Canadians.

We offer these proposed recommendations in the spirit of ensuring that good quality public health care is available for future generations.

## SUMMARY OF RECOMMENDATIONS

### RECOMMENDATION 1

**Promised health program initiatives should receive additional funding**

The promise of $3 billion for home care should not come at the expense of total federal funding to health care. This should be additional new monies from what is contained in the CHT.

### RECOMMENDATION 2

**Negotiate with provincial and territorial governments using the 3 priorities**

The federal government must continue the process of fair and open negotiations with their provincial and territorial counterparts to achieve a new Health Accord. The federal government is urged to adopt 3 priorities in their negotiations:

1. stable and sufficient funding for health care;
2. sufficient federal funds to have a meaningful voice in provincial and territorial health care delivery;
3. national standards to be attached, in addition to the principles of the *Canada Health Act*, to increased funding, and ensure that they are followed.

### RECOMMENDATION 3

**Develop accountability mechanisms**

An independent public accountability system would track public funds in health care in order to monitor how much is going to investor-owned private for-profit health care, home care, and long-term care, as well as track health outcomes to assess the financial cost or benefit to Canadians.

## RECOMMENDATION 4

### Minister of health must monitor and enforce the *Canada Health Act*

The federal minister of health must correct the deficiencies in monitoring, reporting, and enforcing the *Canada Health Act*. In particular, the ban on queue-jumping, user-fees and extra-billing by doctors, other health providers, and corporate entities must be strictly enforced. Violations must result in financial penalties.

## RECOMMENDATION 5

### Enact *Whistleblower* legislation

The federal government should enact legislation to protect whistleblowers who report violations of the *Canada Health Act*. This legislation would need to be accompanied by an administrative process for individuals to make these reports, in a safe manner, to CHA inspectors.

## RECOMMENDATION 6

### Public administration must also mean public delivery

It seems incongruent that the *Canada Health Act* would mandate that federal monies allocated for health care be publicly administered but not necessarily publicly delivered. The federal government needs to interpret the *Canada Health Act* so as to prohibit the private for-profit delivery of health care.

## RECOMMENDATION 7

### Remove the P3 screen for federal funding and close PPP Canada

Public-Private Partnerships have been shown to be a poor option for governments when delivering important health and social services. The previous federal government introduced an expectation that federal funds for some projects must use the P3

model. This screen should be removed from all federal funding initiatives. Furthermore, the agency PPP Canada, established by the previous federal government to facilitate the adoption of P3s, should be closed and its funding reallocated.

## RECOMMENDATION 8

### More health professionals

Our public health care system is confronted by a serious shortage of health professionals. We need a pan-Canadian strategy to recruit, train, and retain more health professionals.

## RECOMMENDATION 9

### Create a Pan-Canadian Health Human Resources Agency

The development of a Pan-Canadian strategy for health human resources will require a review of the research, insights, and precedents—from both local and international sources. There is a lot that can be learned from international examples of innovative approaches to health workforce planning and deployment. A Pan-Canadian Health Human Resources Agency, operating with the cooperation of provincial and territorial health systems, could play a considerable role in conducting research and liaising with other such agencies around the world.

## RECOMMENDATION 10

### A national public drug plan

Pharmaceuticals are an important part of health care and can often reduce demand for surgeries. Universal first dollar coverage for cost-effective, safe prescription drugs will save money and lives.

## RECOMMENDATION 11

### A national public home care program

Most people want to receive quality care to enable them to remain in their own home for as long as possible. Home care is cost-effective and can ease the stress on acute hospital beds and long-term care facilities. With a national public home care program, people will need fewer hospitalizations or readmissions, require shorter hospital stays and will be able to delay admission to long-term care.

## RECOMMENDATION 12

### A national public long-term care program

There needs to be a continuum of quality public long-term care residences available to Canadians depending on their needs. These long-term care residences should be available in the communities that Canadians live. These residences should be available to Canadians regardless of their ability to pay and at no personal expense.

## RECOMMENDATION 13

### Implement the *Mental Health Strategy* for Canada

The ongoing human and economic costs of the lack of supports to people with mental health and addictions problems is a national shame. The 2012 *Changing Directions, Changing Lives: A Mental Health Strategy for Canada* provides positive initial steps towards incorporating mental health fully into Canada's health care system. There needs to be federal investment in helping provinces reach the goals established in the mental health strategy.

## RECOMMENDATION 14

### Indigenous communities must be consulted on new Health Accord

The scope and breadth of the health crisis confronting Aboriginal peoples in Canada makes simple fixes impossible. The first step must be to engage these communities in the discussions around a new Health Accord. This must include consultations with community leaders and experts as well as public gatherings within the affected communities.

## RECOMMENDATION 15

### Not just hospitals and clinics

Improving access to basic health care services is an essential step in addressing the health crisis that exists in Indigenous communities. However, there also needs to be steps taken to deal with the discrimination and racism directed at Aboriginal peoples within Canada, as well as at the poverty and living conditions in urban, rural and remote communities.

## RECOMMENDATION 16

### Restore funding to research on women's health

Health Canada should restore funding to the Women's Health Contribution Program (WHCP). This renewed funding should then be used to reopen the Canadian Women's Health Network, as well as the Centres of Excellence for Women's Health across Canada. Funding should also go to organizations researching issues pertaining to women's health.

## RECOMMENDATION 17

### Health supports for transgender people

The federal government should provide ongoing funding to the provinces and territories to enable them to provide high quality, publicly delivered health care services and supports to transgender people. This should include gender reassignment surgery and procedures, as well as the costs associated with accessing these services.

# Endnotes

[1] A. Vittor, “To Tackle the Zika Virus, Alleviate Urban Poverty,” *New York Times*, January 2016, http://www.nytimes.com/roomfordebate/2016/01/29/how-to-stop-the-spread-of-zika/to-tackle-the-zika-virus-alleviate-urban-poverty
[2] World Health Organization, *Factors that contributed to undetected spread of the Ebola virus and impeded rapid containment*, January 2015, http://www.who.int/csr/disease/ebola/one-year-report/factors/en/
[3] R. Williamson, “Focus: The Hidden Tragedy Behind Ebola,” *SciDevNet*, 2014, http://www.scidev.net/global/disease/analysis-blog/the-hidden-tragedy-behind-ebola.html
[4] Canadian Institute Health Information, *Publicly Financed Health Care in Canada: Who Pays and Who Benefits Over a Lifetime?* May 2013, https://secure.cihi.ca/free_products/Lifetime_distEffects_overview_EN.pdf.
[5] This short history comes primarily from the Canadian Museum of History’s online resource http://www.historymuseum.ca/cmc/exhibitions/hist/medicare/medic01e.shtml.
[6] The Romanow Commission followed on earlier public inquiries on the delivery of health care in Canada. Most notable was Emmett Hall’s 1964 Royal Commission on health care in Canada which recommended the nationwide adoption of Saskatchewan’s system of public insurance for both hospitalization and out-of-hospital medical services. There was also the National Forum on Health, conducted between 1994-1997, led by Tom Noseworthy.
[7] Report of the Council of the Federation Working Group on Fiscal Arrangements, *Assessment of the Fiscal Impact of the Current Federal Fiscal Proposals*, July 2012, http://canadaspremiers.ca/phocadownload/publications/cof_working_group_on_fiscal_arrangements_report_and_appendices_july.pdf.
[8] G. Marchildon and H. Mou, “A Needs-Based Allocation Formula for Canada Health Transfer,” *Canadian Public Policy*, September 2014.
[9] Report of the Council of the Federation Working Group on Fiscal Arrangements.
[10] G. Marchildon and H. Mou, “The Conservative 10-Year Canada Health Transfer Plan: Another Fix for a Generation?” In *How Ottawa Spends, 2013-2014: The Harper Government: Mid-Term Blues and Long-Range Plans*, Publisher: McGill-Queen’s University Press, Editors: Christopher Stoney, G. Bruce Doern, pp.47-63.
[11] G. Marchildon and H. Mou, “A Needs-Based Allocation Formula.”
Liberal Party of Canada, *A New Plan for a Strong Middle Class*, 2015, http://s3.documentcloud.org/documents/2448348/new-plan-for-a-strong-middle-class.pdf.
[13] OECD has 34 member countries that include many of the world’s most advanced countries but also emerging countries like Mexico, Chile and Turkey.
[14] Organisation for Economic Co-operation and Development (OECD), *How does Canada compare?* OECD Health Statistics 2014, *http://www.oecd.org/els/health-systems/Briefing-Note-CANADA-2014.pdf*
[15] Conference Board of Canada, *How Canada Performs*, February 2012, http://www.conferenceboard.ca/hcp/details/health.aspx.
[16] Conference Board of Canada, *How Canada Performs*.
[17] Commission on the Future of Health Care in Canada, *Building Values: The Future of Health Care in Canada*, November 2002, http://www.cbc.ca/healthcare/final_report.pdf.
[18] Canadian Institute for Health Information, *National Health Expenditure Trends, 1975 to 2015*, https://www.cihi.ca/sites/default/files/document/nhex_trends_narrative_report_2015_en.pdf.
[19] Canadian Institute for Health Information, *National Health Expenditure Trends, pg. 6*.
[20] Public Services Foundation, *The sky is not falling*, January 2012, http://publicservicesfoundation.ca/sites/publicservicesfoundation.ca/files/documents/the-sky-is-not-falling.pdf.
[21] World Bank, *General government final consumption expenditure (% of GDP),* 2016, http://data.worldbank.org/indicator/NE.CON.GOVT.ZS?page=4.
[22] Public Services Foundation, *The sky is not falling.*
[23] *Canada Health Act*, R.S.C., 1985, c. C-6, http://laws-lois.justice.gc.ca/eng/acts/c-6/page-1.html#h-4.
[24] http://www.canadian-health care.org/page2.html

[25] A. Silversides, "Canada Health Act breaches are being ignored, pro-medicare groups charge," *Canadian Medical Association Journal,* November 18, 2008 vol. 179 no. 11, http://www.cmaj.ca/content/179/11/1112.full.
[26] J. Munson, "Canada is due for major debate on medicare: Romanow," *iPolitics*, March 2015, http://ipolitics.ca/2015/03/27/canada-is-due-for-major-debate-on-medicare-romanow/.
[27] S. Sholzberg-Gray, "Privatization is not a quick fix for the health system," *Toronto Star*, January 07 2011, http://www.thestar.com/opinion/editorialopinion/2011/01/07/privatization_is_not_a_quick_fix_for_the_health_system.html.
[28] N. Mehra, *Eroding Public Medicare: Lessons and Consequences of For-Profit Health Care Across Canada*, 2008, http://www.ontariohealthcoalition.ca/wp-content/uploads/Eroding-Public-Medicare.pdf.
[29] Canadian Centre for Policy Alternatives, *Privatization Nation: The Canada-wide Failure of Privatization, Outsourcing and Public-Private Partnerships,* November 2015, pg 4, https://www.policyalternatives.ca/sites/default/files/uploads/publications/Saskatchewan%20Office/2015/11/Privatization%20Nation%20%2811-05-15%29.pdf.
[30] Mehra, *Privatizing Nation*, pg 8.
[31] Mehra, *Privatizing Nation.*
[32] C. Hughes Tuohy, C. Flood, and M. Stabile, "How Does Private Finance Affect Public Health Care Systems? Marshalling the Evidence from OECD Nations," University of Toronto, http://homes.chass.utoronto.ca/~mstabile/oecd.pdf.
[33] Dr. V. Brcic, "Evidence is in: privately funded health care doesn't reduce wait times," *Canadian Centre for Policy Alternatives*, 2015, http://www.policynote.ca/the-evidence-on-wait-times-and-private-care/#sthash.lVzPTSzH.dpuf.
[34] Canadian Doctors for Medicare, *The Problem with Profit-Driven Health Care*, http://www.canadiandoctorsformedicare.ca/images/Private_Care_One-Pager_FINAL.pdf.
[35] E. Whitman, "Rising Costs Of Medical Care, Health Insurance: Median Pay For CEOs In Health Care Companies Higher Than Any Other Industry, Analysis Finds," *International Business Times*, May 26, 2015, http://www.ibtimes.com/rising-costs-medical-care-health-insurance-median-pay-ceos-health-care-companies-1938699.
[36] Canadian Foundation for Healthcare Improvement, *Myth: A parallel private system would reduce waiting times in the public system*, 2005, http://www.cfhi-fcass.ca/PublicationsAndResources/Mythbusters/ArticleView/05-03-01/5bda3483-f97b-4616-bfe7-d55d0d66b9a0.aspx.
[37] Office of the Auditor General of Ontario*, Infrastructure Ontario—Alternative Financing and Procurement*, 2014, http://www.auditor.on.ca/en/content/annualreports/arreports/en14/305en14.pdf.
[38] Office of the Auditor General of Ontario, *Brampton Civic Hospital Public-private Partnership Project*, 2008, http://www.auditor.on.ca/en/content/annualreports/arreports/en08/303en08.pdf.
[39] Report of the Auditor General of Québec to the National Assembly for 2010-2011, Special report dealing with the watch over the projects to modernize Montréal's University Health Centers, http://www.vgq.gouv.qc.ca/en/en_publications/en_rapport-annuel/en_fichiers/en_highlights2010-2011-chu.pdf
[40] Office of the Auditor General of British Columbia, *Audit of the Academic Ambulatory Care Centre Public Private Partnership: Vancouver Coastal Health Authority*, May 2011, https://www.bcauditor.com/sites/default/files/publications/2011/report_2/report/OAGBC-P3-Report-May-2011.pdf
[41] A. Picard, "In this PPP, taxpayers are the ones who paid," *Globe and Mail*, Feb. 5, 2009, http://www.theglobeandmail.com/life/health-and-fitness/in-this-ppp-taxpayers-are-the-ones-who-paid/article783175/.
[42] D. Seglins, and J. Nicol, "Who's who? McGill University hospital $22.5M bribery case," *CBC News*, Sept. 03, 2014, http://www.cbc.ca/news/who-s-who-mcgill-university-hospital-22-5m-bribery-case-1.2743193.
[43] P. Fong, "B.C. doctor faces court for billing for private health-care services," *Toronto Star*, Aug. 21, 2012, http://www.thestar.com/news/canada/2012/08/21/bc_doctor_faces_court_for_billing_for_private_health_care_services.html.
[44] A. C. Baillie, *Remarks to the Vancouver Board of Trade*, Apr. 15, 1999.

[45] N. Stall, Robert Bear & Terrence Sullivan, "Who will care for Canada's seniors?," *Healthy Debate*, Aug. 8, 2013,
http://healthydebate.ca/2013/08/topic/community-long-term-care/who-will-care-for-canadas-seniors.
[46] N. Stall, Robert Bear & Terrence Sullivan, "Who will care."
[47] "Health care worker shortage looms as staff retire," *CBC Halifax*, Jan. 02, 2014, http://www.cbc.ca/news/canada/nova-scotia/health-care-worker-shortage-looms-as-staff-retire-1.2481428.
[48] "Health care worker shortage looms as staff retire," *CBC Halifax*.
[49] CIHI, *Canada's Health Care Providers, 1997 to 2011—A Reference Guide: Overview and Methodological Notes*, 2013, https://secure.cihi.ca/estore/productFamily.htm?pf=PFC2161&lang=en&media=0.
[50] CIHI, *Canada's Health Care Providers: 2005 Chartbook*, 2005, Pg 23, http://healthcouncilcanada.ca/tree/2.14-CIHI05_ENG.pdf.
[51] D. Galarneau, *"Health care professionals," Statistics Canada*, December 2003, 75-001-XIE, http://www.statcan.gc.ca/pub/75-001-x/01203/6699-eng.html.
[52] I. Bourgeault, "Why a new Health Accord needs to include better planning for health human resources," Hill Times, Dec. 29, 2015, http://umanitoba.ca/outreach/evidencenetwork/archives/27711.
[53] I. Bourgeault, "Why a new Health Accord."
[54] Health Council of Canada, *Update on health human resources April 1, 2012 to March 31, 2013*, file://nuadott02/USERS/lbush/Desktop/HHR_EN.pdf.
[55] *Pan Canadian Drug Negotiations Report*, March 2014, http://www.pmprovincesterritoires.ca/phocadownload/pcpa/pan_canadian_drugs_negotiations_report_march22_2014.pdf.
[56] Ibid.
[57] Mercer, *Cost Trends in Health Benefits for Ontario Businesses: Analysis for Discussion*, Commissioned by the
Ontario Chamber of Commerce for Release at the Ontario Economic Summit, November 17 2011.
[58] J. White, *A National Public Drug Plan For All Canadians*, *Canadian Health Coalition*, Jan. 2016, pg. 2.
[59] *Pan Canadian Drug Negotiations Report*.
[60] Canadian Institute for Health Information, *Drug Expenditure in Canada, 2013, Table G14.1, Expenditure on Drugs by Type, by Source of Finance, Canada, 1985-2015*. Information available on request from Corporate Communications and Outreach, CIHI.
[61] J. White, *A National Public Drug Plan.*
[62] *Prescription drug access and affordability an issue for nearly a quarter of all Canadian households*, Angus Reid Institute Public Research, July 2015, http://angusreid.org/prescription-drugs-canada/.
[63] Angus Reid Institute Public Research.
[64] Angus Reid Institute Public Research.
[65] M. Gagnon, *A Roadmap to a Rational Pharmacare Policy in Canada*, The Canadian Federation of Nurses Unions, 2014, https://nursesunions.ca/sites/default/files/pharmacare_report.pdf.
[66] M. Gagnon, *A Roadmap to a Rational Pharmacare Policy in Canada*.
[67] J. White, *A National Public Drug Plan.*
[68] S. Pegler and J. Underhill, "Evaluating the Safety and Effectiveness of New Drugs," American Family Physician, July 2010, http://www.aafp.org/afp/2010/0701/p53.html#afp20100701p53-b17.
[69] M. Gagnon, "A Roadmap to a Rational Pharmacare Policy in Canada."
[70] M. Herder, "It's time to think beyond national pharmacare," *Toronto Star*, Feb. 8, 2016, http://www.thestar.com/opinion/commentary/2016/02/08/its-time-to-think-beyond-national-pharmacare.html.
[71] Public Health Agency of Canada, *Growing Older: Adding Life to Years. Annual report on the state of public health in Canada,* 2010, http://www.phac-aspc.gc.ca/cphorsphc-respcacsp/2010/fr-rc/index-eng.php.
[72] Canadian Medical Association, *Health and Health Care for an Aging Population*, 2013, pg 2, https://www.cma.ca/Assets/assets-library/document/en/advocacy/policy-research/CMA_Policy_Health_and_Health_Care_for_an_Aging-Population_PD14-03-e.pdf.
[73] Canadian Institute for Health Information, *National Health Expenditure Trends, 1975 to 2014*, October 2014, https://www.cihi.ca/en/nhex_2014_report_en.pdf.

[74] W. P. Wodchis, P. Austin and D. Henry, "A 3-year study of high-cost users of health care," *Canadian Medical Association Journal*, Jan. 11, 2016.
[75] "Small group of expensive patients account for most health spending," CBC News, Jan. 11, 2016, http://www.cbc.ca/news/health/health-care-high-cost-users-1.3398628.
[76] M. Turcotte, *Canadians with unmet home care needs*, Statistics Canada, Sept. 2014, Catalogue no. 75−006−X, http://www.statcan.gc.ca/pub/75-006-x/2014001/article/14042-eng.pdf.
[77] M. Hollander, *Comparative Cost Analysis of Home Care and Residential Care Services, National Evaluation of the Cost-Effectiveness of Home*, Health Canada, Sept. 2002, http://www.homecarestudy.com/reports/summaries/ss01-es.html.
[78] Canadian Healthcare Association, *Home Care in Canada: From the Margins to the Mainstream, 2009*, pg 10, http://www.healthcarecan.ca/wp-content/uploads/2012/11/Home_Care_in_Canada_From_the_Margins_to_the_Mainstream_web.pdf.
[79] Standing Senate Committee on Social Affairs, Science and Technology, *Time for Transformative Change: A Review of the 2004 Health Accord*, March 2012, pg 28, http://www.parl.gc.ca/Content/SEN/Committee/411/soci/rep/rep07mar12-e.pdf.
[80] Standing Senate Committee on Social Affairs, Science and Technology, *Time for Transformative Change.*
[81] Canadian Institute for Health Information, *Health Spending—Nursing Homes*, Nov. 2014, https://secure.cihi.ca/free_products/infosheet_Residential_LTC_Financial_EN.pdf.
[82] Canadian Institute for Health Information, *Health Spending—Nursing Homes.*
[83] Canadian Institute for Health Information, *Health Spending—Nursing Homes*.
[84] Canadian Medical Association, *Preparing for Canada's aging society*, May 2013, https://www.cma.ca/Assets/assets-library/document/en/advocacy/Aging-society-e.pdf.
[85] Health Council of Canada, *Update on home and community care April 1, 2012 to March 31, 2013*, 2013, file://nuadott02/USERS/lbush/Desktop/Home_care_EN.pdf.
[86] The National Union of Public and General Employees has released a paper discussing mental health issues in Canada in greater details. Readers are encouraged to consult *No Health Without Mental Health: A Way Forward* for a more detailed discussion of this topic.
[87] RiskAnalytica, *The life and economic impact of major mental illnesses in Canada*, Prepared on Behalf of the Mental Health Commission of Canada, 2011, http://www.mentalhealthcommission.ca/English/system/files/private/document/MHCC_Report_Base_Case_FINAL_ENG_0.pdf.
[88] When discussing "Aboriginal peoples" we are referring to the original inhabitants of what is now called Canada and their descendants. This includes First Nations, Inuit, and Métis peoples as defined in Section 35(2) Canadian Constitution Act, 1982.
[89] Wellesley Institute, *First Peoples, Second Class Treatment*, 2015, Pg 6, http://www.wellesleyinstitute.com/wp-content/uploads/2015/02/Report-First-Peoples-Second-Class-Treatment-Feb-2015.pdf.
[90] Statistics Canada, *Aboriginal Peoples Reference Guide: National Household Survey, 2011*, http://www12.statcan.gc.ca/nhs-enm/2011/ref/guides/99-011-x/99-011-x2011006-eng.pdf
[91] Statistics Canada, *Projections of the Aboriginal Population and Households in Canada, 2011 to 2036*. 2015. http://www.statcan.gc.ca/pub/91-552-x/2015001/hl-fs-eng.htm
[92] Statistics Canada, *Projections.*
[93] Indigenous and Northern Affairs Canada, *Urban Aboriginal Peoples*, 2014, https://www.aadnc-aandc.gc.ca/eng/1100100014265/1369225120949
[94] C. Reading and F. Wien, *Health inequalities and social determinants of Aboriginal Peoples' health*. National Collaborating Centre for Aboriginal Health, 2009.
[95] National Collaborating Centre for Aboriginal Health*, Housing as a Social Determinant of First Nations, Inuit and Métis Health*, 2009-2010, http://www.nccah-ccnsa.ca/docs/fact%20sheets/social%20determinates/NCCAH_fs_housing_EN.pdf.
[96] National Collaborating Centre for Aboriginal Health, *An Overview of Aboriginal Health in Canada*, 2013, pg 4, http://www.nccah-ccnsa.ca/Publications/Lists/Publications/Attachments/101/abororiginal_health_web.pdf.

[97] National Collaborating Centre for Aboriginal Health, *The State of Knowledge of Aboriginal Health: A Review of Aboriginal Public Health in Canada*, 2012, http://www.nccah-ccnsa.ca/Publications/Lists/Publications/Attachments/52/SOK_report_EN_web.pdf.
[98] Health Council of Canada, *Canada's most vulnerable: Improving health care for First Nations, Inuit and Métis seniors*, 2013. Pg 5. http://healthcouncilcanada.ca/content_ab.php?mnu=2&mnu1=48&mnu2=30&mnu3=55.
[99] Wellesley Institute, *Executive Summary: First Peoples, Second Class Treatment*, 2015, Pg 2, http://www.wellesleyinstitute.com/wp-content/uploads/2015/02/Summary-First-Peoples-Second-Class-Treatment-Final.pdf.
[100] Health Council of Canada, *Empathy, dignity, and respect: Creating cultural safety for Aboriginal people in urban health care*, 2012. Pg 4.
[101] Canadian Medical Association, *Health Equity and the Social Determinants of Health: A Role for the Medical Profession*, 2012, pg 1, https://www.cma.ca/Assets/assets-library/document/en/advocacy/PD13-03-e.pdf.
[102] P. DeLuca, N. Johnston & S. Buist. "The Code Red Project: Engaging Communities in Health System Change in Hamilton, Canada," Social Indicators Research, 2012.
[103] P. DeLuca, N. Johnston & S. Buist. *"The Code Red Project."*
[104] Saskatoon Health Region, *Better Health for All Health Status Reporting Series One*, March 2014, https://www.saskatoonhealthregion.ca/locations_services/Services/Health-Observatory/Documents/Reports-Publications/2014_SHR_HSRFull_phase1.pdf.
[105] J. Mikkonen, and D. Raphael, *Social Determinants of Health: THE CANADIAN FACTS*, Toronto: York University School of Health Policy and Management, Pg. 7, http://www.thecanadianfacts.org/the_canadian_facts.pdf.
[106] Canadian Institute of Health Information, *Disparities in Primary Health Care Experiences Among Canadians with Ambulatory Care Sensitive Conditions*, 2012, http://secure.cihi.ca/cihiweb/products/PHC_Experiences_AiB2012_E.pdf.
[107] R. H. Glazier RH, G. Booth, P. Gozdyra, M. Creatore and A. Tynan AM, (editors), "Neighbourhood Environments and Resources for Healthy Living—A Focus on Diabetes in Toronto: ICES Atlas," November 2007, http://www.ices.on.ca/flip-publication/neighbourhood-environment-and-resources/index.html.
[108] Canadian Diabetes Association, *An economic tsunami the cost of diabetes in Canada*, December 2009, https://www.diabetes.ca/CDA/media/documents/publications-and-newsletters/advocacy-reports/economic-tsunami-cost-of-diabetes-in-canada-english.pdf.
[109] Canadian Institute of Health Information, *Disparities in Primary Health Care.*
[110] Canadian Medical Association, *Health Equity and the Social Determinants of Health*.
[111] Canadian Medical Association, Health Equity and the Social Determinants of Health
[112] Mikkonen, J. and D. Raphael, *Social Determinants of Health*.
[113] Chief Public Health Officer, *Report on the State of Public Health in Canada 2008 - Addressing Health Inequalities*, 2008, http://www.phac-aspc.gc.ca/cphorsphc-respcacsp/2008/fr-rc/pdf/CPHO-Report-e.pdf.
[114] Kate McInturff and David Macdonald, *Time to Grow Up: Family Policies for the Way We Live Now*, Canadian Centre for Policy Alternatives, 2015, p. 12, https://www.policyalternatives.ca/sites/default/files/uploads/publications/National%20Office/2015/01/Time_to_Grow_Up.pdf.
[115] Kate McInturff and David Macdonald, *Time to Grow Up: Family Policies for the Way We Live Now*, p. 14 ibid.
[116] Kate McInturff and David Macdonald, *Time to Grow Up: Family Policies for the Way We Live Now*, p. 14 ibid.
[117] Population Change and Lifecourse Strategic Knowledge Cluster, *Quebec's family policies benefit childbearing and work*, 2013, Centre for Population, Aging and Health, Western University, http://sociology.uwo.ca/cluster/en/publications/docs/policy_briefs/PolicyBrief12.pdf.

[118] National Union of Public and General Employees, Quality of Women's Lives Survey, 2013, p. 11, http://nupge.ca/sites/nupge.ca/files/documents/key_findings_quality_of_womens_lives_survey_updated_2013_website_version.pdf.
[119] M. Friendly, *Early learning and child care: How does Canada measure up? International comparisons using data*
*from Starting Strong II*. Childcare Resource and Research Unit, 2006, http://www.childcarecanada.org/pubs/pdf/BN_EarlyLearning06.pdf.
[120] Canadian Public Health Association, *What are the Social Determinants of Health?,* http://www.cpha.ca/en/programs/social-determinants/frontlinehealth/sdh.aspx.
[121] Canadian Medical Association, Health equity and the social determinants of health, https://www.cma.ca/En/Pages/health-equity.aspx.
[122] National Union of Public and General Employees*, The Federal Government's Role in Funding Provincial and Territorial Community Services: Past, Present and Future Considerations*, Oct. 16, 2015.
[123] Conference Board of Canada, *Acceptance of Diversity*, How Canada Performs, 2016, http://www.conferenceboard.ca/hcp/details/society/acceptance-of-diversity.aspx.
[124] Rainbow Health Ontario and Association of Ontario Health Centres, *Joint Submission on Patients First: A Proposal to Strengthen Patient-Centred Health Care in Ontario*, 2016, http://www.aohc.org/sites/default/files/documents/RHO%20and%20AOHC%20joint%20submission%20on%20Patients%20First-%20FINAL.pdf.
[125] Sheryl Nestel, *Colour Coded Health Care: The Impact of Race and Racism on Canadians' Health*, Wellesley Institute, 2012, http://www.wellesleyinstitute.com/wp-content/uploads/2012/02/Colour-Coded-Health-Care-Sheryl-Nestel.pdf.
[126] Rainbow Health Ontario and Association of Ontario Health Centres, *Joint Submission on Patients First.*
[127] J. Obedin-Maliver J., E. S. Goldsmith, L. Stewart, W. White, E. Tran, S. Brenman, M. Wells, D. M. Fetterman, G. Garcia, and M. R. Lunn, "Lesbian, Gay, Bisexual and Transgender-Related Content in Undergraduate Medical Education," *Journal of the American Medical Association*, 2011, http://www.ncbi.nlm.nih.gov/pubmed/21900137.
[128] Rainbow Health Ontario and Association of Ontario Health Centres, *Joint Submission on Patients First*
[129] M. Fundira, "Arson at Montreal clinic concerns trans people awaiting surgery Advocate says Centre Métropolitain de Chirurgie is 'only one in Canada' that does gender confirmation surgery," *CBC*, May 03, 2016, http://www.cbc.ca/news/canada/montreal/ahuntsic-medical-clinic-arson-1.3564543.
[130] R. Rose, "Sex-reassignment surgeries funded in all but two provinces," *Daily Xtra*, July 24, 2014, http://www.dailyxtra.com/canada/news-and-ideas/news/sex-reassignment-surgeries-funded-in-two-provinces-89914.
[131] J. Mikkonen and D. Raphael, *Social Determinants of Health: The Canadian Facts*, Toronto: York University School of Health Policy and Management, 2010, p. 44, http://www.thecanadianfacts.org/The_Canadian_Facts.pdf.
[132] T. Bushnik, *The health of girls and women in Canada*, Statistics Canada, 2016, http://www.statcan.gc.ca/pub/89-503-x/2015001/article/14324-eng.htm.
[133] J. Mikkonen and D. Raphael, *Social Determinants of Health: The Canadian Facts*,
[134] C. Weeks, "Why is heart disease in Canadian women still being missed?" *Globe and Mail*, March 6, 2016, http://www.theglobeandmail.com/life/health-and-fitness/health/why-is-heart-disease-in-canadian-women-still-being-missed/article29031816/.
[135] J. Smith, "Canada cuts funding to women's health research groups," *Toronto Star*, Dec. 26, 2012, https://www.thestar.com/news/canada/2012/04/25/federal_budget_2012_health_canada_cuts_funding_to_womens_health_research_groups.html.
[136] Statistics Canada, *Women in Canada at a Glance Statistical Highlights*, 2013, http://www.swc-cfc.gc.ca/rc-cr/stat/wic-fac-2012/sec7-eng.html.

[137] D. Rajan, *Women with Disabilities Identified Problems, Strategies and Recommended Next Steps & Breast Cancer Screening: An Environmental Scan 2013*, Prepared for the Canadian Breast Cancer Network and written by on behalf of DisAbled Women's Network Canada, http://www.dawncanada.net/main/wp-content/uploads/2014/10/Women-with-DisAbilities-Breast-Cancer-Screening-2013.pdf.

[138] Canadian Human Rights Commission, *Report on Equality Rights of People with Disabilities*, 2012, http://www.chrc-ccdp.ca/sites/default/files/rerpd_rdepad-eng.pdf