



**CFNU** Canadian Federation of Nurses Unions

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**Submission to the House of Commons Standing Committee on  
Finance regarding the 2010 Pre-Budget Consultations**

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## Introduction

The Canadian Federation of Nurses Unions (CFNU) represents 138,000 nurses in all provinces except Quebec, as well as over 25,000 associate members who are part of the Canadian Nursing Students' Association. Our members work in hospitals, long-term care facilities, community health care, and our homes. CFNU speaks to all levels of government, other healthcare stakeholders and the public about evidence-based policy options to improve patient care, working conditions and our public health care system.

We thank the Standing Committee on Finance for the opportunity to share our views. In 2009, along with many other Canadians, CFNU noted the tremendous impact that the year's economic turmoil had on Canadians. As a result, we recommended that the federal government:

- 1) Enter into a cost-sharing program with provinces to create a national pharmaceutical program;
- 2) Create and fund a national health human resources observatory; and
- 3) Dedicate an innovation fund for health care authorities, health care worker unions and provincial and territorial governments to undertake projects and programs and to provide needed capital investments to address the nursing shortage.

Since then we have worked with health care experts and economists to re-open the discussion on the sustainability of Medicare with the First Ministers, policy makers and now the finance committee.

On August 4<sup>th</sup>, the CFNU published *The Sustainability of Medicare*<sup>1</sup> written by economist Hugh Mackenzie and health policy expert Dr. Michael Rachlis. This economic analysis of the debate around health care sustainability reveals that Medicare costs are not "out of control" – as some critics would have the public believe. In fact, costs have remained remarkably stable as a share of the GDP for the past 20 years.<sup>2</sup> Any assertion that there is a sustainability "crisis" is, simply put, false.

Our proposals for the 2010 budget remain similar to past years. If implemented, they will have a significant and positive impact on the health and well being of Canadians, and will ensure that our public health care system remains viable in the long term. The 2004 First Ministers Health Accord is set to expire in 2014. The CFNU proposes that the federal government play a leading role in negotiating a successor accord based on the three recommendations below:

**Recommendation 1:** Establish a basis for federal leadership in the creation of a national, universal Pharmacare plan.

**Recommendation 2:** Improve the position of the federal government in funding Medicare.

**Recommendation 3:** Provide opportunities for system change and improvement that are rooted in public funding and delivery of health care.

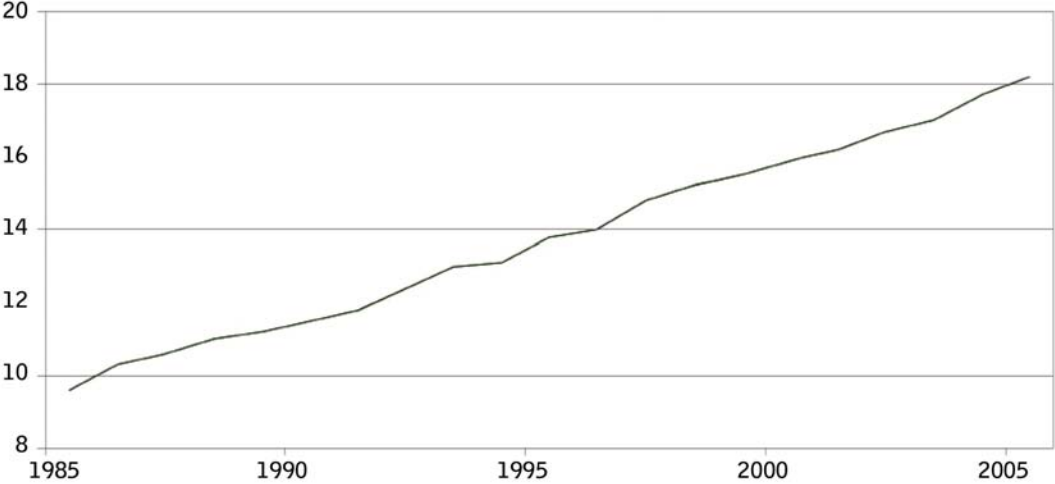
We also ask that the federal budget honour the commitments made in the 2004 accord and also consider the needs of a successor accord, as identified in this brief.

**Recommendation 1: Establish a basis for federal leadership in the creation of a national, universal Pharmacare plan**

Last year, CFNU urged the federal government to work together with the provinces and territories to adopt and fund a national Pharmacare program which: provides access to prescription drugs through first-dollar coverage; controls drug costs through a national drug formulary and bulk purchasing; and increases the safety and efficacy of drugs.

Pharmaceuticals have been responsible for 25% of the increases in Medicare costs as a share of the GDP since 1975.<sup>3</sup> The cost of drugs is the fastest-growing part of the health care pie, and its steady rise as a percentage of total health expenditure is demonstrated in Figure 1 below.

**Figure 1:** Total Expenditure on Pharmaceuticals and Other Medical Non-Durables as a Percentage of Total Health Expenditure Canada, 1985 – 2005



Source: OECD Health Data, 2006, [www.oecd.org](http://www.oecd.org).

Mackenzie and Rachlis explain that “the growth in the share of prescription drugs in public health care costs is particularly important from a cost-control perspective because they are goods produced in the private sector and funded from public revenue.”<sup>4</sup> Responsible spending of public health care dollars is made substantially more difficult by Canada’s inability to negotiate prices for prescription drugs and regulate the relationship between the pharmaceutical industry and drug retailers. Improvements can be achieved through the development and funding of a national Pharmacare program.

Nine out of 10 Canadians pay out of pocket for some or all of their medicine<sup>5</sup>, and it is estimated that over 3 million Canadians do not have any or adequate coverage for drug treatment.<sup>6</sup> Those who cannot afford their prescriptions, the co-payments, or private insurance often go without, or self-ration their prescriptions, resulting in increased rates of hospitalization.<sup>7</sup>

Through a national drug formulary, bulk purchasing, and reduced administrative costs, we can get more value for less money. A cost-sharing, partnership approach between the federal government, the provinces and territories should be considered as a means to build this national

Pharmacare program, which research has shown could save Canada an estimated \$2 billion annually.<sup>8</sup> Among OECD countries, only Mexico, the United States and Poland spend less public money on drug coverage than Canada.<sup>9</sup>

A federal commitment to cost-share with the provinces and territories on a national pharmaceutical strategy will:

- Improve the health of Canadians who do not fill their prescriptions or who terminate them prematurely because they cannot afford prolonged therapy;
- Improve the quality of prescribing and reduce adverse drug events;
- Reduce the number of unnecessary hospitalizations because of the above-mentioned improvements; and
- Create significant opportunities to reduce costs by harnessing the collective purchasing power of governments and promoting the use of the most cost-effective drug alternatives.

## **Recommendation 2: Improve the position of the federal government in funding Medicare**

CFNU, along with many others, acknowledges that Canada could not have achieved what it has in health care without the active participation of the federal government. However, further advancements will require that it adopt an even more active leadership role. This begins with building programs into our federal budget that support the sustainability of Medicare.

As documented in *The Sustainability of Medicare*, methods such as shifting costs from Medicare to individuals, shifting delivery and funding from the public sector to the private sector, and weakening the influence of public policy in the management and delivery of health care services have proven to be ineffective solutions to addressing system challenges. Real solutions lie in the presence of a consistent and reliable role for the federal government as a funding partner to the provincial and territorial governments. It is imperative that this partnership address traditionally neglected areas such as mental health, long-term care, home care, pharmacare, and Aboriginal health.

Some continue to argue that Canada cannot afford to maintain our current investment in health care. But as Mackenzie and Rachlis show, health care costs generally and Medicare costs in particular have been remarkably stable with respect to GDP. What is more, Canada's health care spending is in line with other OECD countries.

The federal government cuts to health care in the 1990s ultimately undermined its ability to enforce the provisions of the *Canada Health Act*. MacKenzie and Rachlis explain that while the federal government's financial commitment to health care has recovered since the 1990s, their influence over the health care system has not. More than just maintaining a significant and direct position in funding health care, they must also influence service delivery and productivity improvements.

In 2004, the first ministers reaffirmed that the federal government has a major role to play in ensuring the viability of Medicare, and the creation of the Health Accord helped to reestablish their role in doing so. The agreement is set to end in 2014, but negotiation of a successor agreement should not wait.

### **Recommendation 3: Provide opportunities for system change and improvement that are rooted in public funding and delivery of health care**

Many economists and health policy experts agree that the most stable components of Medicare are those that are within the public domain. Evidence also shows that there are cost items in the private domain that could be better controlled with more, rather than less, public participation. While public health care is a significant investment, a sound Medicare system is also a significant public asset that encourages investment in provinces by individuals, families and business.

We continue to believe that federal support for public-private partnerships (P3s) for health care infrastructure is a mistake. Evidence from Australia, the UK and different provincial jurisdictions in Canada shows that Auditor Generals are also questioning the value of public-private partnerships.<sup>10</sup> There is a large and growing body of research documenting and highlighting the financial and public policy risks and costs associated with P3 projects in Canada and other countries.<sup>11</sup> Simply put, there is no cheaper, safer or effective method than public financing.

Of course our health care system does have areas in need of improvement – many Canadians need better access to community-based primary health care, long-term care, chronic disease management, and preventive health care. As a result of poor chronic disease management in the community, additional burdens are often placed on hospitals that are left to treat patients whose illnesses could have been prevented. Some provinces have achieved greater access to services for their communities through publicly funded, inter-professional health care delivery that focuses on preventive services, but national leadership is needed to ensure that all Canadians can enjoy the benefits of better access to health care.

Innovation and improvements to health care that are made through public funding have shown great promise. CFNU has first-hand experience with this thanks to Health Canada. In October of 2008, Health Canada approved a proposal by CFNU to implement nine pilot projects designed to increase the retention and recruitment of nurses across the country. In November 2009, a tenth pilot project based in Nunavut was added. Collectively, the pilots are known as *Research to Action: Applied Workplace Solutions for Nurses (RTA)*.

The pilots support programs that enhance the quality of patient care, provide support to new nursing graduates and offer opportunities for continuing education and professional development. All projects are workplace-based and have been developed in partnership with employers, unions, governments and other health care stakeholders in each jurisdiction. While the RTA project will not be complete until March, 2011, preliminary results already suggest that these strategies help respond to one of Medicare's most pressing problems – the nursing shortage, and the danger to patient care this represents.

This is an example of the kind of effective system change and improvement – rooted in public funding and delivery of health care – that can be supported by the federal government in collaboration with provinces and a number of other health care stakeholders. Greater capacity for innovation of this kind should be built into the federal budget.

## Conclusion

Increased capacity for public health care programs like primary health care, home care, long-term care, and Pharmacare is needed. We urge the federal government to re-invest in health care by building a successor agreement to the First Ministers Health Accord that is set to expire in 2014. We ask that in relation to accord renewal, the federal government consider the following in relation to the federal budget:

- Establish a basis for federal leadership in the creation of a national, universal Pharmacare plan;
- Improve the position of the Federal government in funding Medicare; and
- Provide opportunities for system change and improvement that are rooted in public funding and delivery of health care.

Implementation of the above recommendations would demonstrate to Canadians that maintaining Medicare – and by extension, their health – remains a priority for the federal government.

CFNU's latest publication provides research-informed rationale to support our call for the federal government to play a more active role in ensuring the long-term financial security of Canada's Medicare system and in leading improvements in that system. Building this role into the federal budget is necessary to achieve meaningful change.

We invite you to review the attached report on *The Sustainability of Medicare* and welcome any discussion on this issue which is of great importance to all Canadians. Thank you for the opportunity to share our perspective and for your ongoing commitment to open dialogue on the federal budget.

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<sup>1</sup> Mackenzie, H & Rachlis, M. *The Sustainability of Medicare*, Canadian Federation of Nurses Unions, 2010.

<sup>2</sup> Ibid.

<sup>3</sup> Ibid.

<sup>4</sup> Ibid.

<sup>5</sup> Ibid.

<sup>6</sup> Applied Management, Fraser Group, Tristat Resources. *Canadians' Access to Insurance for Prescription Medicines*, 2000.

<sup>7</sup> Tamblyn, Robyn M. et al. Adverse Events Associated With Prescription Drug Cost-Sharing Among Poor and Elderly Persons. *Journal of the American Medical Association*. January 24, 2001.

<sup>8</sup> Steven Morgan, and C. Cunningham, "The Effect of Evidence-Based Drug Coverage Policies on Pharmaceutical R&D: A Case Study from British Columbia," *Healthcare Policy*: 3(3), 2007.

<sup>9</sup> Organization for Economic Co-Operation and development (OECD). *Rising health costs put pressure on public finances*, June 26, 2006.

<sup>10</sup> See the following for examples: The World Health Report 2006, Romanow and Kirby reports, the Nursing Sector Study, the CNAC reports of 2002, the CHSRF report of 2001, and the Quality Work Life Quality Healthcare Collaborative.

<sup>11</sup> MacKenzie, Hugh. *Financing Canada's Hospitals: Public Alternatives to P3s*, Canadian Health Coalition, October 2004.