Found: *Federal funding*
Missing: *A plan to stem privatization*

Canadian Health Coalition's Analysis of the
First Ministers' Health Care Agreement:

"A 10-Year Plan to Strengthen Health Care"

www.medicare.ca

Ottawa
September 28, 2004

Overview

"The devil's in the details. And the devil usually comes out in the details."
- Roy Romanow

"Follow the money…there is a huge amount of money involved in providing for-profit health care. That money, in part, is used to ensure that regulation is weak."
- Arnold Relman, MD

Federal, provincial, and territorial first ministers met in Ottawa September 13-16, 2004 and signed an agreement entitled: *'A 10-Year Plan to Strengthen Health Care'* *http://www.healthcoalition.ca/deal-text.pdf*. The agreement secures stable federal funding for health over the next ten years. Federal cash transfers and the cost escalator were both restored.

The agreement, because it was signed and contains more specifics, is a better deal than those of 2000 and 2003. But it has the same weaknesses: poor accountability, reporting and enforcement. **Medicare is still on life support - not from lack of money - but because of weak controls on where and how the money will be spent.** This agreement falls short of Prime Minister Martin's election promise of "a health care fix for a generation" and it does not live up to his promise to stem the tide of privatization.

The Prime Minister gave Canadians clear assurances that the government would steer away from private, for-profit delivery of health care after the next election. Immediately after being sworn into office, Federal Health Minister Dosanjh said: "*I can tell you that what we need to do is stem the tide of privatization in Canada and expand public delivery of health care so we have a stronger health care system for all Canadians.*"

The agreement does not mention, let alone address, the most serious threat to the integrity and sustainability of public health care in Canada - the tide of privatization and commercialization. Perhaps the economic priorities of the Government of Canada (see Section 14 of this report: "Health Innovation") explain why there is no plan to stem the tide of privatization.

The lack of a plan to protect the public delivery of care is amplified by another glaring omission. The agreement does not affirm the health care vision and values of Canadians as reflected in the Romanow Report. **Canadians view Medicare as a moral enterprise, not a business venture.** Tossing overboard the values that govern our health care system in the name of federal-provincial relations is betraying a public trust.

In light of the election promise of the federal Liberals, Canadians are owed an explanation as to how the federal government intends to stem the tide of health care privatization. Action is required immediately. First, the Prime Minister must signal his expectation that public dollars will only be used for the public, non-profit delivery of health care. Second, the Minister of Health must actively enforce the criteria and conditions of the *Canada Health Act* so that all Canadians receive insured health services on uniform terms and conditions.

Accountability - the real thing, not a decoy – and federal guardianship are necessary to ensure that public funds are used to protect and strengthen Medicare. An independent public accountability mechanism is essential to ensure real health care reform takes place and to defend against the powerful economic interests who want to privatize the 'profitable' parts of health care. This is a role Canadians expect the Federal Government and the new Health Council of Canada to play.

Canadians need to 'follow the money' and insist on a full public accounting of every tax dollar. The future of Medicare and of public health in Canada rests on the ability of citizens and their governments to enhance access to health services while protecting the values and principles in the *Canada Health Act* from the commercial values of the market. What stands between Medicare and its demise are the peoples of Canada.

1. Stable and Predictable Federal Funding Grade: A+

The deal delivered more money than originally promised by the Prime Minister. The federal government will transfer an additional $18 billion to the provinces for health care over the next six years. In the last four years of the ten-year agreement, an additional $23.2 billion will be transferred, for a total of $41.2 billion in new funds.

The funding agreement exceeds the Romanow recommendation and comes close to the demand of the premiers (and the CHC) that the federal share be 25% of health care spending. In addition to restoring cash transfers, an escalator clause will increase the base by 6% every year. This ensures predictable and stable funding and will enable provinces and territories to undertake multi-year planning and serious reforms. The details on the funding are as follows:

- $1 billion in 2004/05 and $2 billion in 2005/06 applied to the base of the Canada Health Transfer
- $500 million in 2005/ 06 to be applied to commitments on home care and catastrophic drug coverage
- Base funding in the Canada Health Transfer to increase to $19 billion in 2005/06
- A 6 percent escalator clause to be applied from 2006/07 and thereafter
- $4.5 billion will be allocated to a "Wait Times Reduction Fund" between 2004/05 and 2009/10
- In 2010/11, $250 million per year will be added for health human resources
- $500 million will be allocated for medical equipment in 2004/05
- $700 million over 5 years allocated to improve the health of aboriginal peoples

2. Accountability and Reporting to Canadians Grade: D

The agreement is based on 'trust' and the assumption that the public will hold their governments to account. This is inadequate. Weak accountability facilitates privatization by stealth. Canadians will have to work to ensure accountability and reporting mechanisms are developed and implemented. Before federal cash is transferred, there need to be rules and penalties in place for failure to keep commitments made in the agreement.

It is no co-incidence that the governments with the most resistance to meaningful accountability (Alberta, Québec and B.C.) are the ones determined to transfer the delivery of insured health services over to commercial, for-profit health care corporations. Proponents of private, for-profit health services do not want public funds accounted for or traced but this is what true accountability requires.

Canadians don't realize that current accountability requirements in federal legislation are being ignored by the federal government. Under the *Canada Health Act*, the Minister of Health has a statutory duty to monitor, report, and enforce compliance with the five criteria of the *Act*. The Minister's annual report to Parliament on the *Canada Health Act* consistently fails to identify, report, and stop privatization initiatives underway in several provinces. This poses a serious threat to the integrity and viability of Medicare.

We expect the Canadian Institute for Health Information and the Health Council of Canada to include in their data collection and anlysis a breakdown, by mode of delivery of health care services specifically, for-profit and not-for profit. A full public accounting would expose unfavourable comparisons between private for-profit and public not-for-profit. These include:

* higher costs
* more serious deficiencies of human (staffing) and material resources
* higher morbidity (a higher rate of complications)
* higher death rates and poorer quality care
* greater inefficiencies
* marketing of inappropriate services
* conflict of financial interest
* greater waiting times for those who can't afford to queue jump
* secret contracts that compromise professional ethics
* cherry picking to shift cost, risk and liability to the public system
* opportunities for fraud

Citizens need an accountability mechanism which is independent and in the public domain. The Health Council of Canada could grow into that role with public pressure and direction. The first task for the Health Council must include tracking every single dollar of 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 and the health outcomes and financial performance achieved. Canadians must also insist that the federal Minister of Health correct the deficiencies in monitoring, reporting and enforcing the *Canada Health Act*.

3. Stemming the Tide of Privatization Grade: D

For-profit health care is an oxymoron. The moment care is rendered for profit, it is emptied of genuine caring.
-Bernard Lown, MD

The First Ministers' Health Care Agreement is silent on the question of for-profit delivery of health services. Indeed, the very day the agreement was signed the bold headline in the *National Post* read: "Privatized Care Keeps Expanding" (September 15, 2004).

The proliferation of investor-owned private, for-profit clinics and facilities acts like a viral infection in the body of Canada's public health care system. The for-profit health care virus cannot exist without feeding off and damaging public bodies. Canada's largest and richest provinces are laying the foundations for a private parallel for-profit regime. This trend threatens the integrity and the viability of the public health care system. This is happening without any public discussion by First Ministers. Indeed, it is a plan whose objectives no politician dare utter in public.

The corporate virus infection in Canada's health care delivery system may have been driven underground. However, it remains a serious threat as it can spread through stealth, deception, and lack of accountability. It flourishes in the dark but runs from the light of public scrutiny. **You don't stop the spread of a life threatening virus by not talking about it**. Instead, you first isolate and then treat and eradicate the virus.

The proliferation of initiatives to privatize health care delivery undermines the letter (objectives) and the spirit (purpose) of the *Canada Health Act*. It represents a significant threat to the publicly funded health care system, in particular including the requirements that universal access to publicly funded health care be provided on uniform terms and conditions to all insured persons.

"The facts are no one has ever shown, in fair and accurate comparisons, that for-profit makes for greater efficiency or better quality, and certainly have never shown that it serves the public interest any better. Never." (Dr. Arnold Relman's testimony to Kirby Senate Committee, Feb. 2002 www.healthcoalition/relman.html).

Why do so many First Ministers and their officials show no interest in the facts, or the values upon which Medicare is built? The noticeable exceptions are Premier Calvert of Saskatchewan and Manitoba Premier Doer, who both explicitly referred to not-for profit delivery of care**. If Canadians are gullible and listen to the true believers in the miraculous powers of the market to solve health care problems, we will pay dearly for the mistake.**

4. Reducing Wait Times and Improving Access Grade: C -

The provinces agreed to reduce wait times by March 31, 2007 in the following areas: cancer, heart, diagnostic imaging, joint replacements, and sight restorations. A Wait Times Reduction Fund ($44.5 billion over 5 years) is allocated to assist the provinces in reaching their goals. Each jurisdiction will establish its own indicators for access and benchmark targets for wait times. The territories and provinces will report progress to their own citizens. The Canadian Institute for Health Information (CIHI) will produce a pan-Canadian report by compiling information from each report.

The real issue of reducing wait lists and wait times is how it will be done. Better management and coordination of the lists, and investment in health human resources and capital infrastructure will have a positive impact on wait lists and wait times. These approaches require long term funding and planning but they are indeed essential elements of a "fix for a generation." Provinces that follow this approach will be closer to a permanent solution.

However, provinces who are already disposed to expanding private, for-profit delivery will contract-out to for-profit providers. The services that are most likely to be contracted are joint replacement surgeries, cataract surgeries and diagnostic imaging. Coincidentally, these services fall squarely on the First Ministers' list of priority areas to reduce wait lists and times.

The inevitable consequence is not reduced wait times, but a flourishing parallel for-profit system of providers who become dependent upon government contracts. Profit-seeking and self-interested, they will have no desire to see wait lists or times shrink. Similarly, physicians who are investors in for-profit clinics and who undoubtedly will be working in both the public and for-profit system, will have no motivation to shrink wait lists.. Their incomes will be dependent upon the wait list and wait times "crises" (real or manufactured).

The contracting-out approach to wait list and wait time reduction is almost guaranteed to increase rather than reduce problems. Aside from the incentives of investors, the tendency is to place more patients on wait lists if there is a belief that they will be seen or treated – whether they need to be or not. The strategy to reduce wait times and improve access is more likely to fail without a plan to stem privatization of delivery. (And the perverse economic incentives). Vigilance is also needed in terms of drug companies – they have their eyes on these new funds.

5. Home Care Grade: B-

The First Ministers agreed to provide first dollar coverage by 2006 for certain home care services, based on assessed need. The text of the agreement states:

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

These are very important steps in expanding home care coverage. However, they are limited and narrowly focused on medical coverage. There is still a long way to go before we have a comprehensive national home care program.

Citizens need to insist that public funds for home care not be used to pay for care by investor-owned for-profit providers. This is needed to ensure the quality of care, to protect the vulnerable from financially motivated individuals, and to avoid public home care dollars going to profits and stock options, instead of patient care. Public funds are for patients, not profits.

6. Elder Health and Elder Care Grade: F

There is no mention anywhere in the ten year agreement of a plan for the health and care of older persons. This is an area of health care that badly needs targeted investment, national standards and serious policy attention. As the population ages and the demand for care increases, the First Ministers failed to allocate any funds to address the issues of care for the elderly into the next decade. This probably signals a continued trend to open for-profit nursing homes and download the cost of this care onto individuals and their families. This lack of attention will probably result in an increase in preventable hospitalizations of elderly persons and an increased need for nursing homes.

Indeed, long-term care is a sector that is being rapidly privatized. The frail elderly are increasingly in the hands of profit-seeking nursing home chains. There are currently no minimum level of standards for nursing care in most for-profit nursing home chains. For-profit nursing homes receive in most instances higher government funding than not-for profit homes and yet they return significant profits to investors. Where do profits come from in nursing homes? Peer-reviewed evidence demonstrates that investor-owned nursing homes provide worse care and less nursing than not-for-profit or public homes.

7. Pharmaceutical Strategy Grade: Strategy: C Implementation: D

"Like sharks, drug companies are marvellous feeding machines.
That's all they live for, relentlessly and skilfully profiteering.
The only way to stop them is to reduce their food supply."
-Robert Sherrill, The Nation

The agreement recognized the need for equity of access to essential medicines. It outlines a number of elements of a national pharmaceuticals strategy.

A Ministerial Task Force will be established to develop and implement the strategy. This includes the development of catastrophic drug coverage with cost options. First Ministers have given no indication that they are prepared to move quickly on expanding coverage. Instead, they have agreed to "report on progress by June 30, 2006". Canadians have waited long enough for access to essential medicines based on need - not ability to pay. The public should insist on the principle of first dollar coverage.

The good news is that the strategy contains the three objectives outlined in the CHC Briefing Note, 'Pharmacare in the Public Interest' (August 23, 2004). The objectives are equity of access, safety and efficacy, and cost control. Other elements in the strategy advocated by the CHC include: a National Drug Formulary based on safety and cost effectiveness, strengthened evaluation of real-world drug safety and effectiveness, purchasing strategies to obtain best prices, improved prescribing behaviour of physicians, accelerated access to non-patented drugs, and enhanced analysis of cost drivers and cost-effectiveness.

Elements that are problematic include: the failure to address the abuse of monopoly drug patents, the call to speed up the drug approval process, and federal plans to eliminate the ban on direct to consumer drug advertising.

The multinational drug lobby in Canada, Rx&D has already announced that they "look forward to partnering with the Ministerial Task Force". The $41.5 billion new dollars flowing into the health care system represents an opportunity to expand drug sales and profits. It is self-evidently absurd to invite drug companies to help make policy about the products they sell. Canadians must not let Big Pharma hijack the agenda. Citizens must work with provincial governments in order to prevent Big Pharma from capturing the *Task Force on Pharmaceutical Strategy*. Fish farmers don't 'partner' with sharks.

8. Primary Care Reform Grade: D

The First Ministers set a target to provide 50% of the population with access to primary care by 2011. They seem to be satisfied that significant progress is being made on primary care reform, and that all they need to do now is to share information on best practices. This view is not shared by millions of Canadians who are in need of family physicians and are awaiting anxiously some meaningful reform that establishes access to primary care on a 24/7 basis with interdisciplinary teams of caregivers. The Community Health Centre model has proven to be successful in delivering primary care in this way. Yet, the governments have taken no concerted steps to promote this model. On the contrary, the Quebec government has taken steps to dismantle the highly successful CLSCs where care was delivered according to the principles that the governments now say they are closer to achieving.

Provinces have to take on the powerful medical associations for real reform in primary care to happen. The challenge is to organize and pay physicians in ways that provide better incentives for high-quality, cost-effective care and interdisciplinary teams with physicians, RNs including NPs (nurse practitioners), pharmacists and social workers. Solo practice and fee-for-service reimbursement of doctors is a barrier to progress in primary care. If not dealt with, the new money in the system will feed excessive use of expensive technology and dubious prescribing behaviour.

9. Electronic Health Records Grade: F

The First Ministers have put electronic health records squarely on the agenda as a prerequisite to health system renewal. However, the First Ministers and the federal government in particular, are to be faulted for not providing any assurances that such programs will be secure to ensure privacy and confidentiality. Our confidence in any electronic health record is rocked by the revelation that health records in B.C. have been contracted to a large US corporation that must follow U.S. law (U.S. Patriot Act) in terms of release of information to the FBI. This does not inspire confidence and the blame for this should surely be squarely on the shoulders of the federal government by not demanding accountability from the provinces for the privacy of their health information.

10. Aboriginal health Grade: N/A

"If the land is not healthy then how can we be?"
-Joseph Masty, elder, Whapmagoostui

On the first day, First Ministers met with leaders of the Assembly of First Nations, the Inuit Tapirisit Kanatami, the Métis National Council, the Congress of Aboriginal Peoples and the Native Women's Association of Canada. The Aboriginal leaders and the federal government agreed to a $700 million plan over five years to implement "specific measures to close the gap between the health status of Aboriginal Peoples and the Canadian public."

The plan includes:

- $200 million for an Aboriginal Health Transition Fund to ensure improved coordination of Federal, Provincial, Territorial and First Nation health jurisdictions
- $100 million for an Aboriginal Health Human Resources Initiative to improve recruitment and retention of aboriginal health care workers
- $400 million for programs of health promotion and disease prevention focusing on youth suicide, diabetes, maternal and child health and early childhood development

The Assembly of First Nations tabled an action plan with six elements: *a sustainable financial base; integrated primary and continuing care; human health resources; public health infrastructure; healing and wellness; and information and research capacity.*

The $700 million plan is a good start, but is only a fraction of the funding that is necessary to address health care issues within aboriginal communities.

11. Access to Care in the North Grade: B

"The health care system used to work quite well. What went wrong?
- Senior citizen, Hay River, NWT, 2003

The federal government has agreed to help address the unique challenges facing the development and delivery of health care services in the North on a priority basis. A Territorial Access Fund ($150 million over five years) will provide direct funding for medical transportation costs as well as long-term health reforms. This amounts to $10 million a year for each Territory.

After years of off-loading health care responsibilities on to the Territories, First Nations and Inuit, the federal government is now restoring transfers that were cut in 1995. This is far from a needs-based federal funding formula but it is a step in the right direction.

12. Health Human Resources Grade: C -

New money is allocated to spur solutions to shortages of health professionals. The First Ministers specifically reference accelerating and expanding the integration of internationally trained health care graduates. This approach implies a reliance on foreign trained health professionals. We caution that any reliance on this approach must not contribute to a "poaching" of health professionals from developing countries and should only be done as a partnership with developing countries such that both may benefit. Such agreements are currently in place in other jurisdictions. Human resources are a global problem that require local solutions. A case in point is nursing where the focus must be on improving work-environments, reducing workloads and opening the doors to full-time employment (rather than part-time and casual) to both retain and recruit.

Recruitment and training of health personnel for aboriginal communities and Official Languages Minority Communities is a welcome addition to any human resources strategy. The task will be to ensure that adequate monies are devoted to this program.

The agreement includes a reference to "measures to reduce the financial burden in specific health education programs." No details are provided. The federal government should re-consider a labour proposal for a pilot project for health care workers to be re-trained and/or upgraded through an Employment Insurance training program. This program would allow for significant mobility of personnel already working in the system into areas where there are shortages e.g., upgrading of care aides to practical nurses, and practical nurses to registered nurses.

Finally, it is time for federal and provincial governments to review and take seriously the studies and recommendations of health human resource studies already on-going or recently completed. The Home Care Sector Study, funded by HRDC is sitting on the shelf with ten recommendations on how to deal with home care human resources issues. The Advisory Council of Health Delivery and Human Resources (a federal/provincial/territorial body) has assiduously ignored this study and done nothing to deal with recruitment and retention issues in home care – placing the expansion of home care and the quality of home care in jeopardy. A Nursing Sector Study, also funded by HRDC, is nearing completion. We fear that without some direction from the federal government this study too will be relegated to the dusty shelves of government reports as did the CNAC Report released in 2002 (Canadian Nurse Advisory Committee). A HRDC funded physicians' study is being conducted and may find a similar fate. Why spend over $7 million in funding health human resources studies and then ignore them?

13. Prevention, Promotion and Public Health

Grade:
Provinces/Territories: C
Federal government: F

"The ultimate goal of Medicare must be the task of keeping people well rather than just patching them up when they're sick."
-Tommy Douglas

Prevention, promotion and public health are part of what Tommy Douglas called the second phase of Medicare. There are a number of serious barriers that stand in the way of this second phase developing as it should. First, the economic incentives in Canada today are not to keep people healthy. The economic incentives are in selling unhealthy food and other products that make people sick, and then selling health products and disease treatments to treat the illness. The money is in 'disease management' (take this pill every day for the rest of your life), not in disease prevention and health promotion. Second, the timid efforts to pay attention to health promotion are focused on a individualistic, life-style approach to the complete exclusion of determinants of health.

Recognizing barriers to prevention, promotion and public health - like the corporate-driven food and drug regulation at Health Canada, is an important step if Medicare is going to have a second phase. During the televised discussion, it was encouraging to hear several Premiers refer to the importance of a health promotion. It was also helpful to hear Manitoba's Premier Doer criticize Health Canada's proposal to lift the ban on direct-to-consumer drug advertising. He was also critical of federal food labelling regulations that exposed Canadians to unhealthy and potentially unsafe food. Unfortunately, the right to know what we are eating (and feeding our children) is not something Health Canada recognizes.

Provincial and Territorial officials and the public are largely unaware of the Health Canada proposal to gut health protection legislation, the *Food & Drugs Act*, and replace it with a Canada Health Protection Act. Instead of preventing harm from happening in the first place, the new law would shift to managing the damage after the harm is already done. The damage Health Canada wants to "manage" is preventable illness and death.

Citizens must work with their provincial and territorial governments to insist that the federal government abandon the proposed legislative changes to federal health protection. In addition, the new federal Minister of Health must: a) instruct his officials to uphold the duty of care in the current *Food & Drugs Act* and b) adopt the Precautionary Principle as the basis for a broad, transparent, and independent assessment of risk to protect and promote public health, and prevent illness. For a detailed analysis, visit: http://www.healthcoalition.ca/jan28-e-ol.pdf

Citizens must also work to insist that the federal government develop a broad public health strategy inclusive of determinants of health. This must be included in the mandate of the new Public Health Agency of Canada.

14. Health Innovation Grade: F

[Health Innovation requires] "Prime Ministerial leadership… as mandatory to encourage public acceptance of private sector involvement in health care."
-Public Policy Forum, 2003

This section was placed in the agreement by the federal government. It represents a serious threat to the integrity and viability of Medicare. 'Health innovation' sounds fairly innocuous, but this short section of the agreement is written in code. Under the cover of 'health innovation' lies a triple corporate agenda - privatization, deregulation and commercialization. It includes the commercialization of public knowledge, human life, health research and finally, health service delivery.

Perhaps these economic priorities of the government of Canada explain why.

* commercialization and privatization of health research
* health industries innovation
* public-private-partnerships
* biotechnology strategy
* international trade negotiations
* trade-related Intellectual Property
* 'smart regulation'
* corporate-driven food & drug regulation

The 'health innovation' agenda views health care not as a moral enterprise but as "an engine of economic growth" and wealth creation – especially for the biopharmaceutical industry. The presence of this corporate agenda in the agreement may have something to with the absence of a mention (let alone a plan) to "stem the tide of privatization". Health innovation means big government working with big pharma to drive up the cost of health care through monopoly patents. A recent example of 'health innovation' is the genetic test for breast and ovarian cancer for which the drug company is charging $3,850 per test. That's wealth creation, but what about treating the sick?

The health innovation agenda seeks to integrate corporate investment and 'market openness' with government health protection regulation. The goal is to attract "tens of billions of new private sector investment" into the health sector "with cost savings to the Crown". This kind of innovative thinking also goes by the name of "smart regulation". Mixing market traders with health guardians creates what Jane Jacobs refers to as a "monstrous hybrid". Corporate investors and public health regulators do contradictory types of work and are prone to corruption when they stray across their functional or moral barriers. When governments mix corporate investment strategies into health protection regulation, lives are lost (bad blood, contaminated water, deadly drugs, medical devices and unsafe food).

15. *Canada Health Act* Enforcement Grade: F

This is the last and the shortest section in the agreement, but it is not the least significant. The *'Canada Health Act* Dispute Avoidance and Resolution' consists of an exchange of letters between Alberta Health Minister Gary Mar and federal Health Minister Anne McLellan (April, 2002). Talk about the fox in the hen-house. In effect, the federal Minister has agreed not to invoke section 14 (non-compliance provisions of the *Act*) until after a 'third party' dispute resolution panel has completed its work. The three member panel will consist of a representative of each government and a third member mutually agreed to. The panel will be delegated with the federal minister's authority to interpret the principles of the *Canada Health Act*.

The federal Minister of Health has the final authority to interpret and enforce the *Canada Health Act*. But what is the likelihood of the federal Minister of Health ignoring the ruling of the Panel? The statutory duty of the federal Minister of Health is not to "avoid disputes" but to enforce the five criteria and two conditions of the *Canada Health Act*.

This section of the agreement is symptomatic of a serious weakening of the role Canadians expect the federal government to play as the national guardian of Medicare. Dispute avoidance - with Alberta, Québec or any other province - must not replace law enforcement. This is paramount.

16. Protect Health Care from Trade Laws Grade: F

Privatization rivers flow into international waters, and governments are not salmon.
- Bob Evans, UBC

There is no plan to protect public health care delivery in this agreement. The federal government does have plans, however, that expose public health services and health insurance programs to the rules of international trade agreements. To date, the federal government has failed to act on the recommendations in the Romanow Report to take "clear and immediate steps to protect Canada's health care system from possible challenges under international law and trade agreements".

For an up to date analysis of what federal trade officials are up to, read the CCPA study by Jim Grieshaber-Otto and Scott Sinclair, *Bad medicine: trade treaties, privatization and health care reform in Canada*, July 2004 http://www.policyalternatives.ca/publications/bad-medicine.pdf

Some politicians in Canada say that Canadians should "experiment" with private, for-profit delivery of publicly funded services. What they fail to mention is there is no such thing as "experimentation" under the international trade agreements that the federal government negotiated. Health care privatization in Canada is therefore a one-way street. If it fails, the public is stuck with it. To paraphrase UBC health economist Bob Evans, the privatization rivers flow into international waters, and governments are not salmon.

www.medicare.ca

First Ministers' Health Care Agreement

Report Card

September 2004

Subject	Grade	Comments
Stable Funding	**A+**	The funding agreement exceeds the amount originally promised by the Prime Minister. The new $19 billion base transfer will increase by 6% each year, ensuring predictable, stable funding, and enabling provinces and territories to undertake multi-year planning.
Accountability and reporting	**D**	The agreement is based more on 'trust' and an assumption that the public will hold governments to account. Since weak accountability facilitates privatization by stealth, Canadians will have to be diligent to ensure real accountability. Medicare is still on life support - not from lack of money - but because of weak contols on where and how the money will be spent. Follow the money!
Stemming the Tide of Privatization	**D**	The Agreement is silent on for-profit delivery of health care services. The proliferation of investor-owned, for-profit clinics acts like a viral infection in the body of Canada's public health care system. Commercialized health care reduces universal and equal access, increases costs and seriously diminishes quality of care.
Reducing Wait Times	**C**	The provinces agreed to reduce wait times by March 31, 2007 in the areas of cancer, heart, diagnostic imaging, joint replacements, and sight restorations. The real issue is how this will be done? Attempts to reduce wait times by allowing more for-profit delivery have failed wherever it has been tried. We need to reduce wait times by expanding the capacity of the public system.
Home Care	**B -**	First dollar coverage by 2006 for acute home care services will be provided. This is a very important step, however, there is still a long way to go before we have a comprehensive national program.
Elder Care	**F**	Despite an aging population and the increased demand for nursing home care, long-term health care was absent from the agreement. To ensure high quality care and equitable access, national standards for care and non-profit delivery are essential. Long-term care must become part of Medicare.
Pharmaceutical Strategy	**C -**	The agreement recognized the need for equity of access to essential medicines, cost controls, creation of a catastrophic drug plan, and other key elements of a national pharmaceuticals strategy. A Ministerial Task Force will develop and implement the strategy. There is no indication that governments are prepared to move quickly as they aren't scheduled to "report on (their) progress" until June 30, 2006. Unfortunately, this means that Canadians won't have expanded coverage for essential medicines any time soon. Citizens must work diligently to ensure the Task Force isn't hijacked by Big Pharma.

continued ...

Primary Health Care Reform	**D**	The First Ministers think they are making significant progress on primary care reform, and that all they need to do now is to share information on best practices. This view is not shared by millions of Canadians who are in need of family physicians and are awaiting anxiously for meaningful reform that establishes access to primary care on a 24/7 basis with interdisciplinary teams of caregivers. The Community Health Centre model has proven to be successful in delivering primary care in this way. It needs to be promoted.
Health Protection and Prevention	**D**	Protecting the health of the public is essential for good health and Medicare's sustainability. Health Canada wants to replace the Food & Drugs Act with a new Canada Health Protection Act. The federal proposal would shift from preventing harm from happening in the first place to "managing the damage" after harm is done. The damage Health Canada wants to "manage" is preventable illness and death.
Aboriginal Health	**N/A**	Aboriginal leaders and the federal government agreed to a $700 million plan over 5-years to implement "specific measures to close the gap between the health status of Aboriginal Peoples and the Canadian public." An important step but additional funds and federal cooperation are necessary to make major improvements in the health status of Aboriginal Peoples.
Access to Care in the North	**B**	The federal government has agreed to help address the unique challenges facing the development and delivery of health care services in the North by creating a $150 million Territorial Access Fund to provide funding for medical transportation costs as well as long-term health reforms. This is far from a "needs-based" federal funding formula but it is a step in the right direction.
Human Health Resources	**C -**	First Ministers will accelerate and expand the integration of internationally trained health graduates. Any reliance on this approach must not contribute to "poaching" health professionals from developing countries. Governments should implement the recommendations of health human resources studies already completed. Why spend over $7 million in funding health human resources studies and then ignore them?
Canada Health Act Enforcement	**F**	The federal government has a legal responsibility to enforce the Canada Health Act. Unfortunately for Canadians, it has abdicated its statutory responsibilities to enforce and monitor compliance. Canadians expect law enforcement, not dispute avoidance.
Protecting Medicare from Trade Laws	**F**	There is no plan to protect Medicare in this agreement. The federal government has failed to act on the recommendations in the Romanow Report to take "clear and immediate steps to protect Canada's health care system from possible challenges under international law and trade agreements".