The federal government needs to work with provinces and territories to improve the quality of health care and access across the health care continuum.

Reaching a Consensus on the Health Accord

by | Linda Silas
Health care joins the weather and hockey as a favourite Canadian conversation topic, and the debate around medicare is as old as medicare itself. Can we afford it? Do we need more or less services covered by public insurance? Could the private sector deliver it better, faster, cheaper? What is the role for the federal government?

The debate will only grow louder as the Health Accord comes to an end.

The Health Accord refers to legal agreements signed among federal, provincial and territorial governments in 2003 and 2004. Currently, it sets out a common vision for health care renewal in Canada and guarantees stable federal funding for health care, escalating at 6% a year. These agreements expire in 2014.

Before the Health Accord, the federal government’s proportional share of health costs had fallen to nearly 10%. Now the federal cash share of provincial health care spending is back up to around 20%.

Under the 2004 Health Accord, provinces and territories agreed to make progress on:

- Wait times
- Health human resources
- Primary health care
- Home care
- Pharmaceutical management and catastrophic drug coverage.

As a result of the renewal of health care, since 2006:

- The number of nurses grew 6%.
- The number of physicians grew 12%.
- The number of pharmacists grew 16%.
- The number of MRI scanners increased 70% and the number of CT scanners 36%.
- Wait times have been reduced for cancer treatment, cardiac care, diagnostic imaging, joint replacement and sight restoration.

Despite these results, the overall record on the Health Accord is mixed according to most observers, including the Health Council of Canada, an arm’s length agency created to report on Health Accord’s progress. For example, no progress was made on a national pharmaceutical strategy; millions of Canadians are still without access to a primary health care provider, we lag many other countries in regards to implementation of electronic health records and access to quality continuing care (home, long-term, respite and palliative care) is inadequate.

Recognizing that improvements need to be made to ensure better care, better health and better value, Canada’s Premiers announced they would meet early in 2012 to prepare for upcoming negotiations on a new Health Accord with the federal government.

On December 19, 2011—a month before the Premiers’ meeting on health care—the federal government announced that the current 6% escalator to the Canada Health Transfer will be reduced in 2016-2017 to gross domestic product (GDP) or 3%, whichever is higher. According to the Parliamentary Budget Officer, this decision will reduce the federal government’s share of health care spending to historic lows over time.

It is only by pulling together, and in the same direction, that governments will be able to achieve better care, better health and better value for all Canadians.

Take, for example, the issue of prescription drugs. Since the Canada Health Act was adopted, drug expenditures have risen from $3.8 billion to more than $30 billion. One out of four Canadians does not have any drug coverage, and 8% of Canadians admit to not filling a prescription due to cost, according to Statistics Canada.

Public plans also differ widely across the country. A patient in British Columbia prescribed medically necessary drugs after heart surgery would pay around $200 a year. In Saskatchewan, that patient would pay around $800. And in New Brunswick, the same drug treatment could be as high as $1,400.

Only 45% of total drug expenditures come from public spending. Canada is second among Organisation for Economic Co-operation and Development (OECD) countries in private insurance for drug expenditures, following only the United States.

However, only 58% of Canadian workers have drug coverage through their employer. There is wide disparity in which treatments are covered, annual limits, premiums and deductibles. Drug claims are 70% of our workplace extended health care benefits and cost Canadian employers more than $10 billion a year. Premiums have been doubling, and increas-
ingly, employers are bringing rollbacks on drug plans to the bargaining table in unionized workplaces.

Federal agencies regulate prescription drug approvals, drug safety, drug pricing and drug patents. Canadians pay 30% more than the OECD average for essential medicines, and the Comprehensive Economic and Trade Agreement with the European Union that is currently being negotiated by the federal government could increase the cost of prescriptions by $2.8 billion a year.

It is only by working in partnership that governments in Canada can provide equal access to prescription drugs and control costs through bulk purchasing and reducing administrative costs. A recent study by Marc-André Gagnon, an assistant professor at the School of Public Policy and Administration at Carleton University, estimated that a national pharmacare plan could provide savings of more than $10 billion. A national pharmacare plan has worked for New Zealand, France, Australia and many more countries.

Critics argue that governments already spend too much on health care. Yet, Canada’s public health care spending is fairly stable at roughly 8% of GDP—in line with other OECD countries. Provincial health expenditures averaged the same share of GDP in 2008 as they did in 1989.

The apparent increase in health spending as a proportion of provincial budgets is due to program reductions in other areas and a reduction in fiscal capacity of governments. Tax cuts at all levels of government amount to around $90 billion a year, or about 6% of GDP. To compare, health care spending has increased about 1.5% of GDP since the mid-1990s.

The 2002 Royal Commission on the Future of Health Care in Canada, the precursor to the Health Accord, concluded by noting that medicare is as sustainable as we want it to be. The commission also asked for evidence that for-profit financing or delivery improves quality and access and drives down cost and found none.

Public spending on health care in Canada is 70.3%, which is low compared to the OECD standard of 81.5%. There are, however, those who believe more private sector involvement will drive down costs and speed access and quality. Evidence from within Canada and around the world shows that instead of speeding access in the public system, a private for-profit parallel system increases waits in the public system. For-profit care providers avoid emergency and complicated cases, cherry-picking low-risk, low-cost and high-reimbursement patients.

In residential long-term care, the evidence is piling up showing that for-profit facilities typically have more negative events such as fractures, falls, ulcers, infections and hospital admissions than not-for-profit facilities.

The Status Quo Is Not an Option

What all Canadians can agree on is that we need our system to move beyond acute care to better prevent and manage chronic diseases and mental illness. As the commission noted, this will take more than a national focus on health care but will also require a national, coordinated effort on social determinants of health.

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Nurses know our system must be redesigned to better meet the needs of patients. Due to a lack of home and community care, more patients end up ill and in hospital emergency rooms. Many are then admitted as inpatients—the most expensive form of health provision. They may stay far too long in the hospital, with no discharge planning, awaiting a spot in a nursing home or for other appropriate community-based services to be arranged. One in every nine...
hospital beds is occupied by a person over the age of 65 who could receive appropriate care elsewhere.

The lack of a consistent approach to the provision of care is resulting in consistently dangerous levels of capacity in hospitals across the country. Care and work conditions are jeopardized by overcapacity in acute care, increasing the likelihood of infections, medical errors and readmissions. The solutions are known and prototypes are in practice. Key words for public sector innovation are integration of care, nurse-led clinics, interdisciplinary team-based models of care, and improved access and quality.

Take, for example, nurse-led care. The Canadian Nurses Association’s independent National Expert Commission set out to discover efficient, effective and sustainable ways to meet health needs of Canadians, now and in the future. Nurse-led care is one prototype that has shown to deliver better outcomes, particularly for chronic disease. The Complex Chronic Disease Management Clinic at the Peter Lougheed Centre in Calgary—which has two permanent nurse clinicians—has reduced by a quarter the number of hospital admissions and by half, the length of stay of those who do need admission.

Ontario has led the way with nurse practitioner-led clinics to provide access to comprehensive primary health care for 40,000 people. Nurse practitioners are registered nurses with master’s-level training that allows them to diagnose patients, provide some forms of treatment, refer patients to testing and prescribe certain medications. Some examples of the positive effect associated with nurse practitioner involvement include shorter length of hospital stay, improved compliance with clinical practice guidelines, better coordination of patient care, lower rates of clinical complications, lower mortality rates and improved interprofessional team collaboration. Of the 2,486 nurse practitioners in Canada, 1,482 work in Ontario.

So if the solutions are known, why do we need a Health Accord?

The Health Accord can commit signatories to substantive and meaningful program improvements, with targeted time lines to assist in accountability. That’s how the federal government can show leadership—it is a road map for health care that all Canadians can read.

Without the federal government working with provinces and territories to improve quality of care and access across the continuum, we will see gaps continue to grow in access to primary health care, pharmacare, long-term care, home care, and in quality and access to acute care.

BIO

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