

SUBMISSION TO THE
RIGHT HONOURABLE STEPHEN HARPER
PRIME MINISTER OF CANADA

HEALTH CARE AND THE FEDERAL GOVERNMENT

presented by the
Canadian Association of Retired Teachers
(ACER-CART)
December 2008

cc: The Honourable Leona Aglukkaq
Minister of Health
The Honourable Michael Ignatieff
Leader of the Official Opposition
The Honourable Jack Layton
Leader New Democratic Party
The Honourable Gilles Duceppe
Leader Bloc Québécois

QUESTIONS

1. **Where is health care going?**
2. **Should the role of the Federal Government in the area of health care be expanded beyond funding and federal transfer payments?**
3. **Is it time for the Federal Government to assume a greater role in setting up national health care standards and programs and, even in the delivery of health care services?**
4. **Should the Federal Government take a more important role in the administration and delivery of health care services?**

OVERVIEW

Through fourteen (14) provincial and territorial associations of retired teachers, the Canadian Association of Retired Teachers (ACER-CART) represents well over 160 000 members across Canada.

Every year, Directors representing these associations meet in Ottawa to discuss issues relating to aging and seniors: government policies and programs, health care, elder abuse, retirement income, downloading of responsibilities between the different levels of government, affordable housing, long term care, property taxes, pharmacare, other major issues involving seniors.

As a member of the Congress of National Seniors' Organizations (CNSO), ACER-CART is in constant contact with the representatives of other seniors' organizations, sharing information and discussing the status of health care services across Canada. ACER-CART strongly supports CNSO's mission: *influence and shape policies and programs on aging through efficient and effective dialogue between seniors' organizations and all levels of government.*

Most seniors fear for the future of health care. In their eyes, the accessibility and quality of services have become a problem. ACER-CART, along with other seniors' organizations, guides its actions on the basis of the following principles:

- Seniors' organizations are an important and invaluable part of the voluntary sector.
- The concerns of seniors are societal in nature and touch all generations, even when the focus is on seniors' issues.
- Seniors' organizations strongly support a *public involvement* approach and want to actively work in close partnership with all levels of government.
- Seniors' organizations strongly believe that all Canadians are entitled to the very best quality of life without endangering the economic framework.

INTRODUCTION

At its June 2008 Annual General Meeting, ACER-CART adopted a series of motions related to the well-being of seniors, in the areas of health care, elder abuse, long term care, pharmacare, annual inflation protection for all retirees, protection from escalating property taxes, protection of lifelong accumulated savings, volatility of markets, increased financial assistance to municipalities, funding of infrastructure projects.

At the same meeting, Directors **unanimously adopted** motions related to the health and quality of life of seniors: setup of a national drug formulary, a more active role of the Federal government on health care issues, enforcement of the core principles of the Canada Health Act, long term care.

ACER-CART values the opportunity to provide this submission to the Prime Minister of Canada and the Minister of Health. Quality health care services are the foundation of healthy well-being and quality of life. Any policy and program development with respect to aging and seniors must take into account the core values '*dignity, independence, participation, fairness and security*' that seniors have espoused over the years and in many submissions to governments of all levels.

What your government, in close cooperation with the provincial and territorial governments, does next with the following brief and recommendations presented will determine how seniors live out their retirement years and how Canadians of all ages continue to benefit from seniors' contributions to society.

It is ACER-CART's hope that the Federal Government will assume greater responsibilities in health care and will act quickly to move forward with strategies to allow seniors to enjoy a life of dignity and independence at a reduced cost for all levels of government. In our view based on research, the status quo is no longer an option.

GUIDING PRINCIPLES

CANADA HEALTH ACT

The Canada Health Act, adopted in 1984, specifies the conditions and criteria with which the provincial and territorial health insurance programs must conform in order to receive federal transfer payments under the Canada Health Transfer.

These criteria require that all insured persons have ***universal coverage*** for all medically necessary hospital and physician services, without co-payments.

With care moving from hospitals to home and community, there needs to be a debate on what should be included as '*insured services*' and on the question of charges (extra billing, user fees, health care premiums often camouflaged as a tax, ...) to insured persons for these services.

If Canadians are to have similar levels of service, it is urgent for the Federal Government to become a key player in all areas of health care services. On the basis of the division of power

spelled out in the Constitution Act of 1982, provinces resisted attempts by the Federal Government to direct implementation of programs, leading to duplication and higher administrative costs. With the existing structure, one cannot claim that Canada has a national health care system. The Federal Government is seen by the provinces as a mere provider of funds; this may explain why, out of fear of antagonizing the provinces, few conditions have been attached to federal transfers.

ACER-CART is of the opinion that the Constitution Act of 1982 gives the Federal Government the power to assume a greater role in health care, at the very least by using its spending powers to set national standards and to ensure that the core principles of the Canada Health Act (public administration, comprehensiveness, universality, portability, accessibility) are strictly followed by the provinces, core principles which are being undermined every day in every province and territory.

CANADIAN CHARTER OF RIGHTS AND FREEDOMS

7. *' Everyone has the right to life, liberty and security of the person and the right not to be deprived thereof except in accordance with the principles of FUNDAMENTAL justice.'* (Canadian Charter of Rights and Freedoms)

15. (1) *' Every individual is equal before and under the law and has the right to the protection and equal benefit without discrimination and, in particular, without discrimination based on race, national or ethnic origin, colour, religion, sex, age or mental or physical disability.'* (Canadian Charter of Rights and Freedoms)

32. (1) *' This Charter applies*

a) to the Parliament and government of Canada in respect of all matters within the authority of Parliament including all matters relating to the Yukon Territory and Northwest Territory; and

b) to the legislature and government of each province in respect of all matters within the authority of the legislature of each province.' (Canadian Charter of Rights and Freedoms)

The Charter guarantees to all Canadians certain fundamental rights and freedoms which cannot be interfered with by government, except in very limited circumstances defined in the Charter. The Charter includes **a provision which is directed towards ensuring that government observes the equality of rights of those whom it serves**. Legal precedents have been set: section 15 is concerned with the application of 'law' to individuals and groups in society, 'law' to include statutes, regulations, policies, plans, directives passed by a government. (Andrews vs Law Society of British Columbia (1989) 1 S.C.R. 143; Harrison vs University of British Columbia (1990), 3 SCR 451; McKinney vs University of Guelph (1990) 3 SCR 570).

SOCIAL UNION FRAMEWORK AGREEMENT

In 1999, an agreement (Social Union Framework Agreement) was made between the Federal Government and the provincial governments (except Québec) and the territories concerning basic rights, in particular, equality of opportunity, social programs and mobility rights. This agreement recognized a number of principles and rights of Canadians: common quality for social programs across Canada and, of extreme importance to most Canadians, health care founded on the core principles of the Canada Health Act (comprehensiveness, universality, portability, public administration and accessibility).

This agreement reflected the fundamental values of Canadians: equality, respect for diversity, fairness, individual dignity and responsibility, mutual aid and our responsibilities for one another. The signing governments committed to the following principles:

-All Canadians are equal; therefore they should all be treated with fairness and equity and given equal opportunity.

-Canadians, wherever they live or move in Canada, must be guaranteed access to essential social programs and services of reasonably comparable quality.

-Governments must ensure adequate, affordable, stable and sustainable funding for social programs.

The agreement recognized as essential the use of the federal spending power to the development of Canada's social union. ***One of the objectives of the transfers to the provincial and territorial governments is to promote equality of opportunity and mobility for all Canadians.*** The agreement also recognized the principle of 'direct federal spending' through transfers to individuals and to organizations in order to promote equality of opportunity, mobility, and other objectives.

While Canadians remain confident that the public health care system can deliver more accessible, more equitable, and higher quality care, a review of present practices and policies across Canada indicates clearly that governments of all levels must rekindle their commitments to health care renewal in Canada, a renewal that reflects the core principles of the Canada Health Act.

Canadians want and deserve a system that is accessible, safe, equitable, patient-oriented, efficient, effective, integrated, appropriately funded, and focused on population health. While the economy may dominate public opinion surveys, Canadians are concerned about the quality of health care and whether it will be there when the need arises and are frustrated about long wait times for medical services, access to family physicians, catastrophic drug coverage, home care, long term care, pharmaceutical management, shortage of skilled technicians, present and future health care workforce, ...

Canadians pay the price for major shortcomings in the system, missing opportunities to receive appropriate health care, better health and quality of life.

COMMENTS ON THE PRESENT HEALTH CARE SYSTEM

MYTH OR REALITY???????

-Universal coverage for all insured persons?

-Equality of rights of those whom it serves?

-All Canadians are equal?

-... all treated with fairness and equity and given equal opportunity?

--... guaranteed access to essential social programs and services of reasonably comparable quality?

FACTS ON OUR HEALTH CARE SYSTEM

Canada does not have a national health care system. With the present division of powers between the two levels (federal and provincial) of government, one must live with the reality that, in Canada, ***there are as many health care systems as there are provinces and territories.***

This submission maintains that ‘ ***Where one lives in Canada, and even within the same province, determines the accessibility and quality of health services.*** ’ Many health care professionals refer to the present system as ‘ a postal code health care system.’ To support this position, an analysis of key health information documents is presented.

1. Health Care in Canada, 2007 (Canadian Institute for Health Information)

-(p.9) In 2006, Canada spent an estimated \$148 billion on health services.

-(p.10) Overall, in Canada, about \$4 548 per capita was spent on health care in 2006,ranging from about \$4 000 in Québec to just over \$4 900 in Alberta and Manitoba.

-(p. 17) In 2005, the number of active registered physicians per 100 000 in Canada was 190 with a low of 46 in Nunavut to a high of 215 in Québec. In the same year, the number of active registered nurses per 100 000 in Canada was 776 with a low of 650 in British Columbia to a high of 1 315 in Nunavut and Northwest Territory.

-(p. 27) As of March 2007, the provinces and territories were required to specify their intention of implementing a patient wait time guarantee in order to qualify for funding under the federal Patient Wait Time Guarantee Trust Fund. Major differences in priority areas, as well as in benchmarks chosen, are evident. For example, in the area of radiation

therapy, Manitoba's benchmark is 4 weeks, Québec's is 6 weeks while most other provinces and territories have an 8-week benchmark.

-(p.28) According to the 2006 census data, more than 80% of Canada's population now live in urban areas. Most physicians, particularly specialists, are also concentrated in and around cities ...with about 9% of all physicians working in rural and/or small town Canada in 2004. Of the registered nurse workforce in 2005, almost 83% lived in urban areas.

-(p.29) Most provinces and territories pay for part of the cost of regular vision and dental care for children, seniors and social assistance recipients. In the case of dental care for social assistance recipients, some jurisdictions provide emergency coverage (relief of pain and infection), others provide basic coverage (restorative and preventive), and only a few provide more comprehensive coverage (restorative, preventive and prosthetic).

-(p. 36) The risk-adjusted proportion of in-hospital deaths within 30 days of admission with a new heart attack varies from region to region in Canada from a low of approximately 6% on North Vancouver Island, B.C. to a high of about 14% in the Bathurst area, N.B.

-(p. 38-39) The frequency of specific types of adverse events varies significantly. ... Emerging data also suggest that adverse events rates may vary significantly across Canada. Provincial in-hospital hip fracture rates, for example, ranged from 0.6 in Ontario to 1.1 in Alberta and 1.0 in B.C. per 1 000 seniors admitted to Canadian acute care hospitals between 2002-2003 to 2004-2005.

-(p. 46-47) ...characteristics of ' place ' can be linked to differences in health outcomes such as mortality, morbidity and physical or mental illnesses. ...adults living in large Canadian cities were less likely to be obese than those residing outside metropolitan areas...annual mortality rates were highest in the most rural areas... rural residents are at greater risk of dying from circulatory and respiratory diseases, diabetes, injuries and suicide... annual rate of cancer diagnoses ranged from 419 to 456 per 100 000 rural men compared to 464 for urban men, and 303 to 324 per 100 000 rural women compared to 336 for urban women.

-(p. 48)... poor health outcomes have been linked to specific neighbourhood and housing conditions as well.

2. Health Care in Canada, 2008 (Canadian Institute for Health Information)

-(p.2) In 2007, Canada spent an estimated \$4 867 per person on health care ... ranging from a low of \$4 371 in Québec to a high of \$5 390 in Alberta.. per capita health care spending is highest in Nunavut at \$10 903.

-(p. 17) In 2006, the ratio of general practitioners and family physicians per 100 000 in urban Canada compared to in rural Canada was 106 to 80, ... 167 to 32 in P.E.I., 92 to 58 in Ontario, 142 to 73 in New Brunswick, 118 to 95 in B.C.

-(p.31) In 2005-2006, 1.1 million visits to the emergency department resulted in patients being admitted to hospital.... Admission rates varied among Canadian jurisdiction-from 4.16 per 10 000 population in Ontario to 6.45 per 10 000 population in New Brunswick.

-(p. 36) Not surprisingly, computed tomography (CTs) and magnetic resonance imaging (MRIs) are not evenly distributed across Canada: 10.2 CTs per million population in Ontario to 21.6 in Newfoundland and Labrador; 4.0 MRIs per million population in Saskatchewan to 8.7 in Québec.

-(p. 78) The table shows differences that exist in joint replacement wait times reported by provinces.

-Hip replacement: 79% to 100% of patients had surgery within 182 days in Newfoundland and Labrador; in Nova Scotia, 36 %; New Brunswick, 26%;

-Knee replacement: 70% to 96% of patients had surgery within 182 days in Newfoundland and Labrador; Nova Scotia, 26%; New Brunswick, 24%.

-(p.82) The table shows the number of devices per million population as of January 1, 2007:

-nuclear medicine cameras: from 2 in P.E.I. to 250 in Ontario;

-CT scanner: from 2 in P.E.I. to 130 in Ontario;

-angiography suites: from 0 in P.E.I. to 74 in Ontario;

-MRI scanners: from 1 in P.E.I. to 72 in Ontario.

3. Understanding Emergency Department Wait Times, 2007 (Canadian Institute for Health Information)

-(p. 6) ...patients in larger hospitals appeared to wait longer in the Emergency Department (ED) for initial physician assessment and visit completion compared to patients visiting EDs in smaller hospitals.

4. Waiting for Health Care in Canada: What We Know and What We Don't Know, 2006 (Canadian Institute for Health Information)

-(p. 15) Most Canadians have a family doctor-86% of adults in 2003. But for some, challenges in accessing the health care system begin here. More than 1.2 million Canadians aged 15 and over were unable to find a family doctor in 2003.

-(p. 22) The table shows the data from four provinces that reported wait times for diagnostic imaging (CT scans and MRIs)

-CT wait estimates from decision to treat to treatment: Nova Scotia, 5 to 80 days; Ontario, 13 to 71 days; Manitoba, 91 days; Alberta, 17 days;

-MRI wait estimates: Nova Scotia, 40 to 95 days; Ontario, 31 to 117 days; Manitoba, 112 days; Alberta, 63 days.

-(p. 31) There are also striking variations in wait times within jurisdictions or facilities.

-(p. 36) The table shows wait times for radiation therapy as reported by six provinces: Ontario: 0.6 to 12.9 weeks; B.C., 1.0 week; P.E.I., 3 weeks; Manitoba, 1.0 week; Nova Scotia, 0.7 to 5 weeks.

-(p.38) The table shows the median wait reported by provincial governments for cataract surgery: Ontario, 85 days; Alberta, 93 days; Nova Scotia, 30 to 60 days; B.C., 93 days; Saskatchewan, 120 to 180 days.

-(p. 39) The table shows the wait times for joint replacements: P.E.I., 76 days for hip replacement, 91 days for knee replacement; Manitoba, 133 days for hip replacement, 154 days for knee replacement; Ontario, 104 days for hip replacement, 146 days for knee replacement; Nova Scotia, 180 days for hip replacement, 180 to 270 days for knee replacement.

-(p. 43) The table shows wait times for bypass surgery: Ontario, 21 days from decision to treatment; Newfoundland and Labrador, 10 days; Saskatchewan, 2 to 21 days from booking to treatment.

-(p. 52) The table shows chemotherapy wait times: Ontario 1.9 to 14.6 weeks from referral to treatment; Alberta, less than a week from oncologist visit to treatment; B.C., 2 weeks from medically able to receive the treatment.

-(p. 54) The table shows major differences in sight restoration wait times: cataract surgery wait estimate to treat 90% of patients ranging from 180 days to 315 days and even 18 months.

5. Report Card on Cancer in Canada, 2006 (Cancer Advocacy Coalition of Canada)

-(p. 4) Access to highly effective (often expensive) new drugs continues to be one of the most urgent problems cancer patients face. Last year we noted that the two richest provinces, Alberta and Ontario, were way behind in providing funding for these drugs. .. Nationwide (except for B.C.) there's now a failure to provide a newly developed lifesaving drug treatment for certain patients with leukemia. Essentially, we will continue to ration life-saving cancer treatment and some Canadians will live and some will die simply because of where they live.

-(p. 4) Another example of restricted access, or inconsistent policies on access, with serious implications for patient health is the denial of PET scans, particularly in Ontario.

-(p. 16) The table shows the availability of publicly funded PET scanning in Canada as of December 2006: B.C. (1 scanning facility, 2 000 funded scans per year, 47 funded scans per 100 000 population per year); Manitoba (1 scanning facility, 900 funded scans per year, 77 funded scans per 100 000 population per year); Québec (7 scanning facilities, 16 000 funded scans per year, 209 funded scans per 100 000 population per year); Ontario (5 scanning facilities, 750 funded scans per year, 6 funded scans per 100 000 population per year).

-(p. 17) Cancer patients' access to PET scanning varies greatly across Canada.

-(p. 23-29) In 2006, B.C. funded 20 of the 24 studied drugs (Xeloda, Eloxatin, Alimta, Temodal, Herceptin, Rituxan, Avastin, Erbitux, Campath, Bexxar, Zevalin, Arimidex, Femara, Aromasin, Thalomid, Velcade, Tarceva, Iressa, Gleevec, various generic); Alberta, 6 of the 24 and allows for third party insurers or self pay for cancer drugs.

Ontario lags behind most provinces in funding cancer drugs and has the most variability in access, particularly by sub-region.

Most provinces appear to have a preference for the type of limited access that will be deployed.

Last year in Canada, only Alberta had a formal self pay program for cancer therapeutics within the provincial cancer agency. Now, the private pay option within the public system is increasing in five additional provinces (Saskatchewan, New Brunswick, Ontario, Nova Scotia, British Columbia).

6. Report Card on Cancer in Canada, 2007 (Cancer Advocacy Coalition of Canada)

-(p. 46) In part three of the report, the table refers to the 24 drugs mentioned in the previous report and to 18 new drug indications. The table indicates major differences among the provinces in the number of approved and funded drugs: B.C. (20 of 24; 12 of 18); Alberta and Saskatchewan (14 of 24, 4 of 18); Manitoba (16 of 24, 3 of 18); Ontario (6 of 24, 3 of 18); Québec (16 of 24, 7 of 18); New Brunswick (6 of 24, 4 of 18).

7. Canada Health Consumer Index 2008 (Frontier Centre for Public Policy)

-The report comes to the following conclusions:

-The quality and accessibility of the Canadian health care system varies from province to province, whether in terms of availability of family doctors and midwives, the affordability and timely approval of new drugs, or the waiting time to see a specialist.

-Canada lacks a culture of accountability and transparency in health care, and still puts providers and bureaucrats ahead of consumers.

-Some provinces are better than others at providing consultations, diagnostics and therapeutic procedures in a timely fashion.

-The report called for a standardized national drug review program that would allow all approved drugs to be available to all Canadians independent of their province of residence.

8. Comparison of provincial prescription drug plans and the impact on patients' annual drug expenditures (Canadian Medical Association Journal, February 12, 2008)

-The study presents the following results:

-Eligibility criteria and cost-sharing details of the publicly funded prescription drug plans differed markedly across Canada, as did the financial burden due to prescription drug costs.

-Seniors pay 35% or less of their prescription costs in 2 provinces, but elsewhere they may pay as much as 100%.

-...a patient with congestive heart failure, his out-of-pocket costs for a prescription burden of \$1 283 varied between \$74 and \$1 332 across the provinces.

9. Working Together to Build a Stronger Public Health System. 2007 Annual report of the Chief Medical Officer of Health to the Ontario Legislative Assembly

-The report raises the question of tracking of communicable diseases. The province of Ontario has implemented the Integrated Public Health Information System in January 2005 to collect, transmit and analyze information across the public health system. (p. 14)

-In the Wake of SARS, several expert panels found serious gaps in the Ontario public health system's ability to adequately respond to infectious disease outbreaks. (p. 14)

-Unfortunately, while many Ontarians are living longer in good health, some segments of the population are in poor health and struggling with multiple chronic diseases. (p. 28)

Fundamental questions remain:

Wherever they live in Canada, are Canadians treated equally, with fairness and equity when it comes to health care services?

Are they guaranteed access to essential social programs and services of reasonably comparable quality, regardless of their postal code?

Health care gobbles up federal and provincial resources. Leaving out servicing the debt, it is the most important budget item. Health care's share of program expenditures is approximately 40%, some provinces at 45%. This percentage is on the increase due to many factors, some beyond government control: aging population, more expensive technology, growing demand, escalating drug costs, ... Everybody knows that such spending increases are unsustainable. The answer does not lie with a greater role for the private sector.

The federal and provincial governments have very different responsibilities in health care. ACER-CART maintains that the Federal government could and should play a greater role in health care. There are many avenues, some of which have been semi-successful in the past.

One must now look outside the box and consider new and more creative approaches. This can only result in better quality and more uniform services across Canada at a much lower overall cost to all levels of government.

In many provinces and territories, health care is approaching the critical zone by eating up a very large share of the budget. A question is now in the forefront: **Is health care approaching the point of becoming unsustainable in the not-so-distant future?**

Other avenues should be investigated, for example:

- The Federal Government could offer the provinces and territories to bring under its wings part of the health care services: for example, long term care, home care, pharmacare.

- The Federal Government could initiate joint national programs: for example, a national drug formulary, national standards for accreditation of health care professionals. Such an initiative is being undertaken in the area of securities regulation. Why not in the area of health care?

- The Federal Government could even offer the provinces and territories to bring under its wings all health care services. Some provinces might just jump at the chance to have another level of government take over a dossier which has become more and more explosive. One must recognize that it is impossible to predict the reaction of the provinces and territories unless such an offer is made.

- The Federal Government should use the constitutional '*spending power*' enabling it to make a financial contribution to certain programs subject to compliance with basic national requirements.

- The Federal Government should impose penalties in order to insure that all residents of a province have access to public health care insurance and insured services on uniform terms and conditions, without financial contributions by patients through user charges or extra billing.

- The Federal Government should use the '*declaratory power*' in the Canadian constitution to put in place basic national health care standards. According to some experts, the declaratory power enables Parliament to realign the distribution of legislative power in the Constitution Act making Parliament the sole judge as to whether or not a '*work*' is of '*general advantage to Canada*.'

- The Federal Government should consider using the power of reservation, allowing the Lieutenant Governor of a province to reserve provincial legislation for the consideration of the federal Cabinet.

-As a corollary to the above, the Federal Government should use the power of disallowance, allowing the Federal Cabinet to disallow a piece of provincial legislation even if it has been granted assent by the Lieutenant Governor, especially in areas where the core principles of the Canada Health Act are being jeopardized.

Our health care system is based on **equal access for all citizens, regardless of income**. Patients deserve **equitable access to the most effective treatments**. A comparative study of the provincial health care insurance plans would clearly show that this is not the case. For example, equal access to cancer drugs is a myth. What is available free to one patient is not available to a similar patient with the same cancer somewhere else in the country.

The Federal government has the responsibility and duty to insure that the core principles of the Canada Health Act are adhered to by the provinces and territories:

- public administration: management in a public, not-for-profit fashion;
- comprehensiveness: coverage for all residents for medically necessary health services;
- universality: uniform terms and conditions for all residents;
- portability: coverage of all residents, wherever they are treated in Canada;
- accessibility: uniform terms and conditions without direct or indirect financial charges, or discrimination based on age, health status or financial circumstances.

On the basis of the avenues open to the Federal government, ACER-CART strongly recommends that the Federal Government take the initiative in at least the following areas of health care:

- introduce a national home care program to include all programs and services that are required by seniors to remain living as independently as possible in the comfort of their own homes and communities;**
- set average standards for long term care guaranteeing to all seniors, regardless of where they live, quality care, a sense of safety and security for the patient and their families, freedom to move across Canada without loss of support and within a sustaining cost to the patient, family and health care system;**
- set up a national drug plan fully integrated into health care, publicly funded and administered, with a national formulary of essential drugs, a single-payer public system allowing for lower drug prices, stronger regulation of drug prices, prohibition of drug advertising, review of granting monopoly to pharmaceutical drugs through patent protection, universal coverage for essential drugs, regulation of drug safety and approval.**

These recommendations are more important now than in the past. Canada, along with many western nations, is facing tough economic times. The small federal surplus may head into deficit; there will be little money for more health care money. The road to recovery will be long, definitely a questions of

years. Governments of all levels must cooperate more than ever to guarantee that they will achieve the very best of return on every dollar spent for services, especially in the area of health care.

In its 2008 report '*Benefitting from Generic Drug competition*', Competition Bureau Canada estimates that close to \$800-million a year could be saved if changes were made to the way generic drugs are paid for and more competition was allowed through preferred pharmacy networks, greater use of mail-order pharmacies, incentives to patients to seek lower price drugs, price control for generics similar to those faced by patented medicines. Information of this type presents strong argument in favor of a more important role for the Federal Government on health care issues. Canadians look to the Federal Government for strong leadership to preserve and maintain, and even improve, the quality and accessibility of health care services.

ACER-CART appreciates the opportunity given to share its views on one of the major issues facing health care in Canada: respect of the core principles of the Canada Health Act. Representatives of ACER-CART would be available, even on short notice to meet with the Prime Minister or the Minister of Health to discuss the main points of this submission.

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