

Response to the Report
of the
Saskatchewan Commission on Medicare

By the
Canadian Union of Public Employees

Presented to the
Standing Committee on Health Care

July 17, 2001



CUPE Research

Introduction

The Canadian Union of Public Employees is pleased to have this opportunity to present our views to this standing committee of the Saskatchewan legislature in response to the recommendations of the Saskatchewan Commission on Medicare.

Our union represents about 23,000 public sector workers in the province in a broad range of workplaces in both urban and rural settings. About one-half our membership – 14,000 to be exact – work in health care. We are the largest union in the province as well as being the largest health care union.

You may or may not be familiar with which classifications of health care workers we represent. CUPE represents diverse front-line health workers in 987 classifications including maintenance workers, nurse and home care aides, laboratory, radiology and diagnostic technologists, therapy, dietary and housekeeping aides, cooks and Licensed Practical Nurses. Our members work in 18 of the 32 health districts in the province and in one northern hospital in Uranium City. You will find the full list of health districts in which our members work in Appendix B of this submission.

As front line workers, our members have seen inefficiencies in our health care system and they strive hard on a daily basis to provide the best health care possible to their patients and residents. They know that there could be a better way of doing things and have an interest in seeing positive changes brought to the system.

We are hopeful that the Report of the Saskatchewan Commission on Medicare, if implemented and expanded upon, will provide some of the needed changes to make our health care system better serve our citizens and the workers in the system.

We would like to present our union's response to the report and outline where we think the recommendations could be strengthened.

Overall CUPE supports most of the recommendations of the Commission on Medicare. In particular we believe that the move toward a Primary Health Care model is an extremely positive proposal. In some instances, however, we believe that the Commission did not go far enough or provide enough detail on

how the recommendations would be implemented. We hope that, through the consultations of this standing committee, further recommendations to strengthen the Commission's report will be developed.

Our submission tonight will not go through every single recommendation of the Commission but will highlight what we consider the most important elements. In Appendix A to our submission we have provided a point-by-point response to the Recommendations of the Commission on Medicare.

1. Primary Health Care Model

The creation of a primary health care model is one of the most positive elements of the Commission's report. In our union's submission to the Commission, we had proposed such a model similar to the Community Clinics in this province or the CLSCs in the province of Quebec. We feel that the creation of interdisciplinary teams of health care providers is the best model for providing health care because it recognizes that there is a broad range of factors that affect health status.

Under this recommendation the Commission also calls for the full utilization of the skills of all health care workers. This is a recommendation that we fully support and a proposal that our union has been making for some time. In particular our union has promoted the full utilization of the skills of Licensed Practical Nurses and has met with health district boards and the provincial government on this matter in the past.

We also support the concept of a Primary Health Network in which specialists would travel to rural communities. We believe that this could provide timely and needed services to residents in rural Saskatchewan and would reduce travel time and out-of-pocket expenses of those who normally would have to travel to one of the major urban centres to see specialists.

Although we are very supportive of this recommendation, we believe it could be strengthened in several areas. We also feel that for this Primary Health Care model to work, it is essential that the government recognize which elements need to be in place first to have success.

- *Provincially-coordinated Emergency Services*

We are pleased that the Commission recommended the creation of a provincially coordinated emergency services system. Our union strongly

believes, however, that emergency services need to be publicly financed, publicly coordinated and publicly managed. A private/public mix of emergency services leads to inefficiencies and complicates the goal of provincial coordination.

- *Compensation of physicians*

The Commission on Medicare recommends that physicians participate in the primary health care teams and suggests that specialists have a contractual relationship with the health districts. We feel that the Commission should have gone further and recommended that the government eliminate the fee-for-service method of compensating physicians and that physicians be paid a salary under contract with health districts. The primary health care model will have limited success unless physicians are integrated into the teams and are accountable to the health districts. Fee for service encourages unnecessary tests and procedures and impedes the success of a new model.

- *Conversion to Community Health Centres*

This recommendation is no doubt one of the most controversial in the Report. CUPE supports the creation of community health centres that provide a broader range of health services than the current limited acute services of many rural hospitals. The number of hospitals that would be closed or converted, however, is a difficult point. It is important that the government develop a health services plan for these communities that outlines how services would be maintained in the event of hospital closures.

There are many factors that need to be considered before any such closures take place. First of all, we believe that there must be a Labour Adjustment Strategy in place, similar to the program in British Columbia, which minimizes job loss and ensures the redeployment of workers in the system. Ideally there would be no job loss. Considering the high workload and stress levels that our members face, we do not want to see fewer workers expected to provide more services under this new health care model.

Secondly, no closures or conversions should occur until a public, provincially-coordinated emergency services system and the primary health care teams are in place and functioning well. Until the health districts and the provincial government can assess the success of emergency services and health care teams in meeting health care needs of rural Saskatchewan, it is unwise to close or convert hospitals. This is a lesson that we should have learned from the last experience with health reform.

2. *Specialized Care*

We support the proposal to concentrate tertiary services in the three major urban centres of Saskatoon, Regina and Prince Albert. The creation of “Centres of Excellence” in these cities may assist in attracting specialists to our province.

The proposal to develop a network of Regional Hospitals is another idea we support and one that we recommended to Mr. Fyke. However, we believe that these regional hospitals need to be able to provide a full range of diagnostic and surgical services to reduce the heavy demands on Saskatoon and Regina health districts. As we noted in our submission to the Commission, 70 percent of all surgery is performed in these two health districts. The provincial government needs to provide appropriate funding for equipment and personnel to the regional hospitals to ensure their surgical capacity.

3. *Making Things Fair*

In this section the Commission on Medicare makes several general recommendations with respect to determinants of health, health promotion and prevention. The report also recommends that measurable and clearly-defined health goals be adopted across the province.

While we are strongly in support of these ideas, we feel that the discussion on determinants of health and the possible solutions should have been dealt with in a much more comprehensive and in-depth manner. Tackling the social and economic determinants of health, we believe, should be one of the major thrusts of health care reform. In our brief to the Commission, we used an example of how the French government reduced the number of premature births by 30 percent by paying women to attend prenatal sessions, providing them with food supplements during pregnancy, expanding maternal leave and allowing pregnant women thirty minutes off work at the beginning and end of each day so they wouldn't have to cope with heavy traffic.

The Saskatoon Health District recently released a report making the links between poverty, substandard housing and poor health status. The report

makes many recommendations for a broad range of multisectoral approaches to improve health status including an increase in the minimum wage.

In our brief to the Commission, we pointed out that health care is the industry with the highest rate of injuries reported to the Workers Compensation Board. Although the Commission makes reference to the improvement of working conditions, we would like to see a more detailed plan for dealing with the high rate of stress, workload and injuries in the health care sector.

We believe that it is essential that a new health strategy recognize that a variety of social and economic factors and physical environments influence our health status. Clean air and water, healthy workplaces, family and social supports and adequate living conditions make a tremendous impact on our health.

The only other point we have on this section is regarding a northern health strategy. We support this recommendation but feel that, in the spirit of self-government, aboriginal communities should have autonomy in defining and implementing strategies that best meets their needs.

4. Getting Results

The recommendations that fall under this section deal with the creation of a quality health system through the development of performance indicators and a Quality Council that sets standards. In general terms CUPE supports this recommendation but we have some concerns about how performance indicators would be developed and under what criteria. We hope that front-line workers through their unions will have input into the development of performance indicators. For example, it may be fairly straightforward to develop best practices for drug prescribing but how do we measure the more subjective aspects of quality of care? Our members tell us how increased workloads have meant less personal time with residents or patients, which has a negative impact on quality of care. Will performance indicators attempt to measure these factors?

The Commission has envisioned a Quality Council as an objective body composed of experts using evidence-based methodology to set standards and

develop performance indicators. We agree that the Quality Council needs to have a level of expertise and objectivity that provides it with some authority to set standards. However, we want to caution that there are some limitations to evidence-based methodologies. Last year the Health Services Utilization and Research Commission (HSURC) released a study that claimed that seniors were more likely to die or lose independence if they received home care services than those who did not receive services. This study raised many questions and ignored the more subjective “quality of life” benefits of home care services.

CUPE would like to see the Quality Council include representatives from groups with a broad range of community experiences, such as anti-poverty and women’s groups, community development activists and unions. If we acknowledge that social and economic factors influence health status, and that the Quality Council will be the watchdog of our health system, then we need expertise from activists on the Council.

5. Support of Change

CUPE supports reducing the number of districts to ensure high quality, consistent services across all health districts. We are not committed to either the 9 or 11-district model but would choose 11 districts over 9. Ideally the creation of districts should follow natural flow patterns that currently exist. Again, as we mentioned earlier, there should be no changes to the health district structure until a comprehensive employment and training strategy is in place.

The Commission’s report recommends province-wide coordination of human resources planning and management but does not address the problem of the duplication of human resources structures in health districts and affiliates. CUPE recommends that the affiliates fall under the jurisdiction of the health districts or, at the very least, that human resources management be centralized under the health districts.

We continue to support the concept of fully elected health boards instead of the current mix of elected and appointed board members. We are totally opposed to any ban on health district employees being able to run for health board positions. We believe that there are adequate conflict of interest guidelines in place that ensures fair participation of health district employees on boards.

While the Commission's report makes references for the need to clarify roles and responsibilities and to ensure accountability between the various structures in health care, we feel that the province must dramatically overhaul the governance structures for health care.

Ultimately the provincial government is responsible for setting the policy direction and delivering health services to residents of this province. Then we have the Department of Health, committees of the department, the health districts, the affiliates and the Saskatchewan Association of Health Organizations (SAHO) in the mix. At present the various roles and unclear lines of responsibility create confusion and frustration. Although the government fully funds health care it has delegated authority for bargaining to SAHO, an organization that seems intent on creating strife in health care labour relations.

The Commission on Medicare's recommendation to create Quality Council will add another layer to this hierarchy. We would like to see fewer layers and clearer lines of accountability.

One proposal would be to create a structure or a body similar in nature to a Crown Corporation. This body would have responsibility for developing policies and standards for health care and ensuring the implementation of health care strategies. It would provide direction to the health districts and the health districts would be accountable to this body. SAHO would be dissolved and this new structure would have responsibility for bargaining with a clear mandate from the provincial government. The Quality Council proposed by the Commission would be an arm or branch of the new structure.

The new structure would have an advisory committee with representation from community organizations active in the area of the determinants of health.

We feel that such a structure would ensure more accountability and direction to our health care system and would ensure more effective delivery of services.

6. Paying the Bills

In this section of the Commission's report, the Commission does not recommend any expansion of services to be covered under medicare but states that costs first need to be controlled through quality control measures. We consider this section to be one of the weakest sections of the report. We strongly believe that our provincial health insurance plan needs to expand to include a broader range of services and that if alternative health services were covered we could see cost savings to health care and social programs.

For example, limited home care services can create burdens on informal caregivers whose own health may then suffer. A study of rural women in Saskatchewan found that half the women interviewed saw their health deteriorate since they began to care for aged or disabled family members. Additional resources invested in home care would reduce health care costs of informal caregivers in the long run.

Funding midwifery could reduce the high costs of obstetrical care. Reinstatement of the children's school-based dental program would be valuable investment in the long term health of children. Although all Saskatchewan residents are guaranteed access to a physician or hospital regardless of income, the economically disadvantaged do not have equitable access to other services that are just as important if not more important to good health. In 1999 only 40% of low income Canadians saw their dentist compared to 80% of high income Canadians.

Conclusion

In conclusion, our union supports the main recommendations outlined in the Commission on Medicare Report, and we are especially pleased with the proposals to develop a primary health care model and restructure the current number of health districts. We feel that this will create a more responsive and integrated health care system.

We do have some concerns with the generality of the recommendations because they leave the door open to interpretation in many cases. What is needed is a detailed implementation plan that outlines how arising problems and obstacles will be addressed.

We also feel that the scope of the report could have been much broader to develop strategies and ideas for addressing socio-economic factors that affect health status. Although the report makes general references in support of

population health approaches, it provides little analysis or no specific recommendations on this important area.

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Appendix A
Summary of CUPE Response to Saskatchewan Commission on Medicare Report

Fyke Commission Recommendation	What CUPE proposed in our brief to Fyke	CUPE Response to the Fyke Report
<p>1. Everyday Services Establish Primary Health Service teams bringing together a range of health care providers including family physicians</p>	<p>Create multi-disciplinary team of health providers in community health centres. Place doctors on salary as employees of health districts and eliminate fee for service.</p>	<p>Fyke calls for doctors being part of integrated primary health teams but falls short of recommending putting doctors on salary. We believe that the elimination of fee-for-service is essential for health reform.</p>
<p>Integrate individual teams into a Primary Health Network, managed and funded by health districts, which includes enhanced community and provincially-coordinated emergency services.</p>	<p>Coordinate the provision of all health and community services through community health centres. Provincially coordinated and fully public emergency services.</p>	<p>Fyke calls for provincially coordinated emergency services, standards and training but does not call for an all public system (p.17). We urge the government to develop an all public, provincial emergency services system.</p>
<p>Convert many small existing hospitals into Primary Health Centres designed to support Primary Health Teams. There would also be 25-30 Community Care Centres in the province, incorporating some of the existing integrated facilities</p>	<p>Create community health centres that use multi-disciplinary health teams</p>	<p>CUPE supports the creation of Primary Health teams that travel to rural communities. It is important that rural communities have good and timely access to health care providers. The development of a provincial, public emergency services system is critical</p>

Fyke Commission Recommendation	What CUPE proposed in our brief to Fyke	CUPE Response to the Fyke Report
and health centres. The centres would only be open 8-12 hrs/day but primary health teams would travel to rural communities to reduce patient travel.		to support rural areas in urgent medical cases.
Ensure that comprehensive services are available 24 hours a day, 7 days a week, including telephone advice service staffed by trained nurses.	Provide 24 hour primary care and emergency nursing and a telephone health advice line.	We support this recommendation. It is critical that the telephone advice line be staffed by highly trained nurses.
<p>2. Specialized Care Develop a province-wide plan for the location and delivery of specialized services that include: tertiary services delivered in Saskatoon, Regina and P.A. Fyke recommends max. 60 mins. travel time to a hospital for 88% of population and max. 80 mins. travel time for 98% of the population.</p>	We made no specific recommendations on tertiary services.	CUPE supports the development of a provincial plan for specialized services. We have some concerns about travel time to hospital. This recommendation is dependent on having a high quality and effective emergency services system.
- a network of 10 to 14 Regional Hospitals to provide basic acute care and emergency services. Fyke states that surgery should only be provided where adequate personnel and equipment can be assured.	Regional hospitals would provide a full range of diagnostic and surgical services	CUPE believes that the provincial government must provide necessary funding to ensure that regional hospitals can provide a full range of diagnostic and surgical services. This would alleviate surgical demands on Regina and Saskatoon.
- districts contracting with specialists to provide outreach services, consult with Primary Health Teams and support overall	That visiting specialists be integrated into health services plan of community health centres	We support specialists traveling to rural patients. This saves time and personal cost for patients and would improve coordination

Fyke Commission Recommendation	What CUPE proposed in our brief to Fyke	CUPE Response to the Fyke Report
goals of health system.		between specialists and local health providers.
- utilization of beds and resources based on standards established by a Quality Council.	Ensure appropriate care in the appropriate setting at the right time.	We urge the government to allow front-line workers to have input into the establishment of standards and level of services so that issues such as workload are considered.
3. Making Things Fair The continuation and/or development of: - public health, health promotion and disease and injury prevention strategies	Our brief emphasized the need for preventive health, social/economic strategies, health promotion strategies and creating healthy workplaces.	Although Fyke supports social programs that help keep people healthy his report is fairly general. CUPE urges the government to develop strategies to improve economic and social wellbeing of Saskatchewan residents, especially the most vulnerable.
- regular reports on defined and measurable health goals	We made no specific recommendations on measurable goals.	CUPE encourages the government to include broad-based sectors in the development of such goals. Unions, who represent front-line workers, would like to have input on issues such as workload, staffing levels, quality of care.
- strategies to address the broader determinants of health The report provides many examples of community population health strategies but does not make specific recommendations other than “continued emphasis on multisectoral collaboration at the provincial	CUPE called for a broad range of social and economic policies to address poverty, healthy workplaces, early childhood education, etc.	As mentioned above, CUPE would like to see more specific strategies outlined in the report. For example, Saskatoon District Health released a report in mid-June linking poverty, substandard housing to poor health status. The government needs to develop strategies for affordable housing, safe water, and to address poverty.

Fyke Commission Recommendation	What CUPE proposed in our brief to Fyke	CUPE Response to the Fyke Report
level to improve the health status of the population.” (p.42)		
- a northern health strategy	That the government develop specific strategies to address aboriginal health needs	In the spirit of self-government, the government should support a process in which aboriginal communities develop their own strategies for health care.
4. Getting Results To sustain a quality health system: - continued development of performance indicators	We made no recommendations on performance indicators.	Front-line workers through their unions should have input into the development of performance indicators.
- establishment of a Quality Council with a mandate to improve the quality of health services in the province. The Council would be an “evidence-based” organization, independent from government that reports directly to the legislature. The members of the QC would be “informed, independent” people and not representatives of organizations.	We made no recommendations on a Quality Council.	CUPE would like to see the Quality Council have representation from groups with a broad range of experiences, such as anti-poverty groups, women’s groups, unions, community development activists, etc. If we recognize that social and economic factors influence health status, then we need expertise from people in these fields, not just from academics and bureaucrats.
- incentives and funding to develop accountability and quality. Funding formula for districts would “reward quality and health status improvements.”	We made no recommendations on incentives but did urge for more accountability and clarification of roles between districts and the province.	

Fyke Commission Recommendation	What CUPE proposed in our brief to Fyke	CUPE Response to the Fyke Report
<p>5. Support of Change To support the proposed changes to the health system: - 9 to 11 health districts and clarification of their relationship to the government of Saskatchewan. The report supports the current mix of elected and appointed board members but suggests that districts revert to fully appointed boards if low voter turnout for the health district elections continues. Fyke recommends that employees of district not be allowed to serve on boards.</p>	<p>Reduce number of health districts and ensure standard, high-quality services provided across all districts. The role of the provincial government and health districts needs to be clarified so there is greater accountability. Health district boards should be fully elected.</p>	<p>CUPE supports reducing the number of districts to ensure high quality, consistent services across all health districts. We are not committed to either the 9 or 11 district model but feel that the districts should be created along natural flow patterns. We continue to support the concept of fully-elected health boards and we are opposed to any restrictions on health district employees running for board positions.</p>
<p>- a structured dialogue on the delivery of health services to aboriginal people</p>	<p>Need to address specific health issues of aboriginal people.</p>	<p>CUPE supports a process whereby aboriginal communities develop and implement health strategies that meet their needs.</p>
<p>Co-ordinated human resources planning and management on a provincial basis. The report supports a labour adjustment strategy, training and retraining measures and the full utilization of health care workers' skills.</p>	<p>Province-wide human resource planning in cooperation with health districts, unions and the province and the creation of a provincial training strategy. We called for greater utilization of workers' skills.</p>	<p>CUPE supports provincially coordinated human resource planning. However, the report does not address the duplication of human resources management between health districts and affiliates. CUPE recommends that human resources fall under the direction of the health district. We also support recommendations for a labour adjustment strategy (as in British Columbia), training and retraining strategies and the full utilization of workers' skills.</p>

Fyke Commission Recommendation	What CUPE proposed in our brief to Fyke	CUPE Response to the Fyke Report
<p>- the renewal of health science education programs, including increased funding for health research, equal to 1% of public health spending</p>	<p>We made no recommendations on health research.</p>	<p>CUPE supports increased funding for health research. A portion of these funds should be allocated to qualitative research.</p>
<p>- investments in information systems including the development of an Electronic Health Record</p>	<p>We made no recommendations regarding information systems.</p>	<p>We support the development of an Electronic Health Record that provides up to date, comprehensive information to health providers. The government must place a strict ban on this information being sold or provided to companies for commercial interests (e.g., pharmaceutical companies).</p>
<p>6. Paying the Bills Future investments be directed to: - changing the organization and delivery of primary and specialized services. The report does not recommend expansion of services under medicare but focuses on controlling costs through quality control measures.</p>	<p>CUPE called for the creation of interdisciplinary health teams and an expansion of services to be covered under the public health system such as home care, dental care, midwifery, pharmacare, rehabilitation and occupational therapy.</p>	<p>We are disappointed that the Fyke report did not address expanded coverage of services under medicare. Only 40% of low income Canadians saw their dentist in 1999 compared to 80% of high income Canadians. The lack of home care services creates burdens on informal caregivers. The average Saskatchewan family's out-of-pocket expenses for health care increased by 25% from 1992 to 1996. Our health care system must address this.</p>

Fyke Commission Recommendation	What CUPE proposed in our brief to Fyke	CUPE Response to the Fyke Report
- enhancing the overall health of the population	We called for the development of social and economic strategies.	
- research to support health services education, and to develop and report on performance measures, service quality and value for money	We made no specific recommendations on these points.	We support research but would recommend that not all funds be directed to evidence-based research. Participatory, qualitative research that involves various communities can yield important and valuable information about our health care system. We cannot forget that there are human beings with complex needs behind the statistics.
- managing change and creating a quality-oriented health services culture	We recommended that the creation of interdisciplinary teams and the full utilization of workers' skills would result in higher quality of care.	We support the creation of a "quality-oriented health services culture" but this must include quality of work life.

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Appendix C

Summary of Recommendations

From

CUPE's Submission to

The Saskatchewan Commission on Medicare

Summary of Recommendations

Rethinking Health Care

1. A renewed health care system must focus on the social and economic determinants of health.
2. All provincial government departments must work together cooperatively to implement healthy public policies that improve health status of Saskatchewan residents, such as:
 - an increase in the minimum wage
 - pay equity legislation that covers both the public and private sector
 - an expansion of social housing
 - changes to the *Labour Standards Act* that provide for increased vacation time, paid family leave days and reduced working hours
 - the creation of a Workers Health Centre that focuses on work-related illness and disease
 - increased funding to day cares and early childhood education
 - improved staffing to reduce workload in health facilities (injury rates in the health care sector are the highest of occupational sectors)
 - reinstatement of the school-based children's dental program

Health Care Delivery

3. The provincial government must review the current structure of regional health districts to ensure the most effective and highest quality of delivery of health services to Saskatchewan residents.

4. The provincial government should develop a list of standard services that must be delivered by all health districts.
5. The provincial government should enhance the services of regional hospitals to ensure a full range of diagnostic and surgical services.
6. The government should create a provincially-coordinated and publicly-delivered ambulance emergency service.
7. The government should establish multidisciplinary Community Health Centres that provide primary care to Saskatchewan residents. Community Health Centres would provide 24-hour nursing services and be the entry point to the health care system.
8. The provincial government should eliminate the fee-for-service method of paying physicians and instead pay physicians by salary.
9. Physicians should become employees of the health districts and accountable for all the services they provide.
10. The provincial government should develop a comprehensive provincial strategy for long-term care that examines increased public support for housing, home care and long term care.
11. Home care services should be expanded to provide a broader range of services, such as increased homemaking and yard work, and an increase in respite services to support family caregivers.
12. The provincial government should increase funding to home care and establish a standard set and a minimum level of home care services to be provided by every health district.
13. The provincial government should re-establish funding to level I and II nursing home care and restrict the number of beds in private and personal care homes to 10.

Creating Health Workplaces

14. The provincial government must increase funding for staffing levels and establish minimum staffing ratios for health care institutions.
15. The provincial government should support the creation of more full-time positions and the reduction of working hours in health care.
16. The health district employees should develop strategies to fully utilize the skills of all health care workers.
17. The provincial government, in conjunction with the health districts and health care unions, should develop a provincial strategy for the retention and retraining of health care workers.
18. The provincial government should amend The Health Districts Regulations to state that all human resources and labour relations matters fall under the jurisdiction of the health districts. This would eliminate the duplication of these functions within the health districts and affiliates.
19. The provincial government should be a partner at the bargaining table with SAHO and the healthcare unions (as it is with the SSTA and teachers).

Governance Issues

20. District health boards should be fully-elected to ensure accountability to citizens in their region.
21. The provincial government must play a stronger role in the planning and delivery of health care services.

22. District health boards must find new and innovative ways of involving and consulting with the public, consumers and stake holders.
23. The provincial government should review the level of administrative positions within health districts and affiliates with the goal of reducing such positions and increasing the number of front line workers.
24. The provincial government should establish maximum salary levels for CEO's and other high level administrators.
25. The provincial government should amend The Health District Act to outline the duties and responsibilities of CEO's.

Enhance Public Services

26. The provincial government should expand the public delivery and funding to the following services:
 - home care
 - long term care
 - pharmacare
 - children's school-based dental program
 - rehabilitation and occupational therapy
 - midwifery