Improving the health of all Canadians: A vision for the future

The CMA’s platform on the 2017 federal/provincial/territorial health accord
## Table of contents

Why Canada needs a new health accord ............................................................................................................ 3
Improving the health of all Canadians: a vision for the future .......................................................................... 3
The vision .......................................................................................................................................................... 4
Focus on the future — seniors care .................................................................................................................. 5
Specific proposals ............................................................................................................................................... 6
A. To support Canada’s seniors .......................................................................................................................... 6
   1. **Demographic top-up** ............................................................................................................................. 6
   2. **Catastrophic coverage of prescription medication** .................................................................................. 7
   3. **Support caregivers by making caregiver and family caregiver tax credits refundable** ....................... 8
   4. **Home care innovation fund** ................................................................................................................ 8
   5. **A national strategy for palliative and end-of-life care** ........................................................................ 9
   6. **Federal investment in long-term care and residential care sector** .................................................... 9
B. To support innovation across the system ...................................................................................................... 10
C. To support healthy public policy .................................................................................................................. 10
D. To ensure ongoing, collaborative review of health care .............................................................................. 10
The federal role and accountability .................................................................................................................. 10
Appendix A: Previous federal/provincial/territorial health accords .................................................................. 13
Why Canada needs a new health accord

The Canadian Medical Association (CMA) is pleased that the federal government has committed to negotiating a new health accord with the provinces and territories. The CMA feels that this commitment by the new Liberal government represents a historic step toward improving health care and developing a new long-term funding agreement.

There have been three previous federal/provincial/territorial health accords (see Appendix A). Health accords provide an opportunity for governments to jointly set a common national direction and to identify pan-Canadian objectives and approaches to address issues facing all health systems.

The stark reality that underlies any discussion on a new health accord for Canada is that our national, publicly funded health care system was created some 50 years ago when Canada’s demographics were quite different. In 1966, our population was just over 20 million (now over 30 million), Canadians’ life expectancy was approximately 71 years (now over 81 years) and the median age of Canadians was 27 years (compared with 41 years in 2016). The aging of Canada’s population is one of the most pressing policy imperatives of our time, given its impact on health care, social services and the economy. In addition to addressing the challenges posed by Canada’s aging population, a new health accord must also deal with the fact that our system has consistently and repeatedly failed to provide timely access to comprehensive, high-quality health care for Indigenous and rural Canadians.

The last health accord was signed over a decade ago, in 2004. A new accord is urgently needed so that Canada’s publicly funded health care system — built on the health programs funded by each of the 13 provinces and territories — can better meet Canadians’ health needs while providing greater value for money and remaining sustainable. If a new accord were signed in 2017, it would represent a laudable contribution to nation building on the occasion of Canada’s 150th birthday.

To be truly relevant and effectively respond to Canadians’ present and future needs, our health care system must provide integrated, continuing care able to meet the chronic and complex care needs of our growing and aging population. This includes recognizing the increased role for patient and family caregivers in the care process as well as the importance of supporting efforts that improve the social determinants of health and healthy living.

Perhaps most importantly of all, to develop and put into effect a modern vision for health care, government officials, health professionals, academics, the public and health care managers must use modern, collaborative approaches to improve the way changes are made to the health care system.

Improving the health of all Canadians: a vision for the future

The first step in creating a new health accord must be to hammer out a common vision of how to improve the health of Canadians. This will provide critical direction and focus for the ensuing discussion, so that the collective challenges facing all health care systems in Canada — both the 13 provincial and territorial systems and the federal system responsible for populations falling under federal jurisdiction — can be overcome.

With this in mind, the CMA offers a vision statement for consideration in the discussions about the next national health accord. The CMA’s vision is based on the Institute for Healthcare Improvement’s (IHI)
Triple Aim framework to optimize health system performance: (1) improving the patient experience of care (including quality and satisfaction), (2) improving the health of populations and (3) achieving better value for money invested in health care. Our vision is also founded on collaborative work we have undertaken with several other health and non-health organizations regarding principles to guide the transformation of health care in Canada.

The vision

Canadians deserve a health system that starts with the patient at the centre. Such a system provides quality services in a timely, safe, effective, evidence-informed way that respects individual choice and that is actively supported by all involved in the health care system. To improve the patient experience, systems of services must be integrated so that professionals providing health promotion and protection, disease prevention, assessment, diagnosis and treatment, palliation and assisted dying work in concert across home, community and hospital settings. Every Canadian must have access to a family medicine generalist team, and affordable and comprehensive prescription drug coverage.

The health system must enable physicians, nurses and other health care professionals to provide the highest quality team-based collaborative care to their patients, guided by peer-led review and fully incorporating patients and their families in decisions. Health care systems must have a well-trained, stable and respected workforce; they must be supported by a sound physical and information technology infrastructure; and their services must be guided by ongoing, evidence-based research. All persons are to be treated equitably and with respect, cultural sensitivity and kindness.

Canada can lead health-system innovation by embracing health information technologies and health informatics. This includes meaningfully using electronic medical records that:

- augment the patient-physician relationship;
- assist with the history and ordering of tests;
- support the shift to community and home-based service delivery;
- support diagnostic and therapeutic decision-making and electronic prescribing;
- support immunization uptake and monitoring;
- allow the collection and use of population health data for disease management; and
- enable all Canadians to have ready access to their medical information from any location in Canada.

Our system should build mechanisms to support the development and testing of innovative, integrated structures and programs that track and analyze health care outcomes and fiscal sustainability. All structures and programs must show clear evidence of improvement in these measures before they are adopted widely in the Canadian health delivery system. Our system must also allow for ongoing, constructive feedback on patient and program outcomes from all stakeholders so that improvements can continue to be made across the system.

If we are to improve the health of our citizens, all levels of government in Canada must work together to improve the underlying social and economic determinants of health of Canadians. To ensure that this happens, all proposed Canadian laws and regulations should undergo a health assessment or be subject to veto if they are found to have a negative health effect.

Beyond the commitment of governments, the health care system itself has a duty to provide Canadians with equitable access to quality care and to pursue multi-sectoral policies to address the social
determinants of health. As a first priority, renewal of the health care system must focus on at-risk patient populations: Indigenous populations; populations living in remote areas, in poverty or in inner cities; populations with addictions and mental health problems; and patients managing multiple conditions.

Canadians (funders, providers, the public/patients/families) are all responsible for ensuring that the health care system is kind, integrated, effective, appropriate and accountable. This includes ensuring that several features are in place: good governance (clear lines of authority and responsibilities), accurate and useful methods to measure performance, a safe process for ongoing critical review and public reporting. Health and health care delivery must be managed at arm’s length from — but in partnership with — federal, provincial and territorial governments.

The federal government plays an important role in ensuring that the Canadian health care system is strong and sustainable in the following ways:

- It must contribute to the bedrock of reform: it must participate in the process of agreeing on the vision for the health care system and it must collaborate with all involved in the health care system on the change process.
- It must participate in the ongoing joint policy discussions necessary to address health issues of national importance.
- It must ensure greater accountability and visibility of services to users and it must ensure that linkages between services are improved.
- It must ensure that the standards of health care service across Canada are maintained and improved including care for patients under federal jurisdiction (e.g., Indigenous populations, veterans, refugees).
- It must ensure that the health care system has the financial stability necessary to effectively plan health care delivery, and it must ensure that there is flexibility in spending across Canada to respond to local circumstances, emerging health needs, and new patient-care modalities.
- It must ensure that federal health cash payments to provinces and territories are indexed to reflect changes in population growth (e.g., demographic changes).
- It must support greater equity across the provinces and territories in terms of their ability to finance necessary health care programs (e.g., to address fiscal incapacities).

**Focus on the future — seniors care**

Previous health accords have focused on specific issues facing all provincial and territorial health systems. For example, the 2004 health accord included a shared commitment to address wait times throughout Canada.

The CMA believes that seniors care is an essential health care issue of our time and must be a priority for the next health accord. Every Canadian jurisdiction, along with many other industrialized countries, is struggling to meet the health care needs of aging populations. In Canada, the proportion of seniors will double over the next 20 years, while the group aged 85 years and older is set to quadruple. By 2036 seniors are expected to make up 25% of the Canadian population.

It is good news that Canadians are living longer and with a greater degree of independence, but this reality brings with it the challenge that more and more of our citizens are coping with a wide range of complex and chronic health conditions. Our current health care system, designed with an acute care focus, struggles to meet their needs because we lack a truly national approach to developing new ways
to arrange, deliver and pay for their care. It is estimated that 2.4 million Canadians aged 65 years and older will need continuing care, both paid and unpaid, by 2026. That’s 71% more people than in 2011; by 2046, the number is estimated to rise to 3.3 million. The cost will go from $28.3 billion in 2011 to $177 billion in 2046.

The CMA contends that getting seniors care right will not only lead to better health outcomes and quality of life for Canada’s elderly population but it will also result in innovations and improvements across the entire health care system, benefiting all patients.

Specific proposals

To support our proposed vision, the CMA has prepared specific proposals for consideration by federal, provincial and territorial governments for inclusion in the next health accord. They are outlined below. Where possible, an estimated cost has been included.

A. **To support Canada’s seniors**

1. **Demographic top-up**

Canada’s provincial and territorial leaders are struggling to meet health care needs in the face of our nation’s demographic shift. In July 2015, Canada’s premiers issued a statement calling for the federal government to increase the Canada Health Transfer (CHT) to 25% of provincial and territorial health care costs to address the needs of an aging population. As an equal per-capita based transfer, the CHT does not currently provide additional funding for population segments with increased health needs, specifically seniors. The CMA was pleased that this issue was recognized by the prime minister in his letter last spring to Quebec Premier Philippe Couillard. However, the CMA is concerned that if a consultation process is undertaken to modify the transfer formula, the delivery of federal support to meet the needs an aging population could be delayed.

To expedite action, the CMA has developed an approach that would deliver critical support to jurisdictions struggling to meet the needs of their aging populations, while respecting the transfer arrangement already in place. The CMA commissioned the Conference Board of Canada to calculate a needs-based projection for each jurisdiction based on the projected increase in health care spending associated with an aging population to arrive at the amount each jurisdiction would receive.

The CMA recommends that the federal government deliver additional funding on an annual basis beginning in 2016–17 to the provinces and territories by means of a demographic-based top-up to the CHT (Table 1). For the fiscal year 2016–17, this top-up would require $1.6 billion in federal investment and would support the innovation and transformation needed to address the health needs of the aging population.
Table 1: Allocation of the federal demographic-based top-up, 2016–20 ($million)\textsuperscript{5}

<table>
<thead>
<tr>
<th>Jurisdiction</th>
<th>2016</th>
<th>2017</th>
<th>2018</th>
<th>2019</th>
<th>2020</th>
</tr>
</thead>
<tbody>
<tr>
<td>All of Canada</td>
<td>1,602.1</td>
<td>1,663.6</td>
<td>1,724.2</td>
<td>1,765.8</td>
<td>1,879.0</td>
</tr>
<tr>
<td>Ontario</td>
<td>652.2</td>
<td>677.9</td>
<td>692.1</td>
<td>708.6</td>
<td>731.6</td>
</tr>
<tr>
<td>Quebec</td>
<td>405.8</td>
<td>413.7</td>
<td>418.8</td>
<td>429.0</td>
<td>459.5</td>
</tr>
<tr>
<td>British Columbia</td>
<td>251.6</td>
<td>258.7</td>
<td>270.3</td>
<td>270.1</td>
<td>291.3</td>
</tr>
<tr>
<td>Alberta</td>
<td>118.5</td>
<td>123.3</td>
<td>138.9</td>
<td>141.5</td>
<td>157.5</td>
</tr>
<tr>
<td>Nova Scotia</td>
<td>53.6</td>
<td>58.6</td>
<td>62.3</td>
<td>64.4</td>
<td>66.6</td>
</tr>
<tr>
<td>New Brunswick</td>
<td>45.9</td>
<td>50.7</td>
<td>52.2</td>
<td>54.1</td>
<td>57.2</td>
</tr>
<tr>
<td>Newfoundland and Labrador</td>
<td>29.7</td>
<td>30.5</td>
<td>33.6</td>
<td>36.6</td>
<td>46.1</td>
</tr>
<tr>
<td>Manitoba</td>
<td>28.6</td>
<td>30.6</td>
<td>33.5</td>
<td>32.5</td>
<td>36.6</td>
</tr>
<tr>
<td>Saskatchewan</td>
<td>3.5</td>
<td>4.9</td>
<td>7.3</td>
<td>12.7</td>
<td>15.4</td>
</tr>
<tr>
<td>Prince Edward Island</td>
<td>9.1</td>
<td>9.7</td>
<td>10.6</td>
<td>10.9</td>
<td>11.5</td>
</tr>
<tr>
<td>Yukon</td>
<td>1.4</td>
<td>2.6</td>
<td>2.1</td>
<td>2.5</td>
<td>2.5</td>
</tr>
<tr>
<td>Northwest Territories</td>
<td>1.4</td>
<td>1.6</td>
<td>1.7</td>
<td>1.8</td>
<td>2.1</td>
</tr>
<tr>
<td>Nunavut</td>
<td>0.9</td>
<td>0.6</td>
<td>0.8</td>
<td>1.0</td>
<td>1.0</td>
</tr>
</tbody>
</table>

2. Catastrophic coverage of prescription medication

Prescription medication plays a critical role in a high-quality, patient-centred and cost-effective health care system. Canada stands out as the only country with universal health care without universal pharmaceutical coverage.\textsuperscript{5} It is an unfortunate reality that the affordability of prescription medication has emerged as a key barrier to access to care for many Canadians. According to the Angus Reid Institute, more than one in five Canadians (23%) report that they or someone in their household did not take medication as prescribed because of the cost during the past 12 months.\textsuperscript{7} Statistics Canada’s Survey of Household Spending reveals that households headed by a senior spend $724 per year on prescription medications, the highest among all age groups and over 60% more than the average household.\textsuperscript{8} Another recent study found that 7% of Canadian seniors reported skipping medication or not filling a prescription because of the cost.\textsuperscript{9}

The CMA strongly encourages the federal government to support measures aimed at reducing the cost of prescription medication in Canada. A key initiative underway is the pan-Canadian Pharmaceutical Alliance led by the provinces and territories. The CMA supports the federal government’s recent announcement that it will partner with the provinces and territories as part of this alliance.

The CMA supports the development of an equitable and comprehensive national pharmacare program. As a step toward comprehensive, universal coverage, the CMA has repeatedly called on the federal government to implement a system of catastrophic coverage for prescription medication to reduce cost barriers of treatment and ensure Canadians do not experience undue financial hardship. The program would cover prescription medication costs above $1,500 or 3% of gross household income on an annual basis. Research commissioned by the CMA estimates this would cost $1.57 billion in 2016–17.
3. Support caregivers by making caregiver and family caregiver tax credits refundable

There are approximately 8.1 million Canadians serving as informal, unpaid caregivers, and they play a critical role in Canada's health and social sector. The Conference Board of Canada reports that in 2007, informal caregivers contributed over 1.5 billion hours of home care — more than 10 times the number of hours worked by paid caregivers in that year. The economic contribution of informal caregivers was estimated to be about $25 billion in 2009. The same study estimated that informal caregivers incurred over $80 million in out-of-pocket expenses related to caregiving in 2009.

Despite their tremendous value and important role, only a small fraction of caregivers caring for a parent receive any form of government support. Only 5% of caregivers providing care to parents reported receiving financial assistance, and 28% reported needing more assistance than they received.

It is clear that Canadian caregivers require more support. As a first step, the CMA recommends that the federal government amend the caregiver and family caregiver tax credits to make them refundable. This would provide more financial support for family caregivers. It is estimated that this measure would cost $90.8 million in 2016–17.

4. Home care innovation fund

The CMA strongly supports the federal government’s commitment to deliver more and better home care services, as stated in the mandate letter for the minister of health. Accessible, integrated home care has an important role in Canada’s health sector, and if these services were properly resourced they could close current gaps in care, such as addressing the needs of alternate level of care (ALC) patients waiting in hospital for home care or long-term care. As highlighted by the Canadian Institute for Health Information, the majority of the almost one million Canadians receiving home care are aged 65 years or older. As population aging progresses, the demand for home care can be expected to increase.

Despite its importance, it is widely recognized that shortages exist throughout the home care sector. While innovations are occurring in the sector, financing is a key barrier to scaling up and expanding services. To fulfill the federal government’s commitment to increase the availability of home care, the CMA recommends creation of a new targeted home care innovation fund. The CMA recommends that the fund deliver $3 billion over four years, including $400 million in the 2016–17 fiscal year, as outlined in the Liberal Party of Canada’s election platform to support new or significantly expanded programming in the following areas:

- Palliative care programs offered in the home and in hospices.
- Telehomecare programs such as home monitoring for therapies, exercise programs, vital statistics, critical responses, crisis support, etc.
- Programs to identify persons at risk of becoming “high users” of health care and to implement mitigation strategies (e.g., team-based complex care plans, expanded paramedic services).
- Community-based programs to provide respite for family caregivers (e.g., day programs and overnight stays).
• System navigator programs that operate 24/7 and provide care coordination, including support for family members.
• Community-based programs that increase access to mental health and addiction services (e.g., harm reduction programs, emergency response support and support programs for families).
• Innovative funding approaches such as personal health care budgets so that patients and family members can manage their own care, if desired.

5. A national strategy for palliative and end-of-life care

An important area of home and community-based care identified by the federal government as requiring urgent attention is palliative care. A report prepared by the CMA in 2015 identified several issues with the state of palliative care in Canada including:
• lack of access to affordable, equitable palliative care across Canada;
• lack of an adequate supply of trained workers supported by national standards;
• lack of a common approach to palliative care across settings, including the lack of an integrated approach across services;
• insufficient support for family caregivers; and
• lack of advance care planning.17

In 2011, the Parliamentary Committee on Palliative and Compassionate Care called for a national palliative care strategy. However, little progress has been made to date. More than ever, Canada requires a national strategy for palliative and end-of-life care.

6. Federal investment in long-term care and residential care sector

All jurisdictions across Canada face continuing care shortages. Despite the increased availability of home care, CMA-commissioned research indicates that the demand for continuing care facilities will surge as the demographic shift progresses.18

In 2012, it was reported that wait times for access to a long-term care facility in Canada ranged from 27 to over 230 days. More than 50% of ALC patients are in hospital beds because of the lack of availability of long-term care beds.19 Because of the significant difference in the cost of hospital care (approximately $846 per day) versus long-term care ($126 per day), the CMA estimates that the shortages in the long-term care sector represent an inefficiency cost to the health care system of $2.3 billion a year.20

Despite the recognized need for infrastructure investment in the continuing care sector, this sector has been excluded from federal investment in infrastructure, namely the Building Canada Plan. The CMA recommends that the federal government include capital investment in continuing care infrastructure, including retrofit and renovation, as part of its commitment to invest in social infrastructure. On the basis of previous estimates, the CMA recommends that $540 million be allocated for 2016–17, if implemented on a cost-share basis.
B. To support innovation across the system

The final report of the Advisory Panel on Healthcare Innovation identified the need for increased innovation in Canada’s health care system including models to support integrated care.\textsuperscript{21} Approximately 5% of patients account for two-thirds (66%) of provincial health expenditures, and many of these patients are elderly. This picture is consistent across the country.\textsuperscript{22} This high use is often due to systemic issues, such as poor integration or lack of access to other care, rather than the choices of these patients. There is general agreement that multi-sectoral approaches integrating clinical, social care and other sectors are necessary to best address this population group, which often has several chronic health conditions.

The CMA recommends the establishment of a National Health System Innovation Fund to help the provinces and territories to adopt health system innovations, including integrated care models. Funding criteria should be designed to not only support the development of innovations but also provide incentives for their adoption on a scaled-up basis.

C. To support healthy public policy

The social determinants of health play a critical role in health care system demand. Governments should require all cabinet decision-making to include a health-in-all policies approach whereby all polices from tax, to transportation, to trade would be examined through a health lens to ensure that negative health impacts were minimized/eliminated and positive health outcomes were supported or expanded. This would help to minimize the often-unintended health consequences that arise from policies outside of the health sector.

D. To ensure ongoing, collaborative review of health care

To develop the right solutions and an effective change process that is enthusiastically supported, the CMA recommends that the federal government integrate input from the key partners in health care (patients/public; representatives from the federal, provincial and territorial governments; academics; Indigenous Peoples; health care professionals, including physicians and nurses; and health care managers from regional health authorities and hospitals). The objectives, broadly, are to agree on a vision for Canadian health care then take a comprehensive approach to effecting change, building on the best of our efforts and our many successes and with each of the partners focused on a philosophy of “what can I do to make this work?”

The federal role and accountability

The federal government has indicated that it does not wish to have a role in any health accord that is limited to simply holding the purse strings. As expressed in the present platform, the CMA contends that the federal government’s role includes maintaining and improving standards of health care service across Canada, ensuring equity across the provinces and territories in terms of their ability to finance necessary health care programs, and facilitating and collaborating on joint policy issues of national importance. We also believe the federal government plays an important role as a system steward for those populations falling under federal jurisdiction (e.g., Indigenous populations).
The now-defunct Health Council of Canada monitored progress on previous health accords; consideration must be given to a new approach to oversee progress on the next accord. An effective accountability mechanism for the next health accord is essential. To this end, the CMA proposes that:

- each level of government (federal, provincial, territorial) sign statements indicating their commitment to undertake the activities specified in the pan-Canadian health accord;
- bilateral agreements be signed (in addition to an overall pan-Canadian agreement) to address provincial and territorial needs while enhancing accountability between the federal government and each jurisdiction; and
- an independent, third-party organization report on the achievements and lessons learned from the initiatives and objectives specified in the accord. This organization could also be involved with disseminating successful innovations across the country that emanate from the accord.

References

4 The Economist Intelligence Unit Ltd. Financing the future. Choices and challenges in global health. London (UK): The Unit; 2015.
18 Conference Board of Canada. Research commissioned for the CMA, January 2013.
APPENDIX A
Previous federal/provincial/territorial health accords\textsuperscript{1,2}

The September 2000 Agreements on Health Renewal and Early Childhood Development

These agreements outlined a shared approach and action plan for renewing health care services and reporting to Canadians on progress made. They provided $23.4 billion in additional funding, including:

- $21.1 billion in additional Canada Health and Social Transfers (CHST) funding over five years, including $2.2 billion for early childhood development earmarked in the CHST;
- $1 billion over two years to provinces and territories in support of necessary diagnostic and treatment equipment;
- $800 million to provinces and territories to support innovation and reforms in primary care including a Primary Health Care Transition Fund; and
- $500 million to Canada Health Infoway to accelerate the adoption of modern information technologies to provide better health care.

First ministers committed their governments to reporting regularly to Canadians on health status, health outcomes and the performance of publicly funded health services and on the actions taken to improve these services.

2003 First Ministers’ Accord on Health Care Renewal

Building on the 2000 agreements, the 2003 First Ministers’ Accord on Health Care Renewal extended funding provided through the CHST, including scheduled increases, out to 2007–08. The aim of the accord was to improve the accessibility, quality and sustainability of the public health care system and enhance transparency and accountability in health care spending.

The 2003 accord provided for federal support for health care to increase by $36.8 billion over the five-year period 2003–04 to 2007–08.

Most of this funding, $31.5 billion, was provided to provinces and territories through increased transfer payments, including:

- $16 billion over five years through a new Health Reform Transfer targeted to primary health care, home care and catastrophic drug coverage;
- $14 billion (including the $2 billion in additional funding announced in the 2004 federal budget) for increases to health and social transfers (through the CHST); and
- $1.5 billion over three years to provinces and territories through a Diagnostic/Medical Equipment Fund in support of the acquisition of equipment (and related specialized training) to improve access to publicly funded diagnostic services.

\textsuperscript{1} Department of Finance Canada, \textit{Federal investments in health care}. Ottawa: The Department; 2012. Available at: http://www.fin.gc.ca/fedprov/fihc-ifass-eng.asp

The federal government also provided $5.3 billion in supported, direct initiatives under the 2003 accord, such as increased funding for federal health programs for First Nations and Inuit, the creation of the compassionate care benefit under the employment insurance program, and support for research hospitals, improved health care technology and pharmaceuticals management.

As part of the 2003 accord, first ministers also agreed to restructure the CHST effective Apr. 1, 2004, to create two new transfers to improve the transparency and accountability of federal support to provinces and territories:

- the Canada Health Transfer in support of health; and
- the Canada Social Transfer in support of post-secondary education, social assistance and social services, including early childhood development and early learning and child care.

Governments also agreed to establish the Health Council of Canada to monitor and make annual public reports on the implementation of the accord, with an emphasis on its accountability and transparency provisions.

The 2004 10-Year Plan to Strengthen Health Care

The agreement extended funding commitments in the 2000 and 2003 health accords and increased cash transfers to provinces and territories for health care over 10 years. This included:

- establishing a new Canada Health Transfer base of $19 billion in 2005-06 and applying a 6% annual escalator effective 2006-07;
- providing $5.5 billion over 10 years through the Wait Times Reduction Fund and the Wait Times Reduction Transfer to assist provinces and territories in their respective strategies to reduce wait times; and
- providing $500 million in 2004-05 for additional investments in medical and diagnostic equipment.

Other areas identified in the plan included the following:

- Health human resources: Agreement to increase the supply of health professionals, on the basis of an assessment of the gaps in health human resources, and to make action plans public, including targets for the training, recruitment and retention of professionals by Dec. 31, 2005.
- Home care: First ministers agreed to provide first-dollar coverage by 2006 for certain home care services, on the basis of assessed need, specifically to include short-term acute home care for physical health needs, short-term acute community mental health needs, and end-of-life care (for case management, nursing, palliative-specific pharmaceuticals and personal care at the end of life).
- Primary care reform: Agreement was reached to establish a best practices network to share information and find solutions to barriers to progress in primary health care reform, such as scope of practice, and accelerate the development and implementation of the electronic health record, including e-prescribing.
- National pharmaceuticals strategy: First ministers agreed to direct their health ministers to establish a ministerial task force to develop and implement the national pharmaceuticals strategy.
First ministers also agreed to collect and provide meaningful information to Canadians on the progress their jurisdictions made in reducing wait times, including the establishment of comparable indicators of access to health care services and evidence-based benchmarks for medically acceptable wait times.