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2016-2017 PROPOSED RESOLUTIONS

AMENDMENT TOOLKIT

Proposed amendments must be received by April 15, 2017.

The forms should be completed and e-mailed as Microsoft Word attachments. In order to assist us with organizing the amendments, please remember to save the file with a name that includes the resolution number and your clubs name. For example, RESOLUTION 1 AMENDMENT VANCOUVER.DOC.

For further information on the amendment process, including proposers' responsibilities and the procedure at the AGM, please consult relevant pages of the resolution guidelines.

Please send your amendments to the following e-mail addresses, where applicable:

Resolution Number and E-mail	Proposing Club	Title	Pages
Resolution 1 resolution1@fcfdu.org	University Women's Club of Winnipeg	The Right to Safe, Clean, Accessible and Affordable Drinking Water and Sanitation on First Nations Reserves in Canada	2 - 5
Resolution 2 resolution2@fcfdu.org	University Women's Club of North York	Universal Pharmacare	6 - 12

RESOLUTION #1:

The Right to Safe, Clean, Accessible and Affordable Drinking Water and Sanitation on First Nations Reserves in Canada

Proposed by: The University Women's Club of Winnipeg

Whereas while most municipal water systems in Canada do deliver safe, clean, frequently tested drinking water and sanitation services, the majority of rural Canadians who lack these services are predominantly reserve-based First Nations people who, because of shared jurisdiction with the Government of Canada, are not currently included under the Canada Clean Water Act and its Regulations,

Whereas many First Nations people consider water a sacred trust which women have a special responsibility to protect,

Whereas the right to "safe, clean, accessible and affordable drinking water and sanitation" is a human right according to a resolution adopted by United Nations General Assembly in 2010,

Whereas the Canadian federal government adopted the United Nations Declaration on the Rights of Indigenous People "without qualification" in 2016, and therefore be it

Resolved, that the Canadian Federation of University Women urges the Federal, Provincial and territorial governments of Canada to move expeditiously to secure access to safe, clean, accessible and affordable drinking water and sanitation for all residents of all First Nations Reserves; and

Resolved, that the Canadian Federation of University Women urges the Federal, Provincial and territorial governments to develop inclusive national water standards as well as five and ten-year plans of action to ensure the funds allocated are adequate and utilized for sustainable solutions, including appropriate training and certification of Reserve residents to ensure regular monitoring and maintenance.

BACKGROUND

According to the Constitution of Canada, the Government of Canada and First Nations share jurisdiction over drinking water and sanitation services. Health Canada, in collaboration with Indigenous and Northern Affairs Canada, are responsible for assuring these services.

In carrying out their mandate, Health Canada uses Drinking Water Advisories (DWA) as measures of adequacy. **There are three varieties of DWA:**

- **Boil-Water Advisories\Orders** (tap water should be boiled for one minute to remove bacteria, viruses or parasites before drinking or brushing teeth);
- **Do-Not-Consume Advisories\Orders** (tap water should not be used for drinking, brushing teeth, cooking, making infant formula or bathing infants but can be used by adults for bathing); and

- **Do-Not-Use Advisories** (tap water should not be used for any reason due to health risks).

The causes for these DWAs are multifactorial: i.e. line breaks and equipment failure in the overall water system, poor filtration during water treatment etc. According to the Globe and Mail's Andre Picard, **waterborne diseases** like dysentery and shigellosis are common. Contaminants such as mercury, PCBs, toxaphene and pesticides are also common. Symptoms of mercury poisoning include weakness in limbs, loss of motor function, difficulty speaking and swallowing and developmental delays in children.

According to Health Canada information, "As of September 20, 2016, there were 139 DWAs in effect in 94 First Nations communities, excluding British Columbia (BC)". On October 1st, 2013 Health Canada transferred its role in the design, management and delivery of First Nations health programming in BC to the First Nations Health Authority, so Health Canada no longer reports DWAs in BC First Nations communities.
Several documents support the principle of equal drinking water and sanitation standards for First Nations Reserves:

1. On July 28, 2010, a United Nations General Assembly resolution recognized the human right to "safe, clean, accessible and affordable drinking water and sanitation". A/RES/64/292
2. In 1982, the Canadian Charter of Rights and Freedoms guaranteed the right to equality and the Constitutional Act obliged governments of Canada to provide "essential public services of reasonable quality to all Canadians".
3. In 2016, the Government of Canada adopted the Declaration on the Rights of Indigenous People "without qualification". A Canadian representative addressed the Permanent Forum on Indigenous issues at the UN stating, "We intend nothing less than to adopt and implement the declaration in accordance with the Canadian Constitution".
4. Dr. David Boyd, a law professor at Simon Fraser University, in his article No Taps, No Toilets: First Nations and the Constitutional Right to Water in Canada asserts that "Indigenous people have constitutional rights under two sections of the Charter" "the right to life, liberty and security" (Section 7) and "the right to equality" (Section 15). He also refers to Section 26 that obliges governments to provide "essential services of equal quality to all Canadians".
5. In June, 2016, Human Rights Watch released a report: Make it Safe: Canada's Obligation to End the First Nations Water Crisis. They lay the responsibility on the Government of Canada for failing to build a regulatory framework that would include First Nations and set standards for water safety.
6. In 2016, The Council of Canadians report Safe Water for First Nations described the ongoing problem of unsafe drinking water on First Nations Reserves. The Department of Indigenous and Northern Affairs funding has been inadequate in addressing either the communities' urgent, immediate drinking water and wastewater treatment needs or their desperate need for more adequate infrastructure to deal with on-going long term problems.

7. In another book by their Chair Maude Barlow, Boiling Point – Government Neglect, Corporate Abuse and Canada's Water Crisis, the data shows an increase in DWAs from in 2014 – 139 DWAs in 94 First Nations communities – to 2016 – 163 DWAs in 119 First Nations communities. However, as Emma Lui of the Council of Canadians points out, the DWAs only cover households with water piping or systems. Close to 2000 First Nations homes are without any water system in their homes at all.

As well as the shortage of funding, bringing equal quality water and wastewater systems to First Nations Reserves is fraught with jurisdictional difficulties. Health Canada states, "For First Nations south of the 60th parallel, responsibility is shared between the Government of Canada and First Nations themselves". The territories are responsible for First Nations and Inuit communities above the 60th parallel. In the south:

1. Chief and Council are responsible for planning and developing facilities and for their day-to-day operations, including sampling and tasting.
2. Indigenous and Northern Affairs Canada provide advice, technical expertise and funding for water services, treatment facility infrastructure, along with training and certification, a responsibility many First Nations say is not being met.
3. Health Canada is responsible for ensuring monitoring systems are in place and being used. They issue DWAs.
4. Environment Canada develops standards, guidelines and protocols for wastewater treatment.
5. The provinces manage and govern water resources, including the source water from which First Nations draw their water supply. Lalita Bharadwaj, University of Saskatchewan toxicologist and associate professor of public health, says this creates a problem because First Nations have their primary relationship with the federal government and there are no mechanisms in place in the provincial systems to manage drinking water. They are left in the vacuum of jurisdictional water management divides.

To improve water quality on reserves, there is a need for new principles, structures and relationships with more accountability for water justice to be achieved. Maude Barlow sums it up as, "The Canadian Government, working in cooperation with First Nations and the provinces, must come up with a plan to meet its obligations and the necessary measures to do so."

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RESOLUTION#2

Universal Pharmacare

Proposed by: University Women's Club of North York

WHEREAS Canada is the only country with a universal health care system that does not cover the cost of prescription drugs,

WHEREAS the current patchwork system of providing prescription drugs to Canadians is neither adequate nor sustainable,

WHEREAS a universal national drug coverage plan that is public and affordable would ensure access for all Canadians; and therefore, be it

RESOLVED, that the Canadian Federation of University Women (CFUW) urges the federal, provincial and territorial governments of Canada to work collaboratively to implement universal Pharmacare, a publicly funded drug plan that would cover medically necessary prescription drugs for all Canadians, regardless of their ability to pay.

RELATED POLICIES:

Health Care Delivery Services (Romanow Report), CFUW 2003 Edmonton

RESOLVED, that the Canadian Federation of University Women urges the federal, provincial and territorial governments of Canada to work collaboratively to implement the recommendations of the Romanow Commission Building on Values: The Future of Health Care in Canada

RESOLVED, that CFUW monitor health care policies, funding and regulations, as they are implemented.

BACKGROUND

Canada's universal healthcare system is largely restricted to care delivered in hospitals or by physicians; there is no coverage when the patient needs to fill a prescription. In the 1960's, when Medicare was implemented, the intent was to add universal Pharmacare as the next phase. Starting with the Hall commission in 1964, there have been numerous recommendations for different versions of Pharmacare. None has been acted on.

The Romanow Commission report, *Building on Values*, recommends some of the building blocks of Pharmacare, including a national prescription drug formulary. However, it only recommends creating a new catastrophic drug transfer to reduce the disparities in coverage across the country. It does not address the need to cover all Canadians for medically necessary prescription drugs regardless of their ability to pay. See Terminology for definitions and Appendix A for a list of Romanow's recommendations.

Current drug coverage is inadequate

Prescription drug access and affordability are issues for nearly a quarter of all Canadian households. One in four Canadians says a member of the household cannot afford to take the medication as prescribed, resulting in skipped doses, split pills or unfilled prescriptions. One in ten Canadians cannot afford to fill prescriptions at all. This preventable underuse of prescription drugs is estimated to cost the Canadian Medicare system up to $9 billion annually. Non-adherence to drugs for chronic care alone accounts for 5% of hospital admissions and physician visits and contributes $4 billion to healthcare costs each year.

According to the Wellesley Institute, 57% of Canadians are covered by private insurance. However, a closer look reveals that this percent drops to 32% for workers earning less than $20,000 and drops even further for those under age 25 and part-time workers. Moreover, women are less likely to have coverage than men. Private plans vary dramatically in both the drugs covered as well as the amount of the coverage for group members.

As for publicly funded insurance, 24% of Canadians are covered by federal or provincial/territorial drug plans. The drugs covered as well as the amount of coverage vary widely by location, age and income. For instance, not all provinces have a plan for those over 65.

The rest of the Canadian population has no insurance.

Drug cost is escalating

The current patchwork system of providing coverage is not sustainable. Both public and private insurance plans are inequitable, inadequate and needlessly expensive.

The good news is that now we have new treatments for rare diseases, such as Cystic Fibrosis and Paroxysmal Nocturnal. However the new and specialty drugs are increasingly very expensive. For example, according to Sun Life in 2005 there was no annual single drug claim over $75K; now they have hundreds of similar claims and there seems to be an upward trend. A 2016 Benefits Canada survey cites that 83% of plan sponsors believe the cost of new drugs coming to market are too high for the sustainability of their plans.

In Canada there are 24 drug insurance companies and the provinces/territories and federal governments operate an additional 46 public plans. This scenario results in huge duplication of administration cost and the coordination is complex, costly and inefficient. Furthermore public insurance administrative costs average 1.8% while private insurance administration, which has tripled over the last 20 years, now averages 23%.

Private plans are not moving to contain costs. Employers are negotiating with insurance companies for a more favorable premium by excluding drugs, limiting (lifetime or annual) the amount of coverage, increasing the percentage of co-payment and having workers pay the dispensing fee. Public plans on the other hand use their government drug formulary to limit coverage and focus on using generic drugs.

The Canadian Centre for Policy Alternatives report, *The Economic Case for Universal Pharmacare*, did a comparison of Canada with members of the Organization for Economic Co-operation and Development (OECD). It revealed that Canada has an inefficient model in terms of drug policy and the system is not sustainable due to the uncontrolled growth of drug costs.

- Canadians spend approximately 25% more per capita on drugs.
- Canadians pay more than 30% over the OECD average for prescription drugs. For example, the report citing a 2007 study comparing 4 major therapeutic classes of drugs, found that New Zealand paid on average 51% less than British Columbia.
- The rate of growth in drug costs in Canada is far higher than other countries (6.9% annually for the years 2001-2008, whereas a small country like New Zealand with a population of 4.5 million grew at 3.1% and France with 66 million people grew at 1.8%, over the same time period).
- The report notes that the private drug plans are particularly inefficient.
- The public plans are inequitable because they do not provide adequate or suitable coverage for a large number of Canadians.
- The meager industrial benefits to the Canadian economy from the Canadian pharmaceutical sector are totally out of proportion with government privileges and grants to the pharmaceutical industry.

Canada is, in fact, the only country with a universal health care system that does not cover the cost of prescriptions.

Current Status

Canadians support the need for universal Pharmacare. A July 2015 poll by the Angus Reid Institute found that 91% of Canadians support the concept of having Pharmacare to provide universal access to necessary medicines. 88% believe that medicines should be part of Medicare; 80% believe that a single-payer system would be more efficient; and 89% believe Pharmacare should be a joint effort involving provinces and the federal government.

Canada has procrastinated in proceeding with universal Pharmacare since the inception of Medicare mostly due to the federal/provincial debate over jurisdiction and the perceived costs. Currently there is work underway at both levels of government by the House of Commons Standing Committee on Health and the Health Care Innovation Working group.

In April 2016, the House of Commons Standing Committee for Health started a study on how Canada might create a national Pharmacare program. By mid-December 2016, 26 organizations and 79 individuals had appeared before the committee. Although universal Pharmacare is not part of the current mandate of the Federal Minister of Health, the mandate does ask the Minister to reduce drug costs by bulk buying and exploring the need for a national drug formulary. Furthermore, the Health Care Innovation Working Group composed of provincial and territorial Ministers of Health started The pan-Canadian Pharmaceutical Alliance (pCPA) in 2010, which has negotiated price reductions for 95 brand name drugs and 18 generic drugs, resulting in a $712 million a year savings. This evidence of renewed interest toward implementing a national universal Pharmacare program is encouraging.

Budget

The estimated cost for universal Pharmacare is about $32 billion annually.

Contrary to widespread belief, universal Pharmacare can be self-funded. A study, published in the Canadian Medical Association journal, by researchers at the University of British Columbia, Harvard and the University of Toronto, concluded that over time, a universal prescription drug program would not cost more money. If Canada consolidated its spending under one program with one payer, a universal drug plan would cost $7.3 billion less per year for a 32% saving in overall drug costs. This does not include savings from reduced hospital and physician visits.

CONCLUSION

The current patchwork system of providing prescription drugs to Canadians is neither adequate nor is it sustainable.

The evidence shows that a universal national drug coverage plan that is public and affordable would ensure access for all Canadians and bring down the high prices paid for prescription medicines.

It is time for CFUW to advocate for a publicly funded, universal drug plan that will cover everyone for medically necessary drugs. Canadians should not have to choose between a life-saving prescription and feeding their families.

APPENDIX A

Pharmacare Romanow Recommendations – Romanow Commission Building on Values; The Future of Health; Pages 252-253

Recommendation 36 – The proposed new Catastrophic Drug Transfer should be used to reduce disparities in coverage across the country by covering a portion of the rapidly growing costs of provincial and territorial drug plans.

Recommendation 37 – A new National Drug Agency should be established to evaluate and approve new prescription drugs, provide ongoing evaluation of existing drugs, negotiate and contain drug prices, and provide comprehensive, objective and accurate information to health care providers and to the public.

Recommendation 38 – Working collaboratively with the provinces and territories, the National Drug Agency should create a national prescription drug formulary based on a transparent and accountable evaluation and priority-setting process.

Recommendation 39 – A new program on medication management should be established to assist Canadians with chronic and some life-threatening illnesses. The program should be integrated with primary health care approaches across the country.

Recommendation 40 – The National Drug Agency should develop standards for the collection and dissemination of prescription drug data on drug utilization and outcomes.

Recommendation 41 – The federal government should immediately review the pharmaceutical industry practices related to patent protection, specifically, the practices of evergreening and the notice of compliance regulations. This review should ensure that there is an appropriate balance between the protection of intellectual property and the need to contain costs and provide Canadians with improved access to non-patented prescription drugs.

TERMINOLOGY

Catastrophic drug transfer is the transfer of targeted funding from the federal government to the provincial and territories to cover a portion of drug insurance costs. *Catastrophic* defines the upper limit beyond which payment would constitute a financial hardship for individuals and families. The Commission on the Future of Health Care in Canada (the Romanow Report) provides this interpretation of the phrase catastrophic drug coverage:
… $1,500 per person per year [is] the point at which drug expenses for an individual would be considered “catastrophic”…

National Drug Formulary is a single list of prescription drugs, both generic and brand name, which is intended to offer the greatest overall value for drug efficacy/safety and the cost–effectiveness.

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