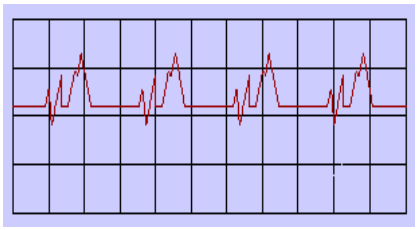
Paying for keeps



Securing the future of public health care

A series by Armine Yalnizyan

Number 1

Beyond Romanow: Why $3.5 billion is not enough

Much has been made of Alberta and Quebec's rejection of the Romanow report's recommendations as an intrusion into provincial sovereignty. But the Premier of Ontario, Ernie Eves, named the real challenge: the success of these recommendations depends on whether enough cash will be provided to implement them.

Given the political consensus that more money is needed, the most critical issue will be how quickly Ottawa ramps up to renewed levels of federal commitment, and how willing the provinces are to work with the feds to make this a reality. Provinces are moving now to deal with the immense pressures on public health care and the public purse by turning to private sector investors and by de-listing publicly insured services and drugs. This isn't an academic exercise. The provinces *are* moving now. It's time for the feds to act. The speed and scale of an increased federal role matters.

For years Ottawa's share for health care has been dropping. From a high in the early 1970s of about 38%, the federal government's cash contributions to provincial spending for public health care fell to 10% by 1998. Today it is estimated to stand at about 16%—less than half of what it used to be. But the provinces have compounded the problem: this year alone they gave up $20 billion in revenues due to tax cuts, money desperately needed to sustain public services such as health care.

Romanow's recommendations are widely viewed as the pragmatic and critical first steps in securing public health care and guarding against rapid erosion towards a direct-pay commercialized system. He wants the feds to unilaterally increase funds for health care by $3.5 billion next year, rising to $6.5 billion a year by 2005-6.

Clearly, this represents a substantial increase in health care spending. It will buy some breathing room for public health care. But it is not enough to tackle today's pressing demands on the system, let alone leverage real change in how we do things.

Taken together the provinces and territories are forecast to spend about $74 billion on public health care this year, an increase of $4 billion over the previous year, which is the smallest increase since 1998. An extra $3.5 billion in federal contributions won't stretch very far. In fact, a lot of pressing needs will remain unanswered.

Both the Senate Committee report and a backgrounder for the Romanow Commission recently suggested that the protection of pub-

lic health care required a much higher infusion of cash immediately from federal coffers. Like Romanow, Senator Kirby's report calls for an extra $6.5 billion in federal cash transfers to the provinces in order to secure the future of public health care ($5 billion in new initiatives paid by new taxes, $1.5 billion from reallocating existing revenues to doctors and hospitals). The difference is, Kirby says the $6.5 billion is needed right away, while Romanow recommends starting slowly and building to $6.5 billion in three years.

Romanow is clearly playing it safe by starting at $3.5 billion and hoping for political consensus. Remarkably, even that modest figure hasn't been embraced by the Finance Minister or the Prime Minister. Any increase is a move in the right direction, but this amount is not nearly a big enough deposit to secure the future of public health care. Here's why.

Not enough to relieve the pressure: Supply issues come with a big price

Provinces are facing built-up pressure to expand the supply of health services. Whether it's buying more MRI and CT scanners or creating more acute or long term care beds, they are reluctant to take on large scale investments through the public purse. In an effort to keep a lid on public spending, governments are increasingly turning to private investors to supply the capital. But this approach comes with a price: it can lead to more commercialized health care (meaning access to services may depend on cash, not need) or it can simply drive up the costs of delivering these services publicly.

Romanow responded to these pressures by proposing a Diagnostic Services Fund, a two-year $1.5 billion program. That gives the prov-

The Price of Progress

- One MRI costs $1.5-2.5 million.
- A CT scanner costs between $1-1.8 million.
- A PET/CT scanner (the latest, most efficient merger of imaging technology) costs $3-4 million.
- Building the lead-lined room that houses the radiation-emitting CT scanner costs $300,000.
- The specialized construction materials that are used to accommodate the highly sensitive magnets in an MRI raise the building costs to $500,000 per machine.
- MRI and CT scanners account for less than 10% of diagnostic exams.
- The Canadian Association of Radiologists points out that about half of all radiology equipment is outdated across the country.

Case in Point: Ontario

The Ontario Association of Radiologists (OAR) recommends the purchase of 35 CT and 51 MRI scanners to deal with the waiting list problem. It estimates capital costs would be $225 million, and a further $75 million to staff the machines

A study by the OAR found that 24,000 pieces of radiology equipment were outdated. The replacement cost? $760 million.

It's safe to assume old technology will not be replaced by old technology. Rather, MRIs, PET/CT scans and emerging technologies will be used to replace and expand diagnostic services more efficiently. But moving towards greater efficiency relies on investments made today. The money needs to come up front.

inces $750 million to split between them next year for equipment and people to run the equipment.

At over $26 billion, the government of Ontario's spending on health care is up $8 billion compared to 1995, and Premier Eves states that it now takes up 47% of the provincial budget.

In its latest round of expansion (2 new hospitals, 20 more MRI and 5 more CT scanners) Ontario is turning to investors, financiers who expect to see a return on their investments. That return comes in two forms – leasing arrangements and using the equipment after 35-40 hours of medically necessary services per week to charge for "uninsured" (not medically necessary) services.

Is the $750 million enough to relieve the pressures the provinces face? Is Romanow's prescription enough to prevent further deterioration of public services and commercialization of public resources?

Not enough to buy change now: How quickly $3.5 billion gets absorbed

For six of the provinces' and territories' health budgets, capital spending was the fastest-growing category last year. It reflects the provinces' move to expand the supply of facilities and equipment in the system. But expanding the system relies on having enough people to do the job.

Labour shortages—in part the result of almost a decade of policy reversals in the system—are driving up the costs of keeping the doctors and nurses who are currently working in public health care. Many provinces are still adding staff after drastic cost cutting that wound up costing taxpayers more than they saved. Other elements of the system relentlessly drive costs too. The growing use of drugs to treat, manage and prevent conditions is a long-term trend in health care. Aging of the population, and reductions in hospital stays, are increasing the use of paid services and facilities in the community.

Viewed by itself, the initial $3.5 billion appears to be a massive new increase in spending. Viewed in the context of the sheer scale of the system, its cost-drivers, and public demand to expand the supply of services, it's not nearly enough. Provinces are starting to commercialize now, claiming inadequate public funds for needed expansions. This seriously jeopardizes

Follow the money: Where did it go?

- Collective agreements signed across this country contractually bind taxpayers to increase payments to health professionals by at least $800 million a year for the next two or three years. This problem will not go away in the next five years. Provinces face tremendous competition to find ways of staffing up, or lose quality staff to other jurisdictions. These increases are a way of hanging on to quality and experienced staff, without whom public health care suffers.
- Spending through provincial drug programs rose by $400 million last year, and that was the lowest rate of growth in many years. Drugs represent one of the biggest cost drivers in the system.
- Many provinces are seeing the growing use of institutions other than hospitals, such as residential long term care facilities. Those costs grew by $560 million last year alone. With an aging population, the need for more long term care is sure to increase in the years to come, whether through home care or facilities based care.

the future accessibilitiy of Canada's public health care system.

Passive-aggressive privatization

Money, whether public or private, is the key to accessing health care. Public health care makes access a right of citizenship, at least where doctors and hospitals are concerned, by adequately funding these services through our tax dollars. Romanow validated this position in his report, accurately reflecting the concerns of most Canadians. As Romanow says, it's double solidarity: between the rich and poor, and between the sick and the well.

Commercialization of health care services erodes the principles of universal access in two ways. It siphons off labour that is already in very short supply from the public system, making the public waiting lists longer. And, by aggravating the shortages, it creates more pressure for those with more money to demand the ability to jump the queue—moving ahead of people with greater medical need—simply by virtue of their ability to pay.

If the federal government balks at providing quick and significant expansion of federal transfers, the fix is in: public health care will keep shrinking under the force of passive-aggressive privatization. Universal access to medically necessary services will turn into a guarantee to wait if you have no money.

It's time for decisive federal action. Without hesitation, the federal government has found $100 billion for tax cuts, $46.7 billion for debt reduction and $7.7 billion for security measures in the last few years. Though the provinces need to take responsibility for health care too, if clear federal commitment, backed by real hard cash, doesn't kick in soon, a fast-eroding medicare system will be the ultimate security issue for Canadians.

Armine Yalnizyan is an economist and CCPA Research Fellow. She was the first recipient of the Atkinson Foundation Award for Economic Justice and is the author of the forthcoming book ***Paying for keeps: Securing the future of public health care in Canada****, to be published by the CCPA.*

Canadian Centre for Policy Alternatives
410-75 Albert Street, Ottawa, ON K1P 5E7
tel: 613-563-1341 fax: 613-233-1458
email: ccpa@policyalternatives.ca
http://www.policyalternatives.ca