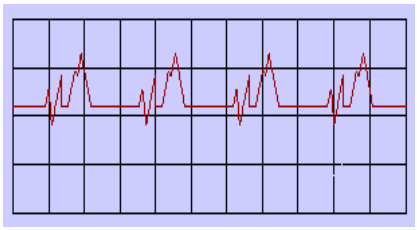
Paying for keeps



Securing the future of public health care

A series by Armine Yalnizyan

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Accountability: Why strings need to be attached to health care dollars

Now that there is emerging consensus that Canada's public health care system needs a serious cash injection, it's time to talk about the next cure for what ails us: accountability.

If the provinces had their way, the federal government would wire them more cash without a single string attached — and that's a problem.

The recent debacle of the Medical Equipment Fund serves as the ultimate case in point. Half of the $1 billion Medical Equipment Fund that came out of the landmark September 2000 federal-provincial agreement remained untouched. Most of the money sat in trust funds. Some of that money could not be accounted for — nobody knew where it went.

Even when the provinces used and accounted for the money, the records show they did not necessarily use the fund for its intended purpose.

In New Brunswick, the fund was used to purchase lawn tractors, icemakers and floor scrubbers in hospitals, equipment that was not geared to either diagnoses or treatment.

In Ontario, large for-profit chain operators of long-term care facilities have received grants for the purchase of inventory such as specialized beds and bathing equipment. Public money has provided grants to investor-owned firms to purchase diagnostic equipment that could be used "after hours" to generate a profit.

On December 12th, CBC TV revealed that Ontario granted about $9 million to Diagnosticare, a company that was going to shut down operations when their 15% profit margin did not match their corporate goal of 23% rate of return.

Flush with the new publicly-paid investments, the company's assets were subsequently purchased by another for-profit chain, Canadian Medical Laboratories. Diagnosticare shareholders saw the value of their stocks rise from 12 to 13 cents a share before the public grant, to 35 cents after the grant. The purchase was at 60 cents a share.

What happened in Ontario and New Brunswick serve as two prime examples of why accountability needs to be structured into any new funding agreements for health care.

Accountability – the real meaning of fiscal responsibility

The sting of the Enron and Worldcom cases and, closer to home, the Canadian blood scan-

dal has been chastening. People now expect greater transparency from large organizations, public or private. Governments top that list. Taxpayers are paying the bills for health care. They want to know — and in a democratic system they deserve to know — how that money is being spent.

As the Romanow Commission validated, the public is indeed willing to spend more for health care, but they want to make sure more money buys real improvement. Increased political cynicism and heightened public scrutiny means, now more than ever, that public spending is subject to the "value-for-money" test.

Acountability matters, now more than ever; yet the provinces have been rejecting efforts to build accountability into the health care funding mechanism. They have aggressively lobbied for "flexibility" in their use of cash transfers from the federal government, such as block funds or targeted funds.

Claims of fiscal responsibility from both levels of senior government will ring hollow if they are not accompanied by a quick readiness to be responsible and accountable to those who pay the bills, the taxpayers.

Targeted funds…or targeted objectives?

Accountability is not the only sticking point in the federal-provincial discussions on how to secure the future of public health care. The provinces are also rejecting targeted funds, money dedicated to priority areas for improvement of public health care.

New Brunswick's criticisms of targeted funding are hard to dismiss. That province is at the head of the pack with respect to the per capita availability of advanced diagnostic equipment. New Brunswick does not need more equipment, but there are many other areas of health care that can be improved in that province. If New Brunswick didn't take up targeted funds for diagnostic services because they had already made appropriate investments, would it be frozen out of access to an equivalent amount of cash? Just because it is ahead in one area, it would be indefensible if New Brunswick lost out on scarce resources for other priorities, such as primary care reforms or training for health care workers. Clearly, some flexibility is needed.

But generally, the argument — provinces need more flexibility to address their priorities than funds "with strings attached" will permit — only passes muster if it meets three tests:

1) Minimum standards or targets for priority areas have already been met;
2) Incremental funds only go to health care; and
3) There is documentation to show the first two conditions have been met.

Is the issue targeted funds or targeted objectives? Those who have described health care as a sink hole are simply observing how easy it is for huge quantities of money to be absorbed by the sheer scale of this system, showing little improvement in quality or timeliness of service. More money alone is not enough to assure improvement.

Comparable standards

The Canadian public has a right to expect a set of common standards since it is supplying a common level of resources across the country. Federal taxes are the resources in question. If consistency of service throughout Canada is a goal, public health care needs to

be funded centrally. That means nationally raised cash, for national purposes.

The clash between the sovereignty and equalization cultures needs to be resolved. The alternative is to give the provinces tax points and let the system devolve into thirteen definitions of public health care, based on public and private ability to pay. That is what Canada has been moving towards, and that is clearly what the Canadian public has rejected.

Comparable standards are at the very heart of what this debate is about. Without them, there is no rationale for any federal funding. Indeed, the unanimously supported principles in the Canada Health Act require funding from the centre to achieve common — or at least comparable — standards of quality service and access for all citizens. That is what Canadians are paying for, that is what they expect, that is what they want.

Value For Money – Why we need cooperation and coordination

The best way to assure greater value for money and control costs is through a single payer system. Key to achieving the improvements possible through a single payer system is better coordination and planning — difficult, but not impossible, to achieve among 13 jurisdictions.

It may be assumed that there is no political will for such cooperation, given the fractious nature of federal-provincial talks over funding. But there is already plenty of evidence that the feds and the provinces are able to negotiate successful deals when they both come to the table ready to make it work

In 2003, the Common Drug Review will be initiated — a hallmark of federal-provincial coordination, cooperation and trust announced in September 2002.

The review promises to streamline the process of clinical evaluation of the effectiveness of new drugs and examine their cost-effectiveness, necessary but costly steps for every province, all of which are pressured to add drugs on the formularies of their provincial drug plans. This is an important step towards ensuring the most efficient formulary possible, from both cost and health outcome perspectives. It also moves us a step closer to the greater efficiencies of a national formulary, with the potential for reduced costs through bulk buying.

Another process underway, again coordinated by the federal government, focuses on a review of human resources issues in public health care. It attempts to accurately assess needs for doctors and nurses both in terms of numbers and distribution. This is key to ensuring thoughtful and appropriate investments in such areas as: expanding education and training opportunities, increasing opportunities for skills upgrading, and improving the accreditation system for existing health workers who reside in Canada.

While individual provinces are also moving on these issues, a coordinated approach will pay off in two ways: 1) it will help identify systems and strategies for dealing with regional bottlenecks that are caused by inadequate allocation of health human resources; and 2) within five to 10 years, a reduction in the sharp rates of increase in pay that health professionals can command during periods of labour shortage — both the current global one, and regionally specific pressures.

Achieving priorities – does the end justify the means?

But coordination and cooperation, key as they are to a more effective system, will not suffice. Targeted funds identify priority areas where improvement must occur — the same priority areas that have consistently been identified by Romanow, Kirby, and the provinces themselves.

Targeted federal funds simply provide an infusion of resources to achieve commonly held goals for improvement.

Without strings attached to public resources, access to public health care will remain in jeopardy — not abstractly, not in some distant future, but now, in homes, waiting rooms and emergency departments across this country.

Chronic supply shortages of doctors, nurses, technicians, equipment and beds in the public system have led to waiting lists — sometimes with devastating consequences. One critical dimension of these shortages is poor geographic distribution of resources, especially in non-urban areas.

Instead of dealing with these shortages and expanding public or not-for-profit service provision, some are agitating for more rapid access through expansion of services provided by *investor-owned facilities*. These facilities provide a return to the investor by accommodating a tier of paid access for services that are not "medically necessary" or by leasing arrangements in return for capital expansion.

Three provinces (Ontario, Alberta and B.C.) are moving rapidly in this direction, while others are more circumspect. All provinces and territories are dealing with huge pressures on tight public treasuries and growing demand.

The first backgrounder in this series argued why the Romanow recommendation for $3.5 billion in increased federal cash for 2003/04 was not enough to secure the future of public health care. It must be said that it is not clear how much money *would* be enough given current pressures. The point is that more money alone is not enough.

Money alone is not enough

Pharmatherapy continues to be the fastest growing area of health costs, due to rising utilization and increasingly expensive prescriptions, but new issues are emerging too. Diagnostic tools are used for pro-active and defensive reasons as well as medically necessary treatment. The medical profession is also agitating for richer compensation, though the impact of that compensation on increasing supply is not clear.

An expanded public purse provides undeniable opportunities for some suppliers of health-related goods and services to make big money. It is very easy to spend a great deal more on new technology, drugs, infrastructure or salaries. It is far more difficult to prove whether that is the best buy for improving peoples' health in specific and Canada's public health care system in general.

As the misuse of the Medical Equipment Fund amply illustrated, more money, even when directed through targeted funds, may or may not yield improvements. If the objective is to buy improvements and greater efficiencies, Canadians deserve to be shown what their money bought.

If it is deemed more fruitful to let provinces specify how they will use their share of the "improvement" transfer over the next two years, two issues need to be addressed: What if individual provinces do not move to improve access or timely service in key areas, such

as rural and remote service or primary care reform? How would we know if they did?

Following the money

The point is that some form of accountability is required. That means that strings must be attached to money that is transferred to the provinces. The strings should ensure minimum standards are met and improvements are made to the system. Provinces must be required to document how money was used to achieve commonly held goals and objectives, including an assessment of the improvements the incremental funds bought.

The provinces have already agreed to file annual reports based on common criteria. The first ones came out in September 2002, but are only available on a province by province basis and do not highlight the incremental changes that were achieved with the incremental funding.

That such documentation should be filed in a national repository, like CIHI, is not an affront to provincial sovereignty. It allows cross-jurisdictional comparisons, an instrumental aspect of assuring greater value for money to citizens in every province and territory. Following the money helps avoid another round of claims that billions of dollars achieved nothing, as some commentators have suggested in the aftermath of the September 2000 agreement.

The provinces understand: Without conditions and limits there is no way to contain costs. Without some techniques of accountability, the single-payer system is reduced to a grossly inefficient funding mechanism, feeding bottomless corporate, institutional and professional appetites without necessarily assuring accessible quality health care.

Without more money it is impossible to make the investments needed today for more efficient and well functioning public health care tomorrow. More money is critical at this stage; but more money, by itself, is not enough.

Health care costs will be rising on the private and the public sides of the ledger for the foreseeable future. Only the public side has the capacity to account for rising costs in a clear and comparable manner. Only accountability — true strings attached to federal funding — can assure Canadians that when it comes to more health care spending, they are getting their money's worth.

Accountability means national standards and objectives are tied to national cash…and vice versa. Accountability means both levels of government are accountable to citizens, to assure quality service and value for money.

Accountability is the cure for what is ailing public health care, and the way to ensure a strong, secure system is there when we need it.

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