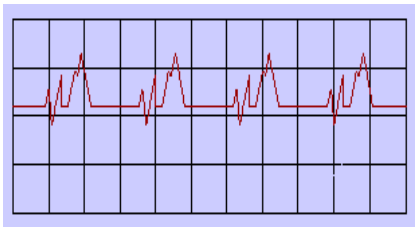
Paying for keeps



Securing the future of public health care

A series by Armine Yalnizyan

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Highlights on the Health Accord money numbers

- The amount of "new" money from the feds that goes to the provinces and territories to help pay for health care over the next three years will be $9.6 B (billion). As a point of comparison, the Romanow Report called for $15 B in additional health funds over the next three years.
- This amount is calculated by removing "old" money ($3.9 B in September 2000 Agreement announcements), this year's windfall transfer to the provinces ($2.5 B in 2002-03) and the aboriginal fund ($1.3 B over 5 years) from the $17.3 B announced in the Health Accord for the next three years.
- The bulk of the remaining "new" money has very weak strings attached.
- About $6 B of the $9.6 B in "new" money is estimated to flow through the Health Reform Fund over the next three years. (The whole fund is $16 B over five years. The budget will provide the roll out over the next three years.) This is a very loosely conditional fund for primary care, catastrophic drugs, and home care. Only $1 B is devoted to the Reform Fund in 2003-04, rising to $5.5 B in 2008-9.
- About $3.6 B of the "new" money will flow from a range of initiatives to meet common objectives (medical equipment, immunization, electronic health records, etc.). The cost of this group of initiatives, as a whole, totals $5.5 B over 5 years. The budget will provide the roll-out details over the next three years. Based on past practice, it is assumed that $1 billion or less of this money flows in year 1 (2003/04).
- The timing of how these funds and the $1.3 B for aboriginal health will be rolled out over 5 years will be in the budget. The amounts are likely to be back-end loaded, as has been the feature of most five-year plans by Finance in recent years.
- The "old" money, i.e. the September 2000 Agreement increases to the CHST, overstates the amount that is available for health care. These are general increases to the CHST. When the new Canada Health Transfer (CHT) is put into place during the coming fiscal year, the share of the CHST that goes specifically for health will be nailed down.

  The Health Accord did not specify the share of CHST that will go to the CHT. The CHT represents the new "transparent" funding vehicle that has been called for, but as yet we don't know what the new base funding for health care will be, nor how much of the September 2000 increases will be booked specifically for health care. The amounts may be smaller than specified in the Accord.
- This is not a "transformative change" approach. The pressure on the system (waiting lists, cost drivers) is now, but most of the money flows through later and has no strings attached that could lever change.

The context:

All proposals for a renewed federal investment in health funding came over and above the increases already fixed to flow through in the coming years due to the September 2000 agreement.

- Kirby said $6.5 B was needed immediately (2003/04), and the amount should rise by GDP after that. It was suggested that the funding formula for health care acknowledge the proportion of the population that is over 70. *Total over the next three years*: no less than $19.5 billion over and above the September 2000 agreement.
- Romanow said $3.5 B (2003/04) rising to $6.5 B in year three, with an escalator of 1.25% of GDP growth to kick in after that. *Total over the next three years:* $15 B
- The Provinces and Territories had three positions
  - Dec 18: the Finance Ministers asked for $5.1 B this fiscal year (2002/03) then rising to $7.4 billion by 2005/06. Total, including this year: $24.7B
  - Jan 23: the Premiers asked for $5.4 B this fiscal year (2002/03), $7.1 B by 2003/04 and rising by 1% thereafter until the fed contribution hits 25% of provincial spending. Total, including this year: $27B +
  - Feb 5: The Premiers indicate they were looking for the ***$15B*** of the Romanow Recommendation for the next three years, plus something for this fiscal year (2002/03).

On February 5th, the federal government announced the following elements of a "Health Accord":
$17.3 B over next three years
$17.5 B over following 2 years
totaling $34.8 B over five years.

The provinces asked for and received an immediate amount for this fiscal year: a $2.5 B "supplement" with no strings attached. This is counted in the first, three-year increase ($17.3 B), though it technically is transferred prior to the three-year increase.

The three year amount ($17.3 B) offered by the federal government also counts in previously negotiated increases from the September 2000 Agreement. These increases were pitched as making new funds available for health, but technically they are general increases to the CHST, which includes non-health care specific money. The five-year amounts announced as part of the Health Accord include amounts that extend and enhance the September 2000 Agreement, which includes funds for non-health care specific expenditures.

What the Health Accord does over the next three years is critical, for two reasons:

a) deteriorating public confidence and growing expectations for improvements in public health care places the premium on high visibility change now, rather than in four or five years; and
b) the benchmark is, *de facto*, Romanow's modest but eminently do-able proposals for change. Did the federal government dilute or enhance this vision monetarily?

Comparing the federal announcement to Romanow or other recommendations requires answering two questions about the $17.3 B offered over the next three year period:

- How much is new? (Flip side of this question is: How much of this is the roll-in of the September 2000 agreement?)

- How much is tied to "buy change", i.e. strings attached?

(For those who prefer, see the table on page 8. It breaks out the distribution of "old" and "new" funds, distribution of targetted and unconditional amounts, and, where known, the amounts over the three and five year horizons.)

How much "new" money is there for health costs in the provinces and territories?

Of the $17.3 B in increased transfers to the provinces and territories over the next three years, increases to the CHST which were negotiated and agreed to in the September 2000 agreement total $3.9 B over the next three years (see page 8). That means $3.9 B is "old" money being folded into the Health Accord announcement. [$17.3 - $3.9 = $13.4]

This leaves $13.4 B in previously unannounced amounts over the next three years.

As far as the provinces are concerned, $1.3 billion of that amount doesn't count. This amount is for a five-year plan put aside for aboriginal health issues. The funding will flow through the federal government. While these are new health expenditures, they will not flow to the provinces for improvements to the provision of health care. [$13.4 - $1.3 = $12.1]

This leaves $12.1 billion to flow to the provinces in the next three years.

Another $2.5 billion doesn't count as money specifically targetted towards health care because the provinces are allowed to spend it in any way they see fit. This is the "Health Supplement" of $2.5 billion in 2002/03, which could be viewed as a "signing bonus" in that it stands apart from the Accord. It comes out of this year's federal budgetary surplus and is not rolled into the CHST base. Though called a Health Supplement, it is simply a one-time increase to the provinces. It is not conditional to any dedicated purpose, health or otherwise. The Prime Minister has stated that, if the budgetary surplus allows in 2003-04, a further $2 billion may be transferred similarly – i.e. unconditionally – to the provinces in this manner. This amount is counted into the "three-year" amount of $17.3 B, but indeed precedes the three-year clock. [$12.1 - $2.5 = $9.6]

This leaves **$9.6 billion over three years** for the provinces, new monies that could be used explicitly to lever change in the provision of health care.

The break-out of the "new" $9.6 billion over three years is roughly as follows:

- Approximately $6 billion in the Health Reform Fund ($1 billion announced for 2003/04, and estimating about $2 billion in 2004/05 and $3 billion in 2005/06). This fund is a rather fungible cash pot set aside for the purposes of improving three areas of health care provision – primary care, catastrophic drugs, and home care. If past practice is any guide, the money grows larger with every passing year and is therefore back-end loaded.

  The only information we have to date from the backgrounders to the Accord state the amount in this fund is $1 billion in 2003-04, rising to $5.5 billion in 2008-9. The fund, a five-year project, totals $16 billion. At the end of the five years, the amount of the fund is rolled into the non-conditional base funding for health care.

  The terms and conditions of access to these funds are so loose as to make these essentially non-conditional funds.

- Approximately $3.6 billion spread over a number of initiatives that have had no time frame linked to them beyond taking place in a five-year horizon. This will be clarified in the February budget. The $3.6 billion is a guesstimate of how a series of initiatives, totaling $5.5 billion, will be phased in over a five year horizon. These initiatives include specified amounts for the following targetted areas. (All figures are expenditures within a five year time frame.)
  - Diagnostic and Medical Equipment - $1.5 billion
  - Electronic Health Records - $600 million
  - Research Hospitals - $500 million
  - A collection of initiatives totaling $1.6 billion, covering health human resources, patient safety initiatives (immunization), technology assessment (CCOHTA), health promotion strategies, innovation and research
  - An unarticulated $1.3 billion for new initiatives (could include an amount for the Health Council, for supports for caregivers through EI and/or GST rebates)

How to calculate the "old" money in the Health Accord

Before September 2000 agreement, the cash transfer base for health care, post-secondary and social assistance programming was $15.5 B.

The September Agreement did not raise the base, but it added cash increments which were sunset in 2005/6. These were spin-doctored as "for health" but in fact they were general increases for the CHST. (The allocation for health is not yet determined. The share of the CHST that will end up as the CHT is a key absence from the Accord.)

The amounts flowing from the September 2000 agreement over the next three years total $13.2 B over next three years, plus another $400 million for the primary health care fund.

Only three relatively small amounts were specifically tied to health costs:

- Medical/Diagnostic Equipment ($1 B spread out over 2000-01, and 2001-02)
- according to the Radiologists, about half of this money remains unspent, though it has been drawn down by the provinces
- Primary Care Fund ($800 M spread out over four years, 2001-02 to 2004/5, with annual pots of $200 M available)
- according to the Globe and Mail, as of Jan 23 2003, only $21 M of this money was paid out/spent, though fed-prov announcements from Sept – Nov 2002 total $480 M in allocations
- Health Info Technology ($500 M in 2000-01 only)
- this amount is still being spent by Canada Infoway

The Health Accord treats the CHST value, in cash terms, as $19.1 B. This is the value of the CHST in the current fiscal year (2002/03).[1] Consider this the starting point of the accord, and the new "base" for all federal cash transfers for social programs. Increments referred to in the Health Accord are built onto this amount.

The following table shows how the CHST increases over the next three years. The CHST will be transformed into the CHT (Canada Health Transfer) during the course of the upcoming fiscal year (2003-04). The numbers regarding base cash funding for health care will be different from these numbers.

The September 2000 Agreement

(in $billions)	2000/01	2001/02	2002/03	2003/04	2004/05	2005/06	Over 5 years
General Increase		2.5	3.2	3.8	4.4	5	18.9
Early Childhood Development		0.3	0.4	0.5	0.5	0.5	2.2
CHST Increases		**2.8**	**3.6**	**4.3**	**4.9**	**5.5**	**21.1**
Targetted funds:							
Primary Care Fund		0.2	0.2	0.2	0.2		0.8
Med Equip. fund	0.5	0.5					1
Health Info. Tech	0.5						0.5
TOTAL INCREASE	**1**	**3.5**	**3.8**	**4.5**	**5.1**	**5.5**	**23.4**

The increments total $3.9 B over the 3 years in terms of cumulative new transfers.

The allocation for health care in the federal transfer to the provinces (i.e. the base size of the CHT) will not likely be determined by the Department of Finance and announced in the February budget. More likely, it – and the proportion of the increments going to health – will be negotiated with the provinces and territories over the course of the fiscal year.

It is important to note that the CHT may not include the full amounts noted above as increases to base funding for health care. The increments noted above are general increases to the CHST and include unspecified allocations for post-secondary, social assistance and early childhood development expenditures as well as spending for health.

How much of the new money is for buying change?

As can be seen, the amount available for fiscal 2003/04 that is in any way tied to levering change is very small.

The Health Reform Fund, worth $16 billion over five years, comes in next fiscal year at $1 billion, to be used for any purpose within three target areas for change (primary care, catastrophic drugs, and home care). As men-

(in $ billions)	2003/04	2004/05	2005/06
CHST	$19.8 billion	$20.4 billion	$21.0 billion
General Transfer Increase Increment over previous year *	$700 million	$600 million	$600 million
Cumulative increase	$700 million	$1.3 B	$1.9 B

* ***as per September 2000 agreement. Note that the fiscal-year plan sees an additional $600 million added to the base amount every year. This simple extension of the September 2000 agreement means transfers under the CHST go up by a cumulative $9.5 B over the five years.***

[1] It includes the Early Childhood Development amount, but excludes the amount for the Primary Care Fund, as this is not block fund money. The Primary Care Fund is not CHST money. Instead it is tied to a particular purpose, and sits in a trust fund to be drawn down for that purpose. A Globe and Mail article on Jan 23, 2003 documented that less than $21 million of this fund has been paid out to date, i.e. it has hardly been used. However, press statements from the federal Health Minister show that about $480 M has been announced for these purposes between September and November 2002. This discrepancy relates at least in part to the accrual method of budgeting, i.e. the money is declared in year one as "booked", though the actual spending is expected to take place over the next few years.
According to the Fiscal Monitor, November 2002: "The budgetary balance is presented on a modified accrual basis of accounting, recording government liabilities when they are incurred, regardless of when the cash payment is made [and recording tax revenues only when the cash is received]. In addition, the budgetary balance includes only those activities over which the Government has legislative control. http://www.fin.gc.ca/fiscmon/2002-11e.html

tioned, that $1 billion is not really conditional, as the conditions appear to be very loose.

That leaves only initiatives related to specific programs, such as the purchase of medical equipment ($1.5 B), the development of health informatics ($600 M), the implementation of immunization programs or support for caregivers (some share of $1.3 B). The sum total of these initiatives is $5.5 B over five years. Of this $1.3 B is put aside for unspecified initiatives, to be announced in the federal budget.

Speculation is that some of the as-yet unallocated $1.3 B will flow to the Health Council; health human resources; or support for caregivers. The latter could take the form of EI payments, tax credits and/or GST rebates.

Health human resources could be a promising avenue, but the amounts are small, and efforts in this arena will likely be eclipsed by the sheer scale of increasing labour costs. Settlements with physicians' associations across 13 jurisdictions will, conservatively, cost taxpayers another $2 billion to increase fees paid to the 58,000 doctors currently employed (i.e. not hiring new doctors); collective agreements with the 232,000 employed registered nurses will cost about another $500 million. Both amounts refer only to wages, not benefits. These agreements do not cover the wider range of health workers.

In any case the amount to flow through in 2003-04 for a wide range of initiatives totaling $5.5 billion over 5 years could be less than $1 billion.

We can thus anticipate the upcoming budget to provide something in the order of $2 to $2.5 billion in new, previously unannounced federal supports to the provinces in 2003/04. This is the amount that is expected to buy change, in a system that now sees the provinces and territories spending a combined $73 billion or so on public health care.

To repeat, the additional unconditional increases over the next three years all flow from the September 2000 agreement. The "new money" in this case is due to extending the agreement to 2006/07 and 2007/08, and consolidating the amounts as base cash transfers.

The concern is that the pressures on the system at this time are very great, and that little is being done to make the public system more efficient and less prone to commercialization. The latter concern is based on the fact that the more prolonged and entrenched the issue of waiting lists becomes, the more there is agitation for access to services by being able to "buy" services, or by insisting on a care "guarantee". Both approaches ultimately raise the costs of the public system. The former approach also erodes the principle of universal access to timely, high quality care.

Another element of increased commercialization due to chronic underfunding comes under the guise of insufficient capital to invest in necessary upgrades or builds of facilities (acute care, community-based, and long-term care). Insufficient public resources has become the primary rationale for turning to private sector investors for financing, building, and sometimes operating health care facilities in Ontario, B.C., Nova Scotia and New Brunswick. A growth of investor-owned facilities are one aspect of commercialization of health services.

Commercialization of services has long-term implications for the cost effectiveness and quality of the public system of health care. The move towards greater commercialization has greatly accelerated since September 2002 in three provinces (Ontario, B.C. and Alberta). Hence the pressure for adequate pub-

lic funding is very much now. The Accord, as agreed to, does not rise to the challenges that exist today in the effort to secure the future of public health care.

Analysis of february 5th health accord monetary proposals pre-budget - all amounts in $billions

How the CHST was rolled into the announcement

	2002/03	2003/04	2004/05	2005/06	2006/07	2007/08
September 2000 Agreement (base CHST cash set at $19.1 B)						
Annual Increment		0.7	0.6	0.6	0.6	0.6
Cumulative Increment		0.7	1.3	1.9	2.5	3.1
Cumulative over First Three Years			3.9			
Cumulative over Five Years			9.5			
Supplemental	2.5					

September 2000 Agreement – Increase in Cash Transfers			
Over First Three Years		3.9	
Cost of Extension to Last Two Years		1.8	
Cumulated Increases Over Five Year Horizon		9.5	
Total Federal Announcement		Of Which Unconditional Amounts Are	
Over Three Years	17.3	6.4	
Last Two Years	17.5	5.7	
Over Five Years	34.8	12.1	
Of First Three Years:	17.3		
Minus Sept 2000 Agreement	-3.9		
Minus Supplemental in 2002-03	-2.5		
Minus Aboriginal Fund	-1.3		
Total Funds For Change	9.6		

Four pots of cash

Transfers: CHST/Sept 2000 Increase	9.5	UNCONDITIONAL FUNDS	12
Transfers: Supplemental (2002/03)	2.5		
5-Year Health Reform Fund	16.0	TARGETTED FUNDS	22.8
5-Year Tied Initiatives*	5.5		
5-Year Aboriginal	1.3		
*includes $1.3 B in unspecified initiatives to be announced in the budget			
TOTAL	34.8	TOTAL	34.8

Why provinces say $12 b in new money over next 3 years

CHST/Sept 2000 seen as pay-back for cuts, water under the bridge	
Aboriginal funds out	
Health Reform Fund over 3 years	6
Allocation of part of $5.5	2.5
Supplemental	
TOTAL	

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