

**INVESTING IN THE PUBLICLY FUNDED HEALTH SYSTEM:
IMPROVING HEALTH SYSTEM PERFORMANCE**

Brief Submitted to the House of Commons Standing Committee on Finance

By the

Canadian Healthcare Association



November 2004

INVESTING IN THE PUBLICLY FUNDED HEALTH SYSTEM: IMPROVING HEALTH SYSTEM PERFORMANCE

CHA'S RECOMMENDATIONS TO THE HOUSE OF COMMONS STANDING COMMITTEE ON FINANCE

1.0 INTRODUCTION

The Canadian Healthcare Association (CHA) is the federation of provincial and territorial hospital and health organizations across Canada. Through our members, CHA represents a broad continuum of care, including acute care, home and community care, long term care, public health, mental health, palliative care, addiction services, children, youth, and family services, housing services, and professional and licensing bodies. These services are provided through regional health authorities, hospitals, and other facilities and agencies that serve all Canadians, and are governed by trustees who act in the public interest.

CHA's mission is to improve the delivery of health services in Canada through policy development, advocacy and leadership. CHA's distance learning programs, conferences and publishing services contribute to this national leadership. CHA and our members are committed to realizing the vision of a publicly funded health system that provides access to a broad range of comparable health services across Canada.

Accordingly, we are very interested in the work of the House of Commons Standing Committee on Finance, and are pleased to have this opportunity to state our case for appropriate federal investments in the health system, linked to health system performance outcomes and the achievement of pan-Canadian objectives.

1.1 The Current Situation

In the past several years, two major national task forces, the Romanow Commission on the Future of Health Care in Canada, and the standing Senate Committee on Social Affairs, Science and Technology (chaired by Senator Michael Kirby), have concluded that Canada Health Act services (that is medically necessary hospital and physician services that are provided on the basis of health need, rather than the ability to pay) comprise a cherished program based on national values of shared risk and responsibility. The First Ministers 2004 Health Care Plan reiterates a commitment to these values.

Our publicly funded health system is respected internationally for ensuring healthy workers and affording businesses based in Canada a distinct competitive advantage. (For example, General Motors in the USA spends more on health care for its pensioned employees than on steel for its automobiles.) The health sector is also a potential source of wealth creation, exports, and 21st century jobs for Canadians. Our single payer system provides economies of scale that could drive the development of a domestic export

industry, by building upon our first class health professional training programs, researchers, delivery systems, and information technology development. Rather than considering investments in health innovation and reform a burden, we should approach them as investments in product development. And while we recognize the health sector as a potential creator of jobs and exports, we are not suggesting that we import foreign control and/or delivery of health services to Canada, a concern that has been expressed by many, including Romanow, about Canada's participation in world trade negotiations. It is up to Canadians to decide on the future nature of our health system and this cannot be left to the vagaries of trade negotiations.

Polls show that Canadians greatly value our public funded health system. However, there is also evidence that Canadians do not have confidence in our health system's ability to provide timely and quality care now and in the future. Increasing numbers of Canadians and their families are concerned about: emergency room overcrowding; insufficient numbers of primary care providers (over 3.6 million Canadians don't have a family doctor) and some specialists; excessive wait lists and wait times for diagnostic procedures (Canada has less MRI units per million population than most other OECD countries) and surgical treatment (29% of Canadians who received specialized care in the last year reported that the waiting period was too long, and our waiting times for medical treatment appear to compare unfavourably with other OECD countries); and lack of appropriate access to medically necessary services ranging from home care to maternity care, (some of which are not Canada Health Act services). These concerns were aired at the recent First Ministers' Meeting on Health that resulted in the Ten Year Plan to Strengthen Health Care (to be referred to hereafter as the 2004 Health Care Plan or the 2004 Health Accord). At this meeting, it was agreed that access to timely care across Canada is a national priority.

The service issue is not only about access and quantity, but also about safety and quality. With respect to quality of care, concerns over patient safety have resulted in the creation of the Canadian Patient Safety Institute in 2003. A recent report from the Canadian Institute for Health Information (CIHI) based on the joint CIHI/Canadian Institutes of Health Research (CIHR) Adverse Events Study reinforces the need to address patient safety and quality issues in hospitals and other health settings. In Canada in 2000-01, adverse events occurred in 7.5% of medical/surgical admissions in non-specialized acute care hospitals, and 37% of these events were considered highly preventable. Investments in infection control, quality improvement and safe systems are essential.

Regarding public health, outbreaks of *C. difficile*, Severe Acute Respiratory Syndrome (SARS) and Bovine Spongiform Encephalopathy (BSE) have demonstrated the importance of strengthening our public health system in order to protect Canadians, the health system, and the national economy. CHA is pleased with the creation of the Public Health Agency of Canada and the appointment of a Chief Public Health Officer, who will provide leadership in the federal government's efforts to help keep Canadians healthy, as well as ensure that Canada is prepared in times of emergencies.

With respect to the broad continuum of care, pilot projects suggest that broadening both the range of services delivered (for example, the inclusion of palliative care in the basic publicly funded health system across Canada), and the range of providers (for example, increasing the use of midwives and nurse practitioners), can produce positive outcomes with high patient and provider satisfaction, for less money. Further, the integration of other components such as home and community care into the overall system will likely promote a more financially sustainable system, and enable hospitals to focus on the patients who require hospitalization, rather than those patients who require alternative levels of care in another setting.

Finally, there are special populations within Canada, Aboriginal peoples in particular, who trail other Canadians in all key quality of life indicators, including health.

1.2 CHA's Position

CHA advocates for a responsive, sustainable, publicly-funded health system, and believes that such a system is achievable, but requires strong leadership from governments, health system managers and trustees, front line providers, researchers, and the public to make it happen. It also requires sufficient, ongoing and predictable funding.

It is important to note progress. Health system renewal has been taking place across the country in various ways. There are continuous changes being made to enhance efficiency, effectiveness, integration, and quality. There is still work to be done to improve productivity and outcomes in our health system, but there are many examples across this country of best practices that can be shared and implemented. It is important to remind members of the Finance Committee and Canadians generally why there is a lack of confidence in our health system. This developed to a large extent because of: inadequate federal funding in the past; the stop and go approach to funding on the part of all governments in the 90's; inadequate investment in information technologies and data management; a lack of understanding of the labour intensive nature of the health system, (70-80% of health spending pays people who provide care and services) – and generally, the fact there are those who look for magic solutions in a complex industry. There are solutions, but there is no magic bullet.

There are also key individuals, even possibly political figures, who remain nominally committed to a publicly funded health system because it is politically popular, but believe that it is not sustainable or are not really committed to it. These people fail to see the good news, as follows:

- A new report on provincial and territorial health spending from the Canadian Institute for Health Information (CIHI) reveals projected provincial/territorial expenditures for 2004-2005 are \$83.9 billion, reflecting the lowest growth rate since 1997-1998, that is 5.1% in nominal terms, or only 2.9% in real terms. (This may not be sufficient to deliver the services Canadians need, but it demonstrates that spending is not out of control).

- Administrative costs in Canada are approximately 13%, which compares favorably with other countries (administration costs in the USA are 30%). Administration costs for hospitals are 8.4%, among the lowest within OECD countries.
- Canada has been spending from 9 to 10% of its GDP on health for the last 20 years. This includes both public and private spending. Public spending is about 6.5% of our GDP (less than the United States spends on publicly funded medicare and medicaid as a percentage of their GDP).
- Based on 2003 OECD health data, Canada ranks 6th among thirty countries in terms of total (public and private) expenditures on health care, and trails the United States, Switzerland, Germany, Iceland and France respectively. In terms of public spending on health care per capita, based on purchasing power parity, Canada recently dropped to 10th out of 30 OECD countries.
- Twenty years ago, hospitals expended 45% of Canada's health budget whereas today, hospital services are 30% of the health care budget. At the same time, hospitals are taking care of larger volumes of patients through new technologies, day surgeries, and shorter lengths of stays.
- Reforms are taking place that are moving care into the most appropriate setting. However, change requires funding and people need care while change is taking place.
- Projections of future costs cannot be based on straight-line projections, but need to take into consideration reforms that will be implemented.
- Integration of health services is proceeding across the country at a different pace and in different ways, but everyone is committed to a patient-centred approach.
- All governments (federal, provincial, territorial) have made a commitment to the same values, principles and objectives in various health accords.

CHA has consistently made the following points:

- Inadequate funding for existing medicare services in some regions of this country (that is, hospital and physician services), has left some health institutions and providers stretched to the limit and operating in a non cost-effective, crisis mode. Canada has the highest acute care bed occupancy rate among all of the OECD countries (88.6%), leaving no flexibility in the system.
- All parts of the continuum of care need appropriate funding and Canadians deserve access to comparable health services across the continuum. While hospitals need appropriate funding to help address wait times issues and meet the

- needs of acute care patients, part of the solution is to move forward on primary health care reform and to ensure access to services in the community.
- The federal government has not been paying its fair share of health expenditures for a number of years. In order to have the moral authority to work with the provinces and territories to achieve mutually agreed-upon, pan-Canadian objectives, the federal government needed to contribute more to the health transfer and fill the “Romanow gap”. Therefore CHA was pleased with the substantial increase to the transfer in the 2004 Health Accord (an amount similar to what CHA had been advocating for).
 - An explicit escalator was required in order to ensure long-term predictable funding and CHA is hopeful that the 6% escalator that was agreed to in the 2004 Health Accord will allow health facilities and agencies to undertake long-term initiatives to improve health system outcomes.
 - In addition to investments in the health system, the federal government must invest in the determinants of health. A recent Conference Board study has estimated that about 25 % of a person’s health status depends on the health system while 50 % is related to living conditions – factors such as income level, education and environment. Investments in these areas will improve the health status of Canadians and reduce costs to the health system. To this end, CHA has advocated for an escalator to the Canada Social Transfer, similar to what has been promised for the Canada Health Transfer.
 - The federal government must support health promotion programs and healthy lifestyle initiatives. For example, Canada has had superb success in addressing the health costs associated with tobacco use through a health promotion effort that included legislation, education and healthy public policy. This same effort must be brought to bear on the growing problems of obesity and physical inactivity. A recent comparison by the Conference Board of Canada on health system performance among leading countries found that countries with a greater commitment to addressing non-medical factors, such as obesity, road traffic accidents and immunization, have better health outcomes.
 - Equalization payments help to ensure that Canadians have reasonable access to comparable health and social services regardless of the fiscal capacity of their province or territory. Therefore, CHA has urged the federal government to resolve issues related to Canada’s equalization program and recognizes the progress made in the recent federal/provincial/territorial meeting on equalization.
 - There needs to be a home and community program supported by a legislative framework that addresses not only acute care (hospital) replacement services but also the ongoing chronic care needs of various population groups, including seniors, persons with disabilities, mental health clients and children with special

needs. Not all of these services need first dollar coverage, but they must be provided in a way that enhances access to needed services. While the 2004 Accord contains a limited home care program including acute care replacement services, short-term community mental health, and end of life care, CHA continues to advocate for access across this country to both acute care replacement and on-going continuing/chronic home care services. This is unfinished business that will ultimately require additional federal investments.

- There is also the issue of facility-based long term care and appropriate supportive housing solutions for a growing older population, which needs pan-Canadian solutions and future federal investments.
- With respect to drug coverage, funding and management must occur as part of an integrated health system. Gaps in access, lack of equity, and undue financial burden must be addressed through a pharmacare strategy and program with pan-Canadian objectives and a commitment to develop and support best practices.
- As was recognized within the 2004 Health Care Plan, none of these goals will be achieved without adequate health human resources. CHA continues to advocate for a pan-Canadian health human resource strategy.
- The federal government's commitment to health research has been demonstrated by the creation of the Canadian Institutes of Health Research (CIHR) and enhancements to the budget of CIHR. CHA supports further federal investments in health research.

1.3 Cost of Necessary Investment

While the overall increase to the CHT base in fiscal year (FY) 2005-06, as a result of the 2004 Health Accord is somewhat less than what CHA was advocating for, by 2007-08 the difference is minimal due to the compounding effect of the 6% escalator. If these investments are directed to ensure progress in the areas agreed to in the Plan, CHA believes that with appropriate leadership and commitment to reform, there is sufficient funding to achieve the health system performance outcomes that the plan envisages. Funding should be tied to the achievement of mutually agreed upon pan-Canadian objectives, and CHA will examine the details of the legislation implementing the 2004 Accord expenditures to see whether it also includes reference to the objectives and outcomes which are linked to the new funding.

1.4 Where Should the New Funding Come From?

CHA believes that health funding commitments need to be part of a sound fiscal and budgetary plan and not based on surpluses that may appear after the fiscal year has ended.

That is, they must be built into the government's fiscal envelope at the outset. A federal dedicated tax (as proposed by Senator Kirby) does not appear to be required given the current predictions of federal revenue and planned expenditures. CHA believes that commitments to health spending should never again be dependent on a surplus (e.g., the \$2 billion conditional commitment in the 2003 Accord which was on and off-again for many months while the Government tried to predict whether or not a surplus would materialize). Fortunately the government kept the commitment, and as it turned out, the surplus for the fiscal year 2003/04 was \$9.1B.

CHA understands that tax rates need to be appropriate for the stimulation of economic growth and development, but has noted in the past that there is a trade-off between tax cuts and government services. We need a plan that accurately predicts the fiscal framework and includes up-front planned expenditures for health and social programs, tax reductions, and debt management.

1.5 Single Tier or Co-Payments

CHA has always urged that Canada Health Act medically necessary services must continue to be publicly funded (single-tier) along with acute care replacement home care services. However, CHA has also recognized that there is room for co-payments for some services e.g. home support services for some clients, reasonable accommodation payments for facility-based long term care, and co-payments for pharmaceuticals, provided that this does not reduce access.

On the issue of private delivery as opposed to private funding (which are two different things) CHA does not believe that private delivery options are a panacea for addressing escalating health care costs. A recent report from the Canadian Health Services Research Foundation concluded that based on American research:

- Health spending is higher and increases faster in communities served by for-profit hospitals compared to communities served by non-profits;
- For-profit hospitals spend significantly more on administration for each patient each day; and
- For-profit care leads to higher mortality no matter what the administrative system is like.

For-profit private sector delivery may be appropriate and is currently in place in some instances, (for example, contracting out ancillary services such as food and parking lot management, or the use of private diagnostic services for routine blood testing, x-rays, etc., with public payment). However, hospitals must always have the necessary diagnostic equipment and staff before private clinics can be considered as an additional

delivery option. And care must also be taken to ensure cost effectiveness, access, quality, and accountability within private delivery options, if and when they are contemplated.

1.6 Strengthening the Current System

Although our health system has considerable strengths, recent events have raised concerns about the adequacy and sustainability of the system now and in the future. Years of under-funding left the Canadian health system with no surge capacity to address serious public health epidemics or catastrophic events such as a bio-terrorism pandemic, or environmental disasters. (Based on 2001 OECD data, Canada had the highest acute care bed occupancy rate and the lowest percentage of available beds among all 21 countries that provided data.) This has occurred at the same time that investments in essential public health services (prevention, protection, and promotion) have fallen. As a percentage of the health dollar, Canada spends less today on public health than in the 1990s. Therefore, CHA welcomed additional investments in public health in the 2003 Budget and looks forward to future enhancements.

There are also shifts in the consumption of health care dollars. Although hospitals continue to account for the largest single component of total expenditures at 30% in 2003, this is down from about 37% in 1993 and 45% 20 years ago. Further, administrative costs have been declining in recent years. In contrast, retail drug sales, the second largest category, rose to 16% of total expenditures from 13% a decade earlier.

While it is impossible to totally prevent catastrophic events, both a strong public health system and an adequately funded treatment system are essential to successful surveillance and control, cost-containment within the health system, and minimizing the impact of a catastrophic event on the overall economy. (In 2003, in Ontario, the impact of SARS on the tourism industry contributed to a substantial net decline in revenues).

Of further concern regarding the economy is that further erosion of the publicly funded system in Canada or shifting of services to employer health plans may diminish our competitive advantage. Conversely, enhancements to a broader continuum of care in Canada, including home care, would increase our competitive advantage.

The growing concern nationally and internationally about the prevalence and cost of adverse events, provides another reason to strengthen the existing system. CIHI reports that almost a quarter of Canadian adults report that they, or a member of their family, have experienced a preventable adverse event in 2000-01, during which time it is estimated that more than one million additional hospital days a year may be attributed to adverse events. New technology, innovation, electronic health records and a non-punitive reporting system for adverse events have been recommended. Where they have been implemented, automated health information systems have had a positive impact on both health care quality and costs, including a reduction in preventable adverse events. In Sweden, which was recently ranked second in terms of overall performance of the health system by the Conference Board of Canada, hospitals spend 4 percent of their budget on

information and communication technologies (ICTs). Canada ranked thirteenth in terms of overall performance, and our acute care organizations spend only between 1.8 and 2.5 percent on ICTs.

In addition to automated information systems, the Canadian health care system requires timely access to the latest medical technologies, where there is substantial evidence that these improve patient care and health outcomes. Without the capital to invest in such technologies, we are missing opportunities to improve the performance of our system.

The changing demographics within Canada are another important consideration. Managing chronic illness and an aging population requires investments in community-based care in order to reduce the demand on acute and long-term care institutions. The Conference Board of Canada reports that in Sweden, pharmacare and extended support services are helping to manage the level of health expenditures and the needs of an aging population. There is also a growing body of evidence that community based programs that focus on health promotion for the frail elderly result in a decrease in overall health care costs, including hospital costs.

A recent study by the Manitoba Centre for Health Policy found that although most people wish to die at home, almost half of Manitobans die in hospital. In addition, those who died in hospital during the study period (representing 1% of the province's adult population) used 24% of all hospital days. The care of dying patients in hospitals and long-term care facilities costs significantly more than the care of individuals dying in the community, even when the severity of the illness is comparable.

And finally, while Canadians deserve access to care and services in a timely manner, the issue is not only one of quantity, but also quality and appropriateness.

1.7 The Need for Federal Leadership

Canadians expect the federal government to ensure that all Canadians have access to comparable services, regardless of the jurisdiction in which they reside. Since jurisdiction over health delivery is a provincial/territorial responsibility, some argue that the federal government should only provide the funding, without linking it to conditions, objectives or strings. However, the federal government has the constitutional right to use its spending power to achieve pan-Canadian objectives in areas of provincial jurisdiction. This is how and why the federal government's hospitalization program was created in 1957 and physician-based medicare in 1966, which were later articulated in the 1984 Canada Health Act. The story of conditionality and strings tied to federal cash is the story of Confederation. Canadians expect access to comparable services wherever they live in this country which speaks to the need for pan-Canadian objectives linked to federal dollars. At the same time, provinces note that they are responsible for health services delivery and can decide how services are delivered, which speaks to the need for federal flexibility. All levels of government must work together to ensure progress for Canadians.

Working together, the federal/provincial/territorial governments can identify and support successful initiatives and champions from across the country, including the development and implementation of evidence-based practice guidelines and performance objectives, and alignment of economic and administrative incentives with the use of appropriate care and attainment of desired health outcomes. It is important that opportunities be provided for the federal government and provinces and territories, together with providers, health system managers and trustees to meet and discuss what works in their jurisdictions.

1.8 Monitoring and Measuring Outcomes

Canadians are willing to invest in the Canadian health system. In return, they expect tangible results, publicly reported information about health outcomes and costs, and clear lines of accountability. While recognizing that the delivery of health services is a provincial/territorial responsibility, Canadians expect the federal government to provide additional funds in exchange for assurances that pan-Canadian objectives such as reduced waiting times will be met, and mutually agreed-upon performance indicators developed, collected, analyzed and utilized to enhance the effectiveness of funds spent on health care.

Information based on comparable indicators and pan-Canadian benchmarks and targets needs to be communicated to Canadians.

1.9 Adequate Human Resources are Key

Ensuring the sustainability and quality of the health system depends not only on adequate levels of funding, but also adequate numbers of trained health care providers. There is a growing body of evidence highlighting serious current and impending shortages of health care providers at a time when the age-related needs of the population are increasing. Since health providers are a mobile resource, a coordinated pan-Canadian approach to the issue is required to reduce competition within and among provincial/territorial labour markets.

CHA has long advocated for a pan-Canadian Health Human Resources Framework and Strategy. This strategy and framework should be developed collaboratively, with federal/provincial/territorial government representatives, employer representatives from health facilities and agencies, representatives of the professions, and employee representatives. The 2004 Health Accord committed to addressing human resources but a greater emphasis on co-ordination at a pan-Canadian level is urgently required.

2.0 CONCLUSION AND SUMMARY OF RECOMMENDATIONS

In summary CHA continues to advocate for:

- A health system that reflects the Canadian value that access to health services should be provided on the basis of health need, not on the ability to pay;
- Improved management and reporting on health system expenditures and outcomes based on mutually agreed upon, evidence-based targets;
- Increased investments for the development of an electronic health record and improved information technology;
- Appropriate health system renewal that improves access, safety, quality of care, and cost-effectiveness.
- Investment in health research at at least 1% of total health spending.
- A legislative framework that will tie federal funding commitments to measurable outcomes.
- The development of a pan-Canadian, health human resources strategy.
- Appropriate funding for Canada Health Act services (medically necessary hospital and physician services).
- Bringing a greater proportion of the health system continuum – including home, community, and long-term care - under the public envelope on a pan-Canadian basis, while recognizing there will be co-payments in some aspects of these services.
- Primary health care reform.
- Funding and managing enhanced drug coverage as part of an integrated health system.
- Future enhancements to public health funding (while welcoming the announcements in the 2003 federal budget regarding public health).
- An annual escalator for the CST, similar to what was provided for the CHT.

CHA urges this Committee to support the investments that were agreed to in the 2004 Health Accord in order to improve outcomes and efficiencies in the future including:

- Increasing the CHT base to \$19 billion in 2005-06.
- Implementing a 6% annual escalator from 2006-07 onwards to address increases in inflation and health system costs.
- Provision of \$10 billion over 10 years, beginning in 2004-05 for a Wait Times Reduction Fund that will be used for jurisdictional priorities including hiring more health professionals, developing tools to manage wait times, and clearing back logs.
- A standardized approach to establishing clinically appropriate wait times together with adequate levels of funding and human resources.
- Additional new dollars totaling \$41.285 billion over 10 years.
- Working together with all levels of government and with Aboriginal peoples to improve the health status of Aboriginal peoples, and ensure that Aboriginal peoples benefit from improvements to the Canadian health system.

While there is still some unfinished business, CHA and its members acknowledge the substantial progress made in the 2004 Health Accord and will work within its framework to achieve measurable progress for Canadians.

CHA appreciates the opportunity to appear before the Committee.