FOUR FEDERAL INITIATIVES TO IMPROVE AFFORDABILITY, PRODUCTIVITY AND ACCOUNTABILITY

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INTRODUCTION

Maintaining a high quality healthcare system in the current era of slower economic growth and greater healthcare demand will be a huge challenge for Canada. The task of addressing and managing this challenge falls largely to public sector decision makers (since the public sector currently provides 70% of Canadian health services financing). Such decision makers must cope with the combined effects of two key factors: (i) an aging population and higher dependency ratios but also (ii) the vast number of new healthcare interventions, both diagnostic and in treatment, and the seemingly boundless public appetite for these. It is not aging *per se* that is the problem but aging in the context of increased healthcare options.

The Government of Canada has an important leadership role to play in ensuring a sustainable, high quality healthcare system into Canada's future. This paper describes four key initiatives that would help it build on past successes and provide more dynamic and substantive leadership at this critical time. Each initiative has the potential to drive both an improvement in delivery and an increase in the affordability of healthcare.

BACKGROUND: CHANGES ALREADY MADE

Beginning in the early 1990s, the federal government made significant changes and invested substantial sums in the areas of health information, health research and health informatics.

// **Health information** The Canadian Institute for Health Information (CIHI), was first proposed in the early 1990s by then federal Deputy Minister of Health Margaret Catley-Carlson to consolidate, rationalize and improve the collection of health information. Prior to this, four separate taxpayer-funded bodies were engaged in the collection of information: Statistics Canada, Health Canada, the Hospital Medical Records Institute (HMRI) in Ontario and MIS in the rest of Canada. The information they provided was often up to three or four years out of date. HMRI and MIS were therefore merged into CIHI. Health Canada transferred much of its health statistics activity to the new organization and a strong bond was built between CIHI and Statistics Canada as the Chief Statistician serves as Vice Chair

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of the CIHI Board. CIHI's budget – which is drawn from both federal and provincial sources – has increased from about $10 million a year to over $40 million. The Institute now stands as an important cornerstone of health information in Canada. With significant analytical capacity, it provides critical data on issues such as hospital admissions, discharges and lengths of stay in a timely manner.

// **Health research** In 2000 Dr Henry Friesen, Chair of Canada's federally-funded Medical Research Council (MRC), convinced the federal government to transform the organization into the Canadian Institutes of Health Research (CIHR). The aim was to move away from a research agenda driven largely by the MRC and its staff, to one with broader linkages to the health system as a whole. This important federally-led initiative has resulted in both an increase in and a diversification of federal health research dollars. Funds now flow to thirteen virtual health research institutes which are much better linked to clinical decisions and health policy. At the same time the Canadian Health Services Research Foundation, (CHSRF) was established to link the health information and research areas. Its mandate is to "promote the use of evidence to strengthen health service delivery in Canada".

// **Health informatics** Canada Health Infoway was created to lead the development of electronic health records. Although the provinces worked with the federal government on this initiative and are represented on its governing board, the $2.1 billion in financing provided to date has all come from federal coffers.

These key investments have positioned Canada to be much more effective in applying evidence both at the point of patient care and in the management of healthcare services. But are these initiatives bearing fruit? Is the sizable federal investment that has already been made making a difference to Canadian healthcare?

WHAT NEEDS TO BE DONE

Despite all the investments, many health funding decisions are still driven by vested interests advocating for their particular causes, rather than by hard evidence as to the efficacy of treatment. Individual patient cases land on the front page of our daily newspapers and cause public opinion and politicians to swing in favour of new treatments. Public fears rather than medical evidence drive many decisions. As an example, all available data supports the view that we are over-medicated, yet payments to pharmacists for reviewing patient medications are only gradually being introduced.

In order to capitalize on existing investments and achieve an effective and affordable health system for the future, the Government of Canada must move to put in place an evidence-based set of strategies: it needs to provide very specific leadership, in partnership with the provinces and territories, to achieve concrete goals in health services performance. Below we outline four key initiatives that we believe would help it do so.

1 Improve accountability to drive quality improvement

One of the key thrusts of the 2004 Healthcare Accord was an improvement in accountability. However this fell short due to a failure of political will and problems with the detail of the accountability. What we have ended up with instead is too much measurement and too little management.

What were supposed to be "comparable indicators", on issues such as waiting times, became different indicators in different

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provinces. Such obfuscation has meant that it is hard to hold the provinces to account. While the differences in indicators are slight, they are sufficient to preclude any sensible national comparison or overview.

Consider the analogy of the labour force survey. This provides both public and private sector decision makers with a great deal of information on how the economy is doing and on unemployment rates province-by-province, within various age groups and across gender lines. Such information enables targeting of remedial efforts: the labour force survey provides an effective framework for decision making about employment and economic policy. If provinces were to set different measures for unemployment (as they do for healthcare) then most of this value would be lost.

Another problem has been the massive number of indicators developed. When it comes to healthcare indicators, more is not better: what is required is a simple set of easily understood indicators that measure quality, timeliness, affordability and access.

The federal government needs to show courage and leadership in the next round of health negotiations with the provinces and insist on a limited set of relevant indicators across the country. The aim should be to make the system more accountable (but accountable to the public – who can draw their own conclusions about performance – as opposed to the provinces being more accountable to the federal government). Canadians have much to gain and nothing to lose from having a more accountable healthcare system.

Fortunately we already have the health services data gathering and analysis capacity in place, through the institutions mentioned above, as well as a host of provincial health services organizations (such as the Institute for Clinical Evaluative Sciences in Ontario) that can contribute. What is needed now is political will.

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2 Tackle safety in health delivery

The Baker Norton study, jointly commissioned by CIHI and CIHR and released in 2004, documented huge safety issues in the Canadian healthcare system. These take an enormous toll both in terms of human suffering and financial cost to the system. The authors calculated that between 9,000 and 23,000 Canadians die unnecessarily each year, as a result of avoidable errors within the health system. Since then, others have looked at the burden that avoidable injuries pose to the healthcare system. It is estimated by Baker and Norton that the equivalent of nine hospitals, each with 200 beds, are utilized just for "repair" work.

The Baker Norton report led to the creation of the Patient Safety Institute (PSI) headquartered in Edmonton and funded by the federal government. Despite the excellent efforts of this organization, the safety problem in Canadian healthcare (and in the healthcare systems of other nations) remains both large and intractable. A much more forceful national effort is required to solve it.

Other jurisdictions, including American states such as Minnesota, have been grappling with this problem. They have used legislation and a number of other tools, such as mandatory public reporting of adverse events, to address it. Meanwhile, Canada has stuck with a largely voluntary approach, relying on the PSI and somewhat strengthened health facility and health services accreditation through Accreditation Canada (even this is voluntary in some parts of the country). The PSI's budget is a paltry $10 million a year against a total Canadian healthcare budget of over $140 billion.

Contrast this with the enormous mandatory efforts undertaken in civil aviation. Each plane crash in Canada is thoroughly investigated to determine the cause and indicate remedial actions. Pilots are tested and recertified frequently. Healthcare providers, by contrast, can often practice for an entire career without formal recertification or assessment of their competency. The healthcare system tends to run on the basis that regulatory colleges, run overwhelmingly by the healthcare professionals themselves, will deal with outlier behaviour. There is no focus on systemic aspects of the lack of safety in healthcare.

The safety problem in Canadian healthcare remains both large and intractable

One way for the federal government to change this would be for it to commission a smaller-scale Baker Norton review, looking at specific indicators across the country, on an annual basis. This would keep the safety issue front and centre. Other ways of addressing the problem include increasing the PSI's funding and insisting on mandatory review and accreditation of hospitals and staff. It would be nice to think that hospital stays could be made as safe as flying.

3 Transfer healthcare delivery for First Nations and Inuit

Statistics Canada reported in 2000 that life expectancy for aboriginal people was markedly shorter than the Canadian average: 7.4 years shorter for men and 5.2 years for women. In addition, aboriginal communities saw increased rates in: infant mortality (22% higher); tuberculosis (6.2 times higher); diabetes (almost 20% higher); and foot amputations as a result of diabetic foot ulcers (18 – 22% higher). These are dismal statistics.

The First Nations and Inuit Health Envelope was introduced by the federal government in 1994. At that time it totaled more than $1.1 billion for all health programs; today it amounts to about $2 billion per annum. The continuing huge difference in health outcomes between First Nations/Inuit and other Canadians begs the question: is this money being well spent?

The federal government has made some progress in shifting responsibility and dollars to aboriginal organizations and provincial governments, but a much more rapid transfer is needed. Fortunately there are some models of successful practice from which to learn.

- In BC, a tripartite agreement between the federal government, the province and aboriginal authorities has resulted in placing $318 million in the hands of a new BC First Nations Health Council. This has given tribal councils greater power to solve issues within their own communities, rather than having to abide by decisions made in Ottawa or by an ineffective system of regional offices run from Ottawa.

- In 2006 the federal government provided $3.1 million to a partnership struck between Saint Elizabeth Health Care, an NGO with expertise in nursing care, and the Assembly of Manitoba Chiefs. The aim was to map ways to manage diabetic foot ulcers and avoid amputations. The parameters were realistic and included there being no commitment to increase healthcare staffing levels in areas that cannot attract such resources under normal conditions. The pilot project built capacity and care pathways that assisted health care staff to utilize prevention strategies, undertake early detection, and then provide treatment and quick access to specialists as required. The result was embraced by the Assembly of

Manitoba Chiefs and local communities and has since been expanded.

- In Ontario, Aboriginal Health Access Centres – aboriginal community-led, primary health care organizations – have, since 1994, brought tens of thousands of aboriginal community members into the circle of care and support.

These examples make sense. Provinces and NGOs have expertise in implementing health care delivery and aboriginal communities understand their own needs. The federal government, not really an expert in either, provides the financing.

It should therefore move ahead to:

- dismantle the inefficient and ineffective First Nations and Inuit Health Branch (FNHIB) and regional health bureaucracy;
- shift dollars into more agreements such as the tripartite one outlined above;
- promote health among First Nations youth; and
- contract out to NGOs for specialized services such as the non-insured Health Benefits Program, currently run by Health Canada (the management of which could be akin to the Veterans Affairs drug administration or health delivery for the Canadian Armed Forces).

4 Stabilize human resources in the health system

Canada's health system has numerous human resources problems that undermine its effectiveness. These include quality concerns, chronic shortages and a poor distribution of health professionals. In order to address these, the federal government should support the provinces to:

- encourage professionals to leave practice before their skills deteriorate;
- break down the barriers that prevent individuals practicing in the care setting of their choice;
- provide professionals with cost effective, attractive alternatives to higher pay.

All three problems could be at least partially addressed by reform of the pension system for healthcare workers.

A lack of pension portability is the main reason why healthcare workers are unwilling to move out of an acute-care setting into a community-care setting. A community-care setting is not only less costly for the funding government, it can also provide a less stressful work environment and a better quality of life for healthcare professionals. Many such professionals are willing to accept somewhat lower wages in return for these benefits, but the sticking point is that hospital employees cannot take with them their generous defined benefit (DB) pensions. Likewise, community-care organizations (which are also provincially funded) find it hard to attract qualified workers in the first place because of their lower pension offerings.

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Extending DB plans to other parts of the health system (beyond acute care settings) would cost money, albeit not a great deal of money. In Ontario, for example the Healthcare of Ontario Pension Plan estimated that it would cost just $20 million to bring most of the community sector in line with the hospital sector on the issue of DB pension

premiums. At least some of this increase in the pension envelope could be funded by the federal government.

Negotiations should have very specific goals in place for performance, for productivity, for safety and for affordability

The biggest direct contribution the federal government could make to reforming healthcare pensions would be to enable physicians to belong to DB pension plans. This would help keep costs in check as many physicians would consider trading pay increases for the ability to belong to a DB plan. The actual move would be funded not by the taxpayer, but by participating physicians through their medical corporations. However, effecting such a switch would require changes in Canada Revenue Agency (CRA) legislation. While the required changes are of some complexity, they are certainly not insurmountable.[1] A similar legislative change was made in 2002 when the federal government revised the law to enable doctors to create medical corporations that would benefit from similar tax regimes to other small businesses. This move helped physicians immeasurably and provided the provinces with significant leverage in negotiations with medical associations.

CONCLUSIONS

The federal government has a crucial role to play in achieving sustainable and high quality healthcare services in Canada. With a focused and strategic approach the Government of Canada can assist provinces in modernizing Canadian health services. It can also realize a return on the significant investments it has made over two decades in improved health information, health informatics, health research and evidence gathering.

Negotiations for renewed health funding for the provinces post the expiry of the current Health Accord in 2014 should have very specific goals in place for performance, for productivity, for safety and for affordability. These should be set out in advance by the Government of Canada. There will, as always, be howls of jurisdictional protest from the provincial premiers but if the federal government sticks to specific and public performance goals, Canadians will be better off.

[1] Under CRA rules employers can be pension plan sponsors provided they have workers who qualify as employees. Medical corporations do not meet CRA rules for inclusion because their physician employees, also shareholders, are not classified as employees.