



Federal Health Financing (Update 2008)

The Canadian Medical Association believes that financial support from the federal government for health care should provide the following:

- The maintenance and improvement of standards of health care service across Canada.
- The financial stability necessary to effectively plan health care delivery and flexibility in spending across Canada to respond to local circumstances, emerging health needs, and new patient-care modalities.
- The indexing of federal health cash payments to provinces and territories to reflect changes in population growth, ageing, epidemiology, current knowledge, new technology and economic growth.
- Greater accountability, visibility and improved linkages of services to users.
- Greater equity across the provinces and territories in the ability to finance necessary health care programs.
- The joint policy discussions necessary to address health issues of national importance.

The CMA is committed to preserving the right of reasonable access to high-quality health care regardless of ability to pay. It is also committed to achieving national health care standards (accessibility, universality, portability, comprehensiveness and public administration) and to developing health goals to ensure that all Canadians receive the best possible care when required. The CMA supports the goal of maintaining the national integrity of the health care system. It encourages the federal government to be sensitive to the concerns of equity, and to ensure that provinces and territories that have not attained a level of health care services and facilities equivalent to those of other provinces and territories, because of fiscal incapacities, have access to additional funding requirements to reduce the gap. The CMA recognizes that flexibility in spending across Canada is important to respond to changing health care needs and changes in the delivery of health care, as is the necessity of joint policy discussions to address health issues of national importance. Stability in funding is viewed as the mechanism to achieving effective health care planning.

Over 50 years of federal financing

In 1957 and 1966, the federal government introduced the *Hospital Insurance and Diagnostic Services Act* and *Medicare Act*. These programs reflected the federal government's desire to implement 50-50 basis with the provinces for the funding of hospital and physician services. The federal support was program specific, with contributions determined to be about half the national average of per-capita expenditures on health care. This provided greater assistance to provinces with lower per-capita costs.

In 1977, the funding arrangement was replaced by the negotiated Established Programs Financing (EPF) arrangements. The new "block-funding" agreement established a predetermined level of financial contributions by the federal government that was linked to the rate of change of gross national product (GNP) and changes in the provincial/territorial populations. It is important to note that federal transfers are comprised of cash and tax points.

The objectives of the EPF arrangements as set out by the Prime Minister in June 1976, were (a) to maintain across Canada the standards of service to the public under these major programs, and to facilitate their improvement; (b) to put the programs on a more stable footing, so that both levels of government are better able to plan their expenditures; (c) to give the provinces the flexibility of in the use of their own funds which they have been spending in these fields; (d) to bring about greater equity among the provinces with regard to the amount of federal funds that they receive under the program; and (e) to provide for continuing joint policy discussions relating to the health and post-secondary education fields.

The need for funding predictability

Over the course of their existence, the EPF arrangements were amended four times — 1982 (Bill C-97), 1984 (Bill C-96), 1989 (Bill C-33) and 1991 (Bill C-69). These changes resulted in freezes in the growth of federal health transfers and created a period of funding uncertainty for provinces and territories.

On April 1, 1996, the federal government introduced the Canada Health and Social Transfer (CHST) which combined two transfer programs, EPF and the Canada Assistance Plan into one transfer program for insured health services, post secondary education and social assistance programs. Cash payments under the CHST were subject to the five program criteria of the *Canada Health Act* (1984) — accessibility, portability, comprehensiveness, and public administration as well as the single condition that the province/territory must provide social assistance to applicants without a minimum residency requirement.

In combining these programs the federal government used the opportunity to cut cash entitlements to the provinces/territories from \$18.5 billion per year 1995-1996 to a low of \$11.1 billion per year in 1999-2000. However, due to improving economic conditions and a rapidly impending balanced budget, the federal government announced in its September 1997 Throne Speech that it would be increasing the cash floor to \$12.5 billion per year in 1998-1999 to 2002-2003. This measure was announced in the 1998-1999 budget; however, rather than an increase in funding, it was merely a partial reversal in cash reductions to the provinces/territories.

Targeted federal financing

Since 2000, the federal government has increased the use of targeted investments and in the health arena.

On Sept. 11, 2000, First Ministers issued a Communiqué on Health announcing a series of investments, over five years, which focused on health and other social programs. The CHST cash floor was “increased” by \$2.5 billion effective April 1, 2001.

The February 2003 Budget in support of that year’s First Ministers’ Accord on Health Care Renewal confirmed: (1) a two-year extension to 2007-2008 of the five-year legislative framework put in place in September 2000, with an additional \$1.8 billion; (2) a \$2.5 billion CHST supplement, giving provinces the flexibility to draw down funds as they require up to the end of 2005-2006; and (3) the restructuring of the CHST to create a separate Canada Health Transfer and a Canada Social Transfer effective April 1, 2004, in order to increase transparency and accountability.

In September 2004, First Ministers signed an agreement on health care that included commitments to reduce wait times, address gaps in health human resources, expand home care, continue efforts in primary care reform, implement a national pharmaceutical strategy, and develop national public health goals.

To support the new agreement, the federal government committed to increase health funding by a total of \$18 billion over 6 years or \$41 billion over 10 years. This includes:

- \$3 billion to close the “short-term Romanow gap;”
- \$500 million for home care and catastrophic coverage;

- \$4.5 billion for a Wait Time Reduction Fund;
- \$1 billion for health human resources (to be transferred in last four years of agreement);
- \$500 million for medical equipment; and
- a 6% escalator for the Canada Health Transfer.

The 2007 budget provided over one billion additional dollars for the health care system mainly through a \$612 million investment to accelerate the implementation of patient wait-time guarantees, \$400 million for Canada Health Infoway to support the further development of health information systems and electronic records, and \$300 million for a vaccine program to protect women and girls against cancer of the cervix.

Clarifying responsibilities and accountability

The 2007 budget made reference to the federal government’s constitutional responsibilities for health care and stressed an increased concern of accounting for federal health transfers to the provinces/territories.

The Oct. 16, 2007 Speech from the Throne, to open the second session of the 39th Parliament of the Government of Canada, included a commitment to introduce legislation that would place formal limits on the use of the federal spending power for new cost-shared programs in areas of provincial/territorial jurisdiction, and would also provide an opt-out option with compensation for provinces and territories if they offer compatible programs.

The main foundation for this proposal is set out in the Feb. 4, 1999 *Social Union Framework Agreement* (SUFA), in which the federal government gave several undertakings

with regard to new “Canada-wide initiatives” in areas of provincial jurisdiction:

- collaboration with provincial/territorial governments to identify priorities and objectives;
- not to introduce new initiatives without agreement of a majority of provincial governments;
- provincial/territorial governments to determine detailed program design and mix;
- provincial/territorial governments can reinvest any funds not needed to deliver objectives;
- federal/provincial/territorial governments to agree on accountability framework; and
- funding to be contingent on meeting or committing to objectives specified in accountability framework.

The most notable application of SUFA principles in respect of new programs to date has been the Sept. 15, 2004 *Asymmetrical Federalism that Respects Quebec’s Jurisdiction Agreement* in which Quebec agreed to develop and implement its own plan to attain the objectives of the First Ministers’ *10-Year Plan to Strengthen Health Care*, and to report progress to Quebecers using comparable indicators, mutually agreed to with other governments.

The accountability framework set out in SUFA would appear to be the linchpin of assuring the national character of any future health programs. Its implementation has thus far been a failure. While governments did agree to common indicators in 2000 and 2003, and did produce them in 2002 and 2004, they have been resistant to any attempts at comparability/benchmarking between jurisdictions and they failed to produce them

at all in 2006. The Health Council of Canada lamented this lack of cooperation in its 2007 annual report.

Ensuring federal health financing is responsive to Canadians’ health needs

The CMA believes that the federal government has a special responsibility for financing health care. The development of the health care financing system on a cooperative federal/provincial/territorial basis has many merits. It has resulted in the clear perception that the federal government has an obligation to ensure that reasonably comparable, high quality health care services are available, on a reasonably comparable basis, to all Canadians.