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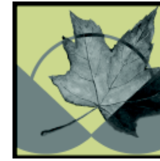

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What Does the Increased Federal Funding for Health Care Mean for Medicare Advocates?

By Sheila Block

Introduction

The federal-provincial-territorial health care funding landscape has changed dramatically over the past four years. The 1990s were characterized by a diminishing role for the federal government and increasing fiscal pressures on provincial health care funding. This trend began to reverse with the increases in federal funding in the 2000 Agreement between first ministers and the 2003 Accord. The recent agreement between first ministers provides for a dramatic increase in transfers to the provinces and territories. Effective 2006-2007, the agreement commits the federal government to a 6 per cent escalator in the Canada Health Transfer (CHT). This escalator is the first open-ended federal commitment to a shared-jurisdiction social program in recent memory.

This agreement has met, and exceeded, the funding recommendations of the Romanow Commission. During the life of this agreement, the federal share of total provincial/territorial health spending will approach 25 per cent. This is the share that the provinces and many health care advocates have demanded. The increased funding is a victory that should be celebrated.

This increased flow of funds will require a shift in approach for health care advocates — toward following the money rather than demanding it. While increased funding is a necessary condition for sustaining and protecting our publicly funded, not-for-profit health care system, it is not sufficient. In fact, unchecked, the substantial increase in federal funding could serve to accelerate the rate of privatization. The combined impact of increased funding, lack of conditionality and accountability mean that large amounts of public resources might be used for private profit rather than the public good – hence the important role for an activist agenda.

The agreement is lacking in a number of key areas: conditionality, accountability and enforcement. Furthermore, the agreement makes no mention of for-profit delivery of health care, let alone any commitment to limit the further privatization of the health care system. [1] Importantly, the preamble to the plan refers to the Canada Health Act's five principles, but is silent on the Act itself and two key conditions: the prohibition of user fees and extra-billing.

Conditionality, Accountability and Enforcement in the Plan

Because the agreement was signed by the first ministers and contains more specifics, it is better than the previous two agreements. However, it still leaves much to be desired. The only condition in the document is contained in one sentence. It states:

> All funding arrangements require that jurisdictions comply with the reporting provisions of this communiqué.[2]

There are no conditions on how the federal transfers are spent. There are therefore no requirements that provinces spend the new funds from the federal

government on incremental health-care spending. These funds could be used by governments to balance budgets to maintain unsustainable tax cuts. Even if the increase in funding is spent on health care, there are also no requirements on how the funds are used. They could be used to pad the bottom lines of for profit health care providers.

This one sentence does not outline any enforcement mechanism. How is compliance with the reporting provisions to be measured? What is the impact of non-compliance? Does future funding not flow? Will funds be clawed back?

The reporting requirements in the plan, limited though they are, act as accountability mechanisms. There is no reporting requirement/accountability mechanism for the commitments on prevention, promotion and public health. On primary care reform, first ministers agreed only to establish a network to share information and find solutions. And, they agreed to regularly report on progress. On a national pharmaceutical strategy, first ministers agreed to establish a taskforce to develop the strategy, outline what the strategy would include, and commit to report on the progress of the strategy development by June 30, 2006. The nine requirements for what will be included in the pharmaceutical strategy are quite specific. However, there is no deadline for the actual implementation of the strategy. Health ministers were provided with 21 months before they have to report on their progress on only the strategy development. Given that similar requirements on establishment of standards for homecare were also given a deadline of September 30, 2004, and that this deadline came and went with no comment from the provinces and territories, this is no guarantee that the deadline is a significant target.

The areas in the plan with the strongest accountability measures include the sections on wait times and improving access and home care services. The section on wait times includes language with some suggestions on how the wait time reduction fund might be used:

> The wait time reduction fund will be used primarily for jurisdictional priorities such as training and hiring more health professionals, clearing backlogs, building capacity for regional centres of excellence, expanding appropriate ambulatory and community care programs and/ or tools to manage wait times.[3]

The reporting requirements associated with wait times include: [4]

- Establishing comparable indicators of access to health care professionals, diagnostic and treatment procedures with a report to citizens by December 31, 2005.
- Joint development of evidence-based benchmarks for medically acceptable wait times starting with cancer, heart, diagnostic imaging procedures, joint replacements and sight restoration to be established by December 31, 2005.
- Multi-year targets to achieve priority benchmarks to be established by each jurisdiction by December 31, 2007.
- Provinces and territories will report annually to their citizens on their progress in meeting their multi-year wait time targets.

As part of efforts to reduce wait times, there are also commitments to Health Human Resources Action Plans:

> Federal, provincial and territorial governments agree to increase the supply of health professionals based on their assessment of the gaps and to make their action plans public, including targets for training recruitment and retention of professionals by December 31, 2005. Federal, provincial and territorial governments will make these commitments public and regularly report on progress.[5]

These accountability mechanisms are more precise and concrete than those in other parts of the agreement. It could also be argued that while it commits provinces and territories to action on wait times, it provides flexibility to account for the differing circumstances and priorities of each jurisdiction However, there remains a lack of commitment from first ministers to work together on a national strategy to address Health Human Resource issues, including efforts to increase full-time employment for nurses and to eliminate poaching of health professionals between jurisdictions.

The home care section of the agreement has the most concrete commitments. They are also the narrowest commitments. The text of the agreement reads[6]:

> First ministers agree to provide first dollar coverage by 2006 for certain home care

services, based on assessed need, specifically to include:

- Short-term acute home care for two-week provision of case management, intravenous medications related to the discharge diagnosis, nursing and personal care;
- Short-term acute community mental health home care for two-week provision of case management and crisis response services; and
- End-of-life care for case management, nursing palliative-specific pharmaceuticals and personal care at the end of life.

Each jurisdiction will develop a plan for the staged implementation of these services, and report annually to its citizens on the progress in implementing home care services. First ministers task their health ministers to explore the next steps to fulfill the home care commitment and report to First Ministers by December 31, 2006.

The text, however, leaves room for interpretation. For example, the first sentence refers to providing coverage based on assessed need. Is this assessed need health related or could it be referring to financial need? There is some inconsistency in the accountability measure with respect to home care between the reporting requirements and the commitments. The report on next steps to fulfill the commitments is required by December 31, 2006. However, first ministers agree to provide this coverage by 2006. As a result, the reporting on next steps for implementation will not occur until after the program has begun. Furthermore, the agreement did not expand the scope of the *Canada Health Act* (CHA) to include home care in insured services. As a result, home care remains outside the purview of the five criteria and the conditions prohibiting extra billing and user charges.

Finally, at the end of the document there is a reference to formalizing the agreement on dispute avoidance and resolution with regard to the CHA. The increases in federal transfers increase the potential for enforcement of the CHA, and the impact of that enforcement. However, nothing that is agreed to in this document is enforceable under the Act.

As a result of both the increased funding and wording of the Plan, it imperative that advocates monitor the funds spent by their provincial or territorial governments to ensure that they are used to provide not-for-profit health care. What follows are some measures of the magnitude of the increases in federal funding, and estimates of individual provincial allocations to assist in this process.

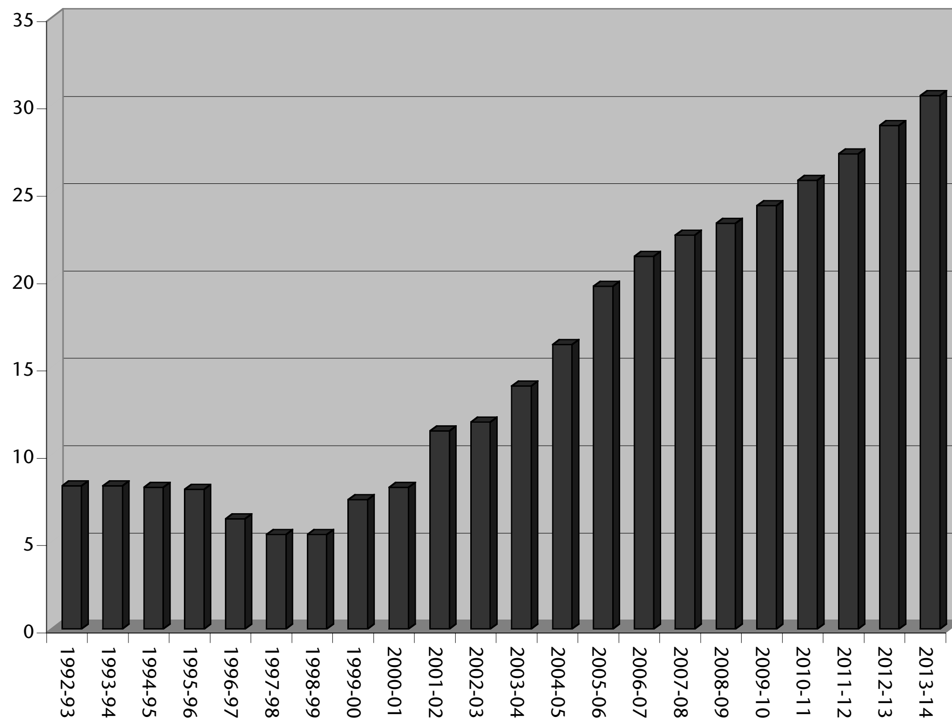
Increased Federal Funding in Perspective

The Liberal government's approach to funding health care has shifted over its mandates. In his 1995 budget, then Finance Minister Paul Martin changed the manner in which health care funds were transferred to the provinces. The Canadian Health and Social Transfer replaced the separate transfers for health, post-secondary education, social housing, child welfare and social assistance Eight years later, the 2003 Health Accord provided for a return to a dedicated transfer for health, called the Canada Health Transfer (CHT) as of fiscal 2004-05.

Chart 1 shows estimated federal cash transfers for health. The estimates were constructed using federal estimates of health cash transfer from 1991-92 to 2000-01.[7] Estimates for 2001-02 to 2003-04 used Federal Finance Department CHST figures as a base.[8] The federal estimate of 62 per cent of CHST funds going to health was used.[9] Total transfers for this period include the notional health portion of the CHST and the Health Reform Transfer. For 2004-05 and beyond, the total new funding levels from the Plan were used. Federal transfers dropped from a peak of $8.2 billion in 1992-93 and 1993-94 to a low of $5.4 billion in 1997-98 and 1998-99. In fiscal 1999-2000, the federal government began to reverse the cuts. It wasn't until 2001-02, after the 2000 health agreement, that federal health transfers approached their nominal level in 1992-93.

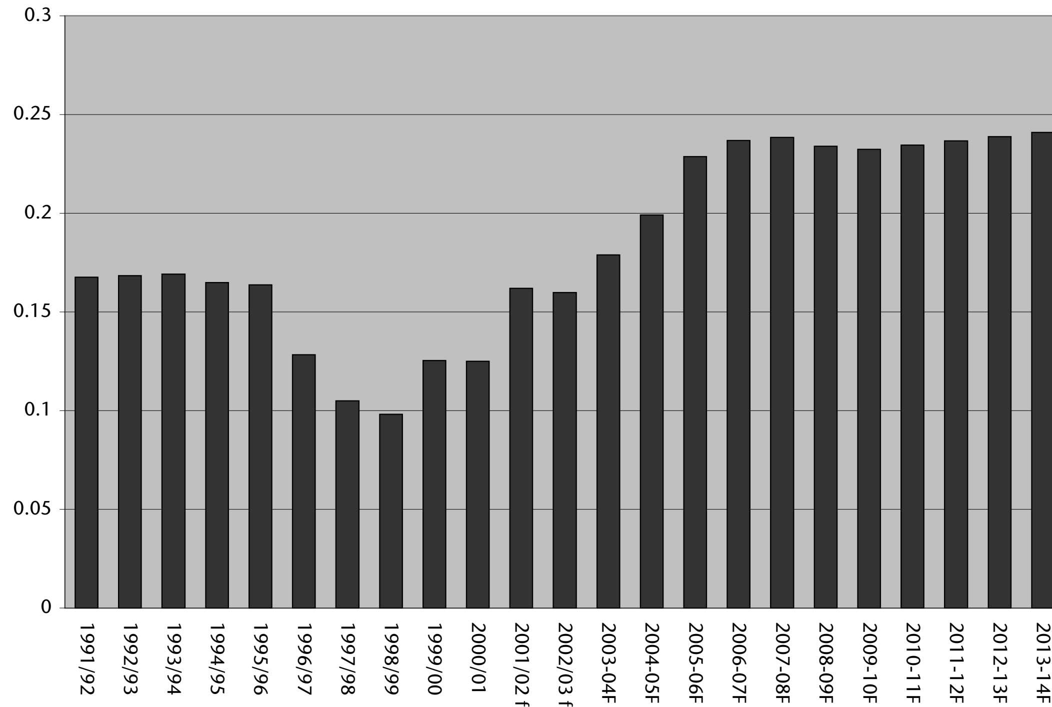
Given this history of nominal and real decreases in federal transfers for health care, recent increases in federal funding are even more dramatic. In 2004-05, federal transfers will be twice their level in 2000-01. By 2013-14, transfers will be a further 88 per cent above their level in this fiscal year.

Chart 1
Federal Health Transfers: 1992-93 to 2013-14



Source: Federal Department of Finance and author's calculations.

Chart 2
Federal Health Transfers as Share of Provincial/Territorial Health Spending



Source: Federal Department of Finance, Canadian Institute of Health Information, NHEX data, and author's calculations.

The most recent data on provincial territorial health spending available from the Canadian Institute for Health Information are forecasts for 2002-2003. We estimated spending past that point using the Romanow Commission estimate of 5 per cent increase per year.[10] These estimates were used to forecast the shares of federal transfers of total provincial/territorial health spending – pre and post Accord. The results of these estimates are in Chart 2.

The federal share of total provincial/territorial spending has increased from 10 per cent in 1998-99 to an estimated 20 per cent in 2004-05. Thereafter, the federal share fluctuate between 23 and 24 per cent.

Provincial and Territorial Implications of 2004 agreement

There are large increases in funding flowing to provinces and territories. There are very limited commitments and controls on how that money will be spent. Health care advocates need to follow the money, and ensure that these federal funds are spent in on reforming and sustaining our publicly provided, not-for-profit health care system.

The federal government made public the provincial/territorial allocations for the 2003 Accord. As of the writing of this paper, they have made public only the CHT Allocation for 2004-05[11]. Tables 1 and 2 show

Table 1
Increase in Funding from 2004 Plan
Equal Per Capita Provincial/Territorial Allocation

	2004-05	2005-06	2006-07	2007-08	2008-09	2009-10	6 year Total	2010-11	2011-12	2012-13	2013-14	10 Year Total
Newfoundland and Labrador	35	50	55	52	47	46	286	52	74	96	120	627
Prince Edward Island	9	13	15	14	13	13	78	14	21	27	34	175
Nova Scotia	62	91	100	95	87	87	522	97	140	184	231	1,175
New Brunswick	50	73	80	76	69	68	416	76	109	143	179	924
Quebec	502	736	807	772	695	693	4,204	778	1,119	1,476	1,852	9,430
Ontario	825	1,217	1,345	1,294	1,196	1,205	7,082	1,365	1,981	2,638	3,340	16,405
Manitoba	78	114	125	120	110	110	657	123	178	235	296	1,489
Saskatchewan	66	96	105	100	96	96	560	108	155	205	257	1,284
Alberta	213	314	347	334	292	292	1,791	328	473	626	787	4,005
British Columbia	278	409	449	430	415	418	2,400	474	688	918	1,163	5,642
Yukon	2	3	4	3	3	3	18	3	4	6	7	38
Northwest Territories	3	4	5	4	4	4	24	4	6	8	11	53
Nunavut	2	3	3	3	3	3	17	3	5	6	8	39
TOTAL	2,125	3,125	3,440	3,298	3,029	3,037	18,055	3,426	4,952	6,569	8,283	41,285

Source: *A 10 year Plan to Strengthen Health Care* , and author's calculations based on Federal Investments in Support of 2003 Accord on Health Care Renewal and Statistics Canada Cat. No 91-520 Population Projections for Canada Provinces and Territories, 2000-2026

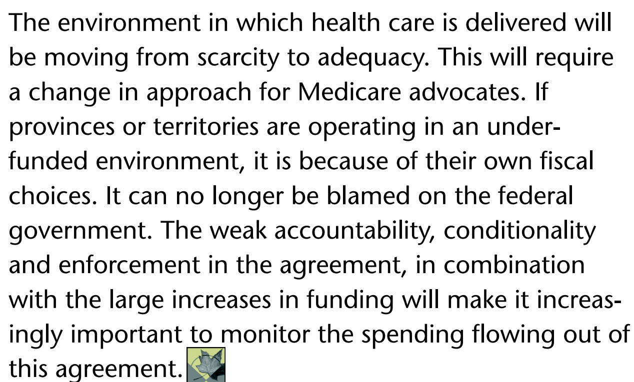
Table 2
Total Health Care Transfers
Equal Per Capita Provincial/Territorial Allocation

	2004-05	2005-06	2006-07	2007-08	2008-09	2009-10	2010-11	2011-12	2012-13	2013-14
Newfoundland and Labrador	265	317	342	358	361	371	387	404	422	441
Prince Edward Island	71	85	92	97	99	103	108	114	120	127
Nova Scotia	478	573	619	649	668	693	729	768	808	851
New Brunswick	383	459	495	519	528	546	572	600	629	660
Quebec	3,842	4,619	5,007	5,275	5,331	5,533	5,831	6,146	6,478	6,828
Ontario	6,318	7,645	8,342	8,845	9,174	9,613	10,227	10,880	11,573	12,311
Manitoba	597	717	778	819	841	875	924	976	1,032	1,090
Saskatchewan	508	606	652	683	739	766	808	851	897	946
Alberta	1,629	1,972	2,153	2,284	2,236	2,327	2,459	2,598	2,745	2,900
British Columbia	2,131	2,567	2,788	2,943	3,180	3,335	3,551	3,781	4,026	4,286
Yukon	16	20	22	24	21	21	22	23	25	26
Northwest Territories	22	26	28	30	30	31	33	35	37	39
Nunavut	15	19	21	22	22	23	24	26	27	29
TOTAL	16,275	19,625	21,340	22,548	23,229	24,237	25,676	27,202	28,819	30,533

Source: *A 10 year Plan to Strengthen Health Care* , and author's calculations based on Federal Investments in Support of 2003 Accord on Health Care Renewal and Statistics Canada Cat. No 91-520 Population Projections for Canada Provinces and Territories, 2000-2026

estimates of increases in total health transfers by province and territory using an equal per capita distribution.[12] (It includes: all CHT increases, wait times reduction and medical equipment funds). These tables should provide health care advocates at the federal and provincial levels information to start the process of "following the money."

Conclusions

The environment in which health care is delivered will be moving from scarcity to adequacy. This will require a change in approach for Medicare advocates. If provinces or territories are operating in an under-funded environment, it is because of their own fiscal choices. It can no longer be blamed on the federal government. The weak accountability, conditionality and enforcement in the agreement, in combination with the large increases in funding will make it increasingly important to monitor the spending flowing out of this agreement. 

Sheila Block is Director of Health and Nursing Policy at the Registered Nurses Association of Ontario.

Endnotes

1. Canadian Health Coalition, *Found: Federal funding, Missing: A Plan to Stem Privatization Canadian Health Coalition's Analysis of the First Ministers' Health Care Agreement: " A 10-Year Plan to Strengthen Health Care"* Ottawa, September 28, 2004
2. *A Ten Year Plan to Strengthen Health Care*, 15 September, 2004, p.10
3. Ibid, p.3
4. Ibid, p.3
5. Ibid, p.4
6. Ibid, p.5
7. *Backgrounder on Federal Support for Health in Canada*, Government of Canada, March 29, 2000.
8. *Federal Transfers to Provinces and Territories*, Federal-Provincial Relations Division, Department of Finance, October 2004
9. *Federal Support for Health Care*, Department of Finance, March 2004 (http://www.fin.g.ca/facts/fshc6_e.html)
10. *Building on Values: The Future of Health Care in Canada*, Roy J. Romanow, November, 2002, p.313
11. *Federal Transfers to Provinces and Territories*, Federal-Provincial Relations Division, October 2004
12. The distribution up to 2007-08 is based on the Department of Finance distributions for the 2003 Accord. After that point, population estimates are used from Statistics Canada.