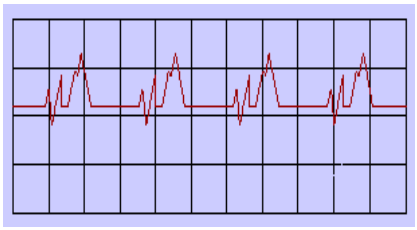
Paying for keeps



Securing the future of public health care

A series by Armine Yalnizyan

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Health care talks: The constitutional debate revisited

The upcoming First Ministers' meeting – and February's federal budget – will profoundly shape the future of public health care. But through these two events, Canadians will also learn whether their governments will choose to reaffirm nationhood or continue their experiment with devolution.

Just like the constitutional talks in Charlottetown in 1992, the meeting and the budget will determine whether we will move forward together, in some form of cooperative federalism, or move off in fourteen different directions.

Unlike the constitutional debate, this is not an abstract discussion of jurisdictional rights and notions of sovereignty. These negotiations are about how governments provide for their citizens across the entire country. Currently this discussion is informed by three proposals for securing the future of public health care, proposals put forward by Roy Romanow, Senator Michael Kirby, and the provinces.

Medicare is the closest we get to the embodiment of the principle of equality of access, regardless of where in Canada one lives or how much money one has to spend. It is a concrete example of how, together, we can assure the basic needs of everyone.

That's why the next budget is the "big one". It will reflect the federal/ provincial/ territorial discussions at the Health, Finance and First Ministers' tables. But with or without consensus backing his decisions, Finance Minister John Manley's budget will ultimately set the direction of where we are heading.

Manley's choice takes place in a context shaped by three competing visions:

- Romanow wants to see $3.5 billion more for health care in the upcoming budget. But the real story here is Romanow's push for a strong system of national health care. He proposes that any new federal money gets used to work cooperatively with the provinces to expand public provisions and assure public accountability for all health spending.
- Senator Kirby calls for an additional $6.5 billion starting this spring, targeted to address the individual's needs through guaranteed access to care and extended health care coverage, with the money administered directly by a federal government willing to act decisively on key items.
- The provinces and territories want an immediate $5.1 billion injection of cash (to offset their costs in this fiscal year), with

$5.7 billion more in February. They are fighting for a "fair share" of stable, long-term funding but don't square this position with the fact that if the federal cash increases are big enough, the feds can reasonably call for a voice in the way health care is delivered and health outcomes are measured. That doesn't mean federal control, but it does mean giving weight to a federal push for the development of national standards and national objectives in return for more money. That the provinces reject this approach can only compromise the development of national standards for health care.

For their part, the federal Liberals have long used the "non-interference"/ "provincial flexibility" argument as a cover for their position, since 1995, that small government is good government (at least where federal governments are concerned). The only way they can keep their commitment to the $100 billion tax cut package introduced two years ago, and to an aggressive debt pay-down campaign, is not to let program expenditures rise too quickly, for health care or anything else.

How will Manley balance these positions in the next budget? So far he has played coy, saying the size of the budgetary surplus makes even Romanow's modest package unlikely, but admits that the evidence increasingly makes this year's surplus look many multiples bigger than the $1 billion officially forecast, as has been the case in the past. The numbers themselves have called his bluff.

What is clear is that the way this budget will lay out the path to securing the future of public health care is symbolic of far more than a simple fiscal decision. It will chart the course and nature of our federation for the foreseeable future. It will either confirm this government's experiment with accelerated decentralization and balkanization of public policy; or it will acknowledge the problems of such an approach, and set out a plan for nation building.

How much more?

There are three major proposals on the table regarding how much more the federal government should pay for public health care.

Both the Romanow and Kirby documents explicitly state that increased federal contributions should "buy change" in the way the system currently works, primarily to achieve greater fairness and lever more efficiencies system-wide. Consequently, they have emphasized key areas for change, and targeted money to those areas.

The provinces, after years of doing all the heavy lifting for rising costs as federal support declines, want payback, no strings attached.

Table 1:
The three proposals for a renewed federal cash commitment to health care

Fiscal Year (in billions)	2002-03	2003-04	2004-05	2005-06	TOTAL
Romanow	$0	$3.5	$5.0	$6.5	$15
Kirby	$0	$6.5	$6.5*	$6.5*	$19.5 (+/-)*
Provinces/Terr.	$5.1	$5.7	$6.5	$7.4	$24.7

* See text box on Page 8 for how Kirby's numbers increase over time.

The amounts in Table 1 come in on top of the cash already being transferred to the provinces and territories for health care through the Canada Health and Social Transfer (CHST), a block fund that helps finance the provincial delivery of health care, post-secondary education and social assistance.

The base cash transfer for the CHST is $15.5 billion, for any combination of those three programs. Because it is a block fund, no particular share is dedicated specifically for health care, but history shows that the provinces have used between 52 and 62 percent of the total transfer (cash and tax) for health care.

The September 2000 agreement between the federal and provincial/territorial governments saw an increase in the cash amounts transferred to the provinces specifically for health care, totaling $21.1 billion over five years. This amount does not add to the base transfer or $15.5 billion, which remains fixed over this period. Consequently, the September 2000 agreement provides no guarantees as to the cash amount the feds will transfer for health care after 2005-06. Under the terms of the agreement, some pockets of money were earmarked for the purchase of medical equipment and expansion of primary care reforms, but it was mostly transferred under the same terms as the CHST – no strings attached.

There is near universal agreement that these amounts are not enough to assure the viability of the public health care system until 2005-06. But the new calls for funding frequently ignore the new amounts of money that are already on stream.

What the September 2000 Agreement means when combined with the three proposals for new funding is displayed in Table 2.

Through its 2000 agreement, the federal government has committed to provide more than $18 billion in new health care funds over the following four years. While this is a large increase, no one can show how the increases have thus far contributed to improving public health care, and there is no mechanism to show how they will. In fact, many of the old issues remain unresolved: this agreement did not restore historic relations with the provinces and territories for sharing the costs of the most important public program in Canada.

Table 2:
Tallying up the September 2000 reinvestment with the three proposals for more federal health cash

Fiscal Year (in billions)	2002-03	2003-04	2004-05	2005-06	TOTAL
September 2000 Agreement (New cash over base CHST cash transfer)	$3.6*	$4.3	$4.9	$5.5	$18.3 (out of 21.1 over 5 years)
Total Increase With Romanow	$3.6	$7.8	$9.9	$12.0	$33.3
Total Increase With Kirby	$3.6	$10.8	$11.4	$12.0	$37.8
Total increase with Provinces	$8.7	$10.0	$11.4	$12.9	$43.0

** The amount in 2001-02 was $2.8 billion, so the incremental growth in this fiscal year was $800 million.*

What's the federal share?

As shown, the September 2000 increases in cash transfers for health care come on top of the funds that are already transferred for health care through the CHST. Romanow, Kirby and the provinces each pile more demands on top of these two amounts. It deserves mention, again, that the increases of the September 2000 accord do not go beyond 2005-06.

What is the base cash for health care, the amount these increases are designed to supplement? Department of Finance documents peg the cash transfer to the provinces for health care at $8.1 billion in 2000-01, rising to $8.3 billion in 2001-02. It is fixed at that amount until 2005-06, just as the base cash amount for the whole CHST transfer remains fixed at $15.5 billion.

Putting all these numbers together, and comparing them to what the provinces and territories actually spent on health care reveals a fascinating picture. (See Table 3.)

Despite the wide variation in approaches and in rationale for the amounts of money proposed, the numbers add up to a remarkable consensus: the appropriate federal contribution for public health care in this country should be about 25% of *all* public health spending undertaken by the provinces and

Table 3:
What federal cost sharing of health would look like

Fiscal Year (in billions)	2000-01	2001-02	2002-03	2003-04	2004-05	2005-06
Provincial/ Territorial Health Spending*	$63.4	$68.8	$73.1	$76.2	$80.1	$84.1
CHST base cash, health**	$8.1	$8.3	$8.3	$8.3	$8.3	$8.3
Sept 2000 Agreement	$0.0	$2.8	$3.6	$4.3	$4.9	$5.5
Federal Cash Share	12.8%	16.1%	16.3%	16.5%	16.5%	16.4%
Total Federal Health Care Cash Adding:						
Romanow Proposal			$11.9	$16.1	$18.2	$20.3
Kirby Proposal			$11.9	$19.1	$19.7	$20.3
Provinces' Proposal			$17.0	$18.3	$19.7	$21.2
Renewed Federal Cost-Share For Health Care After Implementing:						
Romanow Proposal			16.3%	21.1%	22.7%	24.1%
Kirby Proposal			16.3%	25.1%	24.6%	24.1%
Provinces' Proposal			23.2%	24.0%	24.6%	25.2%

***** *Provincial/Territorial Spending figures come from CIHI, NHEX 2002 for 2000-01 to 2002-03. Forecasts for spending up to 2005-06 come from the Conference Board of Canada*

***** *Calculations of the base cash for health care in the CHST transfer is from a Department of Finance backgrounder, "Federal Support for Health in Canada", dated March 29, 2000.*

territories, not just spending for doctors and hospitals.

Without significant amounts of new cash, the feds will be signaling they are willing to turn their backs on the historic "bargain" with the provinces, based on a 50-50 cost-shared approach to public health care.

In the 1960s, when the bargain was struck, governments worked together to make the costs associated with doctors and hospitals affordable for all citizens. In the 1960s, spending for doctors and hospitals was basically most of health care's costs.

Today the feds' share is measured – just as it was in the first days of public health care – by how much cash it provides to help finance the delivery of critical health services that most provinces offer in some way. These services now include drug programs for the elderly and those on social assistance, chronic, long-term and palliative care, and preventive programs.

While the federal health financing started out on a strictly cash basis, by 1977 the federal half of the costs was based on a transfer of both cash and tax points, with the cash portion declining over time and the tax portion increasing.

By 1998 the formula for funding, combined with federal cutbacks, had reduced federal cash transfers for health care to a low of 10% of provincial and territorial spending for health care. By the federal government's own calculations, cash and tax transfers together accounted for only 28% of health spending in the provinces and territories in that year.

Budgetary changes beginning in 1998 restored the cash share to just over 16% today, but it is forecast to begin declining once again over time. All proposals for renewed federal contributions focus on the cash portion of the transfer, basically writing off the federal transfer of tax points as water under the bridge.

So we are again at the point that begs for a clear, predictable and established formula that spells out the federal role in the provision of public health care.

Stable, predictable financing - What can we count on?

Both Romanow and Kirby rely heavily on economic growth as the basis on which renewed federal commitments to health care would continue to rise over time.

Kirby adds the twist that the federal transfer, which is based on per capita funding for each province, should be weighted in some way to accommodate and acknowledge the costs of an aging population. The suggestion is to triple the per capita transfer for each resident aged 70 or older.

Romanow ramps up new federal investments in health care to $6.5 billion over three years and suggests that, thereafter, future funding be based on one of two methods: a) a rolling five-year plan approach, or b) a built-in escalator that takes into consideration both the growth in expenditures under the Canadian Health Act and the growth in the economy. The option preferred by Romanow sets an initial formula for growth at a 1.25 multiple of the growth in the economy, reflecting the historic relationship between the growth in total health expenditures and the growth in the Canadian economy between 1960 and 2000.

The provinces and territories have not yet made public their preferences. But it is no overstatement that, from their perspective, stable and predictable funding is perhaps more

important an issue to be resolved than the amounts put on the table for this year or next.

This is because, from the late 1980s to the late 1990s, federal governments have unilaterally changed the rules around health care financing. Starting in 1986, the federal government tightened up formulas regulating the rates of growth in public health spending, which had been tied to growth in the GDP.

By 1990, funding restrictions began in earnest: the federal government froze per capita transfers to the provinces. The Department of Finance estimates the cumulative impact of the changes to entitlements between 1986 and 1996 was $23.6 billion in lost transfers to the provinces for the purpose of health care alone.

The first time federal transfers for health care were cut since the beginning of Medicare was in the 1994-95 budget. Though there is some debate on how to calculate the cuts in a block-fund transfer, according to the Department of Finance's calculations, it took until the 2000 budget for federal transfers for health care to return to the amounts they were in 1993-94. In the meantime, provinces lost $8.2 billion in transfers from these cuts.

So, after more than 10 years of being burned by federal policies, the primary goal of the provinces and territories is to nail down a process that ensures federal commitment and, if possible, to do so in such a way as to make such commitment too politically costly to ignore or unilaterally reverse again.

One of the legacies of the September 2000 agreement was that, despite injecting another $21.1 billion over five years, the real issue was not resolved: stable financing.

Stability cannot be achieved if the amounts transferred are not enough to prevent the underlying problem in the first place. These amounts have not reversed widespread concern that the provision of public health care is deteriorating, or that growing regional divergence is eroding the effectiveness of a national system of public health care.

This is not a problem of inadequate process or shared financial responsibilities. This is a problem of leadership. To this point, the federal government has refused to take on a leadership role to secure the *national* aspects of public health care, a role that no provincial or territorial government can or wants to take on.

Without this role, Medicare will no longer be synonymous with a national program of health care. Partly due to fiscal constraints, and partly due to political pre-dispositions as to the role of government, the provinces and territories have been moving in very different directions as they revisit the three core questions about public health care: what is a medical necessity? how should we fund public provisions? how should they be delivered?

Renewed commitment to a national goal

Everyone agrees that the feds were caught sneaking out the back door on public health care. Everyone wants them back in the game.

The three proposals on what the feds should do next on health care are not just about more money. They provide three different visions of what the federal government is for, and three different visions of federalism.

The provinces and territories only voice interest in decentralized "solutions", solutions that emphasize the priorities of each government, with politics highly colouring the direction and degree of new investments and reforms in health care.

Kirby emphasizes the federal government's relationship to individual citizens, irrespective of location, and reinforces its role as "blind banker" to the provinces.

Romanow alone sees the proposed federal reinvestment as an opportunity for nation building. The renewed federal commitment would be used to lever provincial willingness to extend and build on public services, and create the framework for working cooperatively with the federal government to articulate national objectives and systems of accountability for the future of Medicare.

Across this country Canadians are frustrated that they cannot get appropriate and timely care. They are worried about the supports that an aging population can expect. They are embarrassed by the abysmal health outcomes of First Nations people. They are nervous about the lack of political leadership and about the lack of national vision for a social program that needs to function effectively from coast to coast to coast.

The challenge to Medicare is providing access to all medically necessary care in a reasonably equivalent way. As health care evolves, there is increasing emphasis on prevention, pharmatherapy and continuing and palliative care, services required to manage and treat chronic disease, disability and aging.

The Canada Health Act does not include these aspects of health care – except within the acute care system – a glaring omission that leaves it up to the provinces to determine how to deliver these services. So the provinces are doing more and more of the heavy work. Given major differences in resources and priorities among them, the result is checkered access to health care services, and different definitions of the goals of public health care.

The solution is not having the feds simply pay more for this fractured system. Paying the bills without receiving credit for delivery or having a say in what is delivered is a non-starter for securing the sustainability of Medicare. Nor is it sustainable for the federal contribution to continue to focus only on acute care while the provinces struggle to meet increasing needs for home care, long-term care and assistance with the costs of drugs.

The solution is a pan-Canadian public health care system, integrated across jurisdictions, and expanded beyond acute care to include services that help manage and improve our health over the course of our lives. This requires a seamless system that sets clear norms and guidelines that meet the medical needs of all Canadians – as a right of citizenship.

Such a system can only be achieved and sustained with overarching national standards, national payment, and national political credit. No single province or private sector provider can achieve this objective. The federal government is the only player than can negotiate and guide health care reforms towards this end-goal.

Without the combined efforts of the federal and provincial/territorial governments, such a health care system is impossible. Without it, we lose a defining feature of what makes us whole, as a nation.

Deciphering Kirby's numbers: How do they increase over time?

Funding for Senator Kirby's proposal comes from a complex set of sources so it is difficult to estimate the growth in health care spending required to finance his vision.

His proposal for new federal funding is based, foremost, on the notion of raising $5 billion in new revenues by introducing a new four-tier health care premium. The premium amount is tied to the brackets of the income tax system. The $5 billion is raised from a fixed health care "price tag" per person, per income tax bracket, with no provision for increase over time.

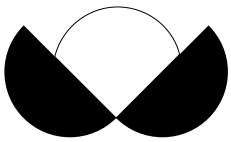
A further $1.5 billion would come from reallocated GST revenues. It would increase (or decrease) according to changes in GST revenue. Dependent on domestic consumption, the GST is currently forecast to grow at the same rate as GDP over the next two years (roughly 3.5% in inflation-adjusted terms), but could fall in response to a war.

Overall, Kirby's package is based on a proposal to provide a cash transfer for health care equivalent to 62% of the cash in the CHST, which the report identifies as the de-facto share of the block fund used for health care. Kirby calls for this amount to be earmarked from GST revenues, equivalent to about half the GST take. Though the focus is on earmarking the source of funds, the implication is that the monies would be transferred to the provinces through a specific health fund rather than through the block fund; but this is not explicit.

Because the base cash transfer of the CHST is $15.5 billion, the 62% reference point brings the cash transfer for health to $9.61 billion.

Adding the annual supplements in the September 2000 accord raises the cash transfer for health by $3.6 billion in 2002-03, bringing the whole cash transfer for health to $13.2 billion in this fiscal year.

The $6.5 billion increment is in addition to this amount. So $5 billion of a $19.7 billion, and rising, cash transfer for health would remain a fixed amount, while the rest rises at roughly the same rate as the GDP.



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