

Federal Health Transfers to the Provinces: Expensive and Ineffective

Main Conclusions

- In total, the federal government has provided the provinces with \$234.5 billion in cash transfers for health since 1980/81. Interestingly, though, more than half that amount (\$115.7 billion) has been provided since 1997/98.
- Fiscal year 1997/98 represents an important turning point as health care transfers begin to grow at a higher rate and inflation-adjusted health spending per capita begins to increase after a number of years of decline. It is also the first year the federal government records a financial surplus during the period examined.
- The average annual rate of growth in federal cash transfers for health since 1997/98 is 12.9% compared to 3.09%, the rate required to account for population growth and inflation. The average annual rate of growth for the previous ten-year period (1988/89 to 1997/98) was 1.4%.
- Since 1997/98, Ottawa has increased its cash transfers for health to the provinces by \$36.0 billion more than needed to compensate for population growth and inflation.
- Unfortunately, the large-scale increase in federal cash transfers to the provinces for health care did not correspond with an improvement in the performance of the health care system.
- Between 1997 and 2006, the average Canadian could expect to wait nearly 50% longer for the delivery of specialist care after being referred by a General Practitioner: in 1997 (base year), the average Canadian could expect to wait 11.9 weeks from the time a General Practitioner (GP) referred him for specialist care to the time a specialist delivered the treatment required. In 2006, the average Canadian could expect to wait 17.8 weeks.
- More specifically, wait times for a specialist after referral by a general practitioner increased 72.5% between 1997 and 2006 while wait times to receive treatment after an appointment with a specialist increased 32.4%.
- Canadians in 2006 could also expect to wait longer for access to technology. The wait time for a CT scan increased from 4.1 weeks to 4.3 weeks between 1997 and 2006 while the wait time for an MRI scan increased from 9.6 weeks to 10.3 weeks over the same period. Finally, the wait time for an ultrasound scan increased from 2.6 weeks to 3.8 weeks between 1997 and 2006.
- The ratio of physicians to Canadians improved by 4.1% between 1997 and 2005.
- The number of nurses per 1,000 Canadians fell from 10.4 in 1997 to 9.9 in 2004, a decline of 4.8%.

Introduction

With the prospect of another federal election around the corner, in which health care will inevitably play a leading role, and the federal budget approaching quickly with rumours of a new or expanded transfer, a review of the performance of existing federal health transfers is timely. This Alert examines the effectiveness of marked increases in federal cash transfers to the provinces in promoting a better and improved Canadian health care system. The first section outlines federal transfers to the

provinces for health; the second examines a series of health care performance indicators in 1997 and compares current performance to determine if any changes have occurred.

Federal Cash Transfers for Health¹

The first section of this paper summarizes federal cash transfers to the provinces for health. Over the last 25 years, there have been three major federal transfer programs to the provinces: Established Program Funding (EPF), the Canada Health and Social Transfer (CHST), and the Canada Health Transfer (CHT). The three transfer programs and the values of the transfers beginning in 1980/81 are shown in table 1.

Prior to 1996/97, funding from Ottawa to the provinces for health and post-secondary education took the form of grants under Established Program Funding (EPF).² In 1980/81, EPF cash grants to the provinces for health totalled \$4.0 billion. That amount had increased to nearly \$8.0 billion in 1995/96, the last year EPF grants were issued. In 1996/97, the federal government eliminated EPF and the Canada Assistance Program (CAP), which helped finance social assistance programs in the provinces, and replaced them with the Canada Health and Social Transfer (CHST). The CHST was a block grant for health, post-secondary education, and social assistance. Replacing EPF and CAP with CHST meant that provinces continued to receive financial resources from Ottawa but were made more directly responsible for any growth in spending in those programs. This change also

provided the provinces more flexibility in how they provided for post-secondary education and social assistance.³ In 2004/05, the CHST was split into two separate transfers: the Canada Health Transfer (CHT) and the Canada Social Transfer (CST). The former is dedicated to health while the latter helps to fund both post-secondary education and social assistance.

One-Time Transfers⁴

In addition to these three major transfer programs, the federal government also made a number of one-time transfers to the provinces after 1996/97. For example, between 1998/99 and 2003/04, the federal government made several one-time supplemental payments to the CHST (column 3, table 1). In total, these supplemental additions to the CHST between 1998/99 and 2003/04 amounted to \$10.5 billion. There were also a number of one-time, health-specific transfers made by the federal government to the provinces from 2000/01 to 2004/05 (column 4, table 1). These one-time transfers were dedicated to purchases of medical technology, health reforms, and the recent strategy to reduce wait times; they totalled \$9.25 billion.

Clarifying the CHST Health Component

Because the CHST is a block grant, it is difficult to distinguish the amount of money transferred from Ottawa to the provinces for health care rather than post-secondary education or social assistance. Table 2 summarizes the CHST payments as well as the one-time



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Table 1: Federal Cash Transfers to the Provinces

	EPF Cash Entitlement (in \$ Millions)	CHST—Cash (in \$ Millions)	Supplemental Additions to the CHST—Cash (in \$ Millions)	Supplemental Health-Specific Transfers (in \$ Millions)	Canada Health Transfer—Cash (in \$Millions)
1980-81	4,033				
1981-82	4,508				
1982-83	5,043				
1983-84	5,871				
1984-85	6,326				
1985-86	6,735				
1986-87	7,010				
1987-88	7,085				
1988-89	7,274				
1989-90	7,542				
1990-91	7,571				
1991-92	7,904				
1992-93	8,197				
1993-94	8,221				
1994-95	8,073				
1995-96	7,955				
1996-97		14,911			
1997-98		12,421			
1998-99		12,518	3,500		
1999-00		12,391	2,500		
2000-01		13,500		1,000	
2001-02		17,300			
2002-03		18,600	2,500	1,500	
2003-04		19,325	2,000	1,000	
2004-05				5,750	13,650
2005-06					19,000

Sources:

Receiver General for Canada, Public Accounts of Canada, 1997-2006. Ottawa, ON: Ministry of Public Works and Government Services; and Department of Finance Canada (2002). Special data request for total health EPF, cash and tax from 1980 to 1995. Received from Annik Bordeleau.

Note: The CHST and CHT data are from the Public Accounts and will, therefore, deviate from budget and Department of Finance data due to accounting definitions. The authors determined that the Public Accounts data were therefore the most appropriate source.

Notes for CHST Supplements

\$3.5B CHST supplement accounted for in 1998-99 and available 1999-00 to 2001-02; \$2.5B CHST supplement accounted for in 1999-00 and available 2000-01 to 2003-04; \$2.5B CHST supplement accounted for in 2002-03 and available 2003-04 to 2005-06; \$2.0B CHST supplement accounted for in 2003-04.

Notes for Health-Specific Transfers

\$1.0B accounted for in 2000-01 and \$1.5B accounted for in 2002-03 for payments to a trust for Medical and Diagnostic Equipment; \$1.0B accounted for in 2003-04 for Health Reform Transfer; \$4.25B accounted for in 2004-05 for Wait Times Reduction transfer; \$1.5B accounted for in 2004-05 for Health Reform Transfer.

Table 2: Adjusted CHST and CHST Supplements to Reflect Health-Specific Transfers

	CHST—Cash (in \$ Millions)	CHST Supplements—Cash (in \$ Millions)	Adjusted CHST Transfers to Reflect Health Component (in \$ Millions)
1996-97	14,911	—	9,438.7
1997-98	12,421	—	7,862.5
1998-99	12,518	3,500	10,139.4
1999-00	12,391	2,500	9,426.0
2000-01	13,500	—	8,545.5
2001-02	17,300	—	10,950.9
2002-03	18,600	2,500	13,356.3
2003-04	19,325	2,000	13,498.7

Sources

Receiver General for Canada. Public Accounts of Canada, 1997 - 2006. Ottawa: Ministry of Public Works and Government Services; and calculations by the authors.

supplements. There have been a number of methods used in the past to try to clarify the extent of the resources provided to the provinces for health care by the federal government.⁵ The division of the CHST into two components, CHT and CST, by the federal government provides an independent method by which to estimate how much money goes to each component: in 2004/05, 63.3% went to health care and 36.7% for post-secondary education and social assistance (Receiver General for Canada, 2005). The final column in table 2 provides an estimate of the health-specific component of both the CHST and the supplements paid between 1996/97 and 2003/04.

Table 3 summarizes the cash transfers for health from Ottawa to the provinces between 1980/81 and 2005/06. Note that the series presented in table 3 includes the

one-time supplements to the CHST and the one-time, health-specific transfers discussed previously.

Determining Incremental Transfers

In order to determine the impact of increased federal cash transfers on the performance of health care in Canada, a base year for analysis must be selected. The year 1997/98 was selected for several reasons. First, in 1998/99 federal cash transfers for health to the provinces begin to grow at a much higher rate than it had previously. This is readily apparent from the *Federal Health Cash Transfers* series in figure 3. Second, 1997/98 was the first year in the period studied that the federal government had a financial surplus. Third, it is the year in which real, per-capita public health spending began to increase after

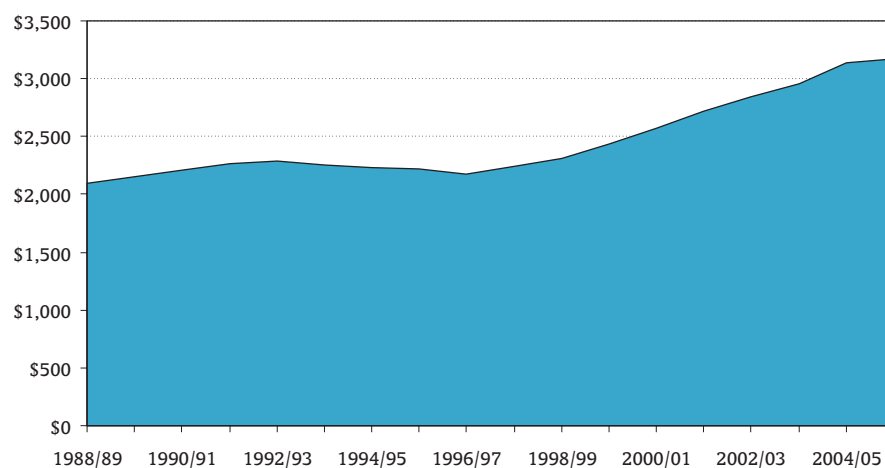
Table 3: Federal Cash Transfers to the Provinces for Health (in \$ Millions)

1980-81	4,033.3
1981-82	4,508.1
1982-83	5,043.1
1983-84	5,871.0
1984-85	6,326.2
1985-86	6,734.6
1986-87	7,009.7
1987-88	7,084.8
1988-89	7,274.3
1989-90	7,542.3
1990-91	7,570.9
1991-92	7,904.0
1992-93	8,196.7
1993-94	8,220.8
1994-95	8,072.8
1995-96	7,955.3
1996-97	9,438.7
1997-98	7,862.5
1998-99	10,139.4
1999-00	9,426.0
2000-01	9,545.5
2001-02	10,950.9
2002-03	14,856.3
2003-04	14,498.7
2004-05	19,400.0
2005-06	19,000.0

Sources: Receiver General for Canada. Public Accounts of Canada, 1997-2006. Ottawa: Ministry of Public Works and Government Services; and Department of Finance Canada (2002). Special data request for total health EPF, cash and tax from 1980 to 1995. Received from Annik Bordeleau.

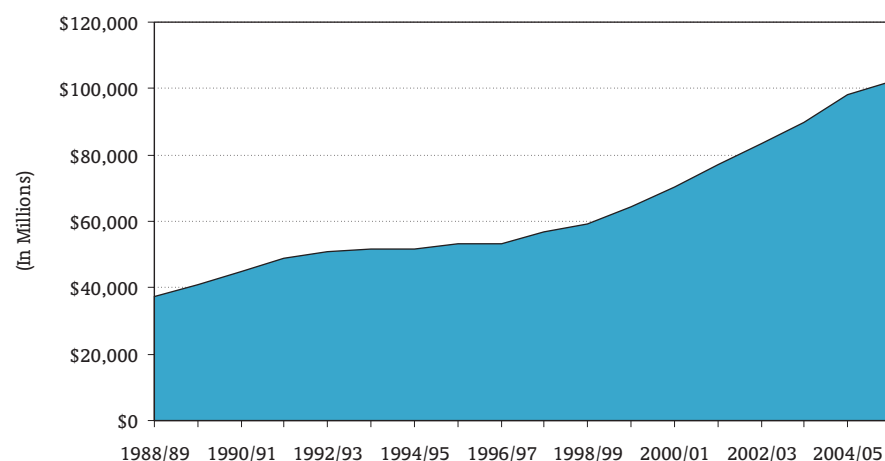
several years of decline (figure 1). Finally, it is the year in which total government spending on health

**Figure 1: Per Capita Health Spending 1988/89 to 2005/06
(Inflation Adjusted)**



Source: Statistics Canada, Public Institutions Division, 2006, Financial Management System.

Figure 2: Total Public Health Spending



Source: Statistics Canada, Public Institutions Division, 2006, Financial Management System.

care began to grow at a faster rate (figure 2).

The calculation used to determine the amount of the incremental federal cash transfers for health to the provinces after 1997/98 (figure 3) was based on the assumption that federal cash transfers to the provinces for health would remain stable, accounting only for population growth and inflation.⁶ Specifically,

the rates of population growth plus inflation were added each year to calculate a total rate of growth. This growth rate was then applied to the amount of federal cash transfers present in 1997/98 and in each subsequent year.

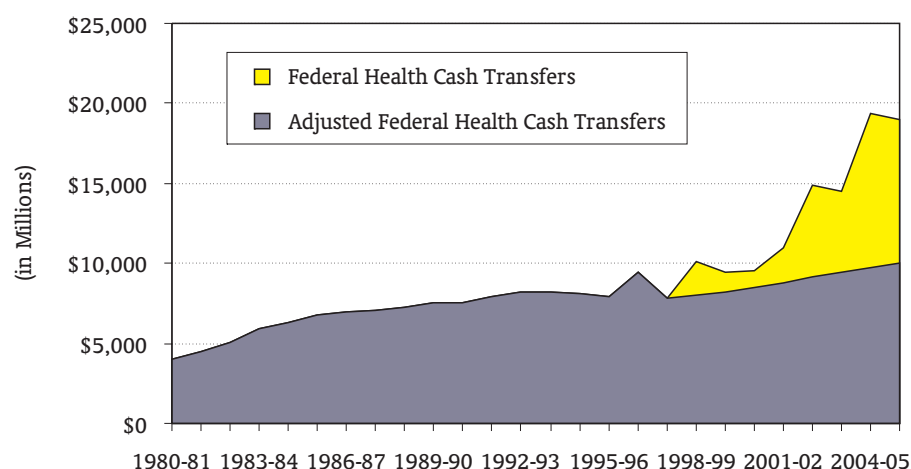
The result is two series of federal cash transfers for health (figure 3). The first series in figure 3, labelled *Federal Health Cash Transfers* is

taken from table 3 and includes all health-specific cash transfers made by Ottawa to the provinces over the time period. The second series, labelled *Adjusted Federal Health Cash Transfers*, is based on the calculation described previously that maintains per-capita, inflation-adjusted spending at 1997/98 levels. The two series are exactly equal between 1980/81 and 1997/98. They diverge after 1997/98, as discussed previously.

The average annual growth rate used for the adjusted series from 1997/98 to 2005/06 is 3.09%.⁷ This rate is markedly higher than the actual average, annual growth rate in federal cash transfers for health experienced in the previous 10 years between 1988/89 and 1997/98 (1.4%). It is also substantially below the actual average growth rate in federal cash transfers for health between 1998/99 and 2005/06 (12.9%). The large difference between the actual growth rate in federal cash transfers for health (12.9%) and the rate based on population growth and inflation (3.09%) results in large differences in actual cash transfers from 1998/99 to 2005/06. For example, in the last year of the series examined (2005/06), actual federal cash transfers for health totalled \$19.0 billion while the adjusted series indicates transfers amounting to only \$10.0 billion.

The total cumulated difference between actual federal cash transfers for health and the amount calculated using population growth plus inflation (1997 base year) was \$36.0 billion. In other words, the federal government provided the provinces with an additional \$36.0 billion between 1997/98 and 2005/06 for health spending beyond

Figure 3: Federal Health Cash Transfers



Sources

Statistics Canada (2006). Provincial Economic Accounts.
Statistics Canada, Public Institutions Division (2006). Financial Management System, Provincial Accounts. Ottawa: Statistics Canada.
Statistics Canada (2007). The Consumer Price Index December 2006. Catalogue No. 62-001-XPB.
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Receiver General for Canada. Public Accounts of Canada, 1997-2006. Ottawa, ON: Ministry of Public Works and Government Services.
Calculations by the authors.

that predicted by population growth and inflation.

Health Performance—Are We Better Off?

The next logical question to ask—particularly when there are indications that the federal government is thinking of increasing existing cash transfers or creating a new one—is how successful the increased federal cash transfers and the subsequent spending, almost all of it at the provincial level, have been in improving health care in Canada. The methodology used to answer this critical question is to compare a series of health performance indicators from 1997 (base year) to the most current year available.

Wait Times for Health Care in Canada

Wait times for health care in Canada have increased significantly since 1997 (table 4). In 1997, the average Canadian could expect to wait 11.9 weeks from the time a General Practitioner (GP) referred him for specialist care to the time a specialist delivered the treatment required. In 2006, the average Canadian could expect to wait 17.8 weeks, nearly 50% longer than in 1997. The increase in the total wait time for treatment was the result of a 72.5% increase in the wait time to see a specialist after referral by a general practitioner and a 32.4% increase in the wait time to receive

treatment after an appointment with a specialist (table 4).

Wait Times for Diagnostic Medical Technology

Canadians in 2006 could also expect to wait longer for scans with various types of medical technology than they did in 1997. For example, the wait time for a CT scan increased slightly from 4.1 weeks to 4.3 weeks between 1997 and 2006 (table 4). The wait time for an MRI scan also increased from 9.6 weeks in 1997 to 10.3 weeks in 2006, an increase of 7.3%. Finally, the wait time for an ultrasound scan increased significantly between 1997 and 2006, rising from 2.6 weeks to 3.8 weeks, an increase of 46.2%.

These deteriorations in wait times for diagnostic care occurred at the same time as new investments were being made in these technologies that increased their availability. For example, the ratio of MRI machines to population increased 233.3% while the ratio of CT scanners to population increased 41.5% between 1997 and 2006 (table 4).

Access to Physicians and Nurses

The ratio of physicians to Canadians improved only slightly during the period from 1997 to 2005 despite the significant increase in health spending. Between 1997 and 2005, the number of physicians per 1,000 people in Canada improved by 4.1%. The number of nurses per 1,000 people, however, fell between 1997 and 2004. In 1997, there were 10.4 practicing nurses per 1,000

Table 4: Canada's Performance on Selected Indicators of Access to Health Care

	1997	Present*	% Change	Trend
Median Total Expected Waiting Time from Referral by GP to Treatment, in weeks, Canada	11.9	17.8	49.6%	–
Median Patient Wait to See a Specialist after Referral from a GP, in weeks, Canada	5.1	8.8	72.5%	–
Median Patient Wait for Treatment after Appointment with Specialist, in weeks, Canada	6.8	9.0	32.4%	–
Median Wait Time for CT Scan, in weeks, Canada	4.1	4.3	4.9%	–
Median Wait Time for MRI Scan, in weeks, Canada	9.6	10.3	7.3%	–
Median Wait Time for Ultrasound Scan, in weeks, Canada	2.6	3.8	46.2%	–
Physicians per 1,000 population (including interns and residents)**	2.1	2.1	4.1%	+
Practicing nurses per 1,000 population	10.4	9.9	-4.8%	–
CT scanners per million population	8.2	11.6	41.5%	+
MRI scanners per million population	1.8	6.0	233.3%	+
Lithotriptors per million population	0.5	0.5	0.0%	↔

***Notes**

Present physician inventory data is for 2005;

Present nurse inventory and lithotripter data is for 2004;

Present wait time, MRI, and CT data is for 2006.

**The percentage change is calculated from exact values, which have been rounded for inclusion in this table.

Sources: Nadeem Esmail and Michael Walker with Dominika Wrona (2006). *Waiting Your Turn: Hospital Waiting Lists in Canada*, 16th ed. Vancouver: The Fraser Institute; Cynthia Ramsay and Michael Walker (1998). *Waiting Your Turn: Hospital Waiting Lists in Canada*, 8th ed. Vancouver: The Fraser Institute; Organisation for Economic Cooperation and Development [OECD] (2006). *OECD Health Data 2006*. Version 10/17/2006. CD-ROM. Paris: OECD. Canadian Institute for Health Information (2006a). *Supply, Distribution and Migration of Canadian Physicians 2005*. Ottawa: CIHI. Canadian Institute for Health Information (2007). *Quick Data by Topic*. Electronic document available on the Internet at www.cihi.ca (accessed Feb 7, 2007). Calculations by authors.

people while in 2004 there were 9.9 (a decline of 4.8%).⁸

Conclusion: Health Performance

The conclusion to be drawn from examining Canadian health performance in 1997 with current performance is disturbing. Canada actually improved in only two categories: the availability of MRI units and CT scanners, both of which are inputs to medical service, not outcomes of success. And, while there

were more machines available, the wait times for service from those machines actually increased over the same period. Further, while the availability of physicians improved slightly between 1997 and 2005, wait times for services provided by physicians increased. By contrast, access to lithotriptors was unchanged over the period. All of the remaining indicators including wait times for care and technology and access to nurses all showed declines in performance.

Conclusion

Unfortunately for Canadians, the significant increase in federal cash transfers for health of \$36.0 billion since 1997/98 have not resulted in better performance of the health-care system. Indeed, the overwhelming evidence from a variety of indicators of health care performance is that Canadians are actually worse off currently than they were in 1997.⁹

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Notes

- 1 This paper examines cash transfers exclusively and does not include tax-point transfers in its analysis.
- 2 The information for EPF–Health Cash transfers comes from a special information request received from the Federal Department of Finance (October 2002).
- 3 For a more thorough discussion of the effects of the CHST reform, please see Schafer *et al.*, 2001.
- 4 Please note that the year in which the one-time transfers were recognized in table 1 were based on commitments contained in the federal budgets rather than the year of recognition contained in the Public Accounts. In many cases, the Public Accounts recognize the transfer in the following year as a result of the timing of the budget relative to the date when the legislation was enacted.
- 5 For an empirical discussion of this issue, please see Veldhuis and Clemens, 2003.
- 6 Please note that the rates of inflation and population growth were national figures. This means that at a provincial level certain provinces would have been experiencing higher rates of population growth and inflation over the period (Alberta) while others would have been experiencing less (Quebec).
- 7 The annual rate of growth ranges from a low of 1.77% to a high of 3.72%.
- 8 The ratio of physicians to population is derived from 2005 statistics, of nurses to population from 2004 statistics as these are the most recent statistics available for comparison. Note that in table 4 the rate of physicians to population appears as 2.1 per 1,000 in both years because this slight improvement in the availability of physicians is masked by rounding.
- 9 Increased cash transfers for health from the federal government to the provinces have not resulted in improved health performance over the period examined largely because of the incentives and structure of Canada's health system. Please see Esmail, 2003 for a discussion of the relationship between health spending and wait times; Esmail and Walker, 2006 for empirical data and a discussion comparing Canada's health care system with other OECD countries that maintain universal health care; Esmail, 2006 for a discussion of physician shortages in Canada and possible explanations; and Esmail, 2002 for a discussion of non-medical wage pressures in the health care system.

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