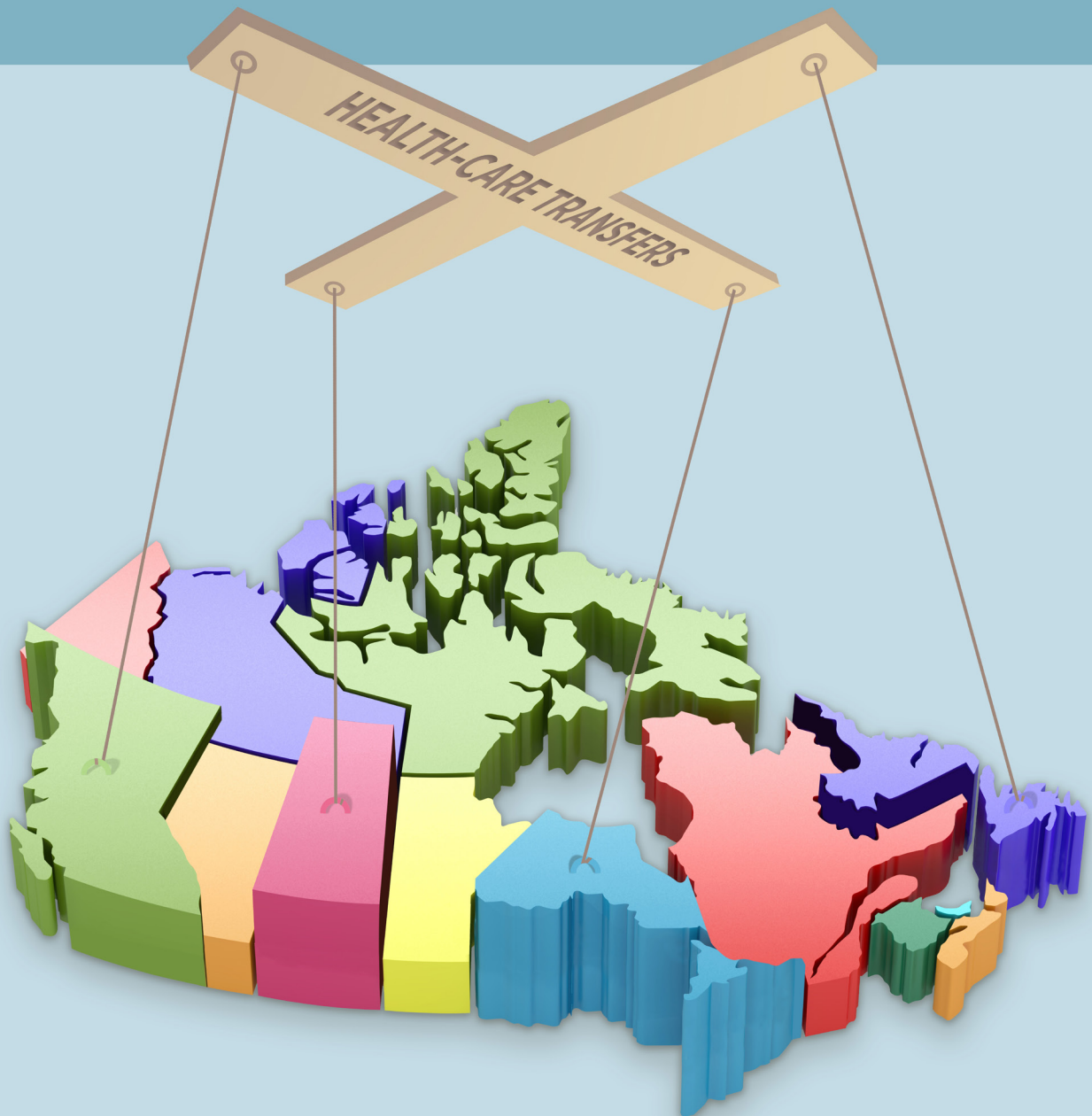


LESS OTTAWA, MORE PROVINCE

How Decentralization Is Key to Health Care Reform

Ben Eisen, Bacchus Barua, Jason Clemens, and Steve Lafleur



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Fraser Institute

Less Ottawa, More Province

How Decentralization Is Key to Health Care Reform

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Executive Summary

Despite high levels of public spending, Canada's health-care system consistently performs more poorly than a number of peer jurisdictions with universal health-care systems. Governments across the country must address this policy challenge in a context of constrained resources, as the federal government and a number of provinces currently face increasing debt loads and other significant fiscal challenges. This paper considers the extent to which policy lessons from Canada's past can help governments in Canada address the dual challenges of an underperforming health-care system and growing fiscal pressure on governments. Specifically, it considers the extent to which Canada's experience with reform of federal-provincial transfers and welfare during the 1990s provides lessons that can be applied to the process of reforming Canadian health care.

During the 1990s, the federal government transformed its approach to providing financial assistance to the provinces to support their welfare and social assistance programs. Specifically, the federal government reduced transfers to the provinces but, in exchange, removed a number of "strings" previously been attached to federal funding that prohibited certain types of policy reform. For example, the provinces were permitted to create work requirements for receipt of welfare payments, which previously would have triggered the withholding of federal transfers.

The reform of federal transfers to the provinces led immediately to a wave of policy innovation and reform at the provincial level, as governments across the country pursued various policy paths designed to improve their welfare programs, create solutions that actually addressed local problems, and reduce program costs. Many of these reforms had the intended effects, as there was a marked decline in welfare dependency and government spending on public assistance in subsequent years.

However, no similar wave of policy innovation occurred following the 1990s transfer reforms in Canadian health care. This is largely because the government maintained the various "strings" that were attached to health spending transfers and, specifically, the terms and conditions of the Canada Health Act. As a result, health-care policy in the Canadian provinces has since the 1990s generally been largely characterized by policy inertia while spending on health care has increased considerably.

Canada's experience with welfare reform provides a model with important implications for how to begin reforming and improving Canadian health care. By reducing transfers in real terms while amending specific provisions of the Canada Health Act that inhibit reform, the federal government can

partially address the fiscal challenges it faces today while providing provinces with the freedom to innovate and pursue policy reforms to improve their health-care systems.

Such changes would allow for greater experimentation by each province as they seek out what policy arrangements have the best possibility of improving health-care performance. For instance, provinces would be well served to examine the introduction of cost-sharing arrangements (co-insurance, deductibles, and co-payments) used in most other universal health-care countries to ensure more efficient use of the health-care system by patients. Provinces might also look at removing regulations that currently prevent a greater supply of needed health-care professionals and investment within the health-care sector.

It is uncertain exactly what reforms different provinces would choose and this paper does not weigh the advantages and risks of specific reform options in detail. Instead, based on Canada's experience with welfare reform, this paper recommends a crucial change, the devolvement of decision-making powers to the provinces, with the federal government permitting each province maximum flexibility (within a portable and universal system) to provide and regulate health-care provision as they see fit.

Introduction

Two of the most important ongoing challenges in public policy facing Canada are the deterioration of government finances and the underperformance of our health-care system. The two problems are related as the cost of Canada's inefficient health-care system continues to grow over time, consuming a larger share of government resources and putting pressure on public finances.

Providing health-care services is the responsibility of provincial governments, but the policies of the federal government play an important and in many respects harmful role in shaping how health care is financed and delivered across the country. Specifically, the Canada Health Act, which governs the federal transfer payment to the provinces (and territories) in support of health care, restricts the ability of provinces to pursue policy experimentation and innovation.

This study focuses on the challenges facing Canada's health-care system and the fiscal environment in which provincial governments across the country must face these challenges. Further, we consider policy options by which the federal government can reform its approach to fiscal transfers to help the provinces develop their own strategies for health-care policy reform. More specifically, we examine the critical lessons Canada should learn from the reforms enacted to social transfers in the 1990s, especially with respect to welfare and social services. We consider the extent to which the reforms to the social transfer in the 1990s provide a template that can be followed to reform Canadian health care today.

The paper will first provide an overview of how federal support for health care has evolved between the post-war era and the present day. This will be followed by a discussion of the fiscal challenges currently facing governments at the provincial and federal levels across the country. Next, the paper assesses both the performance and cost of the Canadian health-care system at this time. The paper will then summarize the reforms made to federal transfers for social programs during the 1990s and the experimentation and reforms implemented by various provinces to their welfare programs in subsequent years. Finally, with these lessons from the 1990s in mind, the paper discusses policy options for reforming federal health-care transfers to the provinces with the objective of stimulating policy innovation at the provincial level.

1 Federal support for provincial health care

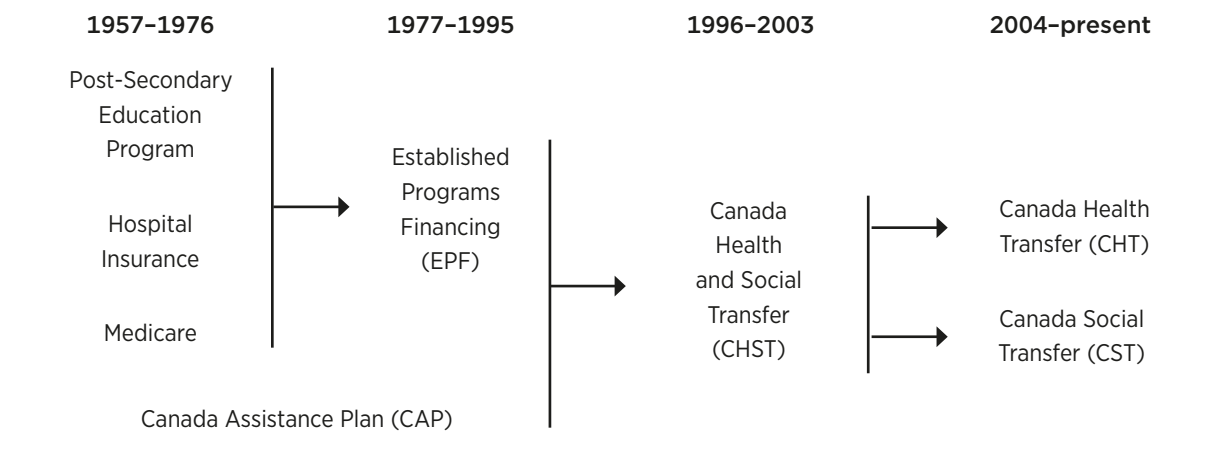
While health care is a provincial responsibility under the constitution, the federal government has long been actively involved in health-care funding and, through such funding, in regulating the provision of health-care. Specifically, the federal government has maintained a policy of assisting provincial governments in financing their health-care systems through annual transfers in return for adherence to the terms and conditions laid out in the Canada Health Act.

The structure of federal health transfers to the provinces has changed several times in important ways since the creation of the modern welfare state during the post-war era. In the 1950s and 1960s, federal transfers to the provinces for health services were primarily provided on a cost-sharing basis. Passage of the Hospital Insurance and Diagnostic Services Act in 1957 and the Medical Care Act in 1966 entrenched the practice of federal cost sharing for health-care spending—namely, physician and hospital services. This changed with the introduction of a block-grant program known as Established Program Funding (EPF) in 1977 to provide federal funding to provincial health-care systems. The EPF was divided between a tax point transfer and a cash transfer to the provinces (Health Canada, 2012).

The shift away from cost-sharing arrangements towards block grants has been one of the most important ways in which Canada's system of federal transfers to the provinces has evolved. Under cost-sharing programs, provinces faced a powerful disincentive to restrain spending because the fiscal benefits of efficiency gains to the province would be partially offset by a resulting reduction in federal transfers (Eisen, Lammam, and Ren, 2016). In short, the move to block grants overcame the incentive problems that plagued the cost-sharing approach by eliminating the incentive for provinces to increase federal assistance to their governments by increasing health-care spending. Furthermore, the cost-sharing arrangements placed significant pressure on the finances of the federal government, which was responsible for 50% of health-care spending increases at the provincial level but had no direct input on spending decisions.

In 1996/97, the EPF (which was also used to fund post-secondary education) and the Canadian Assistance Plan (for social welfare funding) were eliminated to make way for the Canada Health and Social Transfer (CHST). The CHST was a block-grant program intended to help provinces fund health care, post-secondary education, and social assistance. Unlike the previous arrangement, the block grants were a flat transfer unaffected by provincial spending levels.

Table 1: Federal funding for health care, social assistance, and education in Canada, 1957 to present



Source: Canada, Department of Finance, 2014.

In 2004/05, the CHST was split into two parts: the Canada Health Transfer (CHT) and Canada Social Transfer (CST). The Canada Health Transfer remains the primary mechanism through which the federal government assists the provinces in financing health-care services. [1] Under the Canada Health Transfer, all provinces receive equal per-capita transfers in nominal terms, meaning no adjustments are made for demographic differences or for differences in the purchasing power of a dollar across provinces (Crowley and O’Keefe, 2006) (table 1).

In social-policy areas other than health care, a second benefit of the transition away from cost-sharing arrangements and towards block grants has been an enhancement of the provinces’ ability to innovate and develop new strategies to improve program delivery, develop more effective solutions to policy problems, and reduce costs. This has occurred because the federal government has generally removed “strings” that were attached to cost-sharing transfers for social welfare programs as these transfers were converted to block grants.

This second benefit of increased autonomy for provinces, however, has not been realized when it comes to health-care policy. The primary reason is that in 1984, the federal government enacted the Canada Health Act (CHA), which set the terms and conditions upon which EPF funding would be contingent, and created provisions for withholding transfers if they were not met. The terms and conditions (set by the CHA) under which provincial governments receive federal health transfers remained in place when the EPF was replaced by the CHST, and remains in place to this day.

[1] Some provinces also receive considerable federal support through the equalization program, which is also available for health spending.

Clemens and Esmail (2012) argued that, of the 23 sections that constitute the CHA, certain sections may pose significant barriers to introducing the sort of policies routinely found in other countries with successful universal health-care systems. [2] For example, of the commonly cited five principles outlined in sections 8 to 12 (see **table 2** for an overview), section 8 (public administration) disallows multiple insurers; section 10 (universality) disallows individually tailored insurance plans; and the ambiguity of wording in section 12 (accessibility) can be interpreted to disallow parallel health care, private for-profit ownership of hospitals, and dual practice [3] for medical practitioners. Perhaps most significantly, sections 18 to 21 (in concert with section 12) explicitly disallow user charges and extra billing. Collectively, these terms and conditions represent a barrier to the reform of health-care policy at the provincial level and, therefore, have had the effect of maintaining homogeneity in Canadian health-care policy. They effectively prohibit provinces from pursuing a number of policy reforms that have already been successfully implemented in other developed countries with universal health-care systems. [4]

The Canada Health Transfer (CHT) represents a major source of revenue for all provinces (a total of \$34 billion in 2015/16), to the point that the prospect of losing these transfers makes it impractical for provinces to pursue meaningful policy reform that carries a risk of being deemed non-compliant with the Act. The CHT funded approximately 23.6% of all provincial health-care spending that year. [5]

Since the post-war period, the precise structure of federal health transfers to the provinces has changed on numerous occasions, leading to the present arrangements under which the federal government helps finance provincial health-care programs through the CHT, contingent upon compliance with the Canada Health Act. Unfortunately, these arrangements are, in important respects, not serving Canadians well.

More specifically, there are two major problems that have either emerged as a result of, or been exacerbated by, the current system of federal transfers. The first of these has been that the growing cost of the Canada Health Transfer and increases in health-care spending have, over time, been placing increased pressure on public finances. Recent research has raised serious concerns about

[2] Clemens and Esmail (2012) do note, however, that provinces have not pursued a number of policies that are not explicitly disallowed by the CHA in clear terms but that could be determined to be disallowed according to certain interpretations and readings of the text.

[3] That is, the freedom to serve patients both in the public and private health-care systems.

[4] For discussions of how the CHA obstructs policy reform and how various amendments to the Act could enable greater policy innovation see Esmail and Walker, 2008 and Clemens and Esmail, 2012. For examples of universal health-care systems with for-profit hospitals and insurers, see Barua and Esmail, 2015. For examples of universal health-care systems that employ cost-sharing (copayments, user-fees, deductibles), see Globerman, 2016.

[5] Authors' calculation based on data from Barua, Palacios, and Emes, 2016.

Table 2: Summary of key provisions of the Canada Health Act

Section 8: Public Administration	Requires that the health-insurance plan of a province be administered and operated by a public authority that is accountable to the government on a not-for-profit basis.
Section 9: Comprehensiveness	Mandates that all "medically necessary" health services are covered by a provincial or territorial health plan.
Section 10: Universality	Requires that 100% of the insured persons of the province be entitled to the insured health services provided for by the plan on uniform terms and conditions.
Section 11: Portability	Requires that residents be entitled to insured health-care services when they relocate from one province to another, and when traveling within Canada.
Section 12: Accessibility	Requires provincial health plans to provide insured health services on uniform terms and conditions and on a basis that does not impede, either directly or indirectly, whether by charges made to insured persons or otherwise, reasonable access to those services by insured persons.
Sections 18–21: Extra Billing and User Fees	Prohibit user-fees and extra billing for insured medical services; mandate non-discretionary penalties requiring dollar-for-dollar deductions from federal transfer payments for all extra billing or user fees charged in the province.

Source: Canada, Government of, 1985; Clemens and Esmail, 2012: 3–4.

the sustainability of trends in health-care spending in Canada, demonstrating the need for policy reform to curb the growth of health spending costs (Barua, Palacios, and Emes, 2016). Secondly, a significant body of evidence suggests that, despite sustained spending growth, Canada's health-care system is underperforming relative to peer countries with universal health-care systems. The constraints imposed by the Canada Health Act and the resulting inertia of health-care policy have been identified as potentially important contributors to the relatively weak performance of the Canadian health-care system. The following two sections discuss these challenges in turn, demonstrating the need for policy reform.

2 The state of Canadian public finances

Healthy public finances are crucial to the long-term provision of important social programs such as health care. Any discussion of the cost and sustainability of health-care spending needs to begin with a review the state of public finances in Canada. Health-care policy making must be informed by the fiscal context in which decisions must be made, particularly given that health spending consumes a large share of all provincial government spending in every province in the country. An examination of Canada's public finances clearly shows that governments across the country are facing significant fiscal challenges and must address their policy challenges in the face of constrained resources. Further, it shows that growth in health-care spending is a major contributing factor to the fiscal challenges facing governments across the country.

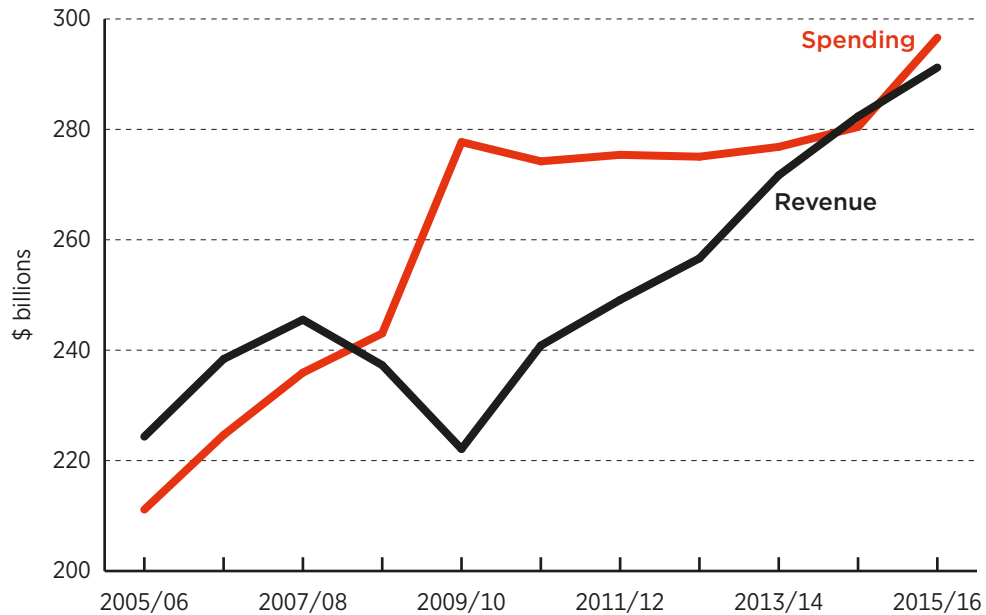
Federal finances

In recent years, the majority of the accumulation of public debt has taken place at the provincial level. Since 2007/08, approximately 61% of all new federal and provincial public debt has been accumulated at the provincial level (Lammam, Palacios, MacIntyre, and Ren, 2016). While the federal government has not been accumulating new debt as quickly as the provinces taken collectively in recent years, there has nonetheless been some debt accumulation, primarily as a result of regular deficit spending. Furthermore, while the federal government's fiscal performance in recent years has been somewhat better than the provinces' taken as a group, the federal government's most recent budget forecasts show a significant acceleration in the accumulation of debt in the years ahead. In fact, the Parliamentary Budget Office has conducted analyses suggesting current spending levels are not sustainable in the absence of significant tax increases (Parliamentary Budget Office, 2016).

Fiscal position of the federal government—recent developments and outlook for the future

Figure 1 shows government spending and government revenues each year from 2005/06 to 2015/16. It illustrates how the substantial uptick in spending coupled with a decline in revenues during the Great Recession led to the opening of a substantial gap between the two and, as a result, a significant budget deficit. The federal government would continue to run budget deficits before finally balancing the budget in 2014/15 and posting a small deficit in 2015/16.

Figure 1: Federal fiscal balance and government spending (\$ billions), 2005/06–2015/16



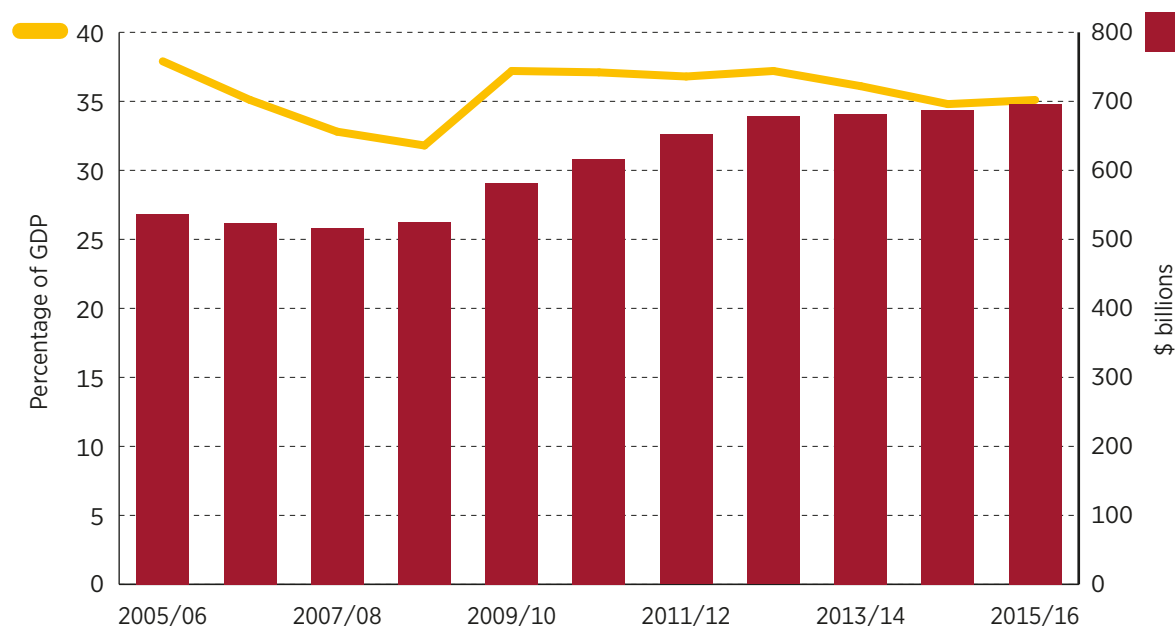
Sources: Based on Clemens, 2011: figure 1. Data 2005/06–2014/15: Canada, Department of Finance, 2016c. Data 2015/16: Canada, Department of Finance, 2016a.

It has run seven budget deficits over the past eight years, managing only one small surplus since 2008/09. Predictably, this string of budget deficits has led to an increase in federal government debt.

Figure 2 shows how federal debt has increased over time from 2005/06 to 2015/16. While net debt decreased slightly from 2005/06 to 2007/08, it subsequently increased by \$114 billion between 2008/09 and 2015/16 to \$696 billion. The federal government's fiscal performance has been notably stronger than the provinces taken as a group, with the result that federal government's debt as a share of the Canadian GDP stabilized and actually began to fall slightly in the years following the Great Recession. Federal debt relative to GDP is still above pre-recession levels but, unlike the provincial governments taken as a group (which will be discussed shortly), the federal government has at least succeeded at restraining the growth of its debt to the extent that the debt-to-GDP ratio has stabilized.

Troubling, however, are indications that the federal government will significantly increase the size of its budget deficits in the years to come. This year alone, for example, the federal government projects it will run a deficit of approximately \$30 billion. This would be the second-largest budget deficit since the mid-1990s, exceeded only by the deficit during 2009/10, immediately following the global financial crisis. What is more, the federal government projects significant budget deficits in the years ahead: it forecasts that it will accumulate a deficit of \$113.2 billion between this year and 2020/21. By

Figure 2: Nominal federal debt and federal debt as a share (\$) of GDP, 2005/06-2015/16



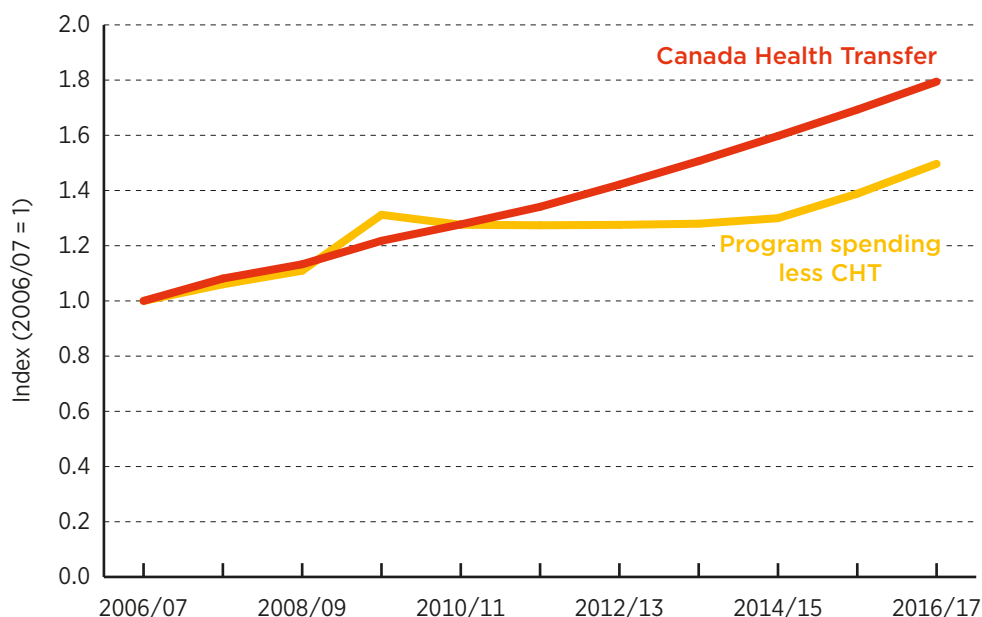
Sources: Based on Clemens, 2011: figure 3. Data 2005/06–2014/15: Canada, Department of Finance, 2016c. Data 2015/16: Canada, Department of Finance, 2016a. GDP: Statistics Canada, 2016c.

comparison, in the five-year period between 2011/12 and 2015/16, the accumulated deficit was less than half as large, at \$53 billion. The larger projected deficits in the years ahead are primarily the result of large spending increases, including a 7.6% increase in 2017/18 alone.

Troublingly, there are reasons to believe that the federal government's fiscal position may deteriorate even faster than is projected in the most recent budget in the years ahead. A recent analysis by the Fraser Institute projected that under a range of plausible spending scenarios, the debt may rise much faster than the government now forecasts, with an accumulated budget deficit approaching \$200 billion (Veldhuis, Palacios, and Lammam, 2016). Under these scenarios, the federal government's debt-to-GDP ratio would once again begin to climb significantly for the first time since 2009/10.

For the purposes of this paper, it is important to recognize that growing health-care costs and, specifically, increases in the Canada Health Transfer (CHT) are contributing to the fiscal pressure facing the federal government and the recent increases in federal debt. **Figure 3** shows the growth in the CHT as well as program spending less the CHT from 2006/07 to the projected total for 2016/17. During that period, CHT transfers will have grown from \$20.1 to \$36.1 billion. In total, nominal spending on the CHT has increased by 79.4% during this period, well above the 49.7% growth in program spending excluding the CHT.

Figure 3: Canada Health Transfer (CHT) and program spending less CHT as an index of levels in 2006/07



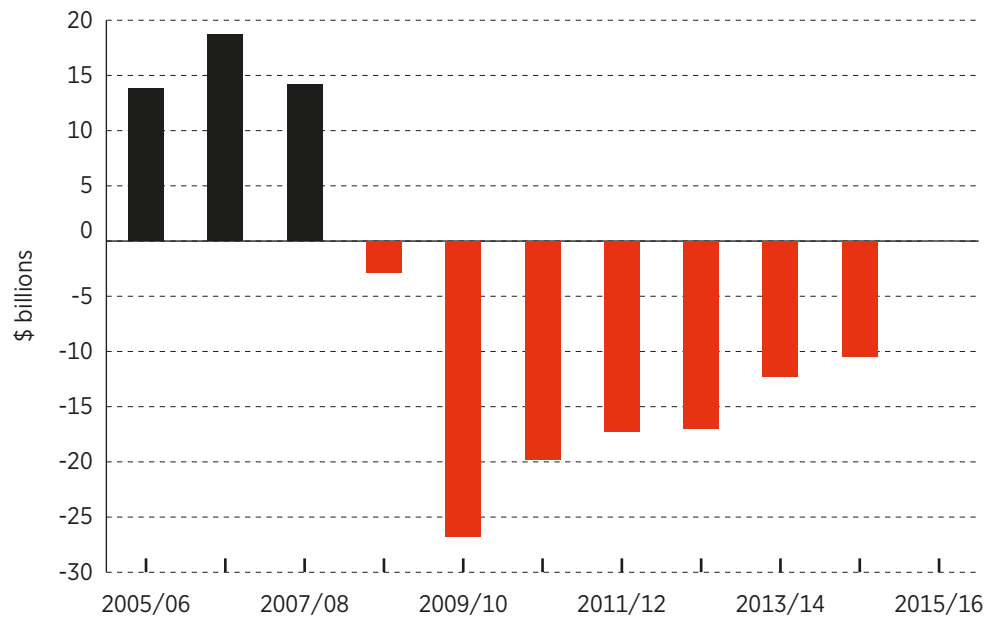
Sources: Based on Clemens, 2011: figure 8; Data 2007/08–2016/17: Canada, Department of Finance, 2016b. Data 2005/06–2006/07: Canada, Department of Finance, 2016d. Program spending 2005/06–2014/15: Canada, Department of Finance, 2016c. Program spending 2015/16–2016/17: Canada, Department of Finance 2016a.

Clearly, the Canada Health Transfer is a significant and rapidly increasing component of the federal government's budget. Although the growth rate of the CHT is scheduled to be reduced after 2017 (barring another formula change), this growth has implications for the government's financial position today and in the future. These implications are made more troubling by the emergence of a significant budget deficit this year and projections for further substantial deficits for the next several years.

Provincial finances

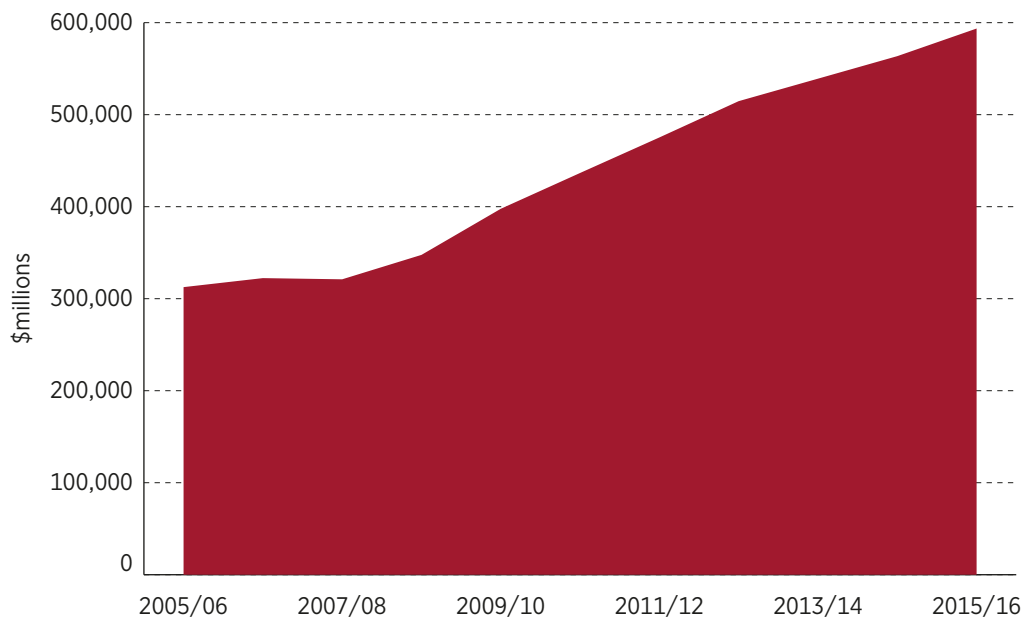
We have seen that the fiscal position of the federal government is currently deteriorating. Unfortunately, the fiscal picture at the provincial level is even worse. What is more, a close look at provincial finances demonstrates that increasing health-care costs are a major contributing factor to the financial pressure facing many provinces. These realities raise important questions about the sustainability of our current approach to health-care financing and delivery and help highlight the need for reform. **Figure 4** shows the total of provincial surpluses and deficits by year over the past decade. While the provinces collectively ran surpluses from 2005/06 to 2007/08, they have collectively run deficits in every fiscal year since. For 2015/16, the total of the provincial financial budgetary balances is a \$15.8 billion deficit.

Figure 4: Total provincial surplus or deficit, 2005/06–2015/16



Sources: Based on Clemens, 2011: figure 4. Data 2005/06–2014/15: Canada, Department of Finance, 2016c. Surplus/deficit 2015/16: TD Economics, 2016.

Figure 5: Total provincial net debt, 2005/06–2015/16

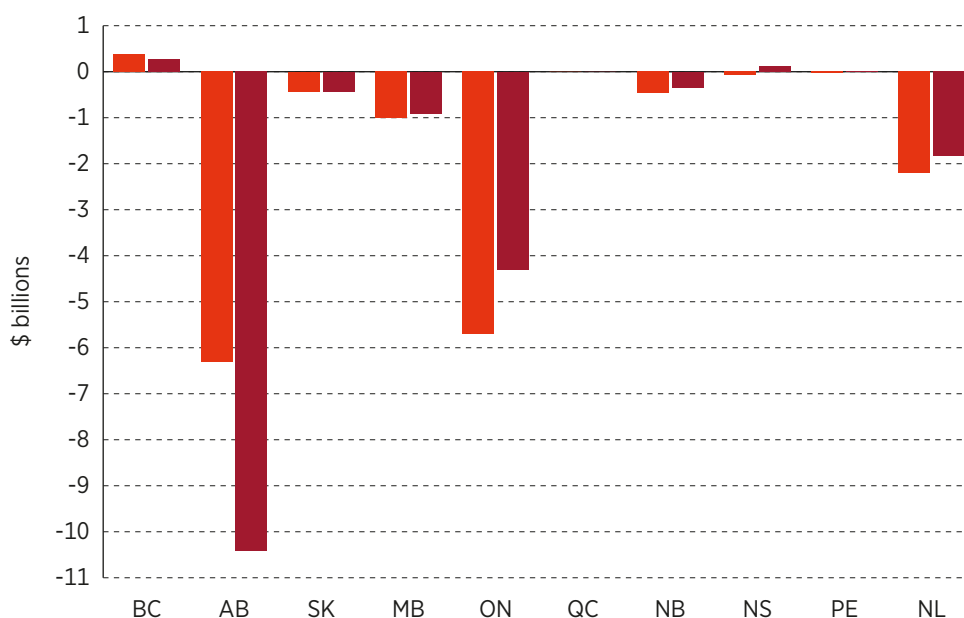


Sources: Statistics Canada, 2016a (table 385-0034); authors' calculations.

Figure 5 shows that these deficits have had a significant toll on provincial finances. In 2005/06, the total net debt for all provinces amounted to \$312.5 billion. Over the course of ten years that has ballooned to \$593.6 billion—an increase of 90%. The quick run-up in provincial debt in recent years is concerning, as it may mean additional taxes will be levied on future generations to service and repay that debt. It is also troubling that today, approximately eight years removed from the end of the Great Recession, nearly all of the provinces are still running budget deficits. As **figure 6** shows, in 2015/16 eight out of the ten provinces ran operating deficits and seven provinces are projecting budget deficits in 2016/17. This suggests that the recent run-up in provincial-level debt that has been documented in this section is still ongoing.

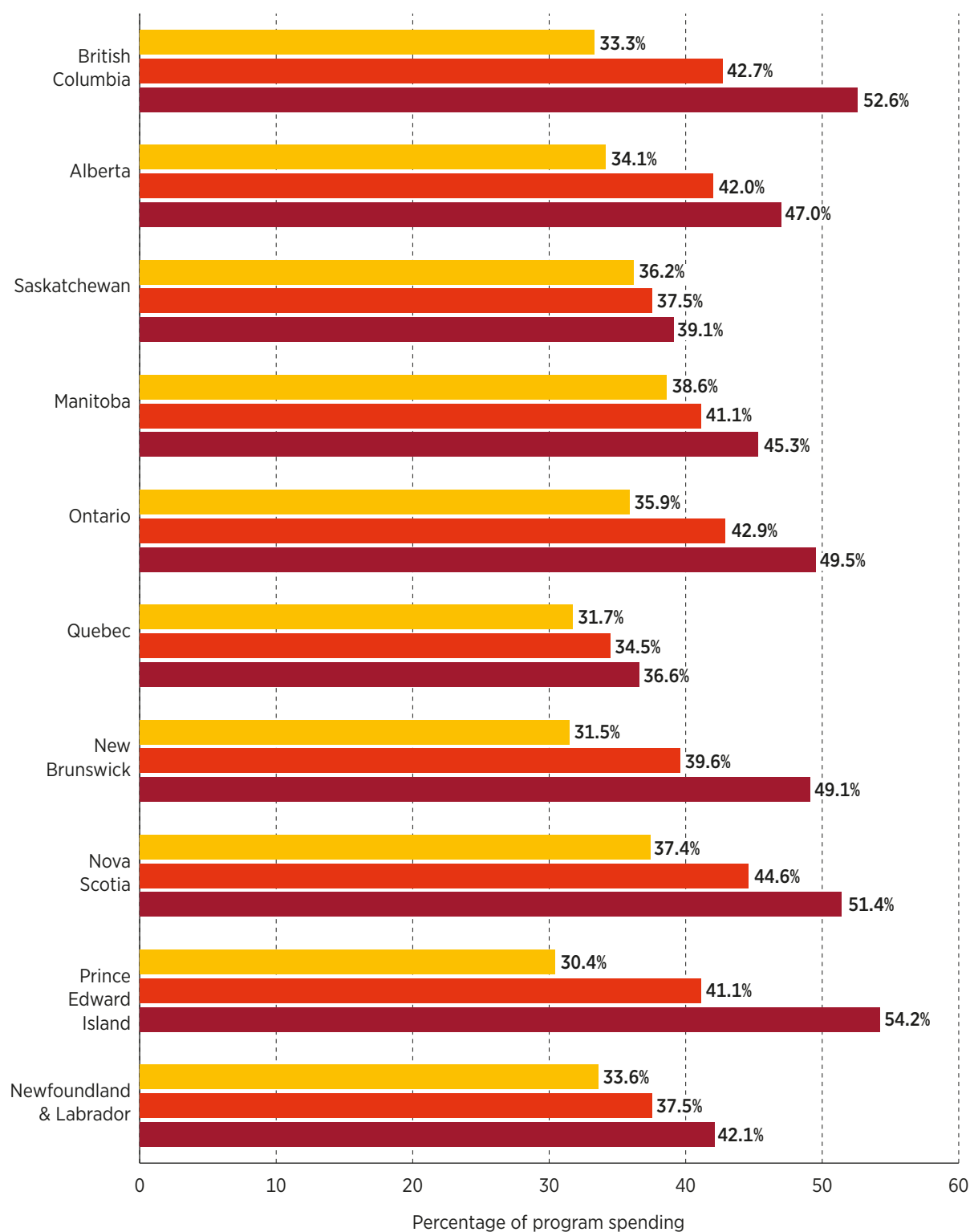
A major contributor to the emergence of large budget deficits at the provincial level in recent years has been rapid growth in health-care spending. Health care is the largest expense for every provincial government in the country and spending on health care has significantly outstripped provincial spending growth in other budget areas in recent years. As a result, the share of provincial budgets dedicated to healthcare is on the rise. **Figure 7** shows provincial health-care spending as a percentage of total program spending. Health-care spending has become an increasingly large component of provincial program spending since 1998/99, when it was 34.3%, and, by 2030/31, could grow to 46.7% of provincial program spending on average, with a range between 36.6% in Quebec and 54.2% in Prince Edward Island.

Figure 6: Surplus or deficit for each Canadian province, 2015/16 ■ and 2016/17 ■



Sources: Based on Clemens, 2011: figure 5. TD Economics, 2016.

Figure 7: Provincial health spending as percentage of program spending, by province, 1998 ■, 2015 ■, and 2030 ■



Sources: Based on Barua, Palacios, and Emes, 2016: figure 12. Canada, Department of Finance, 2015; Canadian Institute for Health Information, 2015.

The growing share of program spending projected for health care will put increasing pressure on both the federal and provincial governments, requiring changes to other policy areas to accommodate increases in health-care spending. This will either mean less spending on other policy priorities, greater debt, or higher taxes in the future unless the provinces are able to find ways to deliver health care more efficiently. Given that health-care budgets already consume an average of 40.3% of provincial budgets, reforming health-care spending will be crucial to ensuring the fiscal health of Canada's provincial and federal governments.

Summary

In recent years, public debt in Canada has increased in nominal terms at both the provincial and federal levels. Cumulatively, federal and provincial net debt in Canada increased by more than 50% between 2007/08 and 2015/16, reaching \$1.3 trillion last year. Combined, provincial and federal debt reached 64.8% of Canada's GDP in 2007/08 (Lammam, Palacios, MacIntyre, and Ren, 2016). The growth of debt has been significantly faster at the provincial level than at the federal level, leading to an increase in provincial debt relative to GDP. While the federal government's fiscal performance has been stronger than the provinces' in recent years, the federal government has now begun to accumulate significant new debt as well and expects to continue doing so in the years ahead.

In short, our analysis supports the findings of many other studies that have demonstrated that the finances of the federal government and its provincial counterparts are constrained. [6] Several governments including the federal government and the provincial government in Alberta are projected to accumulate substantial new debt in the years ahead while others, such as Ontario, are not currently on course to shrink the substantial new debt burdens they have acquired over the past decade. In 2015/16, approximately eight years removed from the global recession, only two provincial governments managed to balance their budgets.

The key implication of this analysis is that governments across the country do not have the fiscal capacity to simply throw more money at the problems their health-care systems face. Moreover, their fiscal situations have not yet led to an immediate debt crisis given the historically low interest rates that have prevailed. Any increase in interest rates could lead to an increase in the costs of servicing the debt and worsen public finances.

[6] For examples, see Veldhuis, Palacios, and Lammam, 2016; Eisen, Lammam, and Palacios, 2016; and Lafleur, Eisen, and Palacios, 2016.

3 The state of Canadian health care

Health-care spending by provincial governments has increased significantly across Canada over the last decade. While the growth of such spending has slowed during the last few years, this may be a temporary trend. Regardless, it is clear that the general trend of increases in health-care spending by provincial governments will continue to pose a threat to the sustainability of government finances in Canada (Barua, Palacios, and Emes, 2016).

These facts raise important questions about the sustainability of our current approach, and suggest the need for policy reform to bring Canadian health-care spending onto a more sustainable medium- and long-term trajectory. However, the pressure rising health-care spending is placing on provincial budgets is not the only evidence that points to the need for meaningful reform. Also of great importance is the fact that, despite what are high levels of spending on health care by international standards, Canada's health-care system underperforms relative to several other universal health-care systems around the world. [7]

In this section, [8] we provide an overview of recent comparative international research surrounding health-care performance to demonstrate the weakness of the Canadian system in a number of important areas and, therefore, the need for policy reform. It is useful to compare the performance of different countries' health-care systems, as well as the amount of money they spend on health care (see, e.g., Esmail and Walker, 2008; Rovere and Skinner, 2012; Barua, 2013). That is, the performances of various healthcare systems can be assessed using indicators measuring: [1] the expenditure on health-care (the cost); and [2] the provision of health care in terms of availability of resources, use of resources, access to resources, and clinical performance and quality. [9] While indicators of health status are important, they are not discussed here because they can be influenced to a large degree by non-medical determinants of health (lifestyle choices, environmental quality, genetic features, and so on) that lie outside the purview of a country's health-care system and policies.

[7] When speaking of the Canadian health-care “system”, it is important to note that delivery of health care is a provincial responsibility, and there are some differences among provincial health-care systems, both in how programs are delivered and outcomes.

[8] Data in this section are based on Barua, Timmermans, Nason, and Esmail forthcoming.

[9] See Barua, 2013 for more detail about the framework used for value-for-money comparisons.

Spending on health care

When attempting to measure the performance of healthcare systems, it is essential to consider the costs of maintaining such systems. It is not meaningful to either “define higher national levels of spending on health as negative without considering the benefits” (Rovere and Skinner, 2012: 15) or, conversely, to define a health system with higher levels of benefits as positive without considering the costs.

There are two measures that can help inform us about the relative differences between the amounts of money spent by different countries on health care. The first is health-care expenditure as a percentage of GDP. As Esmail and Walker note, this indicator “controls for the level of income in a given country and shows what share of total production is committed to health-care expenditures” (2008: 17). Such a measure also helps avoid potentially “flawed comparisons with low spending in less developed OECD countries ... while also not overvaluing high expenditures in relatively rich countries” (2008: 17). As can be seen in **figure 8**, out of 28 countries Canada ranks third highest in terms of age-adjusted [10] health-care expenditure as a percentage of GDP.

A second measure of relative differences between the amount of money spent by countries on health care is the amount of health-care expenditure per capita, adjusted for comparison using data on purchasing power parity [PPP]. While there are some important theoretical concerns about the reliability of international comparisons using data reliant on PPP, there are a number of benefits as well. Apart from being more straightforward from a conceptual standpoint, how countries rank on this indicator is far less susceptible to short-term fluctuations in GDP. Canada ranks fifth highest of the 28 countries examined in terms of age-adjusted health-care expenditures per capita.

Clearly, the indicators examined above suggest that Canada spends more on health care than the majority of high-income OECD countries with universal health-care systems.

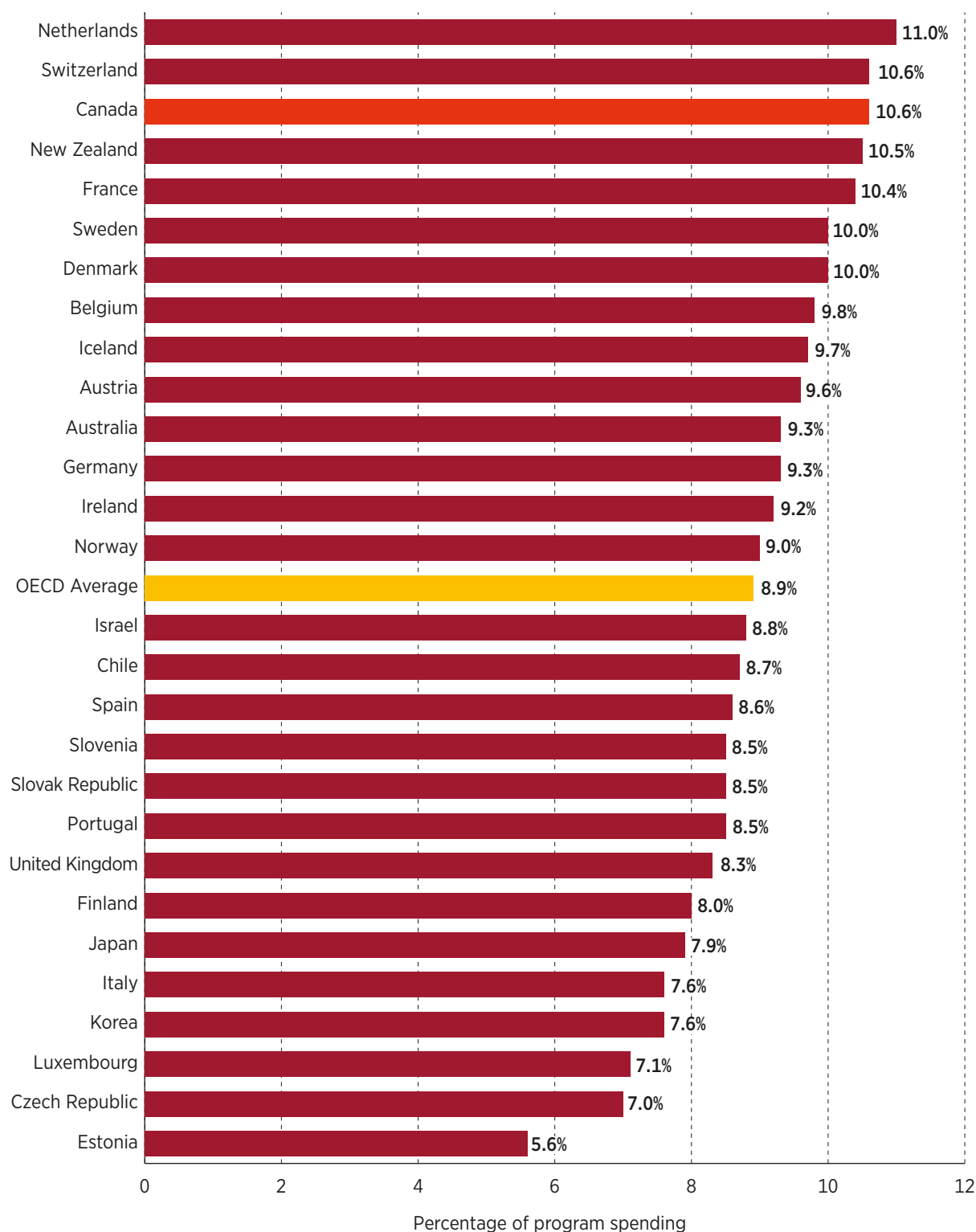
Provision of health care

Availability of resources

Human resources are often considered “the most important of the health system’s inputs [and] usually the biggest single item in the recurrent budget for

[10] It is well established that older populations require higher levels of health-care spending because they consume more health-care resources and services. As a result, indicators of cost, availability of resources, and use of resources are adjusted based on each country’s age profile. For a detailed explanation of the methodology used for age-adjustment, see Barua, Timmermans, Nason and Esmail (forthcoming). It is unclear whether indicators of timely access to care need to be adjusted for age, and the methodology for making such an adjustment has not been explored by the authors of this report. Indicators of clinical performance and quality are already adjusted for age (and sometimes sex) by the OECD.

Figure 8: Age-adjusted spending on health care as a share of GDP, 2012 or most recent



Sources: OECD, 2015; calculations by authors.

health” (WHO, 2000: 77). At the same time, services cannot be effectively delivered without physical capital such as hospitals, [11] beds, and equipment. As can be seen in **table 3**, out of 28 countries, Canada ranks 24th for physicians, 13th for nurses, 28th for curative (acute) care beds, and 24th for psychiatric care beds per thousand population on an age-adjusted basis.

Research also suggests that medical technology plays a significant role in improving the efficiency of medical services, ultimately benefiting patients while reducing health-care expenditures over time (Or, Wang, and Jamison, 2005). For example, medical technologies such as new diagnostic equipment and innovative surgical and laboratory procedures improve the efficiency of hospitals and increase the comfort and safety of patients (Esmail and Wrona, 2009). As can be seen in table 3, Canada ranks 18th (out of 26) for MRI units, 18th (out of 26) for CT scanners, 15th (out of 24) for PET scanners, first (out of 23) for Gamma cameras, 14th (out of 20) for Digital Subtraction Angiography units, 14th (out of 20) for Mammographs, and 18th (out of 18) for Lithotriptors on an age-adjusted basis. While Canada has the most Gamma cameras (per million population), it has fewer other medical technologies than the average high-income OECD country with universal health care for which comparable inventory data is available.

Taken together, these data demonstrate that Canada has substantially fewer human and capital medical resources than many peer jurisdictions that spend comparable amounts of money on health care.

Use of resources

While measurement of the availability of medical resources is valuable, it does not provide us with information about their use. In order to get a better idea of the quantity of health-related goods and services provided by different countries (in the context of health-care expenditures), we examine indicators measuring the number of doctors consultations per capita, hospital discharge rates [12] per hundred thousand population, MRI examinations per thousand population, and CT scans per thousand population.

[11] While data on the number of hospitals in the countries examined in this report are available, they are not included because of the large variability in size and specialty. The number of beds, in some ways, serves as a proxy for the amount of physical capital that would be represented by a measure of the number of hospitals in a country.

[12] The Organisation for Economic Co-operation and Development (OECD) defines hospital discharge rates as “the number of patients who leave a hospital after staying at least one night” including “deaths in hospital following inpatient care” (OECD, 2015: 106). The OECD notes a number of methodological differences between countries for this indicator (for example, same-day surgeries are included in Chile and the Slovak Republic while healthy babies born in hospitals are excluded in several countries like Australia, Austria, Canada, Chile, Estonia, Finland, Greece, Ireland, Luxembourg, Mexico, and Spain).

Table 3: Availability of resources (age-adjusted), 2012 or most recent

Indicator	Data	Rank
Physicians (per thousand population)	2.6	24 (out of 28)
Nurses (per thousand population)	9.7	13 (out of 28)
Acute Care Beds (per thousand population)	1.8	28 (out of 28)
Psychiatric Care Beds (per thousand population)	0.4	24 (out of 28)
MRI Units (per million population)	9.2	18 (out of 26)
CT Scanners (per million population)	15.2	18 (out of 26)
PET Scanners (per million population)	1.2	15 (out of 24)
Gamma Cameras (per million population)	21.4	1 (out of 23)
Digital Subtraction Angiography Units (per million population)	5.4	15 (out of 20)
Mammographs (per million population)	16.5	14 (out of 20)
Lithotriptors (per million population)	0.4	18 (out of 18)

Source: OECD, 2015; calculations by authors

Table 4: Use of resources (age-adjusted), 2012 or most recent

Indicator	Data	Rank
Doctor Consultations (per hundred population)	8.0	6 (out of 28)
Hospital Discharges (per hundred thousand population)	8628.3	28 (out of 28)
MRI Exams (per thousand population)	52.9	8 (out of 23)
CT Exams (per thousand population)	131.4	8 (out of 23)

Source: OECD 2015; calculations by authors

As can be seen in **table 4**, Canada ranks sixth (out of 28) for doctor consultations per 100 population, 28th (out of 28) for hospital discharge rates per 100,000 population, eighth (out of 23) for MRI examinations per thousand population, and eighth (out of 23) for CT scans per thousand population, on an age-adjusted basis. Canada ranks notably higher than the average high-income OECD country with universal health care for the rate of doctor consultations, and slightly higher than the average for MRI exams and CT scans. Canada ranks as the country with the lowest hospital discharge rate [13] per hundred thousand population (an indicator of hospital activity).

Access to resources

While both the level of medical resources available and their use can provide insight into accessibility, it is also beneficial to measure accessibility directly. One important interpretation of accessibility is the timeliness of care, as measured by waiting lists. Murray and Frenk propose that individuals value prompt attention for two reasons: “it may lead to better health outcomes” and “it can allay fears and concerns that come with waiting for diagnosis or treatment” (2000: 720). Unlike indicators in previous sections, lower rates are preferable for many indicators in this section. However, the performances of countries on each indicator are ordered such that a rank of one indicates superior performance on all indicators.

As can be seen in **table 5**, Canada ranks ninth (out of 9) for the percentage of patients able to get an appointment the same day they fall sick (41%), and ranks eighth (out of 10) for the percentage of patients who report that it is very/somewhat easy to get care after hours (38%). Some 62.1% of Canadian patients reported waiting more than four weeks for an appointment with a specialist, placing Canada last among 14 countries for which data were available. Canada also ranked worst (tenth out of 10) for the percentage of patients who reported waiting two months or more for an appointment with a specialist (29%), and eighth (out of 9) for the percentage of patients who reported waiting four months or more for elective surgery (18%).

Figure 9 illustrates how poorly Canada has performed in delivering timely access to health care. Canada had the highest percentage of patients who were required to wait two or more months for an appointment with a specialist out of a selection of nine OECD countries for which data were available, and the second greatest percentage of patients who waited four or more months

[13] The Organisation for Economic Co-operation and Development notes that “[h]ospital activities are affected by a number of factors, including the capacity of hospitals to treat patients, the ability of the primary care sector to prevent avoidable hospital admissions, and the availability of post-acute care settings to provide rehabilitative and long-term care services” (OECD, 2015: 106). It is useful to reiterate that they are examined here simply as an indicator of the use and provision of health-care services in the context of health-care spending

Table 5: Access to health-care resources, 2013

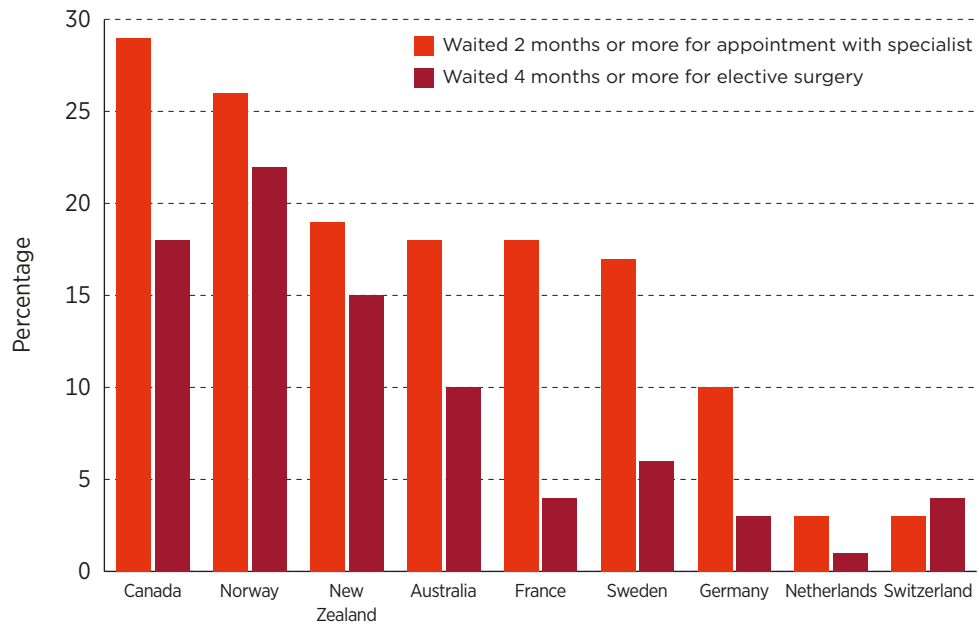
	Same day appointment when sick		Very/somewhat easy to get care after hours		Waited more than four weeks for appointment with specialist		Waited two months or more for appointment with specialist		Waited four months or more for elective surgery		Experienced access barrier because of cost in past year	
	Value (%)	Rank (out of 9)	Value (%)	Rank (out of 10)	Value (%)	Rank (out of 14)	Value (%)	Rank (out of 10)	Value (%)	Rank (out of 9)	Value (%)	Rank (out of 10)
Australia	58	4	46	7	46.2 ^w	9	18	6	1	6	16	7
Belgium					20.1 ^b	3						
Canada	41	9	38	8	62.1 ^w	14	29	10	18	8	13	4
Estonia					39.5 ^w	7						
France	57	6	36	9	49.3 ^w	11	18	6	4	3	18	8
Germany	76	1	56	3	27.2 ^b	6	1	4	3	2	15	6
Israel					20.5 ^b	4						
Italy					54.3 ^w	12						
Netherlands	63	3	56	3	22.6 ^b	5	3	1	01	1	22	10
New Zealand	72	2	54	5	44.1 ^w	8	19	8	15	7	21	9
Norway	52	7	58	2	55.3 ^w	13	26	9	22	9	1	3
Sweden	58	4	35	10	48.7 ^w	10	17	5	6	5	6	2
Switzerland			49	6	17.7 ^b	1	03	1	4	3	13	4
United Kingdom	52	7	69	1	18.3 ^b	2	7	3			4	1
OECD Average	59		50		38		15		9		14	

Note: w = statistically worse than average; b = statistically better than average; a = not statistically different from average.

Calculations by authors based on the upper and lower confidence intervals of each country in relation to the average upper and lower confidence intervals of all countries in each group.

Sources: OECD, 2015a; Commonwealth Fund, 2015; calculations by authors

Figure 9: Wait times for appointment with specialist and elective surgery in selected OECD countries



Source: Commonwealth Fund, 2015.

for elective surgery. In all indicators of timeliness of care, Canada ranked either last or almost last among other countries with universal-access health-care systems. Canada did, however, achieve a middling performance in terms of the percentage of patients who experienced a barrier to access because of cost (13%), ranking fourth (out of 10).

Quality and clinical performance

When assessing indicators of availability of, access to, and use of resources, it is of critical importance to include as well some measure of quality and clinical performance. [14] Canada's rank on indicators measuring quality and performance in the areas of primary care, acute care, mental health care, cancer care, and patient safety are presented in **table 6**. While lower rates are preferable for certain indicators, the performances of countries on each indicator are ordered such that a rank of one indicates superior performance on all indicators.

[14] These indicators differ from those that measure the health status of the population (like life expectancy), which can be influenced to a large degree by non-medical determinants of health (lifestyle choices, environmental factors, genetic features, and so on) that lie outside the purview of a country's health-care system and policies. See Barua, 2013 for more explanation.

Table 6: Quality and clinical performance, 2012 or most recent

	Indicator	Data	Rank (1 is best)
Primary Care	Diabetes lower extremity amputation (Age-sex standardised rate per 100 000)	7.3 ^w	16 (out of 19)
	Hip-fracture surgery initiated within 48 hours after admission to the hospital (crude rate per 100 patients; 65 years and over)	90.4	5 (out of 21)
Acute Care	Admission-based AMI 30 day in-hospital mortality (Age-sex standardised rate per 100 patients)	6.7 ^b	7 (out of 28)
	Admission-based Hemorrhagic stroke 30 day in-hospital mortality (Age-sex standardised rate per 100 patients)	25.7 ^a	17 (out of 28)
	Admission-based Ischemic stroke 30 day in-hospital mortality (Age-sex standardised rate per 100 patients)	10.4 ^w	24 (out of 28)
Mental Health Care	In-patient suicide among patients diagnosed with a mental disorder (Age-sex standardised rate per 100 patients)	0.06 ^a	9 (out of 14)
Cancer Care	Breast cancer five year relative survival (Age-standardised survival percentage)	87.7 ^b	3 (out of 22)
	Cervical cancer five year relative survival (Age-standardised survival percentage)	66 ^a	13 (out of 22)
	Colorectal cancer five year relative survival (Age-standardised survival percentage)	63.5 ^b	6 (out of 22)
Patient Safety	Obstetric trauma vaginal delivery with instrument (crude rate per 100 vaginal deliveries)	17	19 (out of 19)
	Obstetric trauma vaginal delivery without instrument (crude rate per 100 vaginal deliveries)	3.2	19 (out of 19)

Note: w = statistically worse than average, b = statistically better than average, a = not statistically different than average. Calculations by authors based on the upper and lower confidence intervals of each country in relation to the average upper and lower confidence intervals of all countries in each group.

Source: OECD, 2015

Primary care

Canada is tied for last place (16th out of 19) for performance on the indicator measuring the rate of diabetes-related lower-extremity amputation, which is statistically worse than the average range for the OECD countries included for comparison.

Acute care

Canada ranks fifth (out of 21) for the rate of hip-fracture surgery initiated within 48 hours after admission to the hospital. Canada ranks seventh (out of 28) for performance on the indicator measuring 30-day mortality after admission to hospital for acute myocardial infarction (AMI) (statistically better than average), 17th (out of 28) for performance on the indicator measuring 30-day mortality after admission to hospital for a hemorrhagic stroke (not statistically different than the average), and 24th (out of 28) for performance on the indicator measuring 30-day mortality after admission to hospital for an ischemic stroke (statistically worse than average).

Mental health care

The OECD reports a rate of 0.06% for in-patient suicides among patients diagnosed with a mental disorder in Canada. This performance ranks Canada ninth (out of 14). However, the rate is not statistically significantly different than the average for the 11 countries for which data are available.

Cancer care

Canada ranks third (out of 22) on the indicator measuring the rate of 5-year survival of breast cancer (statistically better than average), 13th (out of 22) for the rate of 5-year survival of cervical cancer (not statistically different than the average), and sixth (out of 22) for the rate of 5-year survival of colorectal cancer (statistically better than average).

Patient safety

Canada ranks 19th (out of 19) for its performance on the indicator measuring obstetric trauma during a vaginal delivery with an instrument, and 19th (out of 19) for its performance on the indicator measuring obstetric trauma during a vaginal delivery without an instrument.

While Canada does well on four indicators of quality (like rates of survival of breast and colorectal cancer), its performance on the seven other indicators are either no different from the average or in some cases worse (particularly for obstetric trauma and diabetes-related amputations).

Summary

Canada is among the most expensive universal-access health-care systems in the OECD. However, its performance in terms of availability and access to resources is generally worse than the average OECD country, while its performance in terms of use of resources and quality and clinical performance is mixed. Clearly, there is an imbalance in terms of the performance of our health-care system given the relatively great amount of money our governments spend on provincial health-care systems. In the face of this large expenditure, the question is how we can improve the performance and outcomes of our health system.

4 What we can learn from welfare reform in the 1990s

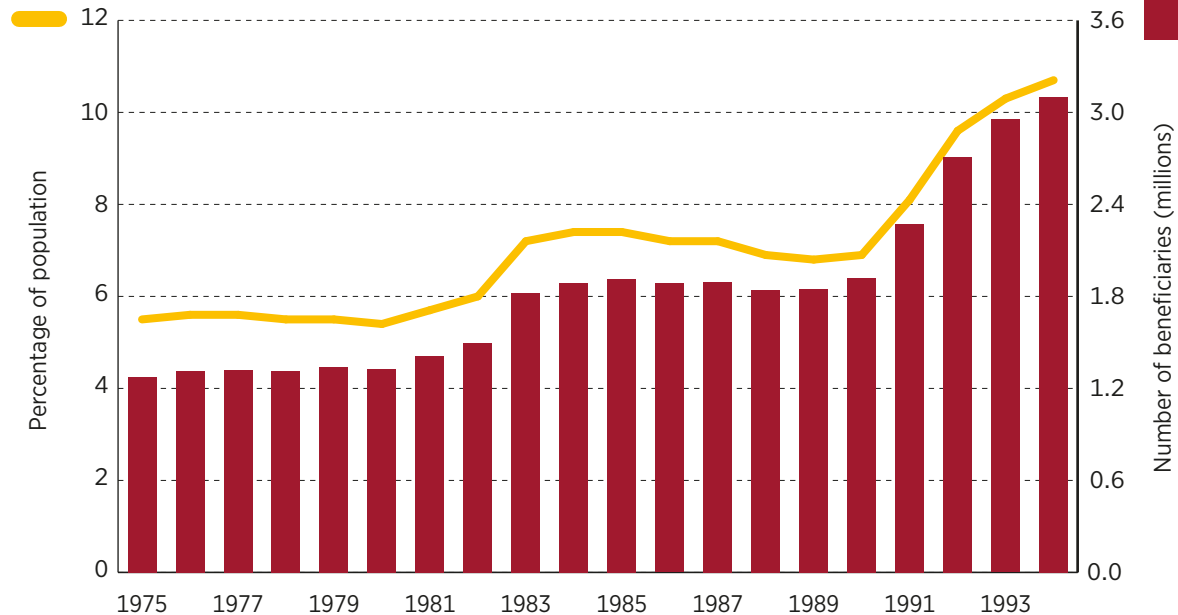
Clearly, Canada's health-care system is among the most expensive in the world and yet it continues to underperform relative to key peer jurisdictions. Furthermore, one of the reasons that Canadian provinces have not to date undertaken fundamental health-care reform in an effort to either cut costs or enhance performance is that they are restricted or discouraged from doing so by the provisions of the Canada Health Act (CHA). Indeed, the CHA effectively forbids the provinces from pursuing a number of policy reforms that have already been proven successful in other universal health-care systems around the world. The result of the CHA's restrictions has been a prolonged period of inertia in health-care policy, as the provinces are unable, in the face of the obvious need for significant reform, to innovate and try strategies to improve care and reduce costs.

Fortunately, this is not an intractable problem. In fact, Canada can look to its own history for a template of how to break this impasse and spark a wave of policy innovation to improve health-care performance while creating even stronger incentives for cost-containment. This template is to be found by studying the history of welfare reform under the Chretien Liberals.

During the 1990s, Canada was afflicted with a severe and growing dependency on welfare. In the wake of the recession of the early 1990s, by 1994, 10.7% of Canadians—a staggering 3.1 million people—were dependent on welfare (Clemens, 2011). Part of the challenge in changing this situation arose from the incentives created by federal fiscal transfers. There were two major fiscal transfers that funded provincial social programs at the time. The first was Established Program Financing (EPF), which was a block grant to provinces intended to fund post-secondary education and health care. The second, the Canada Assistance Plan (CAP), was a cost-shared program that paid up to half of the amount for provincial social programs. This created an incentive to spend more, since reducing expenditures would cost provincial governments matching funds. Allowing provinces effectively to get one dollar worth of social assistance spending for fifty cents of provincial tax revenue was a recipe for ever increasing welfare spending and, indeed, this was the result.

Figure 10 shows the rapid increase in the number of social assistance beneficiaries in Canada from nearly 1.3 million in 1975 to over 3 million in 1994, an increase of more than 100% over the course of two decades. During this period, the percentage of the population on social assistance nearly doubled from 5.5% to 10.7%. Crucially, fluctuations in social assistance rates due to the business cycle

Figure 10: Number of welfare beneficiaries, including dependents, and as percentage of population, 1975–1994



Sources: Based on Clemens, 2011, figure 18. Kneebone and White, 2014; Statistics Canada, 2016b.

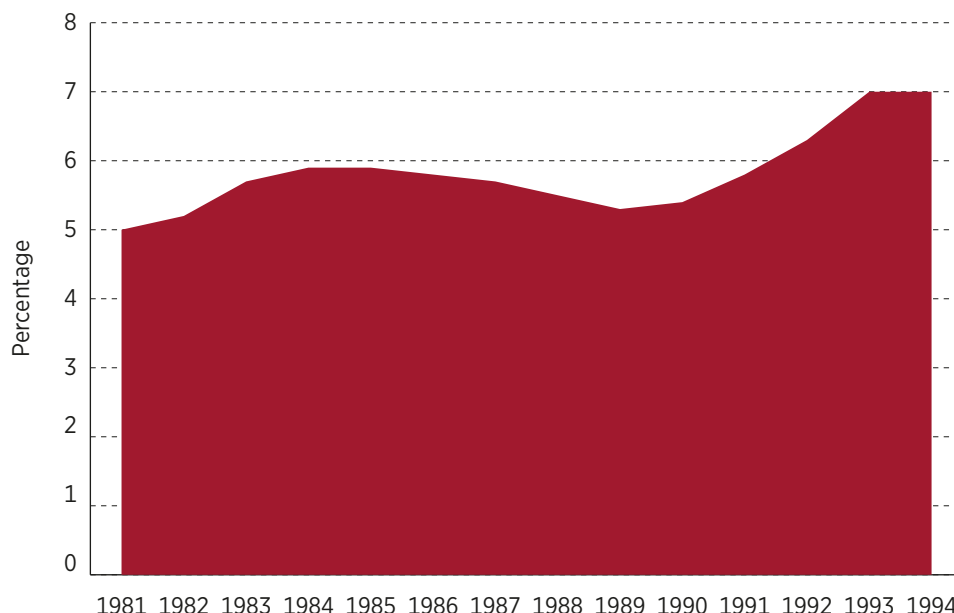
were not symmetrical. In other words, during economic downturns, the base of dependency—the number of Canadians living on social assistance—regularly increased but the increase was not temporary and failed to adjust downwards commensurately when the economy recovered. As a result, social assistance rates remained elevated beyond pre-recession levels in subsequent years.

The increase in social assistance rates took a significant toll on provincial finances. In 1981, social assistance absorbed 5% of provincial expenditures. That increased to 7% by 1994 (**figure 11**). The increased strain on provincial finances provided momentum for reform. As part of the federal government’s plan to reduce its deficit, the 1995 budget restructured and reduced federal transfers to provincial governments for funding social programs. This unleashed a wave of innovation that allowed provincial governments to significantly reduce welfare dependency.

The most significant reform was the replacement of the CAP and EPF with the Canada Health and Social Transfer (CHST). Under the CAP, the federal government stipulated that provincial governments must provide social assistance to all who demonstrated need, while also prohibiting any requirements for recipients to work in order to receive welfare payments (Clemens, 2011). [15] The CHST, on the other hand, was a block grant that did not contain cost-sharing

[15] These were perhaps the most important “strings” attached to federal transfers provided through the CAP but there were others. These included requirements surrounding formal appeals processes for beneficiaries, specific accounting procedures, and residency requirements (Clemens, 2011).

Figure 11: Welfare spending as a share of total provincial spending, 1981–1994



Sources: Based on Clemens, 2011: figure 19. Statistics Canada, 2016d.

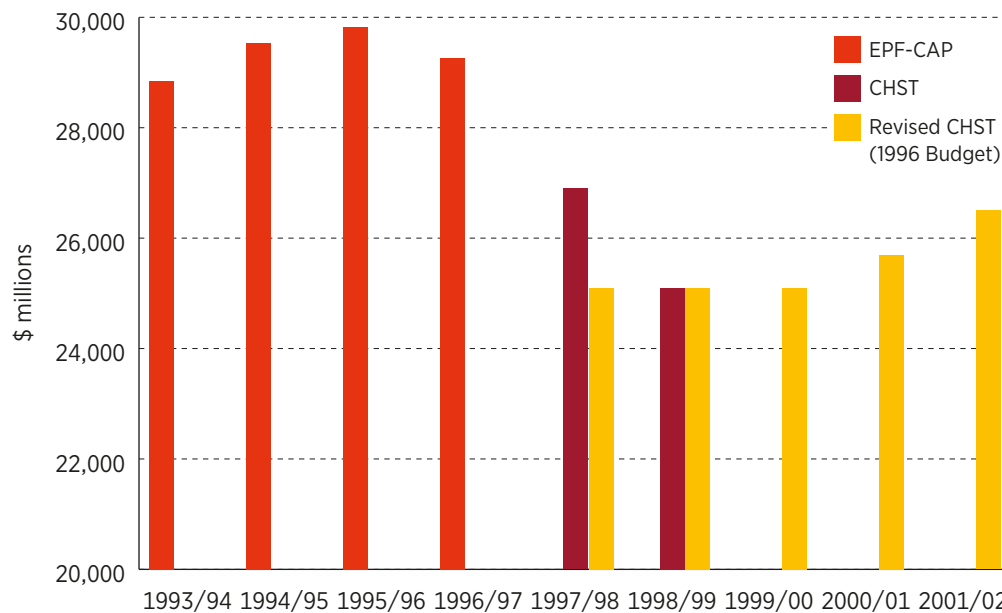
provisions (Clemens, 2011), thus eliminating the perverse financial incentive tempting the provinces, but also had fewer “strings” attached. This led to reduced transfers to the provinces but also more autonomy over use of the funds transferred, freeing them to experiment with policy reforms at the provincial level.

Figure 12 shows that excluding the health component, EPF/CAP funding declined after 1995/96, as the federal government reduced the cash portion of the CHST block grant by approximately one third. When the CHST officially replaced EPF in 1997/98, the total was \$4.1 billion lower than the combined EPF/CAP in the previous fiscal year. The most visible result was that provinces generally reduced welfare-benefit levels—in particular for employable people without dependents. This was aimed at providing a greater incentive for those able to work to seek employment. After all, if the difference in compensation between remaining on welfare and gaining employment is low, that implicit high marginal tax rate greatly reduces the incentive to work.

Examples of welfare reform

Despite the autonomy given to provinces, some reforms were common: tighter eligibility rules, benefit reductions, administrative reforms, and an increased emphasis on diverting people able to work from welfare to employment. Crucially, the removal of the “strings” attached to funding under cost-sharing allowed provinces to set work requirements for welfare, which were previously prohibited (Clemens, 2011). Eliminating national standards gave provinces the flexibility to experiment and arrive at best practices. The reforms allowed provinces to tailor their welfare policies to meet their own specific

Figure 12: EPF-CAP spending compared to CHST spending, 1993/94–2001/02



Sources: Based on Clemens, 2011: figure 20. Canada, Dep't of Finance, 1994: table 9; 1995a; 1995c; 1996.

challenges. Moreover, decentralizing revenue-generating responsibility for welfare programs also created better incentives for provinces to spend money more wisely. The results have been impressive.

While there were common elements to the welfare reforms during this period, there were also significant variations as provinces experimented with new approaches. Alberta, Ontario, and British Columbia provide some of the most interesting case studies.

Alberta

Alberta was a pioneer for welfare reform in Canada and actually began reforms before the 1995 budget introduced the CHST as part of its efforts to reduce the province's debt and deficit after the 1993 election. The provincial government moved aggressively to channel prospective welfare recipients into employment, and worked to reduce fraud and abuse of the system. The province curtailed benefit rates and eliminated some supplemental benefits; it also turned to non-governmental agencies to deliver some social services.

Ontario

In 1998, the Government of Ontario introduced its Ontario Works program, which both reduced welfare benefits and increased work requirements. The addition of work requirements was known to some as "workfare". Welfare recipients were given three options: employment support, mandatory public-sector employment placements, and private-sector employment placements based on

wage-subsidies. Failure to participate in the program resulted in denial of benefits for three months. The province also pursued administrative reforms and the use of non-governmental agencies to assist in delivering some services (Clemens, 2011).

British Columbia

British Columbia was one of the last provinces to undertake large-scale welfare reform, which began in 2001. Despite starting late, the province was the first to limit access to welfare, ending welfare as an entitlement and reverting to welfare structured as an insurance program (Clemens, 2011). [16] The province limited welfare use to 24 months in a 60-month period for employable individuals. The limitation was not applied to several groups such as single parents and those with disabilities. There was also a greater focus on diverting people from welfare into the workforce. The province provided job assistance and training programs, and those deemed able to work were required to do so or face penalties. One particular example of the province's diversion approach was *Job Wave BC*, a joint effort between the government and the Chamber of Commerce to “provide work placement, training, and assistance to those seeking employment” (Clemens, 2011: 42).

Results of welfare reform

Moving away from cost-sharing and reducing the value of transfers to provinces fundamentally changed the incentives of provinces in delivering social services. Moving away from cost-sharing cut the strings that allowed the federal government to impose national standards, allowing for greater experimentation. The CHST gave the provinces freedom to innovate and establish best practices for welfare policies. The results have been impressive.

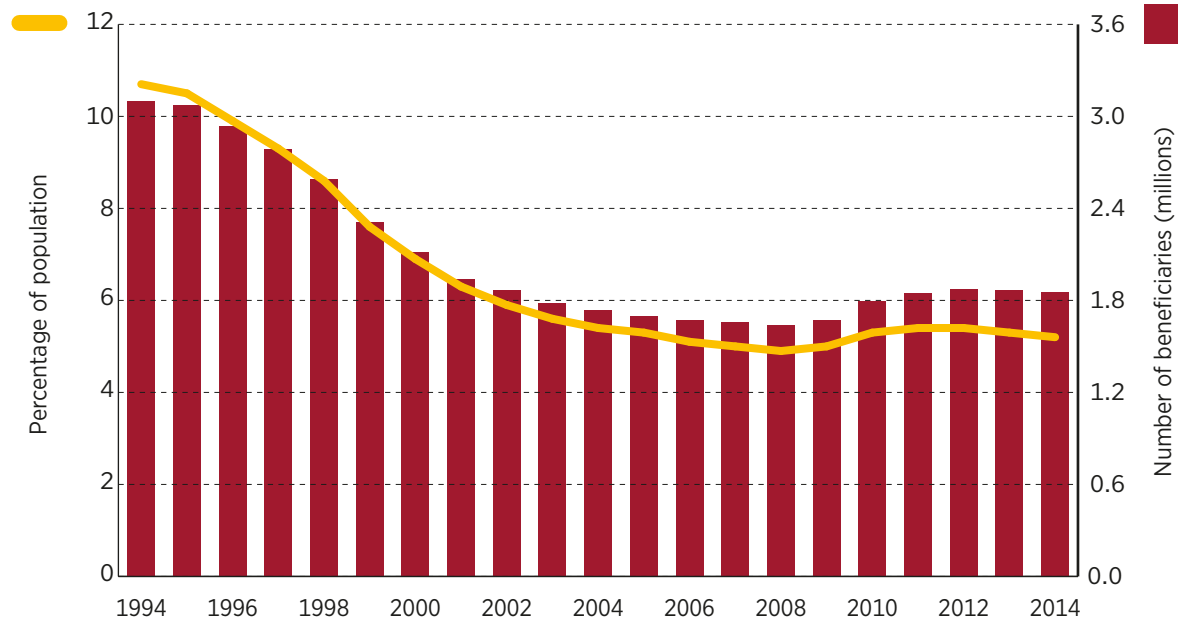
Figure 13 shows that the number of Canadians receiving welfare declined from a peak of 3.1 million in 1994 to a low of 1.6 million in 2008 before increasing slightly to 1.9 million in 2012. The percentage of the population receiving welfare benefits declined from a high of 10.7% in 1994 to a low of 4.9% in 2008, and for the last available year of data (2014) was 5.2%—less than half the rate in 1994.

The decrease in the number of welfare beneficiaries provided substantial relief to provincial treasuries, even as the federal transfers they received had been decreased. Social assistance spending consumed 7% of all provincial spending in 1994, but that fell steadily beginning in 1996 until it reached a low of 3.9% in 2008, increasing slightly to 4.1% in 2009, the last year for which this data has been compiled (**figure 14**).

While the reduction in welfare recipients is an important metric, it would be problematic if not accompanied by an increase in employment. However, welfare reform coincided with both an increase in employment and decrease in reliance on public benefits. The evidence suggests that the reforms of the 1990s achieved many of their objectives (Clemens, 2011).

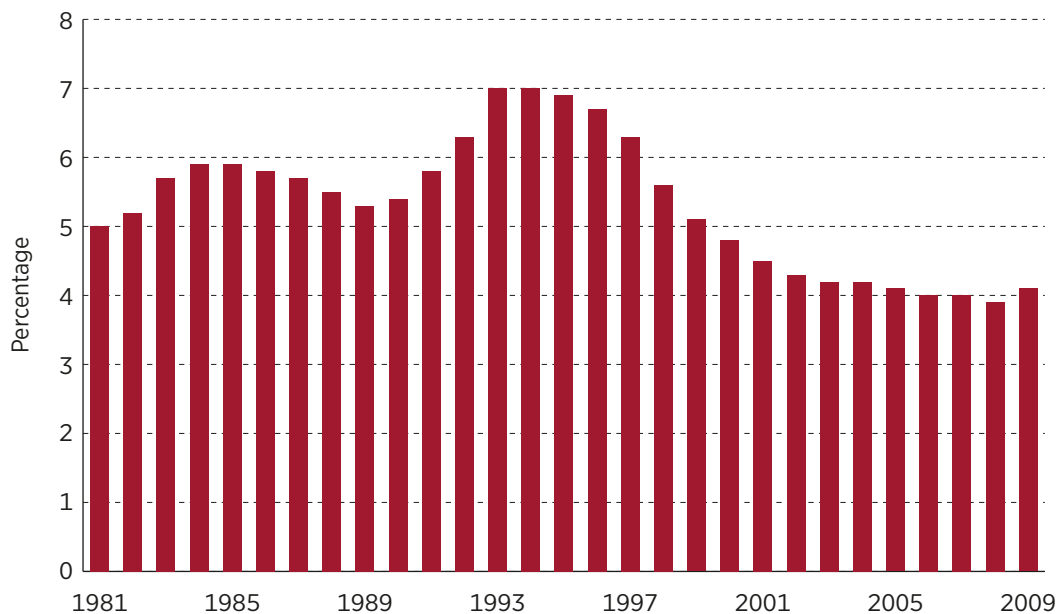
[16] This reform was later undone.

Figure 13: Number of welfare beneficiaries, including dependents, and as percentage of population, 1994–2014



Sources: Based on Clemens, 2011: figure 21. Beneficiaries 1994–2008: Kneebone and White, 2014. Beneficiaries 2009–2012: Kneebone and White, 2014; Caledon Institute of Social Policy, 2015 (data for Prince Edward Island). Beneficiaries 2013 and 2014: Caledon Institute of Social Policy, 2015; 2014 includes 2013 values for Saskatchewan and Alberta. Population: Statistics Canada, 2016b.

Figure 14: Welfare spending as a share (%) of total provincial spending, 1981–2009



Sources: Based on Clemens, 2011, figure 22. Statistics Canada, 2016a; 2016d.

5 Recommendations

Canada's federal and provincial governments face significant fiscal pressures that will increase as health-care costs consume a greater proportion of program spending. With an estimated \$113.2 billion in accumulated deficits over a five-year period expected from the federal government alone and most provinces running annual deficits, governments urgently need to reform spending rather than continuing to accumulate greater debt. Given that health care consumed 40.3% of provincial program spending in 2015/16, a share that is likely to increase to an estimated 46.7% by 2030/31, health care is the natural starting point. Moreover, poor performance relative to other universal health-care systems suggests there are ways to improve our lagging health-care system while reducing expenditures.

There is much to be learned from welfare-reform policies enacted during the 1990s. When the Canadian government decentralized decision-making about welfare and the responsibility for decisions about funding policy by reducing transfer payments and removing most conditions for receiving transfers, the provinces were given incentives to create better outcomes with less expenditure. Greater flexibility led to experimentation and innovation, which created some common best practices as well as some policy variations to meet the needs and desires of different provinces. The results were positive, reducing welfare rates, integrating more people who were able to work back into the workforce, and reducing government expenditures.

Some elements of the transfer reform that took place surrounding welfare have already been implemented with respect to health-care transfers. For example, the Canada Health Transfer (CHT) is already a block grant and not subject to cost-sharing provisions. However, there are other crucial dimensions of the welfare-transfer reforms of the 1990s that have not yet been applied to health care. Specifically, the federal government has not created the conditions that would allow innovation in health-care policy at the provincial level by removing the “strings” attached to health-care transfers. Indeed, this distinction between the two policy areas was made explicit in the federal 1995 Budget, which rolled the EPF and CAP into the CHST block grant:

Provinces will no longer be subject to rules stipulating that certain expenditures are eligible for cost-sharing and others are not. Provinces will thereby be free to pursue innovative approaches to social security reform without having to consider whether such approaches meet requirements for cost sharing ... Although provinces will be able to spend the transferred resources on priorities of their own choosing, the

transfer will not be totally unconditional. No change will be made to the Canada Health Act. The government will continue to enforce it by withholding funds, if necessary. (Canada, Department of Finance, 1995a: 53)

While the 1995 Budget removed harmful cost-sharing provisions and reduced the size of transfers, creating strong financial incentives for policy reform, it failed, by not removing the “strings” attached to funding, to permit the provinces to actually pursue a reform of health care. This critical difference helps explain why Canada experienced a wave of policy innovation surrounding welfare during the 1990s but no comparable wave of innovation surrounding health care.

For this reason, the process of transfer reform that was undertaken in the 1990s remains unfinished with respect to health-care policy. Following the blueprint of welfare reform from the 1990s, if the CHT were reduced from its current level or at least frozen in nominal terms, each province would shoulder a greater share of public health-care expenditures and would be responsible for raising the funds necessary to finance any further growth in health costs.

If, in exchange for taking on this greater responsibility for raising the funds for health-care services, the provinces were granted more latitude under the Canada Health Act to administer their health-care systems as they see fit—so long as the key commitments of universality and portability are maintained—they could engage in greater experimentation with institutional arrangements to find the best possibility of improving health-care performance. [17] In other words, the provinces would be granted more autonomy and flexibility in the regulation, financing, and delivery of health care in their respective jurisdictions. In concert, these changes would represent a devolvement of both decision-making authority and greater responsibility for financing health-care services from the federal government to the provinces.

With such an arrangement in place, provinces would be well served to examine the introduction of cost-sharing arrangements (co-insurance, deductibles, and co-payments) used in most other universal health-care countries to ensure more efficient use of the health-care system by patients (Globerman, 2016). Provinces might also look at removing regulations that currently prevent a greater supply of needed health-care professionals and investment within the health-care sector. While it is uncertain exactly what reforms different provinces would choose, the crucial change would be the devolvement of decision making powers to the provinces, with the federal government permitting each province maximum flexibility (within a portable and universal system) to provide and regulate health-care provision as they see fit.

[17] For a detailed analysis of how various reforms to the CHA could achieve this objective, see Clemens and Esmail, 2012.

Conclusion

Deteriorating finances and the disappointing performance of the health-care system are two of the most important challenges facing Canadian governments. The two are related, given the large share of public resources consumed by provincial health-care systems. It would be incredibly difficult to solve the financial challenges faced by Canadian governments without increasing the efficiency of our health-care systems.

Fortunately, welfare reform in the 1990s provides a template for addressing this problem. Welfare, like health care, is a provincial responsibility but has historically received conditional funding from the federal government. Moving towards smaller, less prescriptive grants from the federal government gave the provinces better incentives to contain costs and provide better outcomes such as less reliance on welfare and more able-bodied people moving out of welfare and into the workforce.

A similar strategy could be employed today to help address the dual challenges of an underperforming health-care system and constrained public finances at the federal and provincial levels. Canada's experience with welfare reform suggests reducing health-care transfers in real terms while, in exchange, reforming the Canada Health Act to allow provinces greater policy flexibility is a promising strategy for achieving these objectives.

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