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Canadian Federal Health Transfers to the Provinces

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Main Conclusions

- In total, the federal government has provided the provinces with \$350.5 billion in cash transfers for health care since 1980-81. More than half that amount (\$231.7 billion) has been provided since 1997-98.
- Since 1997-98, Ottawa has increased its cash transfers for health to the provinces by \$97.6 billion more than needed to compensate for population growth and inflation. Since 2004-05 alone, Ottawa has provided the provinces with \$6.4 billion more in transfers than needed to compensate for population growth and inflation.
- Access to health care has improved in only four of the twelve categories examined since 1997: availability of CT and MRI scanners, wait time for MRI scans, and availability of doctors. All of the remaining indicators, including wait times for care, have declined.
- The increased federal cash transfers for health care since 1997-98 have not led to improved access to health care in Canada. This poor record is not likely to improve under Ottawa's new plan for health care transfers, which makes little change to the current arrangement other than to the promised rate of growth.
- To provide the provinces more flexibility to experiment and innovate with different models of health care finance and delivery, the Canada Health Act should be revised so that it continues to require universality and portability, but removes other requirements that inhibit reform.

Introduction

Canada's federal government sends cash transfers to the provinces to help pay for health care. Under the current arrangement regarding cash transfers, the federal government has committed to increasing its cash transfers for health care by 6 percent annually in addition to the provision of targeted transfers, such as those for health reform and waiting list reduction. Recently, the federal government announced that it would continue the 6 percent annual increase to 2016-17, despite expecting to run planned budget deficits (spending exceeding revenues) until 2014-15. After that, it will change to a rate of increase

matching either the nominal rate of economic growth or 3 percent, whichever is greater. This continued commitment to growing federal cash transfers to the provinces raises the important question of whether or not marked increases in such transfers have previously been effective at improving Canada's health care system. To answer this question, this Alert examines the evidence. The first section outlines federal transfers to the provinces for health. The second examines a series of health care performance indicators in 1997 and 2004, and compares them with current performance to determine if any changes have occurred. The final section provides recommendations.

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 intended to help the provinces pay for health care, post-secondary education, and social assistance. Replacing EPF and CAP with CHST ensured that the provinces continued to receive financial resources from Ottawa, but gave the provinces greater flexibility over their spending priorities.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 care while the latter helps fund both post-secondary education and social assistance.

About the authors



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Federal cash transfers for health

Over the last 30 years, there have been three major federal cash transfer programs to help the provinces pay for their health care expenses¹: Established Program Funding (EPF), the Canada Health and Social Transfer (CHST), and the Canada Health Transfer (CHT). Table 1 lists the three programs and the value of the transfers associated with each beginning in 1980-81.

Prior to 1996-97, Ottawa's funding to the provinces for health care 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 by 1995-96, the last year EPF grants were issued. In 1996-97, the federal government eliminated EPF and the Canada

One-time transfers

In addition to these three major transfer programs, the federal government also made a number of one-time transfers⁴ 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 (table 1, column 3), which amounted to a total of \$10.5 billion. The federal government has also made or committed to a number of one-time, health-care-specific transfers to the provinces from 2000-01 to 2010-11 (table 1, column 4). These one-time transfers were dedicated to purchases of medical technology, health reforms, and the strategy to reduce wait times, in addition to funds to equalize the per capita support to Ontario; they total \$10.8 billion.

Clarifying the CHST health component

Because the CHST was a block grant, it was 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 and the one-time supplements. A number of methods have been used in the past to try to determine the resources provided to the

provinces for health care by the federal government.⁵ The federal government's division of the CHST into two components, the CHT and CST, provides one independent method by which to estimate how much money went to each component: in 2004-05, 63.3 percent went to health care and 36.7 percent to post-secondary education and social assistance (Receiver General for Canada, 2005). The final column in table 2 provides an estimate of the health care-specific component of both the CHST and the

supplements paid between 1996-97 and 2003-04.

A second clarification is required for CHT transfers for 2010-11 onwards. In its *10-Year Plan to Strengthen Health Care* (Health Canada, 2004), the federal government committed to increasing the CHT through a base adjustment and an annual 6 percent increase. Also beginning in 2009-10, the federal government provided additional funding to the provinces through a Wait Times Reduction

Table 1: Federal Cash Transfers to the Provinces

	EPF cash entitlement (in \$ billions)	CHST— cash (in \$ billions)	Supplemental additions to the CHST—cash (in \$ billions)	Supplemental health-specific transfers (in \$ billions)	Canada Health Transfer—cash (in \$ billions)
1980-81	4.0				
1981-82	4.5				
1982-83	5.0				
1983-84	5.9				
1984-85	6.3				
1985-86	6.7				
1986-87	7.0				
1987-88	7.1				
1988-89	7.3				
1989-90	7.5				
1990-91	7.6				
1991-92	7.9				
1992-93	8.2				
1993-94	8.2				
1994-95	8.1				
1995-96	8.0				
1996-97		14.9			
1997-98		12.4			
1998-99		12.5	3.5		
1999-00		12.4	2.5		
2000-01		13.5		1.0	
2001-02		17.3			

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Table 1: Federal Cash Transfers to the Provinces

	EPF cash entitlement (in \$ billions)	CHST— cash (in \$ billions)	Supplemental additions to the CHST—cash (in \$ billions)	Supplemental health-specific transfers (in \$ billions)	Canada Health Transfer—cash (in \$ billions)
2002-03		18.6	2.5	1.5	
2003-04		19.3	2.0	1.0	
2004-05				5.8	13.7
2005-06					19.0
2006-07					20.1
2007-08				0.6	21.5
2008-09					22.8
2009-10				0.5	24.3
2010-11				0.4	25.8

Sources:

Receiver General for Canada, Public Accounts of Canada, 1997-2010; and Department of Finance Canada, 2002.

Note: The CHST and CHT data is 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 was the most consistent and 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 for payments to a trust for Medical and Diagnostic Equipment.

* \$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.

* \$0.61B accounted for in 2007-08 for patient wait times guarantee.

* \$0.49B accounted for in 2009-10 for payment to Ontario related to the Canada Health Transfer.

* \$0.16B accounted for in 2010-11 for payment to Ontario related to the Canada Health Transfer (\$0.16B) and \$0.25B accounted for Wait Times Reduction transfer.

Transfer of \$250 million annually (until 2013-14). Further, Ontario received additional payments related to the Canada Health Transfer for 2009-10 (\$489 million) and 2010-11 (\$160 million) to ensure that it receives the same CHT cash support as other equalization-receiving provinces (Canada, Department of Finance, 2011a). Using these pieces of information, we project CHT transfers and

one-time supplements from 2010-11 to 2013-14.

Table 3 summarizes the cash transfers for health care that flowed from Ottawa to the provinces between 1980-81 and 2010-11. Table 3 includes the one-time supplements to the CHST as well as the one-time, health-specific transfers discussed previously.

Determining incremental transfers

To determine the impact of increased federal cash transfers on the performance of health care in Canada, a base year for analysis had to be selected. This Alert considers two base years for analysis: 1997-98 and 2004-05. The 1997-98 year was selected for several reasons. First, in 1998-99, federal cash transfers to

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

	CHST—cash (in \$ billions)	CHST supplements— cash (in \$ billions)	Adjusted CHST transfers to reflect health component (in \$ billions)
1996-97	14.9	—	9.4
1997-98	12.4	—	7.9
1998-99	12.5	3.5	10.1
1999-00	12.4	2.5	9.4
2000-01	13.5	—	8.5
2001-02	17.3	—	11.0
2002-03	18.6	2.5	13.4
2003-04	19.3	2.0	13.5
Sources: Receiver General for Canada, Public Accounts of Canada, 1997-2010; and calculations by the authors.			

the provinces for health care began to grow at a much higher rate than 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.⁶ Third, it is the year in which real, per-capita public health spending began to increase after several years of decline (figure 1).

The year 2004-05 was selected because it is the year in which the *10-Year Plan to Strengthen Health Care* was agreed to by then Prime Minister Paul Martin and all 14 first ministers. The agreement included considerable increases in cash transfers to the provinces for health care. Two of the agreement’s principal aims were to improve access to health

care services for Canadians and to introduce more stable and predictable health care cash transfer payments from Ottawa. Among other commitments, the plan signed in September 2004 includes:

- a \$3 billion total supplement to the CHT for 2004-05 and 2005-06
- an additional \$500 million for the CHT in 2005-06
- an annual increase of six per cent applied to the CHT from 2006-07 onwards to provide predictable growth in federal cash transfers to the provinces (Health Canada, 2004).

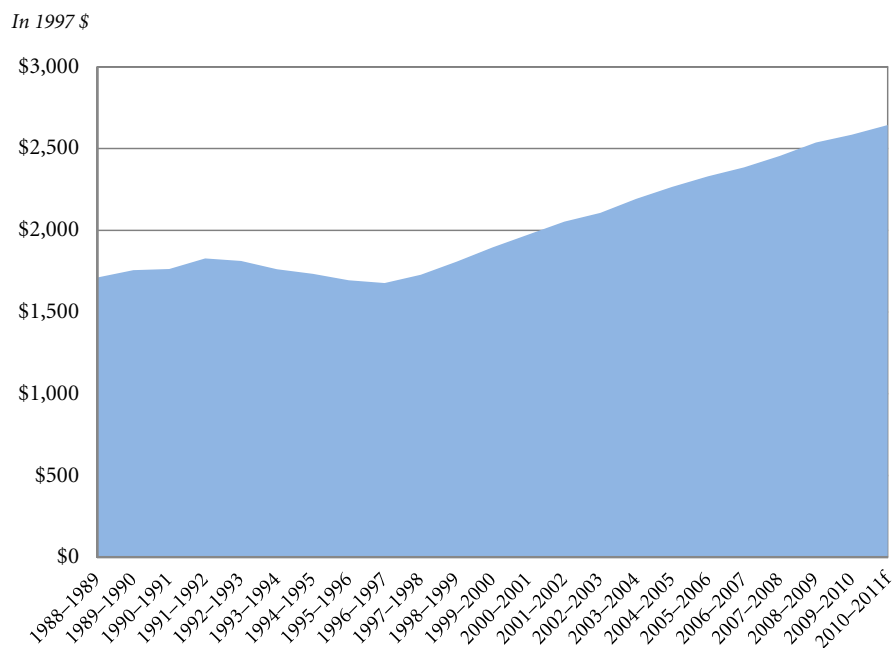
The calculation used to determine the amount of incremental federal

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

1980-81	4.0
1981-82	4.5
1982-83	5.0
1983-84	5.9
1984-85	6.3
1985-86	6.7
1986-87	7.0
1987-88	7.1
1988-89	7.3
1989-90	7.5
1990-91	7.6
1991-92	7.9
1992-93	8.2
1993-94	8.2
1994-95	8.1
1995-96	8.0
1996-97	9.4
1997-98	7.9
1998-99	10.1
1999-00	9.4
2000-01	9.5
2001-02	11.0
2002-03	14.9
2003-04	14.5
2004-05	19.4
2005-06	19.0
2006-07	20.1
2007-08	22.1
2008-09	22.8
2009-10	24.8
2010-11	26.2

Sources:
Receiver General for Canada, Public Accounts of Canada, 1997-2010;
Canada, Department of Finance, 2002.

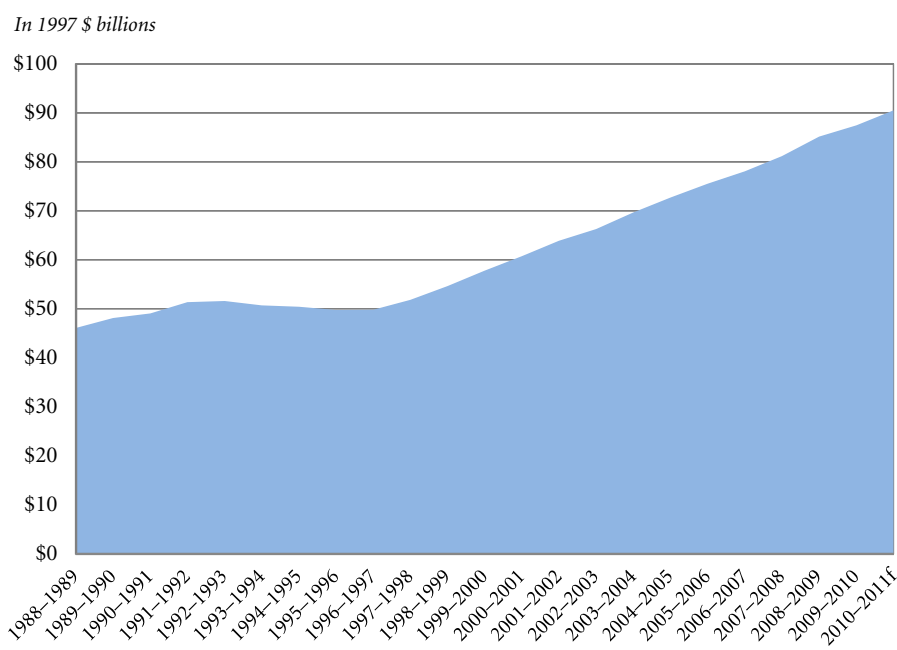
Figure 1: Per Capita Provincial/Territorial Government Health Expenditure (inflation adjusted)



f = forecast

Source: CIHI, 2011a.

Figure 2: Total Provincial/Territorial Government Health Expenditure (inflation adjusted)



f = forecast

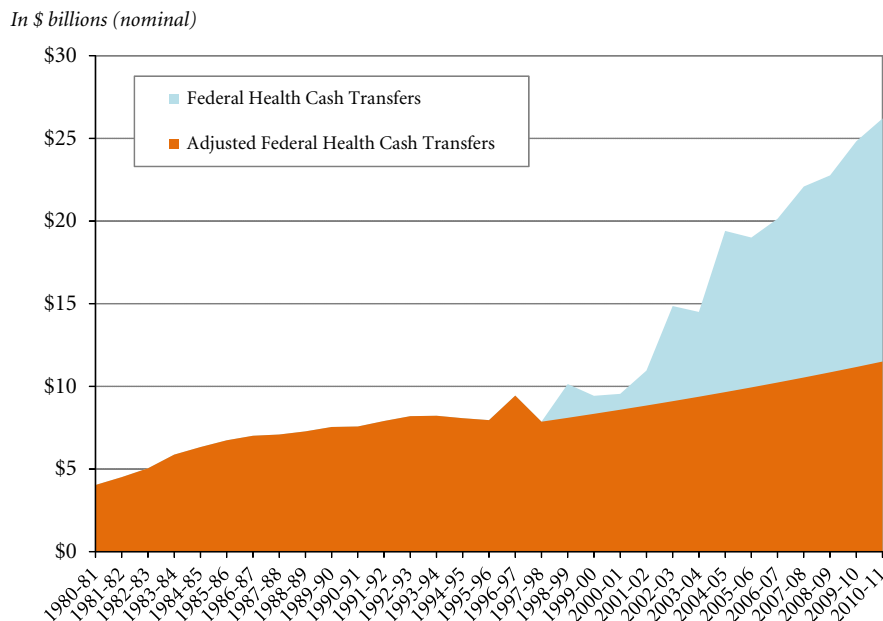
Source: CIHI, 2011a.

cash transfers for health to the provinces after 1997-98 and 2004-05 was based on the assumption that federal cash transfers to the provinces for health would remain stable, accounting only for population growth and inflation.⁷ 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 the base year and in each subsequent year.

The result is two series of federal cash transfers for health for each base year (figures 3 and 4). The first series (in figure 3), labelled “Federal Health Cash Transfers,” comes from table 3 and includes all health-specific cash transfers the federal government made to the provinces over the period. The second series, “Adjusted Federal Health Cash Transfers,” is based on the calculation described above that maintains per-capita, inflation-adjusted transfers at 1997-98 levels. The two series are identical between 1980-81 and 1997-98. They diverge after 1997-98 as discussed previously.

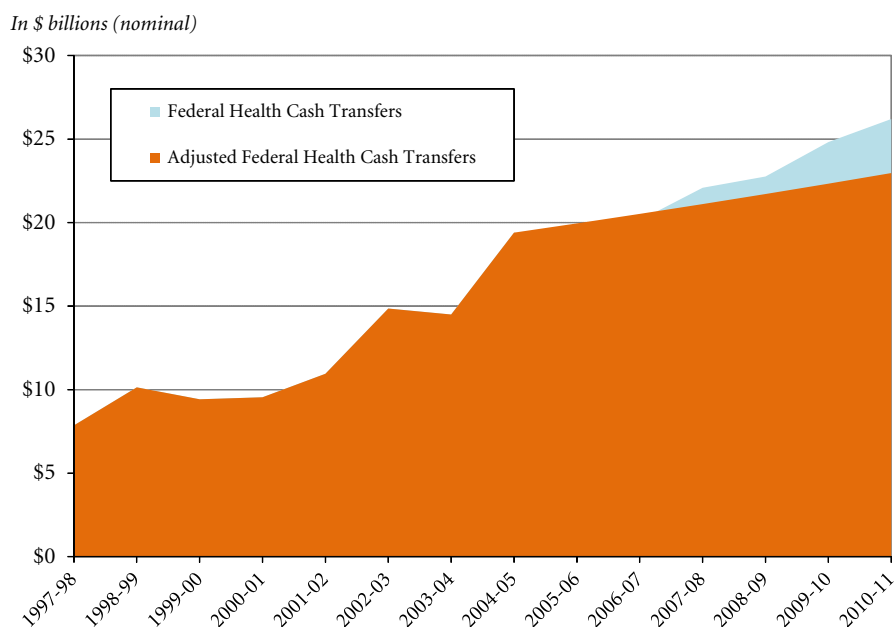
The two series in figure 4 are the same as those in figure 3, except that the second series, “Adjusted Federal Health Cash Transfers,” maintains per-capita, inflation-adjusted transfers at 2004-05 levels. As in figure 3, the two series are identical between 1980-81 and 2004-05. They diverge after 2004-05, the year in which the *10-Year Plan to Strengthen Health Care* was announced.

Figure 3: Federal Health Cash Transfers, 1980-81 to 2010-11



Sources: Table 3; Statistics Canada (various issues and 2011); calculations by authors.

Figure 4: Federal Health Cash Transfers, 1997-98 to 2010-11



Sources: Table 3; Statistics Canada (various issues and 2011); calculations by authors.

Incremental transfers between 1997-98 and 2010-11

The average annual growth rate used for the adjusted series from 1997-98 to 2010-11 is 3.0 percent.⁸ This rate is markedly higher than the actual average annual growth rate in federal cash transfers for health care in the previous 10 years between 1988-89 and 1997-98 (1.4 percent). It is also substantially below the actual average growth rate in federal cash transfers for health between 1997-98 and 2010-11 (10.5 percent). The large difference between the actual growth rate in federal cash transfers for health care (10.5 percent) and the rate based on population growth and inflation (3.0 percent) results in large differences in actual cash transfers from 1997-98 to 2010-11. For example, in the last year of the series examined (2010-11), actual federal cash transfers for health total \$26.2 billion while the adjusted series indicates transfers amounting to only \$11.5 billion.

The total accumulated difference between actual federal cash transfers for health and the amount calculated using population growth plus inflation (using 1997-98 as the base year) is \$97.6 billion. In other words, the federal government provided the provinces with an additional \$97.6 billion between 1997-98 and 2010-11 for health care spending beyond that predicted by population growth and inflation.

A projection forward to 2013-14, the final fiscal year for the 10-Year

Plan to Strengthen Health Care, shows an estimated gap between actual federal cash transfers and that predicted by population growth and inflation of a total of \$148.8 billion. In 2013-14, it is estimated that federal cash transfers will be \$31.0 billion while the adjusted series indicates that transfers would be only \$12.6 billion.

Incremental transfers between 2004-05 and 2010-11

Selecting 2004-05 as the base year of analysis, the average annual growth rate used for the adjusted series (from 2004-05 to 2010-11) is 2.9 percent.⁹ This rate is substantially below the actual average growth rate in federal cash transfers for health between the end of federal deficit spending and the 2004 agreement (1997-98 to 2004-05: 11.0 percent) and well below the actual average growth rate in federal cash transfers between 2004-05 and 2010-11 (5.2 percent). Interestingly, the growth rate in federal cash transfers for health care was lower after the 2004 agreement than in years preceding the agreement.

The large difference between the actual growth rate in federal cash transfers for health (5.2 percent) and the rate based on population growth and inflation (2.9 percent) results in large differences in actual cash transfers from 2004-05 to 2010-11. For example, in the last year of the series examined (2010-11), actual federal cash transfers for health totalled \$26.2 billion while the adjusted series indicates transfers would have amounted to \$23.0 billion.

The total accumulated difference between actual federal cash transfers for health and the amount calculated using population growth plus inflation (2004-05 base year) is \$6.4 billion. In other words, the federal government provided the provinces with an additional \$6.4 billion between 2004-05 and 2010-11 for health spending beyond that predicted by population growth and inflation under the *10-Year Plan to Strengthen Health Care*.

Looking forward to 2013-14, the gap between actual federal cash transfers for health care and that predicted by population growth and inflation is a total of \$21.3 billion from the 2004-05 base year. This is the amount by which the *10-Year Plan to Strengthen Health Care* increased federal cash transfers for health care to the provinces beyond that required to keep pace with inflation and population growth. In the last fiscal year of the 2004-05 agreement (2013-14), actual federal cash transfers to the provinces are expected to total \$31.0 billion while the adjusted series indicates transfers would be only \$25.0 billion.

Health performance: Are we better off?

The next logical question to ask, particularly when the federal government has stated that it will maintain the 6 percent health transfer escalator built into the 2004 agreement past its 2014 expiry, is how successful the increased federal cash transfers and the subsequent spending, almost all of it at the provincial level, have been at improving access to health care in Canada. Importantly, the 2004 agreement

contained a number of goals for health care system performance including reduced wait times for and improved access to medical care, and an increased supply of health professionals. To answer this critical question, we compare a series of health performance indicators from 1997 and 2004 (base years) to the most current year available.

Wait times for health care in Canada

Wait times for health care in Canada¹⁰ have increased considerably since 1997 (table 4). In 1997, the average Canadian could expect to wait 11.9 weeks from the time a general practitioner referred them for specialist care to the time a specialist delivered the treatment required. In 2011, the average Canadian could expect to wait 19.0 weeks, more than 50 percent longer than in 1997. The increase in the total wait time for treatment was the result of an 86.3 percent increase in the wait time to see a specialist after referral by a general practitioner and a 39.7 percent increase in the wait time to receive treatment after an appointment with a specialist (table 4).

In the narrower time frame between 2004 and 2011, wait times for health care also increased overall, from 17.9 weeks to 19.0 weeks (a 6.1 percent increase). Interestingly, that overall growth was driven by a 13.1 percent increase in the wait time to see a specialist, while the wait time for treatment by a specialist after an appointment was unchanged. It is worth noting that efforts to reduce wait times for health care in Canada over this time were largely focused

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

	1997	2004	Present*	Percent change 1997	Trend	Percent change 2004	Trend
Median Total Expected Waiting Time from Referral by GP to Treatment, in weeks, Canada	11.9	17.9	19.0	59.7%	▼	6.1%	▼
Median Patient Wait to See a Specialist after Referral from a GP, in weeks, Canada	5.1	8.4	9.5	86.3%	▼	13.1%	▼
Median Patient Wait for Treatment after Appointment with Specialist, in weeks, Canada	6.8	9.5	9.5	39.7%	▼	0.0%	No change
Median Wait Time for CT Scan, in weeks, Canada	4.1	5.2	4.2	2.4%	▼	-19.2%	▲
Median Wait Time for MRI Scan, in weeks, Canada	9.6	12.6	9.2	-4.2%	▲	-27.0%	▲
Median Wait Time for Ultrasound Scan, in weeks, Canada	2.6	3.1	4.6	76.9%	▼	48.4%	▼
Physicians (family medicine and specialists) per 1,000 population**	1.84	1.89	2.03	10.6%	▲	7.6%	▲
Practicing nurses per 1,000 population	10.4	8.49	9.39	-9.7%	▼	10.6%	▲
CT scanners per million population	8.19	10.66	14.39	75.7%	▲	35.0%	▲
MRI scanners per million population	1.84	4.91	8.35	353.8%	▲	70.1%	▲
Lithotripters per million population	0.47	0.53	0.42	-10.6%	▼	-20.8%	▼
PET scanners per million population	N/A	0.53	1.19	N/A	N/A	124.5%	▲

Sources: Barua, Rovere, and Skinner, 2011; Esmail and Walker, 2004; Ramsay and Walker, 1998; Organisation for Economic Cooperation and Development, 2011; Canadian Institute for Health Information, 2011b; and calculations by authors.

Notes:

*Present nurse data is for 2009.

*Present physician, MRI, CT, PET, and lithotropter data is for 2010.

*Present wait time data is for 2011.

**Percentages are calculated from exact values available from the CIHI. These have been rounded for inclusion in the table.

on the wait time from specialist consultation to treatment, while the wait time from GP referral to specialist consultation received much less government attention.

Wait times for diagnostic medical technology

Canadians in 2011 could also expect to wait longer for scans using various types of medical technology than they did in 1997. For example, the wait for a CT scan increased slightly from 4.1 weeks to 4.2 weeks between 1997 and 2011 (table 4). The wait for an ultrasound scan increased considerably between 1997 and 2011, rising from 2.6 weeks to 4.6 weeks, an increase of 76.9 percent. Conversely, the wait time for an MRI scan fell from 9.6 weeks in 1997 to 9.2 weeks in 2011.

On the other hand, in the shorter period between 2004 and 2011, wait times fell for both CT scans (5.2 weeks to 4.2 weeks, a decrease of 19.2 percent) and MRI scans (12.6 weeks to 9.2 weeks, a decrease of 27.0 percent). At the same time, the wait for ultrasound scans increased from 3.1 weeks to 4.6 weeks, an increase of 48.4 percent.

The changes in wait times for MRI and CT scans occurred at a time when new investments being made in these technologies increased their availability. For example, the ratio of MRI machines to people in Canada increased by 353.8 percent from 1997 to 2010, and 70.1 percent from 2004 to 2010, while the ratio of CT scanners to people increased by 75.7 percent from 1997 to 2010 and 35.0 percent from 2004 to 2010. Looking at other medical technologies, the

availability of PET scanners also increased between 2004 and 2010 while the availability of lithotripters fell by 11 percent between 1997 and 2010 and by 21 percent between 2004 and 2010 (table 4).

Access to physicians and nurses

Despite the significant increase in health spending, the number of nurses per 1,000 people fell by 9.7 percent between 1997 and 2009.¹¹ In 1997 there were 10.4 practicing nurses per 1,000 people while in 2009 there were 9.39 (table 4). Conversely, the nurse-to-population ratio increased by 10.6 percent between 2004 and 2009 from 8.49 nurses per 1,000 people.¹² Meanwhile, the ratio of physicians per capita was higher in 2010 than in either 1997 or 2004. Between 1997 and 2010, the ratio of physicians to Canadians increased by 10.6 percent. Between 2004 and 2010, it increased by 7.6 percent.¹³

Access to health care

The comparison between Canadian health care performance in 1997 and the present leads to troubling conclusions. Within those years, Canada improved in only four categories: the availability of MRI units and CT scanners, wait times for MRI scans, and the availability of physicians. In contrast, all of the remaining indicators, including wait times for care, access to nurses, and the availability of lithotripters, all showed declines in performance. Interestingly, while there were more CT scanners and more physicians available, wait times for their services actually increased over the same period.

The comparison between 2004 and the present is less negative but still concerning. Areas that governments focused on in recent years, including the availability of professionals, advanced medical technologies such as CT and MRI scanners, and long waits for treatment after consultation with a specialist, either improved or remained unchanged. Areas outside of government focus all deteriorated, including the total time patients wait when seeking medical treatment in Canada. Further, in many cases, while performance improved between 2004 and 2010, it still failed to reach the level that prevailed in 1997 when both health expenditures and federal cash transfers for health care were much lower than at present.¹⁴

Reforming the Canada Health Act

Clearly, federal cash transfers for health care have not led to improved access to health care in Canada. This poor record is not likely to improve under Ottawa's new plan for health care transfers after 2014, which makes little change to the current failing arrangement other than to the promised rate of growth. Arguments that the transfers have been insufficiently large to improve health care are unfounded. Canada's health care system is the developed world's sixth most expensive after the United States, the Netherlands, France, Germany, and Denmark; its health care expenditures are 22 percent higher than in the average OECD nation that has a universal access health care system (OECD, 2011; calculations by authors).¹⁵ Not only is Canada's

poor health care performance not reflective of the large growth in federal cash transfers for health care, it is also not commensurate with Canada's comparatively high level of spending.

An often noted barrier to reform and experimentation in health care policy is the position of the federal government and its control over the monies it transfers to the provinces for health care. These funds are available only to those provinces who abide by the rules, regulations, and federal interpretations of the Canada Health Act.¹⁶ The act specifically disallows a variety of policies that other countries use to provide better quality universal health care at lower costs. Among the policies that will reduce federal cash transfers for health care are cost sharing and extra billing.¹⁷

Innovations in social welfare

All of this suggests that it is in the best interests of Canadians for governments to agree to substantially reform health transfers rather than continue with the current failing structure. Reform to federal cash transfers for health care should follow the lessons of the successful welfare reforms the federal government introduced in the mid-1990s. In the 1995 federal budget, as part of a strategy to bring national finances back to surplus, the federal government restructured and reduced federal transfers to the provinces. A core component of this change was the replacement of the Established Program Financing (EPF) block transfer and the Canada Assistance Plan (CAP) cost sharing arrangement with the new

(CHST) block transfer. The change encouraged the provinces to experiment with innovation and improved performance by taking advantage of the increased flexibility and autonomy accorded them by the federal government.¹⁸ Vitality, this increased flexibility and autonomy applied to all areas covered by the Canada Health and Social Transfer—except health care policy, which remained subject to the Canada Health Act.

Under previous cost-sharing arrangements, the federal government had controlled social services standards by linking transfers to the provinces with adherence to national standards. This centralized approach and federal regulation meant that provinces were to a certain extent prohibited, or at least inhibited, from experimenting with alternative delivery models. Indeed, Finance Minister Paul Martin noted in his historic presentation of the 1995 Budget that “the restrictions attached by the federal government to transfer payments in areas of clear provincial responsibility should be minimized... they limit innovation... [and] increase administrative costs” (Martin, 1995: 17-18).

The 1995 reforms set off a period of innovation and experimentation across the country in both welfare design and delivery. The reduced transfers coupled with greater provincial autonomy and responsibility for welfare and its costs meant that the provinces had the incentive and authority to design and deliver more effective and less costly programs than in the past.¹⁹ The success of these reforms is hard to deny. Welfare dependency was reduced well beyond the cyclical level observed over the previous decade-and-a-

half. Welfare-related spending also declined, which helped governments across the country balance their budgets. Most importantly, the innovation and experimentation resulted in provinces doing a markedly better job of identifying problems and helping people back into the labour market.

The link between welfare and health care reforms

There is broad consensus that one serious issue facing Canada's governments in both the short and long term is the delivery and financing of health care. As was the case in 1995, Canada has an opportunity not only to improve its financial position, but also to improve health care for Canadians in a financially sustainable and responsible manner.

The federal and provincial governments are facing serious challenges with respect to health care spending. At the federal level, the growth in health transfers outstrips by a wide margin growth in federal program spending. For example, the average annual growth in cash transfers for health care from 2010-11 through 2013-14 is expected to be 5.7 percent, while average annual growth in total program spending is forecasted at 1.0 percent over the same period (Canada, Department of Finance, 2011b). A larger and larger share of federal program spending is being dedicated to health-related transfers to the provinces; such spending increases are not sustainable without either raising taxes or reducing other spending (which is already occurring in relative terms), both of which have their own set of costs.

The provinces have already made relative reductions in non-health care spending in order to accommodate the near insatiable demand for health care spending. Health spending as a percentage of total program spending for Canada (all provinces) has increased from 30.3 percent in 1990-91 to 36.7 percent in 2008-09 (Statistics Canada, 2009). Every province has increased the portion of its budget devoted to health care. In fact, the growth in health care spending is outstripping almost every other area of provincial spending (Kotlikoff and Hagist, 2005). The proportional increase in health care spending compared to all other provincial spending, coupled with the consistently high annual growth rate in health care spending, means that other categories of provincial spending will continue to be sacrificed unless fundamental changes are introduced.

The successful welfare reforms introduced in the mid-1990s emerged from the increased flexibility that the federal government gave to the provinces. The poor performance of the health care system, despite the high and increasing federal cash transfers to the provinces suggests a similar opportunity exists for health care.²⁰ That is, the federal government should give the provinces more leeway to experiment with different models of health care delivery within a universal and portable framework. Such an arrangement would allow the provinces to deal honestly with the single largest source of spending and one of the fastest growing areas of provincial budgetary spending.

Specifically, the Canada Health Act must be revised so that it continues

to require universality and portability, but so that all its other requirements are eliminated. This change would enable provinces to be more flexible in experimenting and innovating with different health design and delivery models. To be absolutely clear, this proposal maintains the requirement for universal coverage and portability, but allows provinces to try other approaches and test different ways to finance and deliver provincial health care services.

Experimentation and innovation such as this will uncover better ways for Canadians to be provided with health care commensurate with the resources being spent. The reforms might include everything from testing different forms of insurance coverage, to the use of health savings accounts, to expanded public coverage. By allowing each province to pursue its own method of delivering, regulating, and managing health care, we can discover, through experimentation, better and more cost-effective ways to improve our nation's health care system. Again, the key is to allow experimentation and innovation in a fiscally responsible manner and within a framework of universal coverage and access.

Conclusion

Unfortunately for Canadians, the \$97.6 billion increase in federal cash transfers for health care since 1997-98 has not resulted in a better performing system. Instead, a variety of indicators of health care performance provide overwhelming evidence that Canadians are actually worse off now than they were in

1997.²¹ While increased transfers totalling \$6.4 billion more than required to account for population growth and inflation since 2004-05 may seem to have been more effective than the earlier transfer increases, a longer term view of our health care system's performance shows continued lack of value for money from cash transfers to the provinces.

The lessons from reforms to federal transfers for social welfare in the mid-1990s provide clear guidelines for improving the current situation of high and rapidly expanding health expenditures that pay for the poor performance of Canada's health care system. Reform efforts must focus on modifications to the Canada Health Act that will enable provinces to experiment with different models of health care finance and delivery within a universal and portable framework. Experimentation and innovation will uncover better ways for Canadians to be provided with health care commensurate with the resources being spent.

Notes

1 This paper examines cash transfers exclusively and does not include tax-point transfers in its analysis. (A tax point is a permanent transfer of income tax room from the federal government to the provincial governments in which the federal government reduces its basic tax rate by a specific percentage and the provinces increase theirs by an equivalent amount, thereby leaving total federal and provincial tax unaffected. Tax points can be applied to personal income tax or to corporate income tax.)

2 The information for EPF health cash transfers comes from a special

information request received from the Federal Department of Finance in October 2002.

- 3 For a more thorough discussion of the effects of the CHST reform, please see Schafer et al., 2001.
- 4 In table 1, the year in which the one-time transfers were recognized 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. This applies to all data shown in the table except for the separate payments to Ontario for 2009-10 and 2010-11 to ensure it receives the same per capita CHT cash support as other equalization-receiving provinces announced in the 2007 federal budget. These funds are apportioned according to Canada, Department of Finance (2011a).
- 5 For an empirical discussion of this issue, please see Veldhuis and Clemens, 2003.
- 6 The federal government maintained its budgetary surplus position until 2008-09, at which time it returned to deficit spending.
- 7 The rates of inflation and population growth were national figures. Certain provinces would have had higher population growth rates and inflation rates over the period (eg., Alberta) while others would have had lower rates (eg., Quebec). Thus, the effect or value of the federal cash transfers would have been different in each province and would have depended on the rates of population growth and inflation in each.
- 8 This is the average annual growth rate between 1997 and 2009. The annual growth rate ranged from a low of 1.5 percent to a high of 3.8 percent.
- 9 This is the average annual growth rate between 2004 and 2009. The annual growth rate ranged from a low of 1.5 percent to a high of 3.5 percent.
- 10 The examination of wait times here looks at the Fraser Institute's annual wait times measurement, *Waiting Your Turn*, which captures elective wait times for common procedures in 12 major medical specialties. That study is Canada's only national, comparable, and comprehensive measurement of wait times for medically necessary care. It is worth noting that the 2004 agreement identified the priority areas of cancer, heart, diagnostic imaging, joint replacements, and sight restoration as a starting point for governmental measurement and reduction of wait times. Note that *Waiting Your Turn* does not measure wait times for emergency care or access to general practitioners.
- 11 The nurse-to-population ratio is derived from 2009 statistics, as these are the most recent statistics available for comparison.
- 12 The discussion examines only the number of individuals per population. This means changes to hours worked or services provided will not be captured in this measurement. CIHI (2010) reports an increase in the proportion of RNs and LPNs employed in nursing full time between 2005 and 2009.
- 13 The discussion examines only the number of individuals in the population. This means changes to hours worked or services provided resulting from demographic shifts or changes to funding models will not be captured in this measurement. For more on the relationship between changing physician demographics and workload see Esmail (2007). For more on the relationship between physician funding models and services provided see Esmail and Walker (2008).
- 14 Two studies examining worker pay in Ontario hospitals, one study examining rates of surgical care, and a series of papers examining the relationship between wait times and health expenditures, all suggest that the price of health care increased over this period. Mullins (2004), in a study of worker pay in Ontario's hospitals, found that hospital payrolls used up the entire increase in provincial government transfers to Ontario hospitals between the 1997 low and 2002. In addition, high-earner payrolls increased more than three times as fast as provincial government transfers to Ontario hospitals. In a follow-up study in 2005, Mullins found no statistical relationship between pay increases and hospital performance measures and suggested that increased hospital funding seemed to be driving wage inflation. The Canadian Institute for Health Information, in a study examining surgical volumes in all provinces except Quebec, found that in 2007-08: "Age-standardized rates of surgery outside the priority areas [hip and knee replacements, cataract surgery, cardiac revascularization, and cancer surgery] are about the same as they were in 2004-2005" (p.12). Within the priority areas, rates of surgery climbed by seven percent between 2004-05 and 2005-06, and then essentially stopped growing to 2007-08 (CIHI, 2009). Importantly, provincial government health spending (not including Quebec) grew by \$16.2 billion or about 24 percent over this same time period (CIHI, 2011a; calculations by authors). Finally, Zelder (2000), Esmail (2003), and Barua and Esmail (2010) all found either no relationship between access to health care (wait times) and health expenditures, or a positive relationship where wait times increase as health expenditures rise in Canada.
- 15 This comparison is on a percent of GDP basis for the most recent year for which comprehensive data are available (2009). Due to unavailability of 2009 data, 2008 data were substituted for Australia, Japan,

Portugal, and Turkey, and 2007 data for Greece.

- 16 For a detailed explanation of the Canada Health Act, see Canada, Ministry of Health, 2009; for its history, see Orchard and Alsford, 2010.
- 17 Specifically, according to sections 18 through 21 of the Canada Health Act, provinces that implement or allow cost sharing or extra billing “shall” (s. 20) see their federal cash transfers for health and social services offset by the amount of user charges/extra billing. In addition, provinces deemed to have violated any of the principles of the Act “may” (s. 15) be subject to reductions in their federal cash transfers for health and social services.
- 18 For a discussion of the reforms in the federal transfers, see Veldhuis and Clemens, 2003.
- 19 A number of common reforms were adopted by most, if not all, of the provinces. One common reform was a reduction in benefit levels, particularly for single, employable people. There was an increasing understanding that, when welfare benefits surpass comparable income available from low-paid work, incentives are created to enter or remain on welfare. Many of the reductions in benefit levels, particularly those for single, employable people, aimed to re-establishing the balance between welfare benefits and the income available from low-paid work. For an empirical examination of the relationship between benefit levels and welfare rates during the 1990s, see Emes and Kreptul, 1999. For details on selected provincial reforms, see Veldhuis, Clemens, and Palacios, 2011.
- 20 An alternate view is that Medicare suffers from a lack of central oversight, direction, and accountability. Beyond the general conditions contained in the Canada Health Act, the federal government has not

imposed national standards, which has left the provinces considerable latitude to determine what and how much would be covered, and how it would be delivered. The 2004 *10-Year Plan to Strengthen Health Care* did, however, increase federal monitoring and public reporting through the Health Council of Canada and the Canadian Institute for Health Information, and the analysis above does suggest a potential increase in the effectiveness of cash transfers for health care since 2004. However, the Canadian experience with the welfare reforms of the 1990s (discussed in this paper) and with the relatively strong performance of Canada’s K-12 education system which has seen little federal involvement and oversight (Harris and Manning, 2005) both suggest that a more centralized approach to health care would be counter-productive. In addition, a more centralized approach to health care with stronger federal oversight, direction, and monitoring would likely reduce innovation and competition among the provinces and the ability of any province to tailor its health care policy approach to the unique needs of its local populations (Esmail, 2006). Further, such an approach fails to respect the fact that health care is primarily an area of provincial jurisdiction under the constitution. Finally, Canada’s approach to health care policy has been shown to produce an expensive and inefficient health care system that provides poor access to medical services, and it is not clear that an increase in federal oversight and direction would improve this situation by providing sensible reform to health care policy at the provincial level. Indeed, the federal government’s reluctance to embrace policies such as private competition in financing and cost sharing suggest that an increase in federal oversight and direction may prevent such sensible, market-based reform.

- 21 Increased cash transfers for health care from the federal government to the provinces have not resulted in improved health performance over the period examined, largely because of the incentives contained in, and the structure of, Canada’s health system. Please see Barua and Esmail, 2010, for a discussion of the relationship between health spending and wait times; Esmail and Walker, 2008, and Skinner and Rovere, 2010, for empirical data and a discussion comparing Canada’s health care system with other OECD countries that maintain universal health care; Esmail, 2011, and Esmail, 2007, for a discussion of physician shortages in Canada and possible explanations; and McMahon and Zelder, 2002, for a discussion of non-medical wage pressures in the health care system.

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