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FORUMSPACE

The New Canada Health Transfer: Increasing Disparity and Supporting Inertia?

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The current Canada Health Transfer which distributes $27 billion in cash and $13.6 billion in tax points to the provinces to support health care, will expire in 2014. Near the end of 2011, the Harper government surprised Canadians with a take-it-or-leave-it deal, whereby the Canada Health Transfer would be delivered with no-strings-attached and a decline in the rate of increased spending starting in 2017. The proposed deal reflects a growing hands off approach to healthcare in federal politics, furthers the divide between "have" and "have-not" provinces and represents a missed policy window for implementing significant healthcare reforms.

The Canada Health Act and its predecessor legislation explicitly declare that "the primary objective of Canadian healthcare policy is to protect, promote and restore the physical and mental well-being of residents of Canada and to facilitate reasonable access to health services without financial or other barriers."[1] Statements such as these have resonated with Canadians for decades, creating a strong sense of national pride in a health system that values fairness over privilege and need over the ability to pay. With that being said, as the global economy continues to struggle and the baby boomer generation begins to retire, there is a growing concern that our healthcare system may require significant reform.

In the First Ministers' Accord of 2004, the prime minister and the premiers of each province and territory agreed upon a funding strategy to increase federal support for healthcare through yearly cash and tax point transfers, known as the Canada Health Transfer. The ministers also agreed upon priority funding areas to improve healthcare, such as embracing information technologies and reducing wait times.[2] With the Accord expiring in 2014, policy entrepreneurs and health professional associations have been anxiously waiting for new negotiations to commence to push onto the agenda important health system policies on home care, prescription-drug insurance and a variety of other issues. They are going to have to continue waiting.

This past December, the Harper government surprised the provincial and territorial governments as well as the general public when Finance Minister Jim Flaherty announced a take-it-or-leave-it deal, whereby the Canada Health Transfer would be delivered with no-strings-attached and a decline in the rate of increased spending starting in 2017. At the moment, the government's proposal will also remove the equalization formula that balances Canada Health Transfer payments between "have" and "have-not" provinces. The proposal includes no statement about national priority funding areas, which are usually identified during Health Accord negotiations.[2] Canada Health Transfer payments—currently worth $27 billion in cash and $13.6 billion in tax points—will increase at the present rate of 6% per annum until 2017, at which point increases will be tied to economic growth with a guaranteed floor of a 3% increase per annum until approximately 2024.[3] Health care spending has increased by 6.1% per annum over the last few years, meaning provinces will now have to find ways to limit this increase to ensure that their health systems are sustainable.[3]

At first glance, the rich provinces will become richer and the poor will become poorer. Under the terms of the proposal, the federal government will eventually distribute money from public coffers to the provinces and territories on a strict per-capita basis, which will exacerbate the wealth disparity across Canada in two ways. First, tax revenues from wealthier provinces are usually greater than those from poorer provinces on a per capita basis because they are tied to residents' incomes. In fact, Alberta will significantly benefit from the proposed per-capita transfer because their tax points are so "strong" in comparison to the rest of the country (Figure 1).[4]

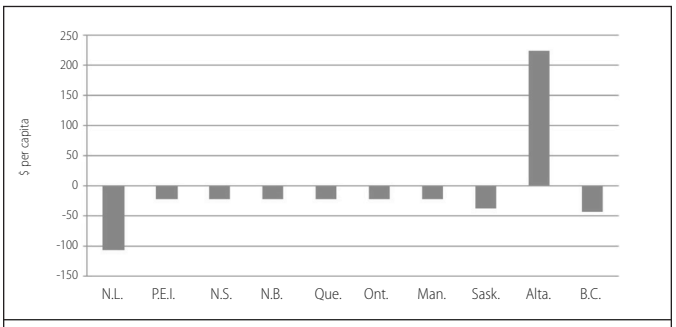

FIGURE 1: Per Capita Difference in Total CHT Entitlement between Current and Equal-per-Capita Cash Transfer, 2011-2012. *Adapted from http://parl.gc.ca/Content/LOP/ResearchPublications/2011-02-e.htm#a6*

Second, increases in economic development upon which the transfers will be based, will be led primarily by the west. In 2018 the Canada Health Transfer will begin to be tied to the growth in nominal gross domestic product (GDP), which is a measure of GDP without adjustment for inflation. While inflation increases the cost of delivering health services, the economic development of resource-rich provinces will significantly overshadow growth in resource-poor provinces.[5] Without an equalization payment to re-distribute wealth across the country, this will negatively affect "have-not" provinces like Ontario and Quebec and positively affect a "have" province like Alberta.

Under the new plan, Stephen Harper threatens to narrow the already limited input that the federal government has in a domain where it makes substantial annual investments. Ottawa has in a sense become a hands-off benefactor, while leaving responsibility to the provinces to continue to provide essential healthcare services that Canadians have come to expect on terms guaranteed by the Canada Health Act.

The re-negotiation of the Health Accord should have been the time to build on the initiatives from the previous agreement that are still in their infancy. Perhaps the most essential of these initiatives was primary healthcare reform, which was mandated to ensure equitable access to seven important areas: health promotion, illness prevention, health maintenance, home support, long-term care, community-based rehabilitation and pre-hospital emergency medical services. There is also a need to continue successful initiatives, such as shifting non-acute resources from hospitals to community-based primary healthcare clinics with inter-professional teams and disease-oriented collaborative practices. Finally, it is important to continue to improve access to care through the implementation of successful wait-time initiatives stemming from the activities of provinces from the previous agreement.[6]

The Health Accord could also have provided an opportunity to expand the Canada Health Act beyond hospital and physician services. The most significant of the potential expansions is arguably the creation of a national pharmacare program, which was first recommended in 1964 by the Royal Commission on Health Services and for which evidence and support has only continued to grow.[7] Of all countries within the Organization for Economic Cooperation and Development (OECD), Canada ranked second (behind only the United States) in the amount spent on prescription drugs. In fact, Canada's total expenditure on pharmaceuticals is about thirty percent higher than the OECD average[8] and now exceeds physician-based care, making it the second largest health expenditure in Canada's health system (Figure 2).[9] Despite high costs, Canada still has the lowest rates of public drug coverage amongst OECD countries and eight percent of Canadians are still unable to fill their doctors' prescriptions due to cost.[8] In order to reduce the inequality in access to medicines, it may be beneficial to unite the formularies of the thirteen provinces and territories into a single evidence-based national formulary. Doing so could reduce prescription drug costs by $10.7 billion dollars, or 43% of the $25.1 billion Canadians currently pay for drugs.[8]

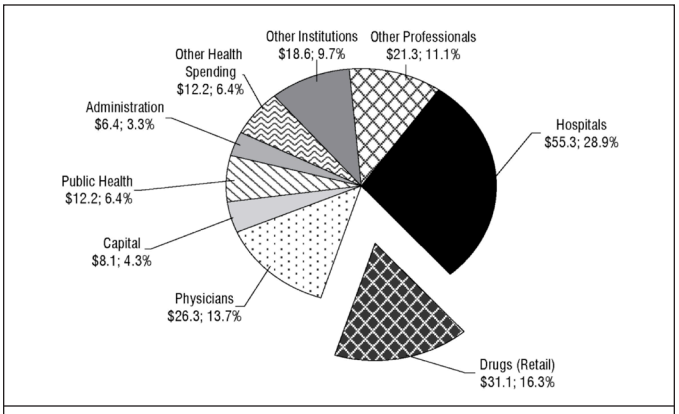

FIGURE 2: Total Health Expenditures by Use of Funds, 2010. *Adapted from http://secure.cihi.ca/cihiweb/products/drug_expenditure_2010_en.pdf*

The Canada Health Act and the Canada Health Transfer remain two of the most important policy levers to develop and implement lasting healthcare reform. As pressure begins to mount on one of the most cherished pieces of the Canadian identity, there is a need for national leadership, not political trepidation. Universal and equitable healthcare is important to all Canadians. A Canada Health Transfer without federal guidelines or equalization payments raises the possibility of creating a patchwork system with no strategic priorities and no efforts to address inequities across the country. ▪

[1]Canada Health Act. Department of Justice Canada. 1985.

[2]First Minister's Meeting on the Future of Healthcare 2004. Health Canada. 2004.

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[4]Gauthier, J. The Canada Health Transfer: Changes to Provincial Allocations. Ottawa: Office of the Parliamentary Budget Officer. 2012.

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[6]Postl B.D. Final report of the federal advisor on wait times. Health Canada. 2006.

[7]Romanow, R.J. Building on Values: The Future of Healthcare in Canada. Ottawa: Commission on the Future of Healthcare in Canada. 2002.

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[9] Drug Expenditure in Canada, 1985 to 2010. Canadian Institute for Health Information. 2010