An Overview of Canadian Health Care Financing

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Abstract—*Canadians value their health system highly, but they are concerned about whether it will survive in the future because of rapidly increasing costs and the need for fiscal balance. Federal transfers for health play an important role in provincial and territorial government spending on health care. The Canada Health Act (CHA) was passed by Parliament in 1984.The act lays out five conditions or principles that provincial health plans must follow to be eligible for federal grants. The five conditions are universality, accessibility, comprehensiveness, portability and public administration. The British North America Act of 1867 had given control of the organization and delivery of health care services to the 13 provinces and 3 territories, while leaving most of the taxation powers with the federal government. The provincial governments receive funding for health through a transfer funding mechanism, which evolved from the cost-sharing arrangements supporting Medicare to "block" grant known as Established Program Financing (EPF).In 1996 the federal government announced the termination of EPF grants and the creation of a new block grant to support health, education and post secondary education-the Canadian Health and Social Transfer (CHST).In 2004 the federal government once again separated the CHST .This time, funds for social programs were combined into the Canada Social Transfer(CST) and the Canada Health Transfer (CHT) was kept separate. The CHST and the CHT both retained the conditions of the CHA. In 2004, the federal and provincial governments signed the 10-Year Plan to Strengthen Health Care. It is in this context the paper attempts to examine the programs and transfers to financing health care in Canada.*

1. INTRODUCTION

Canada is a federal country with 10 provinces and 3 territories. The provinces are: Alberta, British Columbia, Manitoba, New Brunswick, New Foundland and Labrador, Nova Scotia, Ontario, Prince Edward Islands, Quebec, and Saskatchewan. The territorial governments are Nunavut, Yukon, and the North West Territories [1]. The federal government of Canada provides significant financial support to provincial and territorial governments to assist them in the provision of programs and services. There are four main transfer programs: (1) the Canada Health Transfer (CHT), (2) the Canada Social Transfer (CST), (3) Equalisation, and (4) Territorial Formula Financing (TFF) [2].The CHT and CST are federal transfers which support healthcare, post-secondary education and social services. The paper is divided into three sections. Section I defines the health. Section II focuses on the constitutional features of the Canadian system. Section III examines the Canada Health Act 1984. Section IV examines the history of Canadian health care financing.

2. HEALTH

"Health is wealth" is a popular saying and it is fact that without wealth access to health care remains merely an illusion [3].The WHO constitution states that health is not simply the absence of disease but a complete state of physical, mental and spiritual well-being (WHO 2006a).Health is valued in many different contexts from as a consumable product, as an investment, or as a right or entitlement [4]. As a consumable product it strongly associated with the notion of individuals exercising choice in purchasing health care, much as they might purchase food or some other commodity. As far as investment, the thinking of the Commission on Macroeconomics in Health in 2001 advocated that increased public spending for health in low-income countries would contribute to economic growth (WHO 2001).Health as a right or entitlement and it differs significantly from the above views of health as either consumption or investment because it places importance on the intrinsic value of health. This view emerges from the WHO Constitution, which states "the enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being without distinction to race, religion, political belief, economic or social condition" (WHO 2006a)[5].

3. CONSTITUTIONAL PROVISIONS

In Canadian Constitution, the provincial level of government is granted the majority of legislative power in the area of health care. Section 92(7) of the Constitution Act, 1867 grants exclusive authority to provinces over the establishment, maintenance and management of hospitals, asylums, and charities. The federal government has also some important powers like constitutionally responsible for health care delivery to specific groups such as Aboriginals, military personnel, penitentiary inmates, and refugees (Section 91) [6].Furthermore, the Peace, Order and Good Government known as "POGG" clause grants the federal government the power to legislate in times of national health emergency [7].The most important federal power related to health its "spending power". This refers to the constitutional right of a

government to spend money and also represents a key lever for the federal government as a means of exercising authority over the provinces and it influencing health care policy. Each year the federal government gives the provinces billions of dollars to support the delivery of provincial health services and programs. The federal government regularly places conditions on the provinces in conjunction with these funding [8].

4. CANADA HEALTH ACT (1984)

The Canada Health Act (CHA) contains nine requirements that the provinces and territories must fulfill in order to qualify for the full amount of their cash claim under the CHT. They are:

- five funding criteria that apply only to insured health services;
- two conditions that apply to insured health services and extended health care services; and
- extra-billing and user charges provisions that apply only to insured health services[9]

(a)The Criteria

Table 1: Five Funding Criteria of the Canada Health Act (1984)

Criteria	Each provincial health care insurance plan must:
Public Administration (Section 8)	Be administered and operated on a non-profit making basis by a public authority
Comprehensiveness (Section 9)	It requires that the health care insurance plan of a province or territory must cover all insured health services provided by hospitals, physicians or dentists(surgical dental services that require a hospital setting)
Universality (Section 10)	Ensure entitlement to all insured health services on uniform terms and conditions
Portability (Section 11)	Coverage must be maintained when a resident moves within Canada or travels outside the country. Out -of –country coverage is limited to payment at existing provincial rates.
Accessibility (Section 12)	There can be no financial barriers to receiving medically necessary hospital and physician services. Reasonable compensation for physicians and hospitals must be paid, and extra billing (beyond payments made by the provincial plans) is prohibited.

Source: Health Canada (2011), cited in Marchildon, P.,*Health Systems in Transition,* University of Toronto Press,Toronto,Canada,2013.

(b) The Conditions

(i) Information (section 13(a)): the provincial and territorial governments are required to provide information to the federal Minister of Health as prescribed by regulations.

(ii)Recognition (section 13(b)): the provincial and territorial governments are required to recognize the federal financial contributions toward both insured and extended health care services [10]

(c)Extra-Billing (section 18) and User Charges (section 19) Either extra-billing or user charges if confirmed or exist in a province or territory, a mandatory deduction from the federal cash transfer to that provinces or territory is required under the Act. The amount of such a deduction for a fiscal year is determined by the federal Minister of Health [11].

Penalty Provisions of the Canada Health Act (CHA)

Penalties under the CHA are linked to federal transfers to the provinces. If a province fails to fulfill the requirements of the Act, the federal government may impose penalty. Two types of Penalties:

(i)Mandatory Penalty Provisions

The provinces and territories which allow extra-billing and user charges are subject to mandatory dollar-for-dollar deductions from the federal transfer payments under the CHT [12]

(ii)Discretionary Penalty Provision

The consultation process is required with the provinces or territory or province before discretionary penalties can be levied. The discretionary penalty provisions of the Act have not been applied until now [13].

The CHA, which sets out the principles of Medicare, states that the primary objective of Canadian health care policy *"is to protect, promote, and restore the physical and mental wellbeing of residents of Canada and to facilitate reasonable access to health services without financial or other barriers."*[14]. Medicare refers to Canada's national health insurance program. It is a single payer system in that medical care providers directly bill the government for the cost of service. Fees for each type of medical service are set by the government of each province [15].

5. HISTORY OF CANADIAN HEALTH CARE FINANCING/EVOLUTION OF FEDERAL HEALTH CARE TRANSFERS

(i)Pre-Blocking Funding Era to 1977/78: the 50:50 Sharing Principle

In 1947, the government of Saskatchewan became the first province to introduce a program of provincial health insurance. Earlier hospital and medical care in Canada was largely privately funded and individual patients paid doctors

for their services and many hospitals run by religious or voluntary organizations. In 1948 the federal government offered health grants to the provinces to help pay for hospital services. This was followed by the Hospital Insurance and Diagnostic Services Act in 1957, through which the federal government offered to share the cost of hospital services [16].

The sharing of health care costs on a 50:50 basis was accepted by most provinces. In 1966, the Canada assistance Plan (CAP) was introduced, creating a cost-sharing arrangement for social assistance programs [17].

(ii)Transition to Block Funding -1972/73- 1976/77

The federal government was concerned as early as 1972 about its exposures to cost escalation in programs administered by the provinces/territories. The restraint majors adopted by the federal government resulted in considerable fiscal pressure being applied to provinces/territories:

- Growth ceilings were also imposed on Medicare, 14.5% for 1976/1977, 12%for 1977/78, and 10% thereafter.
- The federal government refused to include as sharable, hospital and medical care expenses, and other growing health care program areas, such as psychiatric services, home care, drug benefits, etc [18].

Therefore the pressure for change being applied by some provinces over the potential of cost sharing's "50 cents dollars" as it could distort provincial priorities [19]

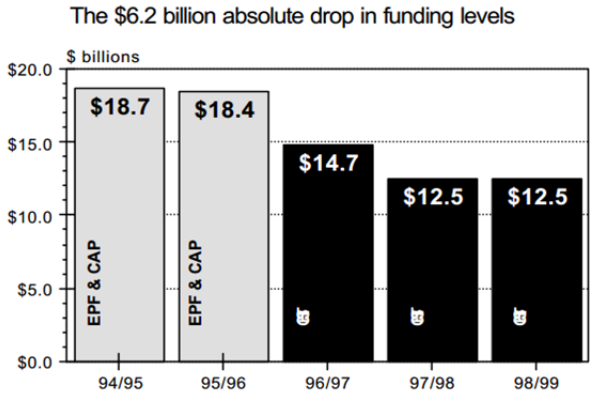
(iii)The Established Programs Financing (EPF) Era-1977/1978 to 1995/1996

The new block fund instituted in 1977/78, the Established Programs Financing (EPF) arrangements, had distinctive characteristics: the federal "contribution" compromised both a cash payment and a notional "tax point value". The cash payment constituted an actual payment or transfer to provinces/territories and the tax transfer reflected the notional value -for a year -of the one-time transfer of federal tax room to the provinces [20].

One needs to understand that EPF was no longer designed to pay one-half of the cost of provincial health programs, but rather was to provide equal per capita grants to provinces to grow at the same rate as Canadian GDP .In 1990,the per capita grant was frozen and restraint continued and finally in 1996 the federal government announced the termination of EPF grants and the creation of a new block grant to support health, education, and post-secondary education-the Canadian Health and Social Transfer(CHST)[21].

(iv) Canada Health and Social Transfer (CHST) 1996 to 2003

With the introduction of CHST in 1996/97, the federal government unilaterally initiated a major change in funding to provinces/territories in support of health, post secondary education and social services. The federal budget announced that the Canada Assistance Plan (CAP) and Established Program Financing [EPF] combined into one block fund-CHST. At the same time, the federal government imposed significant cuts in the level of transfers to the provinces/territories. As Fig. 1 shows by 1997/98 the value of the federal transfers had fallen to $12.5 billion. The CHST was $6.2billion less than EPF and CAP had been in 1994/95[22].Like the EPF, the CHST was a combination of the 1977 tax transfer and a cash transfer and the total was allocated on an equal per capita basis[23].



Source: Finance Canada Official Estimates cited in Provincial and Territorial Ministers of Health, Understanding Canada's Health Care Costs, 2000.

Fig. 1: Falling CHST Cash Payments to Provinces

(v) 2000 and 2003 Health Accords and Canada Health Transfer (CHT)

In 2000, the federal government announced $23.4 billion in new spending over five years on health care renewal and early childhood development [24].In the meeting of the first ministers or premiers of the provinces in February2003, there was an agreement on an action plan for renewing health care. This would result in an increase in federal support to health care and also been agreed to restructure the CHST in April 2003by dividing it into two separate transfers: The Canada Health Transfers (CHT) and Canada Social Transfers (CST). So, once in 2004 again the federal government separated the CHST .The CHT retained the conditions of the Canada Health Act [25].

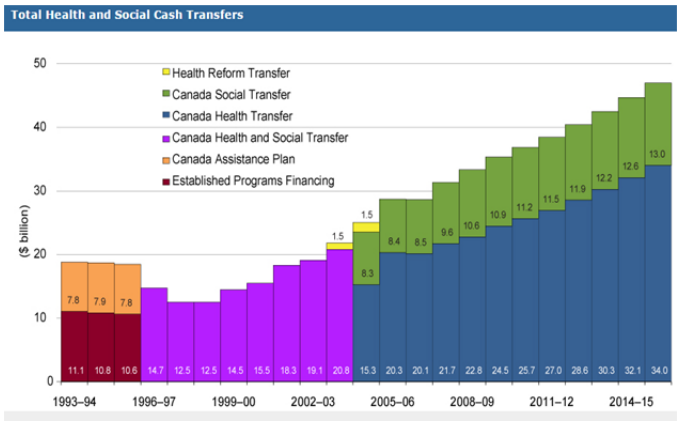
The Canada Health Transfer (CHT) provides block funding to provinces and includes both tax point and cash transfers. The value of the tax point component grows in line with economic activity, while the total CHT cash component is legislated under the *Federal-Provincial Fiscal Arrangements Act* [26]

(vi) 2004 10-year Plan to Strengthen Health Care

In 2004, the federal and provincial governments signed the 10-Year Plan to Strengthen Health Care .In support this plan, the federal government committed additional funding to provinces and territories for health that included increases to the CHT through a base adjustment and an annual six percent escalator[27].Under the 2004 10-Year Plan to Strengthen Health Care, the Health Reform Transform (HRT) was

incorporated into the Canada Health Transfer effective April 1, 2005.A new HRT targeted to primary health care, home care, and catastrophic drug coverage[28].

The CHT is the largest major transfer to provinces and territories, funding for health care, and support the principles of the CHA as shows in Fig. 2.



Source: Department of Finance Canada, History of Health and Social Transfers.

Fig. 2: Health and Social Transfers Over time 1993-94 to 2014-15,

To conclude in today's healthcare environment, where financial realities play an important role. The five funding criteria of the CHA represent the principles and values that underpin Canadian Medicare. But continued rising costs, the role of the private sector in health care financing, waiting times, pharmaceutical coverage, and differences of opinion between governments have been always tension in health care. The evolution of federal health transfers contributes transfers to support health care services.

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