

## Who wants to pay for health care?

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What share of provincial health expenditures is being paid by the federal government? Is the answer 11%, as being argued in a \$3 million advertising campaign by the Ontario government, or 34%, as being argued in a counter-campaign by Ottawa? This is a trick question; there has been no federal transfer specifically for health care since 1977. If we are forced to choose an answer, Ottawa is closer to being right. But the dispute primarily shows the regrettable politicization of what should be a nonpartisan issue and highlights the evident failure of Canada's experiment with untargeted federal transfers.

The question of health care spending is complex and, accordingly, lends itself to "spin." Before 1977 there were cost-sharing arrangements between the federal and provincial governments to fund 4 major programs: hospital insurance, medical (physician) insurance, postsecondary education (colleges and universities), and social welfare programs financed through the Canada Assistance Plan. In that year both levels of government decided to replace cost-sharing for the 2 health programs plus postsecondary education with a new arrangement, under which the provinces would get unencumbered money to spend as they saw fit.

Under this arrangement, called Established Programs Financing (EPF), the federal government computed a per capita "entitlement," which had 2 components. About half of the money came from "tax room," also called "tax points" (i.e., the federal government reduced its tax rates for personal and corporate taxes, which allowed provincial governments to increase their tax yield with no net cost to the taxpayer). The remainder of the EPF entitlement took the form of a cash contribution. The per capita entitlement was initially indexed to growth in the gross domestic product, meaning that increases would take into account inflation and population growth, but not such factors as health-specific inflation, population aging or technological change.

In 1984, however, the Mulroney government unilaterally reduced the indexing formula. Because the revenues from tax room allotted to the provinces continued to increase with inflation, they amounted to an ever-growing proportion of the total entitlement; the cash proportion accordingly shrank and was in danger of vanishing. Without the cash portions of federal transfers, the federal government would have lost its ability to enforce the Canada Health Act. Thus, in 1996 the Chrétien government combined the EPF with the last major cost-shared transfer, the Canada Assistance Plan, and renamed the new block grant the Canada Health and Social Transfer (CHST).<sup>1</sup> This step allowed Ottawa to cut the total transfer again, while retain-

ing a "cash floor" below which the cash portion would not fall. Precise computations of the transfer are complex, particularly since the federal government has made a series of "one-time" payments that have not been incorporated into the base payment. (A statement of the current federal argument can be seen on Finance Canada's Web site,<sup>2</sup> where the government estimates that total federal transfers under the CHST in 2000/01 will be \$15.5 billion in cash, plus another \$15.3 billion in the yield from tax points, and make the arbitrary calculation that 43% of this might be seen as going to health care.)

The whole point of untargeted transfers is to allow provinces to make their own priority decisions. However, under the EPF, both levels of government continued to report "notional" distributions for health and postsecondary education, a pretense that has carried over into the current debate over the CHST. This talk about a "health" transfer is fundamentally at odds with the philosophy underlying this global funding. Provinces could — and did — slash the money they give to postsecondary education and welfare, which are also covered by the block transfer. Deciding whether reductions in federal transfers were to health, education or welfare is thus nothing more than an exercise in creative accounting. Indeed, one could argue that there have been no federal cuts to health care at all, but significant cuts to federal transfers for education or welfare, or both. Again, these arguments miss the point. Since 1977, provinces have had the freedom to determine how best to meet the needs of their constituents. The only relevant question arising from federal transfers, under this arrangement, would be whether provincial governments have enough money to meet their spending needs. A certain paradox arises in tax-cutting provinces. If they did not have enough money to pay for health or postsecondary education, it is hard to see how they had enough money for tax cuts. If, as they claimed, their tax cuts have stimulated the economy and provided more revenues, this presumably would have yielded enough revenue for necessary program spending. In neither case would "health spending" be the responsibility of the federal government.

Even if one wishes to assume that health spending remained a constant proportion of the federal transfers, it seems odd for the provinces to argue that federal contributions "should" be 50% while also arguing that the tax points, which have made up over half of the federal contribution since 1977, should no longer be counted. It also seems odd to compare current spending with the older system under which the federal government cost-shared only

spending for hospitals and doctors, which amounted to about two-thirds of current provincial spending on health care. A rough calculation suggests that the artificial exclusion of the tax points (factor of 2) and the artificial inclusion of spending on services other than hospitals and doctors (factor of 3/2) is enough to account for the 3-fold difference between the 2 parties.

Provincial accounting changes have made it difficult to make accurate comparisons over time. For example, Ontario's shift to accrual accounting means that it is including future intentions with current spending (e.g., plans to create new nursing-home beds are counted as current spending once they are announced, rather than when the money actually flows). However, it is estimated by the Canadian Institute for Health Information that provincial spending on health care, measured in constant 1992 dollars, dropped steadily between 1992 and 1997 (the last year for which inflation-adjusted data are available).<sup>3</sup> Far from being out of control, health spending by provincial governments has not even kept pace with inflation and population growth, which appears to be one reason for widespread perceptions of crisis. Provincial insistence on "restoring" funds cut by the federal government "for health care" therefore undercuts the provinces' case for increasing global transfers through the CHST and instead argues for a return to targeted payments, accompanied by methods to ensure that these are being spent appropriately. There is a certain "disconnect" between provincial calls for greater provincial autonomy and their stance that only targeted federal funds can be spent on health care.

Final answer? See what is needed and provide the re-

quired money. See how to increase overall efficiency (home care? pharmacare? primary care reform?) and make sure the money is well spent. Introduce an accountability framework to monitor costs, access and quality. Recognize that health care must be a partnership that includes not only federal and provincial and territorial governments but also health care providers, patients and communities. It is time to stop the advertising campaigns and start working together to determine how to take a fraying system, which is nonetheless working pretty well, and ensure that it continues to meet the needs of the Canadian public.

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Competing interests: Dr. Deber had a contract from the Atkinson Foundation, Toronto, Ont., to write a background paper for the Dialogue on Health Reform and a contract from HEAL to write a background paper on options for the federal financing of health care (Available: [www.utoronto.ca/hlthadmn/dhr/4.html](http://www.utoronto.ca/hlthadmn/dhr/4.html) [accessed 2000 June 7]).

## References

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2. *Federal support for health in Canada*. Ottawa: Finance Canada. Available: [www.fin.gc.ca/activty/pubs/Health\\_e.html](http://www.fin.gc.ca/activty/pubs/Health_e.html) (accessed 2000 June 2).
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