



Budget Paper C

**FINANCING
HEALTH CARE**

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FINANCING HEALTH CARE

The question of the sustainability of our health care system has been a major concern of Finance Ministers and their departments for the better part of the last ten years. It is well understood that our country's ability to meet the health care needs of our citizens hinges on good science, good public policy and a collective commitment to provide the resources needed to do the job.

From a financial perspective, the issue of sustainability of Canada's Medicare system is inextricably linked to the future of the fiscal arrangements that underpin the Canadian federation. Throughout Canada's history, imbalances between the federal and provincial orders of government, in terms of financial resources and service responsibilities, have been addressed in varying degrees through transfer mechanisms like the Canada Health and Social Transfer (CHST) and the Equalization Program. The sustainability of health and other social programs hinges on an effective resolution to the fiscal imbalances that exist between the federal government and provinces, as well as those among provinces. Public opinion polls, including federal Finance's pre-budget survey, have determined health care to be the number one priority of Canadians. While provincial governments have responded, there is lack of palpable evidence that the federal government accords it the same high priority.

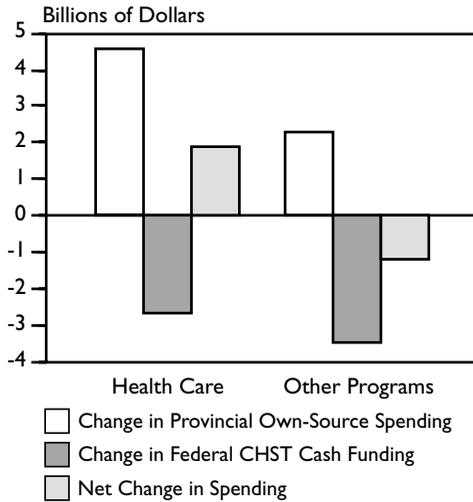
■ Developments in Health Care Expenditure and Financing

In Manitoba, health care is both our largest and fastest growing program. It accounts for 40% of our Budget, up from less than 33% at the beginning of the 1990s. A similar increase in health's proportion of budgets has occurred in all provinces and territories. This dramatic shift reflects the sharp increase in health care expenditure made in

Prepared as the basis for the March 6, 2002 presentation by the Honourable Greg Selinger to the Commission on the Future of Health Care in Canada.

The sustainability of health and other social programs hinges on an effective resolution to the fiscal imbalances that exist between the federal government and provinces, as well as those among provinces.

Chart 1
Net Change in Program Spending by Source of Funding 1994/95 to 1997/98



Sources: Federal and Provincial/Territorial
 Public Accounts and Manitoba Finance

THE HIDDEN IMPACT ON SOCIAL SERVICES

The \$6.2 billion cut in funding in CHST overshadowed another important development. The elimination of the 50:50 sharing of eligible costs under the Canada Assistance Plan (CAP) had a negative direct effect on social service program funding. Indirectly, it affected health care as well, since social services provide early intervention and keep social problems from developing into health problems. The loss of CAP also shifted the financial risk associated with a cyclical economic downturn off the federal government onto the backs of provinces.

response to public concerns that access to, and quality of, care were deteriorating.

While a good part of the shift reflects a conscious decision on the part of provinces to re-invest in health care, much of it can be attributed to the \$6.2 billion cut in federal funding for health and other social programs associated with the introduction of the CHST. The roughly one-third cut in CHST funding meant that provinces had to devote considerable resources just to try to backfill for the revenue shortfall.

Between 1994/95 and 1997/98, despite the federal government's contribution falling by an estimated \$2.7 billion, overall provincial health care spending increased by just over \$1.9 billion. To achieve this, provinces had to spend an additional \$4.6 billion of their own resources on health care (see Chart 1).

At the same time, the federal government's contribution to other social programs fell by an estimated \$3.5 billion. However, total spending in other program areas declined by only \$1.2 billion, despite the provinces increasing spending in these areas by \$2.3 billion. In this case, it was not enough to completely backfill for the federal cuts.

It is clear that rising demand for health care has been met, to some degree, at the expense of needs in other areas, such as education, justice, social services, infrastructure and economic development. Because the activities supported by these programs constitute the base upon which we sustain our health care system, this "crowding out" is not a viable long-term option.

Given underlying cost pressures in health care and the implications of demographic trends on both expenditure and revenue, this share could rise to 50% or more of our Provincial Budget as the baby boom generation makes the transition from work to retirement. Extrapolation of cost trends suggests we would reach this point in about 15 years, or even sooner under other slightly less favourable

circumstances (see Chart 2). While we do not regard these projections as inevitable, they serve to benchmark the challenge that we face.

In and of itself, there is nothing magic about the 50% share, and if we were to come to that point as a result of falling debt servicing costs or reduced need in other areas, that would not be a problem. However, a decrease in the demand for resources in other core areas is not anticipated, and we will face real difficulties as government seeks to maintain a balanced perspective on the very legitimate needs in these other program areas.

Cost pressures on the health care system and the competing demands for other public services form the basis of our concern for sustainability in the medium and longer term. However, we face a sustainability issue that is much more immediate.

The strength and duration of the recent economic expansion helped underwrite our efforts to restore public confidence in the health care system over the past several years. However, since the events of September 11, 2001, forecasts for economic growth, in general, and government revenues, in particular, have moderated. As a consequence, provincial revenue growth has slowed, while cost pressures have continued unabated. The measures being announced by provinces to meet this large and immediate cash crunch reflect the difficult choices all provinces are facing.

It is apparent that the federal government still has considerable fiscal leeway even though similar factors influence its revenue growth. Despite the increases announced for security and defence, it is expected to post a positive budgetary balance in 2001/02. Indeed, according to the January Federal Fiscal Monitor, the federal surplus stands at just over \$11.5 billion. At the same time, provinces, which collectively had just begun to post surpluses for the first time in decades, are now facing deficits or significant draws from stabilization funds or reserves.

Chart 2
Health Spending as a
Share of Manitoba's Budget,
Baseline Projection to 2020/21

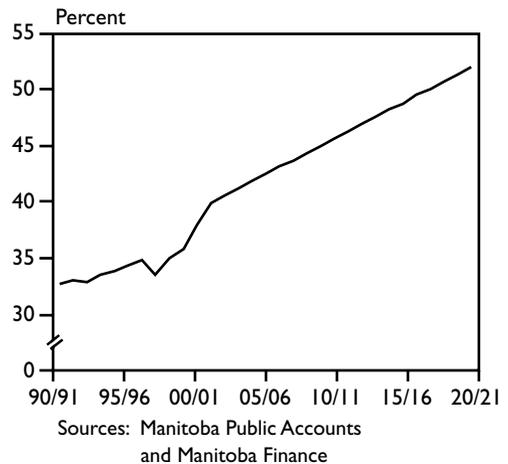
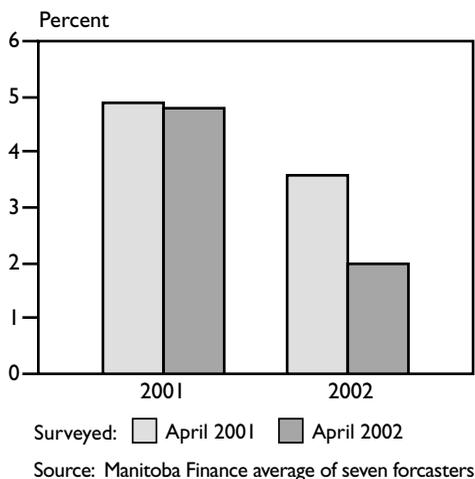


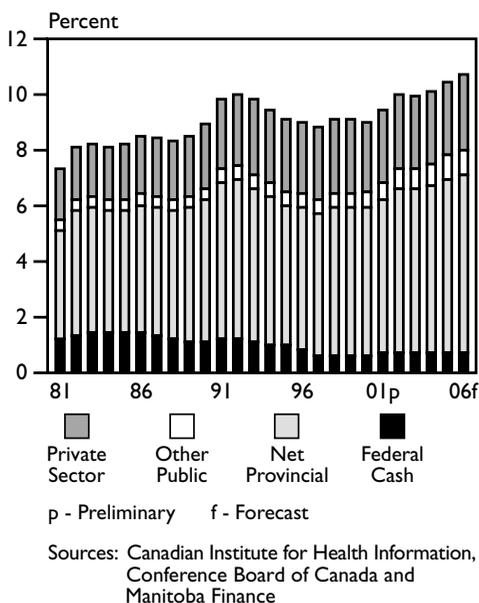
Chart 3
Gross Domestic Product
Forecasts, Canada



The recent round of economic projections from independent private sector forecasters reflects slower near-term growth prospects for Canada (see Chart 3). The strength of the recovery will largely be determined by growth in international trade, particularly with the U.S. The current challenge is to ensure that the transborder flow of goods and services is not unduly constrained by increased security costs and provisions.

Manitoba's economic growth over the past decade reflects the increased importance of international trade. While Manitoba's economy grew by 40% between 1990 and 2000, exports grew by 88%, to \$19.5 billion. Indeed, the annual dollar values of exports and imports now match or exceed personal consumption in Manitoba. This increase in export growth over the 1990s has made a substantial contribution to the strong employment performance posted by the province, the reduction in the unemployment rate, and stable population growth. Strong provincial revenue growth associated with our export performance has contributed to our ability to fund health care and education, along with other social and economic development programs.

Chart 4
Health Expenditure
as a Percentage of GDP,
by Component



It has been observed that, as a percentage of national GDP, health spending has been fairly constant over the past several years at just over 9%, and below its 1992 peak of about 10% (see Chart 4). However, the current economic slowdown and more moderate growth prospects for the medium term, suggest that by next year we could see health expenditure as a percentage of GDP rise to 10%, and set new high-water marks over the next several years.

Total spending on health care as a percentage of GDP is often used in international comparisons. However, it is probably not the best measure when considering the issue at the provincial level – the level at which actual decisions on program spending take place. Health spending as a percentage of GDP varies substantially across provinces. As well, GDP provides only a crude approximation of a province's

fiscal capacity, and does not provide insight into the tax burden required to sustain the public services it provides, nor does it take into account the effects of federal transfers. From a practical perspective, the debate needs to focus on provincial revenue – the actual dollars that are available to fund the health care program.

■ Fiscal Arrangements and Health Care Funding

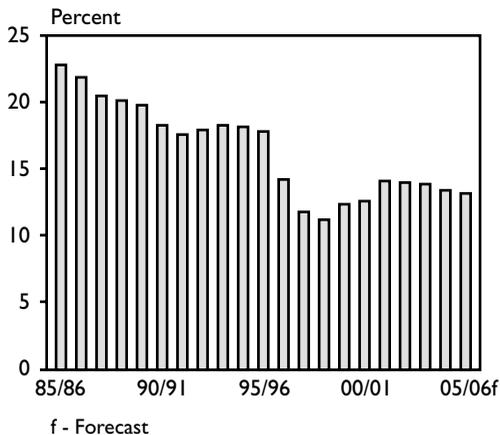
Finance Ministers across Canada have devoted considerable effort in examining the question of how to improve the federal transfer mechanisms in order to address the ongoing fiscal imbalances between governments. Manitoba believes that restoration of the CHST, along with an appropriate escalation mechanism, is necessary to ensure the continuation of effective and comprehensive public administration of health care in Canada.

Canada Health and Social Transfer

Prior to the Established Programs Financing (EPF) arrangement in 1977/78, the key components of health care (hospitals and medical services) were financed on a 50:50 basis between the two orders of government, with the federal government providing cash funding on a conditional basis. Federal concern arose over its exposure to provincial cost escalation. At the same time, provinces were concerned over the federal refusal to include areas such as psychiatric services, home care and drug benefits as shareable expenses. Provinces were also concerned about how the cost-sharing model distorted their priorities, as well as its lack of flexibility.

EPF was designed to address these concerns and was instituted as a block fund transfer for post-secondary education and hospital and medical care, while CAP continued to provide cost-sharing for other social programs. EPF was comprised of a cash payment and a calculated “tax point value.”

Chart 5
Federal Cash Transfers as a Share of Total Provincial/Territorial Government Spending on Major Social Programs



Note: Major social programs include health care, education (elementary and post-secondary) and social services. This definition is broader than that which constituted eligible, sharable program expenditures under the EPF and CAP.

Sources: Federal and Provincial/Territorial Public Accounts, Federal Department of Finance and Manitoba Finance

...CHST...funding decisions by the federal government continue to be unilaterally determined and arbitrary.

Beginning in 1982/83, the federal government reduced its cash share of funding for health and other social programs through a series of adjustments to the funding formulas for both EPF and CAP. The federal share of funding for provincial health, education and social services was 22.7% in 1985/86. This share was more than halved, falling to 11.2% by 1998/99 (see Chart 5).

Much of this drop occurred with the introduction of the CHST in 1996/97. The CHST became the single federal program supporting health, education and social services, replacing EPF and CAP.

The partial restoration of CHST cash announced at the 2000 First Ministers' Meeting was a good first step, although it fell short of the proposal for full restoration that was put forward by Premiers. The announced increase raised the share of federal funding for health, education and social services to just over 14.1% in 2001/02. However, without additional funds, this share is expected to decline over the medium term to about 13%. In 2002/03, the scheduled increase in CHST cash is only enough to provide for a 1% increase in provincial/territorial spending on major social programs.

The schedule announced by the federal government for the CHST did not address the concern of Premiers that funding decisions by the federal government continue to be unilaterally determined and arbitrary. Increases and decreases in funding for social programs are not negotiated with the provinces/territories, nor are they based on any objective criteria such as changes in actual costs, ability to pay (revenue capacity), or a benchmark "share" of total costs. The uncertainty inherent in the current funding mechanism has led Premiers to the position that federal funding for health care and other social services needs to be based on a formula that better matches service need, provides a fixed commitment, and reflects our nation's financial means.

At their 2001 annual meeting, Premiers called on the federal government to increase its funding

commitment through the CHST to 18% of total provincial/territorial government spending on health, education and social assistance – a share equivalent to that which existed in 1994/95. The Premiers also called for a CHST escalator to ensure the commitment of the federal government is not eroded over time. The call to restore funding to 18% is one that Manitoba considers to be both modest and affordable, and quite achievable over the medium term.

Professor G. C. Ruggeri, in a 2001 update of the paper originally presented to Premiers at their August 2000 meeting titled, *A Federation Out of Balance*, examined the projected fiscal situations of the federal and provincial/territorial governments out to 2019/20. His key findings were, while much of the federal surplus over the next four years has already been committed through tax cuts and spending increases, after 2004/05, federal surpluses will resume their fast upward climb, reaching \$126 billion by 2020, while the aggregate provincial fiscal position will, at best, barely remain in balance.

The study by Professor Ruggeri suggests that, notwithstanding the strain that is being placed on provincial budgets by the current economic downturn, there are sufficient resources within the government sector (writ large) to support health care at a sustainable level. What is needed is a tangible commitment from the federal government to redress the fiscal imbalance. Collectively, provinces and territories do not raise sufficient own-source revenues to meet their obligations under the Constitution to provide important public services, such as health care, education and social services, while providing all of the other public services required by their citizens. At the same time, the federal government is generating revenue in excess of what it requires to meet its more limited set of program responsibilities.

However, with fiscal pressures mounting in virtually every province, Manitoba remains concerned that,

STUDY CALLS FOR FISCAL REBALANCING

The spending pressures in health care recently faced by provincial governments indicate that the funds provided by the federal government in the September 2000 agreement were inadequate.

Ensuring that provinces have sufficient fiscal capacity to meet the spending pressures in the financing of national programs, such as health care and post-secondary education, requires an increase in the level of CHST cash payments and a suitable escalator or a rearrangement of the relative occupancy of tax fields between federal and provincial governments.

Our results show that vertical fiscal imbalances will not fade away, but are likely to become more severe in the future partly because the federal government has the ability to hold back the growth of its spending by allocating a portion of its future surpluses to debt repayment, an option not available to all provinces. The experience of the recent federal policies makes it clear that the expected future surpluses in reality will not materialize because discretionary policy actions will be taken to eliminate them. To which policy priorities these surpluses will be committed will determine the future shape of the Canadian federation. One can certainly appreciate the current fiscal needs of provincial governments and may understand intensified efforts at securing additional federal funding for national programs delivered by the provinces. The greater need, however, is for a fundamental change in intergovernmental fiscal relations aimed at rebalancing the fiscal structures of federal and provincial government in a manner that allows both orders of government to fulfill their constitutional spending responsibilities in a fiscally responsible manner and in a manner that respects jurisdictional integrity.

*Prof. G.C. Ruggeri
A Federation Out of Balance: Update (2001)*

Unless the federal government is prepared to assume a major and constructive role in funding health care, its declining share will make it less and less relevant to the future of Medicare in our country.

in the absence of immediate action to address the funding issue, provinces might adopt solutions based more on current budget constraints, rather than moving forward with more optimal and durable solutions that would be much more difficult to implement. Unless the federal government is prepared to assume a major and constructive role in funding health care, its declining share will make it less and less relevant to the future of Medicare in our country.

In seeking a durable solution to the problem of funding health care, Manitoba still regards the CHST mechanism as a preferred option. Provinces have been particularly critical of the proliferation of tied-funding deals the federal government has introduced in recent years. These programs require an ongoing cost commitment for the province that is not matched by the federal government, whose support typically lapses after three years. These programs are typically less affordable for the less affluent provinces, and tend to distort provincial spending priorities. Simply put, the funds could be better spent supporting our core health and social service programs.

The unilateral nature of tied-funding is paralleled in the way in which CHST cash transfers are determined by the federal government. It is clear that a more co-operative model of federalism is required to restore not only funding, but also provincial governments' confidence in a federal partner that has not proven reliable in the past when it comes to vital social programs. CHST funding is not provided on an articulated understanding of the cost of providing health care and other services, the ability of the federal government to pay in terms of revenue, or even a targeted share – as recommended by various observers and the Premiers. Given the uncertainty surrounding, and arbitrary nature of, these arrangements, our ability to do the planning necessary to address the cost pressures that we know about is compromised, and with it, our prospects for the sustainability of all our social programs.

■ A More Co-operative Model of Federalism

The current model for establishing priority and responsibility in respect of funding for health and other social programs is dysfunctional. It is problematic inasmuch as it is hierarchical, with federal decisions being made unilaterally. There is no effective dialogue with provinces and territories, and there is no mechanism to arbitrate disagreements.

At the same time, the federal and provincial/territorial governments have experience with more co-operative approaches to federalism, which have been effective in dealing with problems of common concern, and are definitely worth exploring in this context. The process recently used to effect substantial reforms to the Canada Pension Plan (CPP) is an example. The key issues that the federal government and provinces/territories addressed were those of financing and long-term sustainability. A consensus was developed as to how to meet these challenges, which received the support of the federal government and a more than two-thirds majority of provinces.

Many of the underlying pressures on the CPP are the same as those yet to be addressed in health care financing – a higher percentage of the population reaching retirement age, and a smaller percentage working and contributing to the funding of the Plan. A collective decision was made to move to a payment schedule that provides resources that exceed current requirements, securing additional resources for the future when the need will be greater. Because this has been done in advance of the peaking of program demand, the problem is made more manageable, and the fund will not be subject to the severe strain which could otherwise require more dramatic changes to contribution rates and Plan benefits.

The task we face is not just that of balancing our own books, but doing so in a manner that does not compromise our long-term economic potential and the provision of important public services, of which health is just the first of many.

It is clear that the details surrounding the CPP and health care financing, in particular, are different in both their magnitude and complexity. However, it does offer a better model to build on, and it is imperative that we begin to do so in order to ensure that federal and provincial treasuries are not unduly stressed, and the sustainability of our health care system is maintained over the long term.

■ A Competitive Edge

The task we face is not just that of balancing our own books, but doing so in a manner that does not compromise our long-term economic potential and the provision of important public services, of which health is just the first of many. Manitoba needs to take a broad perspective on its social and economic responsibilities. National, and increasingly global, markets for goods and services impose disciplines that cannot be readily dismissed, both in terms of tax regimes and competition for resources such as doctors, nurses and technology.

Economic research has indicated that Canada's single-payer, publicly administered health care system is cost-efficient, and gives us a competitive edge, although it may not be as widely appreciated as it ought to be. This advantage is worth preserving. For this reason, provincial governments need to be clear in the policies that they pursue, and that there is a difference between cost shifting and cost saving. The apparent long-term shift in the burden of health care, from the public to the private, is not well understood in terms of its impact on total costs facing individual taxpayers and employers. Having said that, it is clear that government efforts to contain, rather than shift, costs could have significant positive financial benefits for the public sector, as well as for businesses and individuals.

What is well understood is the fact that there is a direct linkage between the health of our citizens and their economic well-being, an old idea that falls within the more current concept of “population health.” In seeking to do the greatest possible good with the scarce resources at our disposal, the interaction of the policies that support both of these activities needs to be carefully considered. This is true in respect of the tax system as well, and Finance Ministers have collectively recognized that provinces must maintain affordable tax structures since they contribute to ongoing investment and job creation. These activities ultimately contribute to revenue and our base for funding health services, and so are essential elements in any approach to achieve a sustainable Medicare program.

■ Conclusion

Manitoba’s support for a publicly administered health care system is firm. The unique solutions developed here in Canada to address the weaknesses inherent in market-driven approaches to the provision of health care have proven their value and have contributed to Canada’s global competitiveness. Collectively, the federal and provincial/territorial governments have the financial resources to sustain the health care system into the future. What is needed is a renewed federal commitment to play a larger role in funding. We have confidence in our collective capacity and ingenuity to maintain quality and cost effectiveness, and re-create a public health care system that will be both responsive and sustainable into the future.

Collectively, the federal and provincial/territorial governments have the financial resources to sustain the health care system into the future. What is needed is a renewed federal commitment to play a larger role in funding.