CALEDON INSTITUTE OF SOCIAL POLICY

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June 1998 ISBN# 1-894159-10-1

No Treasure CHST for Health Services

It takes no great insight to know that Canadians are concerned about maintaining a high-quality universal medicare system. Now that the economy is improving, polls show health care services emerging as the highest public priority. With stories almost every day about emergency room overcrowding and doctors' and other health care workers' unhappiness, it is little wonder that many Canadians would expect governments to put our tax money where our priorities are, and pay more money into the health care system.

Yet the federal government's 1998 Budget did not announce new and improved transfer payments to the provinces for health care (above and beyond the previously announced $1.5 billion increase in the cash floor for the Canada Health and Social Transfer), even though Ottawa now appears to have enough fiscal room to spend more money on high priority areas. Given public sentiment about health care, it is not too surprising that many commentators, opposition parties and some Premiers criticized the 1998 Budget for its sin of omission; i.e., its failure to increase federal health financing for the provinces.

But the critics are wrong. If health services are underfinanced, the solution is not to increase federal transfers to the provinces under the Canada Health and Social Transfer. Premiers' protestations notwithstanding, the problem of health financing today falls squarely on the provinces, not Ottawa.

To understand why this is so, it is necessary to take a brief excursion into history. More than 20 years ago, a new block fund, called Established Programs Financing (EPF), replaced cost-matching formulae for federal funding of provincial health and postsecondary education (PSE). Then, in 1995, both Established Programs Financing and cost-matching for social assistance under the Canada Assistance Plan (CAP) were replaced by a single block fund, the Canada Health and Social Transfer (CHST). In 1994-95, combined CAP and EPF cash payments were $18.0 billion (in constant 1998 dollars): in 1998-99, cash payments under the CHST will be $12.5 billion – a decrease of $5.5 billion in real terms.

Like EPF, the CHST is *block funding* and it is also *conditional funding*. *Block*

funding means the amount of money Ottawa pays to a province does not depend upon how much the province actually spends, be it on health or postsecondary education or social assistance or anything else. *Conditional funding* with respect to health services means a province gets the full CHST payment only if the province's health plan meets the Canada Health Act conditions.[1] For Ottawa to be able to withdraw funding as a way of enforcing the Canada Health Act, there must be some money in the CHST to start with. By increasing the cash floor guarantee to $12.5 billion from the original figure of $11 billion, Ottawa has ensured that there will be sufficient cash in the CHST pot to enforce conditions for the foreseeable future.

What all this means is that the CHST requires provinces to deliver health services consistent with the Canada Health Act, but the CHST does *not* require provinces to provide any particular *level* of funding for health services. If the federal government enriched the CHST, the provinces would in no way be required to increase their health budgets beyond what they would have spent on health anyway. Indeed, the provinces could spend the extra federal money in areas other than health, or use it for tax cuts or even to increase their surplus if they wished. In other words, an increase in the federal CHST does not necessarily make any difference at all to health spending by the provinces.

But even if the provinces are not *required* to do so, had the federal government given the provinces additional CHST money, would they have used it to put more funding into health care than they would have spent anyway? This question is hypothetical and cannot be answered definitively, but we can look at the provinces' actual behaviour and see if it provides any clues as to what they might have done with added CHST money.

Ottawa has raised its floor for CHST cash payments to the provinces from $11.0 billion to $12.5 billion. Based on the original CHST funding levels, provinces had built their medium-term fiscal plans around the expectation of about $11.6 billion in CHST cash payments in 1998-99. Under the revised arrangement, provinces are now getting about $900 million more in the 1998-99 fiscal year than they had planned. From the point of view of the provinces' fiscal plans, this is extra money. If we look at what they are doing with this extra $900 million, it will provide some idea of what they might do with even more 'extra' CHST money.

Some provinces are increasing their health budgets in the1998-99 fiscal year. Indeed, Saskatchewan's increase in health is just about equal to its share of the $900 million. But Saskatchewan also put money into social welfare reform and reduced taxes, so it seems very likely that the province would have increased health spending anyway.

Ontario's health budget is scheduled to increase by $342 million in 1998-99, just a few million short of the province's expected 'windfall' of about $360 million. However, anyone vaguely familiar with Ontario politics knows that the provincial government was under great political pressure to make some provision for increased health spending. (In addition, it appears that at least some of the Ontario health budget increase may represent just a reshuffling of municipal ambulance and public health spending.) So how much of Ontario's increased health spending, however much that really is, would *not* have happened had Ottawa not increased the CHST floor? A definite answer cannot be provided, but only in the unlikely event that Ontario's increase in health would have been $0 without the CHST floor increase could the full value of the federal improvement in the CHST have been passed on to the health system in Ontario.

It would take a great leap of imagination to think that the extra federal $900 million going into the provinces' coffers will raise health spending (over and above what it would have been anyway) by anything near that amount. Why expect that the provinces would spend a further CHST increase on health, beyond what would have been spent anyway?

But is there another problem altogether? Do provinces have inadequate *fiscal capacity*, which in turn is causing them to under-fund health services? Increasing the CHST does improve provinces' fiscal capacity, so perhaps this is the reason that the CHST should have been increased?

If there is a problem of inadequate provincial fiscal capacity, it is very uneven. Half of the provinces have balanced budgets. Manitoba not only has a balanced budget but accelerated its debt repayment schedule to put $150 million towards debt reduction rather than the planned $75 million. Saskatchewan has a balanced budget, which is its fifth balanced budget in a row. Alberta certainly cannot claim to have a fiscal capacity problem: It has huge surpluses despite the drop in oil prices and despite being the only province that does not levy a sales tax. Ontario is spending an unknown amount – certainly more than $5 billion – on tax cuts.

Perhaps some provinces – such as Quebec and Nova Scotia – have a fiscal capacity problem. However, the CHST provides more or less equal amounts per capita to *all* provinces, so if fiscal capacity is the problem, increasing the CHST is not a very sensible solution. The alternative would be to look at some needs based addendum to Equalization that would target federal money where it is needed.

So, as contradictory as this may appear at first glance, increases in federal 'health transfers' to the provinces are not synonymous with increases in financing for health services. Ottawa is constitutionally prohibited from direct funding of health care and cannot put money into the core operations of the health care system just by paying it directly to health care service providers. Getting out of block funding and returning to cost-matching is out of the question without unanimous provincial agreement, which is extremely unlikely. Furthermore, it is questionable whether cost-matching would be best for keeping the health system as efficient as possible and keeping federal spending under control.

It is possible to imagine devising a federal-provincial agreement that would purport to require provinces to devote extra federal money to go to their health budgets by 'earmarking' federal transfer increases. Provinces might go along with such a deal to get their hands on more federal money. But an earmarking agreement is mainly political propaganda: It does not necessarily increase overall health funding if the provinces were going to spend that much more anyway. An earmarking agreement mainly would substitute federal money for provincial money.

In Canada today, it is not so easy for the federal government to direct increased funding to a specific area of provincial jurisdiction, such as health care. For better or worse, this state of affairs is where the last decades of federal-provincial and constitutional wrangling have brought us. The level of health care spending is a matter for which we will have to hold our provincial governments accountable.

However, the federal government is not wholly without influence in the field of health care. What Ottawa may be able to buy are *conditions* of health spending, as it does through the Canada Health Act, rather than the *level* of spending.

If the federal government has an extra billion or two to spend on health care, perhaps it

should offer the money to the provinces on the condition that they bring home care and community care more fully into the medicare system in all provinces. Such an initiative would improve Canada's medicare system and perhaps even achieve some efficiencies, although admittedly it would not address the immediate perceived crisis of underfunding: For that, we must turn to the provinces. Of course, expanding medicare to encompass more fully home and community care also would require provincial agreement; but this agreement may be obtainable if sufficient federal funds were offered and public pressure were brought to bear.

There are also a few areas in which the federal government has the main responsibility in the health care system and can provide direct funding. These expenditures are small in dollars, compared to the cost of delivering core health services, but are nonetheless extremely important. For example, the federal government is the main funder of innovation and health research. Although this item is modest in relation to spending in the whole health field, a high-quality medicare system requires reliable and sufficient research funding. Funding was increased in the 1998 Budget, but not enough to restore fully the level of past spending and to keep up with inflation. Another example may be found in the federal laboratories and public health functions.

In summary, people who are worried about deteriorating health care due to underfunding should look to their own provincial governments to reassess their priorities, rather than the federal government. Increased CHST transfers would do little or nothing to affect the level of funding for medicare. The federal government has an important role in health financing – using its leverage carefully and selectively to improve medicare and to finance research – and that is where it should put its money.

Endnote

1. The five principles of medicare set out in the Canada Health Act are: comprehensiveness (all services provided by doctors and hospitals deemed to be medically necessary must be covered), universality (all legal residents of a province must be eligible for coverage after a minimum residency period of not more than three months), accessibility (there can be no financial barriers to insured health care and no discrimination on the basis of income, age or health status), portability (all Canadians are entitled to coverage when they are temporarily absent from home or when moving to another province or territory) and public administration (provincial health insurance plans must be administered on a non-profit basis by a public authority responsible to the provincial government). Because there are penalties for non-compliance – loss of federal cash – the principles of medicare are also conditions.