Budget Paper C

THE 2003 FIRST MINISTERS' HEALTH FINANCING ARRANGEMENT

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On February 5, 2003, Canada's Premiers and the Prime Minister met to discuss a new federal financing plan to support provincial and territorial health care programs. In advance of the meeting, Premiers expected a significant increase in federal funding for health. These positive expectations were based on the following.

- The current federal share of health and other major social program funding had increased as a result of the September 2000 First Ministers' Accord, yet remained low by historical standards.
- Two major federal reports commissioned to examine the federal role in health care called for substantial increases in federal funding of provincial and territorial health care programs.
- The Prime Minister consistently stated that health care would be his government's top priority in its upcoming Budget.
- The federal government's surplus was again larger than expected and the prospects for continued surpluses remained bright.

The health financing arrangement that emerged from the February meeting represented an important increase in federal funding, and will provide some support for Manitoba's plan for health reform.

However, while the 2003 Arrangement strengthens to some degree the federal government's partnership role, it does not address Canadian's expectations in terms of sustainable public financing for their health care system. Nor does it meet the recommendations of Commissioner Romanow and Senator Kirby in their respective health care reports.

While the 2003 Arrangement strengthens to some degree the federal government's partnership role, it does not address Canadians' expectations in terms of sustainable public financing for their health care system.

Manitoba's concerns with the 2003 Arrangement, discussed in this Budget Paper, are summarized below.

- The federal share of funding for health and other social programs remains substantially below the 25% threshold recommended by Premiers and Commissioner Romanow.
- Base funding for the Canada Health and Social Transfer (CHST) was not increased. While the funds flowing from the CHST Supplements are welcome, they do not translate into an ongoing sustainable financial commitment from Ottawa.
- With new funding being either "one-time" or targeted, the 2003 Arrangement does not address the current imbalance between the responsibilities and resource capacity of the two orders of government.
- The annual amounts in the Health Reform and the Diagnostic/Medical Equipment Funds are not adequate to achieve the reforms required in the health care system.
- These targeted funds create additional spending pressure, at least over the short term.
- The decision to set the level of transfers in respect of post-secondary education and social services, substantially below that which existed in 1994/95, creates a significant funding gap for provinces and territories to address.
- This decision to re-allocate funding to health from post-secondary education and social services artificially raises the federal share of health care funding, and raises questions about federal accountability and transparency.
- The Arrangement is back-end loaded insofar as much of the funding in the first three years is financed from the 2002/03 federal surplus. The ongoing financial commitment is modest over this period and only starts to rise, in any appreciable way, in the medium term.

■ Overview of the 2003 Arrangement

The 2003 Health Financing Arrangement is a multi-year plan for federal funding of major provincial and territorial social programs. A detailed table, outlining the payment schedule and purpose of the amounts announced by the federal government over the next five years, can be found in Appendix A. The table below summarizes the 2003 Arrangement for the next three years, identifying previously announced funding increases, and differentiating between the funds which will and will not flow directly to provinces and territories in support of health care programs.

Summary of the 2003 Health Financing Arrangement

	2003/04	2004/05	2005/06	Total
	(Billions of Dollars)			
Total Federal Funding Increases	6.2*	5.4	7.7	19.3
Less: Old Money (previously announced)	(0.7)	(1.3)	(1.9)	(3.9)
Less: Funds for Federal Programs and Priorities	(1.0)	(1.1)	(1.3)	(3.4)
Equals: New Money for Patient Care	4.5*	3.0	4.5	12.0

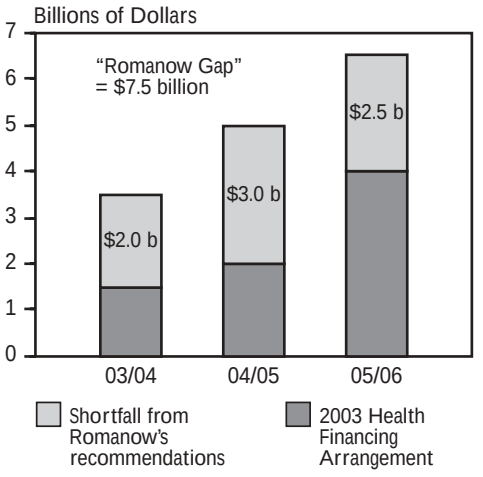
* The Additional CHST Supplement of $2 billion in 2003/04, included in the total, will be made available to provinces and territories if "the Minister of Finance determines during the month of January that there will be a sufficient surplus above the normal contingency reserve to permit such an investment."

At the 2003 First Ministers' meeting, the federal government announced a $17.3 billion increase in funding for health care. As well, it announced that it would provide up to an additional $2 billion in 2003/04 if its surplus exceeded normal contingency requirements. Of this total, $7.3 billion was either previously announced or will flow to federal health initiatives, not directly to provinces and territories for core health care services.

Of the potential $12 billion in new money flowing from the federal government to provinces and territories for patient care over the next three years,

Chart 1

Federal Response to Romanow's Recommendation



Sources: 2003 Federal Budget, Romanow Report, Manitoba Finance

FUNDS FOR FEDERAL HEALTH PROGRAMS

Manitoba believes that the federal government has an important role to play in providing certain programs that fall outside of the scope of provincial and territorial health care programs, such as the development of a National Immunization Strategy. However, federal expenditures in areas like an Employment Insurance family leave benefit or health technology assessment, should not be portrayed as contributions to provincial and territorial health care spending.

The federal government also depicts funding for its own program responsibilities, such as health care for Aboriginal persons and its regulatory process for new drugs, as part of its contributions to provincial and territorial spending. These are programs that the federal government has delivered for many years as part of its constitutional responsibilities.

$7.5 billion has been targeted for health reform initiatives in the areas of primary care, home care, pharmaceutical care and diagnostic medical equipment. This amount is only half of the $15 billion recommended by the Commission on the Future of Health Care in Canada (Romanow Commission) and the Standing Senate Committee on Social Affairs, Science and Technology (Kirby Committee). This shortfall represents what has been termed the "Romanow Gap." It is also substantially less than what was proposed by Premiers at their January 23, 2003 meeting.

The federal government announced that it will provide $2.5 billion as a one-time CHST Supplement "to relieve existing pressures." The federal government also announced that it would provide an additional CHST Supplement of up to $2 billion at the end of the 2003/04 fiscal year if "the Minister of Finance determines during the month of January that there will be a sufficient surplus above the normal Contingency Reserve to permit such an investment." Such contingent funding does not provide a stable and predictable funding base for major social programs. Manitoba believes that funding increases should be negotiated and reflect objective, measurable factors, such as growth in Gross Domestic Product.

■ What the 2003 Health Financing Arrangement means for Manitoba

Funding for health and other social services flowing from the 2003 Arrangement and 2003 Federal Budget will affect the provision of health and other social services received by Manitobans in two ways. First, the CHST Supplement and additional CHST Supplement will be used to offset cost increases for health, education and social services that exceeded CHST support in 2002/03 and are budgeted for in 2003/04.

Second, Manitoba's share of the amounts identified in the federal Budget for health reform, approximately $275 million, will be utilized over the next three years to continue the work of restructuring and enhancing health care delivery in the province.

Costs in health, education, and social services continued to grow as provinces and territories awaited the recommendations of the Romanow Commission and the federal response to it. Moreover, reform of the health care system in the province has proceeded on the assumption that funds would be flowing from the federal government to support this work. In 2002/03 and 2003/04, program costs associated with health, education and social services are cumulatively estimated to be $760 million higher than they were in 2001/02.

Given that the federal government has surpassed its fiscal targets by a wide margin every year since taking office, it is reasonable to assume it will make good on its promise to provide the additional $2 billion CHST Supplement funding to top up the $2.5 billion already announced. Manitoba plans to utilize its $164 million share of this $4.5 billion total to relieve existing pressures in major social program costs anticipated in the coming fiscal year, as well as some that the Province has incurred in anticipation of the Romanow Report and the federal response.

While the immediate cash infusion that the CHST Supplement represents is welcome, previously announced increases in base funding for the CHST and targeted funding will only support about a 1.5% increase in health, education and social service spending in 2003/04 and about 1.0% over the medium term. As a consequence, significant pressure will remain on the Province as it seeks to sustain or enhance these important programs.

Because of the manner in which the federal government has chosen to split the CHST into the Canada Health Transfer (CHT) and Canada Social Transfer (CST), its support for education and social

PATH OF HEALTH CARE REFORM IN MANITOBA

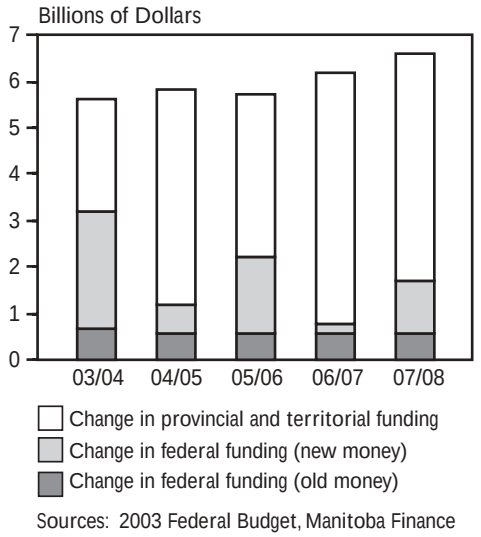
The 2003 Health Financing Arrangement sets out a path for continued reform in four key areas of the health care system. In line with the reforms currently under way in the province, and the Manitoba Government's commitment to a strong public health care system, the Minister of Health will announce, over the coming months, details of key health care reforms in Manitoba.

- ***Primary Health Care** – ensure that Manitobans have access to appropriate health care providers, so that they will be able to routinely access care from multi-disciplinary health care organizations or teams.*
- ***Home Care** – enhance access to services in the home and community that improve the quality of life of Manitobans, particularly short-term acute home care, acute community mental health and palliative care.*
- ***Catastrophic Drug Coverage** – ensure that all Manitobans have reasonable access to catastrophic drug coverage.*
- ***Diagnostic/Medical Equipment** – improve access to diagnostic tests and treatment services, including support for the specialized staff training required to maintain and operate diagnostic/medical equipment.*

Manitoba's share of the amounts identified in the federal Budget for health reform will be utilized over the next three years to continue the work of restructuring and enhancing health care delivery.

Chart 2

Year-to-year Increase in Major Social Program Expenditure and Sources of Funding



Sources: 2003 Federal Budget, Manitoba Finance

services in Manitoba will effectively be set at a level that is about $100 million lower than it was a decade earlier, in 1994/95. This stands in sharp contrast with the fact that actual program costs have risen considerably. By the time the CST is implemented next year, costs in these program areas in the province may be expected to be about $500 million higher than they were a decade ago, reflecting both the impact of inflation and changes in the needs of Manitobans. Such a cut in funding levels will be reflected in services, not only in Manitoba, but in other jurisdictions as well.

■ Assessment of the 2003 Arrangement

Both the Romanow Commission and Kirby Committee, along with the vast majority of Canadians, expected the federal government to seize the opportunity afforded by time and circumstance to define for itself a more substantial funding role in the future of the health care system. Armed with expert advice from federal health care reports and national health care organizations, and knowledge of the serious funding pressures faced by provinces and territories, the federal government should have been able to provide a more substantive response to questions raised about its future partnership role.

The 2003 Arrangement is a step forward, in terms of the scope of services provided under the publically funded health care system. However, the amount provided to provinces and territories is back-end loaded, and only half that recommended by the Romanow Commission (see Appendix A). As well, a number of the priority areas identified by Romanow and Kirby are yet to be addressed (see Reform Priorities Not Addressed). Provincial priorities that require immediate attention, such as an adequate number and distribution of health professionals, have largely gone unfunded by the federal government.

Chart 2 compares the projected year-to-year change in expenditure on health, education and social services with the scheduled increases in federal funding. The year-to-year change in new federal funding is quite variable and ranges from a high of $2.5 billion in 2003/04 to almost nothing in 2006/07.

On average, program costs are expected to increase at a rate of $6.0 billion per year. Provinces and territories will be expected to cover $4.2 billion, or 70%; new federal funding will cover $1.2 billion; and previously announced federal funding will cover $0.6 billion.

At their January 23, 2003 meeting, Premiers called on the federal government to restore immediately its funding share for major provincial and territorial social programs to 18%, and to raise it by one percentage point per year until it reaches 25%, at which time it would be increased annually by an appropriate escalation factor. Chart 3 compares the Premiers' recommendation for CHST cash transfers with the planned federal funding track.

As Chart 3 indicates, the federal CHST cash contribution to health and other social programs is significantly less than is required to restore its funding partnership. Without additional support, over the next eight years, federal cash transfers remain below 17% of total program costs, and do not approach the share identified by Premiers as necessary to constitute an adequate funding arrangement.

For 2002/03, it is estimated that the difference between what the Premiers defined as an adequate federal share, and Ottawa's actual contribution to health and other major social programs, was about $5 billion. By the end of the decade, the difference between the 25% recommended by Premiers and the 17% provided by the federal government would translate into an annual shortfall of over $15 billion, triple its current level.

REFORM PRIORITIES NOT ADDRESSED

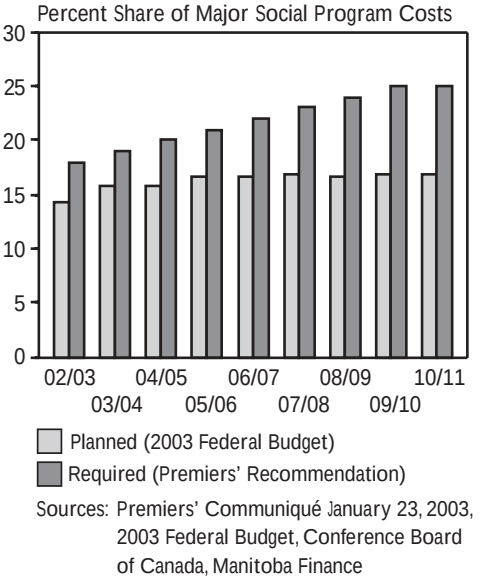
The 2003 Arrangement establishes two funds that cover four of the priority areas recommended by the Romanow Commission – a Health Reform Fund for primary health care, home care and catastrophic drug coverage, and a Diagnostic/Medical Equipment Fund.

Improving health care services in rural and remote communities was not addressed by the 2003 Arrangement. The Report recommended spending $1.5 billion over two years to improve access to health care in rural and remote communities.

The Kirby Committee recommended the federal government contribute $290 million per year to increase enrolment in medical and nursing schools, and increase the number of allied health professionals who graduate each year. The 2003 Arrangement did not address health human resources and the 2003 federal Budget provides only $90 million over five years for planning.

Chart 3

Planned and Required CHST Cash Transfers



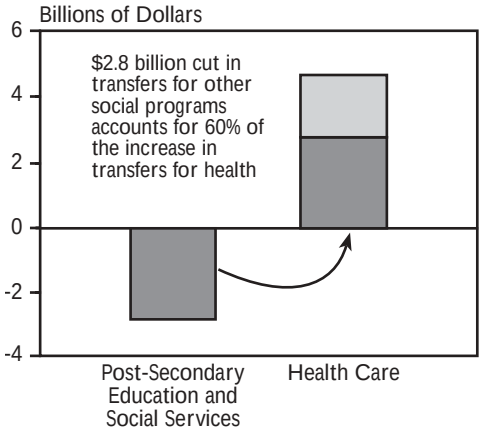
Sources: Premiers' Communiqué January 23, 2003, 2003 Federal Budget, Conference Board of Canada, Manitoba Finance

"In addressing the apparent deficit in health funding, that deficit should not be passed on to post-secondary education and social assistance."

Final Report of the Commission on the Future of Health Care in Canada

Chart 4

Change in Federal Transfers between 1994/95 and 2004/05



Sources: Federal Department of Finance, 2003 Federal Budget, Manitoba Finance

Although the 2003 Health Financing Arrangement lays out the federal government's funding plan, it does not settle the underlying financing issue in respect of major social programs. It does not provide provinces and territories with a level of support that is adequate to address the ongoing cost pressures on core services, and allow them to implement fully their plans for restructuring the health care system. This sets the stage for yet another round of negotiations with the objective of getting the federal government to strengthen its commitment to social programs, in general, and Medicare, in particular.

■ Federal transfers for post-secondary education and social services to be cut

Manitoba supports the principle of splitting the current CHST into separate health and social program transfers in order to increase transparency and accountability to the public. However, the manner in which the federal government plans to execute the split may create serious problems in respect of funding both post-secondary education (PSE) and social services.

Against the advice of the Romanow Commission and Premiers, the federal government announced it would fund post-secondary education and social services under a new Canada Social Transfers at a level significantly lower than it did in 1994/95. This decision is important because it effectively re-allocates a major portion of the transfer payments from post-secondary education, social assistance and other social programs, to health care. This means that a substantial part of the announced increase in the federal government's support for provincial and territorial health care programs is not new money for provinces and territories. Rather, the increase for health care comes at the expense of existing funding for social services and post-secondary education.

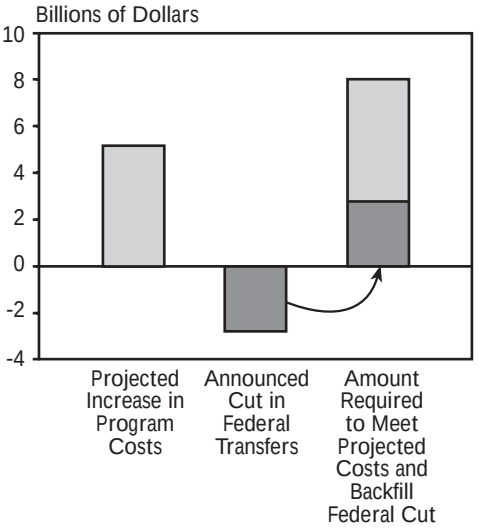
In 1994/95, prior to the introduction of the CHST, the federal cash transfer in respect of health care was $8.1 billion. In its 2003 Budget, the federal government announced that when it introduces the CHT in 2004/05, health will receive $12.7 billion, an amount $4.6 billion higher than in 1994/95. At the same time, when it introduces the CST, funding for post-secondary education and social services will be set at a level of $7.8 billion, an amount $2.8 billion less than in 1994/95. Chart 4 illustrates that almost 60% of the increase in federal support for health care comes at the expense of its commitment to social services and post-secondary education. This action significantly undercuts the value of the announced increases in funding for health care, and represents a significant and imminent problem for provincial and territorial governments.

The drastic reduction in federal financial support for post-secondary education and social services takes place over the same timeframe as program costs are projected to have risen appreciably. Based on cautious assumptions, it is estimated that the cost of these programs will be about $5.2 billion higher in 2004/05 than in 1994/95. Not only will there be no increase in federal funding to assist with the burden of need in these areas, but the federal government will actually be offloading on to provincial and territorial governments an additional cost burden of $2.8 billion. As Chart 5 shows, the bottom line is that, compared to 1994/95, provinces and territories will face an increase of $8 billion in costs by 2004/05, over one-third of which is as a direct result of the way in which the federal government is establishing the base amount for the CST.

The pattern of declining federal support for post-secondary education and social services (in the face of growing expenditure pressures) found in the federal projections, parallels the situation in which declining federal support led to the current crisis in health care in Canada.

Chart 5

Impact of CST Implementation, 2004/05 Compared to 1994/95



Sources: Federal Department of Finance, 2003 Federal Budget, Manitoba Finance

"With the current fiscal regimes in place, the vertical fiscal imbalance will widen in the future, as only the federal government has the financial capacity to pay down its debt or implement new initiatives such as tax cuts and new discretionary program spending. In contrast, the provinces and territories will have no leeway to implement new policy initiatives over the next two decades."

Conference Board of Canada, *Vertical Fiscal Imbalance: Fiscal Prospects for the Federal and Provincial/Territorial Governments* (July 2002)

Although the CST is scheduled to increase once implemented, these modest increases follow a decade in which federal underfunding has been backfilled by provincial and territorial governments. Moreover, the level of federal support that existed in 1994/95 is not restored even in nominal dollar terms. For the federal government to match the share of funding for post-secondary education and social services it provided in 1994/95, it will have to add $4.3 billion in funding in 2004/05 to the amount announced in its 2003 Budget – $2.8 billion to get back to its 1994/95 level, and an estimated $1.5 billion to get back to the same share it provided in 1994/95.

Improvements in health and other social programs tend to reinforce one another. We need a better balance of social and medical services; to achieve better health outcomes and higher levels of investment in students, colleges and universities; to address critical health human resource shortages; and to compete in an increasingly knowledge-based, technologically advanced and global economy.

■ The responsibility-resource imbalance goes unaddressed

According to the terms of the 2003 Arrangement, the Health Reform and Diagnostic/Medical Equipment Funds are to be used to increase access to a wider range of services. As a result, these Funds will serve to establish a higher spending track for health care in the foreseeable future. While provinces and territories work to improve the quality of, and access to, health care, it remains to be seen whether or not these changes in services and program delivery will help contain expenditure growth in the future.

Most of the new money flowing to provinces and territories is tied to expanded services related to health care reform. Therefore, the 2003

Arrangement will do little to address the underlying imbalance between the responsibilities of the two orders of government, to provide services to Canadians and the financial resources required to adequately address them. The CHST Supplements will provide some temporary relief to provinces and territories in addressing existing cost pressures across the range of services they provide. While certainly welcome, these cash supplements do not represent an ongoing commitment by the federal government and, as a result, do not form the basis of a more permanent solution to the resource problem faced by provinces and territories.

Provincial and territorial budgets are expected to continue to be under stress while the federal government enjoys budgetary surpluses. As a result, the responsibility-resource imbalance will worsen.

■ Manitoba's position

Manitoba is actively engaged in the process of reforming the public health care system to ensure that it meets the needs of Manitobans, and continues to be a superior alternative to a for-profit private system. In this regard, it is clear that the federal government's funding commitment is not adequate, by half, to effect the transition to a more sustainable system as envisaged by both Commissioner Romanow and Senator Kirby. Given this shortfall, Manitoba recommends that the federal government fully recommit itself to the longer-term financial sustainability of health care and other social programs. It should reconsider adopting the Premiers' proposal for re-establishing a meaningful partnership with them in sustaining these key programs into the future.

Because the CHST split is a year away, the federal government still has an opportunity to avoid the major problems caused by its proposed funding for the CST. While provinces and territories continue to have issues with respect to the overall funding level of the CHT, the federal government should ensure

"Much of the money available in the Health Reform Fund will be back-loaded toward the end of the term of the 2003 accord. This may end up delaying needed reform in many areas."

"Change will still occur, but it should be understood, it will occur more slowly than should be the pace, ideally, that Canadians and the system demands."

Hon. Roy Romanow testifying to the House of Commons Standing Committee on Health, April 2, 2003

that increases to the health component not come by way of reductions in the social program component of transfers. Provinces and territories should not again have to backfill for a huge de facto cut in federal transfers for post-secondary education and social services.

Manitoba recommends that when the federal government implements the new CST on April 1, 2004, it be established at a level that restores the same federal share of program funding that existed in 1994/95, prior to the cuts in cash transfers for major social programs.

In addition, Manitoba supports the federal provision to "roll over" the Health Reform Fund into the CHT in 2008/09. Manitoba proposes that the federal government consider doing the same with the Diagnostic/Medical Equipment Fund. Rather than allowing it to expire, the federal government could "roll over" funding into the CHT in 2006/07 to help provinces and territories defray ongoing operating and staff training costs.

■ Conclusion

While the CHST Supplements announced in the 2003 Health Financing Arrangement provide some short-term relief to provinces and territories struggling with cost pressures in health and other social programs, the federal contribution still falls far short of what is required to assure sustainability into the future. Moreover, the amounts targeted for health care reform fall short of even the modest amounts recommended by both federal health care reports. Manitoba remains concerned that the amounts available for reform will not be sufficient to transform the system, and that there are numerous issues yet to be addressed.

The announced measures fail to resolve the issue of an adequate federal partnership in funding major social programs. Future federal funding commitments, specific to the CHT and CST, are

inadequate under the current plan. Canadians want their federal and provincial governments to work together to build and fund effective health, education and social programs, which reflect their values and their priorities, meet their needs and are financially sustainable into the future.

Appendix A:

Details of the 2003 Health Financing Arrangement

	2003 /04	2004 /05	2005 /06	Total 3 Year		2006 /07	2007 /08	Total 5 Year
	(Billions of Dollars)					(Billions of Dollars)		
CHST Increase	0.7	1.3	1.9	**3.9**	*Previously Announced*	2.5	3.1	**9.5**
CHST Supplement	1.0	1.0	0.5	**2.5**	*For Existing Programs*			**2.5**
Additional CHST Supplement*	2.0			**2.0**				**2.0**
Health Reform Fund	1.0	1.5	3.5	**6.0**	***$7.5 billion** - Half of Romanow's $15 billion recommendation*	4.5	5.5	**16.0**
Diagnostic/Medical Equipment Fund	0.5	0.5	0.5	**1.5**		0.0	0.0	**1.5**
New Funding for Patient Care*	4.5	3.0	4.5	**12.0**	***New Funding to Provinces/Territories***	4.5	5.5	**22.0**
Information Technology	0.2	0.2	0.2	**0.6**	*Goes to Canada Health Infoway Inc.*	0.0	0.0	**0.6**
Research Hospitals	0.1	0.1	0.2	**0.4**	*Goes to Canadian Foundation for Innovation*	0.1	0.0	**0.5**
Direct Health Arrangement Initiatives	0.2	0.3	0.3	**0.9**	*Direct Federal Spending*	0.3	0.3	**1.6**
Federal Health Priorities	0.3	0.3	0.3	**0.8**	*Federal Budget Priorities*	0.2	0.3	**1.3**
First Nations Health	0.2	0.2	0.3	**0.7**		0.3	0.3	**1.3**
Total Federal Announcements*	6.2	5.4	7.7	**19.3**		8.0	9.5	**36.8**

* The Additional CHST Supplement of $2 billion in 2003/04, included in the total, will be made available to provinces and territories if "the Minister of Finance determines during the month of January that there will be a sufficient surplus above the normal contingency reserve to permit such an investment."

Appendix B:
History of Federal Support for Major Social Programs

In the 1950s and 1960s, the federal, provincial and territorial governments were partners in forging health and other social service programs in Canada. Programs for hospital and physician services, post-secondary education support and social services were all implemented and expanded in partnership, with the federal government usually providing about 50% of the costs. In some instances, as with post-secondary education and support to less affluent provinces, the federal share exceeded 50%.

As new services were added to the original cost-shared programs, provinces wanted greater flexibility in order to achieve greater efficiencies, while the federal government wanted to reduce its exposure to rising costs. The Established Programs Financing Arrangement (EPF) replaced the health and post-secondary education programs, while the Canada Assistance Plan (CAP) for social services remained cost-shared between the federal and provincial governments. Roughly half of the federal share for EPF programs was added to the provincial share, by way of the federal government vacating tax room. Eventually, the combination of federal cash plus tax room was delivered in a formula that recognized the different tax capacities of provinces and offset them to provide equal per capita transfers. The total of the cash plus tax was to grow at the rate of GDP, providing adequate growth in revenue for the provinces, and affordability for the federal government.

In the 1980s and early 1990s, the federal government began to further reduce its commitment to these essential public services – first through reducing the growth rate of transfers and then through caps on its expenditures. This federal withdrawal culminated in 1996/97 when EPF and CAP were collapsed into the Canada Health and Social Transfer (CHST), and federal support was cut drastically. Within three years of the implementation of the CHST, annual cash

transfers to provinces and territories in respect of health, post-secondary education and social services were cut by one-third, or $6.2 billion.

As a result, by September 2000, provinces were struggling under the weight of increased costs for health and other social programs, while federal support for these public programs sank to record lows in terms of its share of costs. In many provinces, hospital beds were closed, health care professionals were stretched to meet expanding demand, and students faced double-digit increases in tuition fees. Manitobans and other Canadians were alarmed as they witnessed the effect that reductions in federal support had, over time, on the public services they valued.

In this context, the 2000 and 2003 Health Financing Arrangements are clearly positive steps, reversing the trend toward declining federal support for social programs, which had fallen to 14% by 1998/99. However, over the next eight years, federal cash transfers are projected to remain below 17% of total social program costs. Manitoba maintains that this represents an inadequate arrangement for sharing the costs of providing Canadians with their most valued public services, and a missed opportunity for the federal government to strengthen its role as a constructive partner.

Chronology of Federal-Provincial/Territorial Arrangements in Support of Major Social Programs

1958 Hospital and Diagnostic Services Act

1966 Canada Assistance Plan

1967 Federal-Provincial Fiscal Arrangements Acts

1968 Medical Care Act (Medicare)

1977 Established Programs Financing

1996 Canada Health and Social Transfer

2004 Canada Health Transfer
Canada Social Transfer