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FEDERAL SUPPORT FOR HEALTH CARE UNDER BILL C-28: THE BUDGET IMPLEMENTATION ACT, 2003

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INTRODUCTION

Bill C-28, the *Budget Implementation Act, 2003*, received royal assent on 19 June 2003. Part 2 of this bill contains specific provisions that amend the *Federal-Provincial Fiscal Arrangements Act* and ensure increased federal support for health care from 2003-2004 through 2007-2008. Together, these provisions set the stage for a new era of federal and provincial fiscal relations through the use of three distinctive funding mechanisms: block funding with cash and tax components; an immediate cash transfer supplement; and targeted cash transfer arrangements.

Currently, *block funding* is provided through the Canada Health and Social Transfer (CHST). Transfers under the CHST cover not only health care, but also post-secondary education and social programs, including public assistance and early childhood development. Bill C-28 will maintain the current block funding approach for transferring funds to the provinces, but it will divide the CHST into two distinct block funding mechanisms: the Canada Health Transfer (CHT) and the Canada Social Transfer (CST).

Bill C-28 also establishes an *immediate CHST cash transfer supplement*. Some $2.5 billion will be allocated to a CHST Supplement Fund to relieve existing pressures on the health care system. This fund will be available to the provinces from 2003-2004 through 2005-2006, but accounted for by the federal government in 2002-2003. The CHST cash supplement will be transferred to the provinces on a per capita basis, initially under the CHST in 2003-2004, thereafter in the CHT transfers in 2004-2005 and 2005-2006.

Finally, Bill C-28 creates a Health Reform Fund (HRF), which operates through *targeted cash transfer arrangements*. The HRF has a budget of $16 billion over five years (2003-2004 to 2007-2008), which is designated for primary health care reform, short-term acute

home care and catastrophic prescription drug coverage. These cash transfers will be distributed to the provinces on a per capita basis. The purpose of the HRF is to give effect to the 2003 First Ministers' Accord on Health Care Renewal. The fund may be integrated into the CHT starting in 2008-2009, subject to a review by the First Ministers by the end of 2007-2008.

This document examines the provisions of Bill C-28 that relate to the three funding mechanisms outlined above. It assesses the financing arrangements in terms of federal funding visibility, transparency, accountability and predictability. Finally, it discusses the evolution of the federal contribution to health care from 1993-1994 through 2007-2008.

THE CANADA HEALTH TRANSFER AND THE CANADA SOCIAL TRANSFER

Bill C-28 provides that, effective 1 April 2004, federal transfer payments for the purpose of health care will be provided to the provinces through a new funding mechanism, the Canada Health Transfer. The CHT will resemble its predecessor, the Canada Health and Social Transfer, in two key respects: it will be made up of both cash and tax transfers; and its cash component will be subject to the requirements of the *Canada Health Act*.

Unlike the CHST, however, the CHT ensures visibility, transparency, accounting and accountability of the federal contribution to health care.(1) The CHT is expressly dedicated to health care, whereas the CHST covers not only health care, but also post-secondary education and other social programs (such as early childhood development). However, federal government support for health care under the CHT remains *notional*. Although the transfer is directed toward health care, it is not tied to provincial health care spending, nor to the delivery of specific health services. It is important to note, moreover, that the CHT is not a cost-shared program; that is, the amounts of the CHT transfers are not linked to the provinces' own spending on health care. Therefore, federal efforts to spell out the Government of Canada's precise contribution to health care will not affect the provinces' flexibility in allocating the CHT according to their own priorities.

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(1) The need to enhance transparency and accountability in federal health care spending was highlighted recently in three major documents: the October 2002 report of the Standing Senate Committee on Social Affairs, Science and Technology; the November 2002 report of the Commission on the Future of Health Care in Canada (the Romanow Commission); and the February 2003 report by the Premiers' Council on Canadian Health Awareness. Bill C-28 can be seen somewhat as a compromise among the various recommendations contained in these three reports.

The proportion of cash and tax transfers allocated to the CHT will reflect the percentage of provincial health care spending within overall provincial spending in the health care and social sectors currently supported by the CHST. The remaining cash and tax transfers will be allocated to the Canada Social Transfer. The calculation of the value of the total equalized tax transfer will not change from current practice. It is estimated that some 62% of the current CHST tax transfer will be allocated to the CHT, while the remaining 38% will be devoted to the CST. Bill C-28 provides that the cash portion of both the CHT and the CST will increase, by fixed amounts, from 2004-2005 through 2007-2008. Therefore, the total entitlement(2) represented by the two transfers (including both cash and tax transfers) will grow progressively. The total entitlement will then be allocated among the provinces on a per capita basis.

A major caveat with regard to the new CHT is the lack of an adequate escalation formula that would determine the annual growth in transfer payments. Bill C-28 does not contain any provision that would adjust the total CHT entitlement or the CHT cash component according to such a formula. (For example, in the case of the Established Programs Financing [EPF] – the CHST's predecessor(3) – provision was made for federal transfers to increase at the growth rate of the GDP.) Thus, any additional transfer increases under the CHT are left entirely to federal discretion.

Finally, by setting out a long-term funding framework (from 2004-2005 through 2007-2008), Bill C-28 provides the provinces with predictable support for health care and other social programs.

THE IMMEDIATE CASH TRANSFER SUPPLEMENT

Bill C-28 establishes a CHST Supplement Fund of $2.5 billion. The supplement is to be used expressly for the purpose of health care. More precisely, the bill states "for the purposes of relieving existing pressures in the health care system." This CHST cash supplement,

(2) An "entitlement" is a non-discretionary government transfer of a stipulated amount subject to certain eligibility criteria, as specified by legislation or regulations (cited in *Termium*).

(3) More precisely, the CHST resulted from the merging of the Established Programs Financing (for the health care and post-secondary education components) and the Canada Assistance Plan (for the social programs component).

which will be transferred to the provinces on a per capita basis, will be available to the provinces from 2003-2004 through 2005-2006, but accounted for by the federal government in 2002-2003. As mentioned above, the cash supplement will be initially transferred under the CHST (2003-2004), and thereafter under the CHT (2004-2005 and 2005-2006).(4)

Transfers under the CHST Supplement Fund are made under an irrevocable trust agreement that provides for the funds to be paid out to the provinces over three years. Individual provinces can draw down their share of this supplement at any time(s) during that period, in a pattern that best meets the needs of their health care systems. In effect, a province could access all its share immediately.(5)

Trust agreements do not specifically require provinces to indicate that the funds will be used for the intended purposes. The drawdown of these funds is thus not contingent on a requirement to demonstrate that the stated priorities will be addressed. Thus, while the CHST Supplement Fund enhances accounting practice, transparency and the visibility of the federal contribution to health care, it does not result in increased provincial accountability for the use of federal funds.

The federal government's provision of an immediate CHST cash supplement is not a precedent. In its 1999 Budget, the federal government provided $3.5 billion as an immediate, one-time supplement to the CHST; the funds were available over the following three fiscal years (1999-2000 through 2001-2002), but were accounted for in 1998-1999. This cash supplement was to be used expressly for the purpose of health care.(6) Similarly, the 2000 Budget announced a $2.5-billion CHST cash supplement, to be accounted for by the federal government in 1999-2000, but to be allocated to the provinces on a per capita basis from 2000-2001 through 2003-2004. This additional funding was to be used for the purposes of health care, post-secondary education and other social programs.(7)

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(4) $1.0 billion in both 2003-2004 and 2004-2005, and $500 million in 2005-2006.

(5) According to information provided in Volume I of the *Public Accounts of Canada, 2003* (pp. 2-33 and 2-34).

(6) $2.0 billion in 1999-2000, $1.0 billion in 2000-2001 and $500 million in 2001-2002.

(7) $1.0 billion in 2000-2001 and $500 million in the three following fiscal years.

THE HEALTH REFORM FUND

Bill C-28 creates a new section in the *Federal-Provincial Fiscal Arrangements Act* that establishes the Health Reform Fund, designed to give effect to the 2003 First Ministers' Accord on Health Care Renewal. Cash transfers under the HRF are provided through *targeted cash transfer arrangements*. The HRF has a budget of $16 billion over a five-year period (2003-2004 to 2007-2008), which is designed for primary health care reform, short-term acute home care and catastrophic prescription drug coverage. These cash transfers will be distributed to the provinces on a per capita basis. The fund may be integrated into the CHT starting in 2008-2009, subject to a review by the First Ministers by the end of 2007-2008. Although not part of the CHST or CHT, cash transfers provided under this fund are subject to the requirements of the *Canada Health Act*.

The HRF clearly improves federal accountability, visibility and transparency with respect to health care. It also provides the provinces with a secure and predictable level of federal funding that can foster health care reform and renewal. Moreover, it initiates a new era of federal-provincial fiscal relations: for the first time since the establishment of block funding, federal transfers are to be devoted to three specific fields of health care – primary health care, short-term acute home care and catastrophic prescription drug insurance. This approach signals a stronger federal presence in setting the direction of health care reform. It is still unclear how provinces will be made accountable for their use of the HRF transfers and what conditions, if any, will apply to the three specific fields.

EVOLUTION OF FEDERAL TRANSFER PAYMENTS

Table 1, below, shows the evolution of federal transfer payments to the provinces under EPF/CAP, the CHST, the CHT/CST and the HRF from 1993-1994 to 2007-2008. Table 2 provides details of cash and tax transfers to the provinces for both the CHT and the CST from 2004-2005 to 2007-2008. These data were used to construct Figure 1.

Table 1
Federal Transfer Payments Under EPF/CAP, CHST, CHT/CST and HRF
1993-1994 to 2007-2008
(in Millions of Dollars)

Fiscal Year	CHST and CHT/CST[1]		Immediate CHST Cash Supplement	Subtotal CHST or CHT/CST	Health Reform Fund	Total Transfer Payments
	Cash	Tax	Cash	Cash + Tax	Cash	Cash + Tax
1993-1994	18,810	10,181	-	28,991	-	28,991
1994-1995	18,719	10,651	-	29,370	-	29,370
1995-1996	18,476	11,406	-	29,882	-	29,882
1996-1997	14,742	12,158	-	26,900	-	26,900
1997-1998	12,500	13,339	-	25,839	-	25,839
1998-1999	12,500	14,341	-	26,841	-	26,841
1999-2000	14,500	15,605	2,000	30,105	-	30,105
2000-2001	15,500	16,415	2,000	31,900	-	31,900
2001-2002	18,300	16,153	1,000	34,450	-	34,450
2002-2003	19,100	16,150	500	35,250	-	35,250
2003-2004	20,800	16,950	1,500	37,750	1,000	38,750
2004-2005	21,400	17,900	1,000	39,300	1,500	40,800
2005-2006	21,500	18,900	500	40,400	3,500	43,900
2006-2007	21,600	20,000	-	41,600	4,500	46,100
2007-2008	22,200	21,100	-	43,300	5,500	48,800

(1) Data correspond to EPF plus CAP for fiscal years 1993-1994 and 1994-1995.

Sources: Economics Division, Parliamentary Research Branch, Library of Parliament. Based on Department of Finance data in the following three documents: *The Budget Plan, 2003*, 18 February 2003; *Canada Health and Social Transfer: First Estimate, 2003-2004*, 18 February 2003; and *Established Programs Financing: Final Calculation, 1995-1996*, 12 October 1998.

Table 2
Federal Transfer Payments Under the CHT and the CST
2004-2005 to 2007-2008
(in Millions of Dollars)

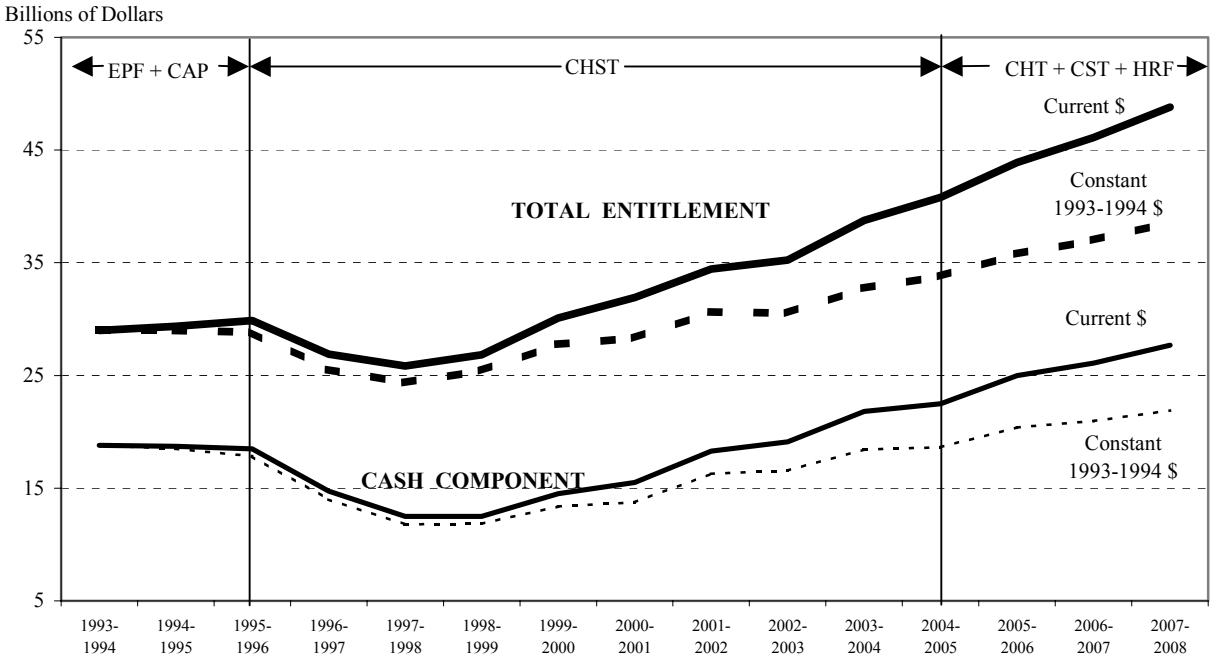
Fiscal Year	Canada Health Transfer		Canada Social Transfer		Total
	Cash[1]	Tax	Cash	Tax	Cash + Tax
2004-2005	13,650	11,100	7,750	6,800	39,300
2005-2006	13,500	11,700	8,000	7,200	40,400
2006-2007	13,400	12,400	8,200	7,600	41,600
2007-2008	13,750	13,100	8,450	8,000	43,300

(1) The immediate CHST cash supplement is included in the CHT cash transfer for fiscal years 2004-2005 and 2005-2006.

Sources: Department of Finance, *The Budget Plan, 2003*, 18 February 2003; and Economics Division, Parliamentary Research Branch, Library of Parliament.

Figure 1 traces the evolution of federal transfer payments to the provinces for the purposes of health care, post-secondary education and social programs, in both current dollars and constant 1993-1994 dollars. It shows that the coming into force of the CHST legislation led to a significant reduction in the total entitlement. The impact of that reduction was more than proportionately reflected in the cash transfer, because the tax transfer continued to grow. These downward trends were reversed in 1998-1999 for the total entitlement and in 1999-2000 for the cash transfer. Thereafter, both the total entitlement and the cash transfer have grown continually. Bill C-28, which enforces the CHT, CST and HRF, will lead to a substantial growth in federal transfer payments for health care, post-secondary education and social programs.

Figure 1
EPF/CAP, CHST, CHT, CST and HRF
Total Entitlement and Cash Component



Sources: Department of Finance and Library of Parliament. The conversion into constant (1993-1994) dollars was made by using the implicit GDP price deflator from Statistics Canada. Projections are based on data produced by TD Economics Forecast.

Expressed in current dollars, the total entitlement regained its 1995-1996 peak level in 1999-2000, while the cash transfer matched its 1993-1994 peak level in 2002-2003. However, when converted into constant (1993-1994) dollars, the total entitlement surpassed the 1995-1996 level only in 2001-2002, while the cash transfer will not regain its peak level of 1993-1994 until 2005-2006. In other words, although Bill C-28 will result in real growth in cash transfers, it will take another three years to restore the level of federal cash funding that was provided prior to the creation of the CHST.

In effect, then, provinces will have to undertake the renewal of the health care system, including reforming primary health care and expanding public coverage to short-term acute home care and catastrophic prescription drugs, with the same level of federal *cash* transfers as some ten years ago, or the same level of total entitlement as some eight years ago. Consequently, the renewal and expansion of health care will be achieved mainly through the increasing value of the federal *tax* transfers.

The concern has been raised that the federal government's increased support for health care may come at the expense of its commitment to social programs such as post-secondary education and early childhood development.(8) Table 3, below, compares federal funding levels for health care, post-secondary education and social programs under EPF and CAP to the levels under the new CHT and CST. As the table shows, federal cash transfers for health care, post-secondary education and social programs will be $21.4 billion in 2004-2005, or $2.7 billion higher than in 1994-1995. This net increase consists of an increase of $5.6 billion in funding for health care and a reduction of $2.9 billion in funding for post-secondary education and social programs.

An examination of the total entitlement levels reveals a similar pattern. The total entitlement for health care, post-secondary education and social programs will amount to $39.3 billion in 2004-2005, or almost $10 billion higher than in 1994-1995. This increase, however, includes $9.5 billion in enhanced federal support for health care, and only an additional $500 million in federal support for all social programs.

It would seem, therefore, that the federal government's decision to split its transfer payments between the CHT and the CST may well result in a reallocation of funds away from post-secondary education and social programs, at a time when the provinces are being pressed to undertake major health care reform in their respective jurisdictions.

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(8) See Canada's Western Finance Ministers, *Federal/Provincial/Territorial Fiscal Relations in Transition*, Report to Canada's Western Premiers, June 2003.

Table 3
Federal Funding for Health Care, Post-Secondary Education and Social Programs
(in Millions of Dollars)

	EPF/CAP		CHT/CST[1]			
	1994-95	1995-96	2004-05	2005-06	2006-07	2007-08
CASH TRANSFER						
▪ Health Care	8,073	7,955	13,650	13,500	13,400	13,750
▪ Post-Secondary Education and Social Programs	10,646	10,521	7,750	8,000	8,200	8,450
Total	18,719	18,476	21,400	21,500	21,600	22,200
TOTAL ENTITLEMENT						
▪ Health Care	15,302	15,697	24,750	25,200	25,800	26,850
▪ Post-Secondary Education and Social Programs	14,068	14,185	14,550	15,200	15,800	16,450
Total	29,370	29,882	39,300	40,400	41,600	43,300

(1) Excludes funding under the Health Reform Fund.

Source: See Table 1.

CONCLUSION

Bill C-28 enhances the visibility, transparency, accountability and predictability of the federal contribution to health care. It also results in a substantial growth in federal transfer payments. However, future increases in federal funding for health care are left entirely to federal discretion. Moreover, growing federal cash transfers will match their 1993-1994 peak level only in 2005-2006. As a result, provinces will have to undertake major reforms in health care with the same level of federal cash transfers, expressed in real terms, as they had a decade ago; these reforms will be funded mostly through the increasing value of the federal tax transfers.

There is concern that the renewal and expansion of health care in the provinces may take place at the expense of other important social programs, including post-secondary education. It would not be surprising if, in the coming months, the provinces were to exert pressure on the federal government to increase its contribution to the other fields supported by the CHST, while maintaining the level of transfer payments allotted to health care under Bill C-28.

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