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ESTABLISHED PROGRAMS FINANCING FOR HEALTH CARE

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ESTABLISHED PROGRAMS FINANCING FOR HEALTH CARE

INTRODUCTION

The federal government helps the provinces to discharge their responsibilities for health care primarily through transfer payments made under Established Programs Financing (EPF). EPF payments to the provinces form the foundations of intergovernmental fiscal relations and represent substantial amounts of money, which are transferred in the form of cash and tax points.

EPF constitutes in fact the main form of federal assistance to the provinces. In the 1991-92 financial year, all federal transfers to the provinces are expected(1) to amount to over $36.9 billion, including all monetary and fiscal transfers; the EPF program alone will account for some $20 billion, or about 55% of all transfers to the provinces. Of this amount, $14 billion will be allocated to health care.

Although the structure of EPF has remained essentially unchanged since its inception in 1977, its rate of growth has moderated. In fact, the constraints on the growth rate of EPF transfers imposed by the federal government over the last few years raise some doubt about the ability of some provinces to maintain a satisfactory level of health services. The slowing growth rate of the transfers has also prompted concern about the preservation of national standards of health care. Finally, together with the prevailing constitutional uncertainty, the reduction in transfers to the provinces once again raises the thorny question of the separation of powers between the federal and provincial governments.

This paper addresses these various questions. The first part examines the reasons for government intervention in health care. The second part describes the nature and mechanisms of EPF arrangements between the federal and provincial governments. The third

(1) Michael H. Wilson, Minister of Finance, The Budget, 26 February 1991, p. 18, 63, and 70.

part discusses the transfer payments to the provincial governments for health care and analyses changes in them over the last 15 years. The last part of the paper addresses the problems raised by the fiscal and financial arrangements on which EPF is based.

A. The Government's Role in Health Care

In 1990,[2] more than $60 billion, or 9.2% of the Gross Domestic Product, was devoted to health care. About 73% of all health-related expenditure was assumed by some level of government, whether federal, provincial, or municipal.

The omnipresence of government in health care is generally explained by reference to certain imperfections in the market system.[3] In the private sector, resources are allocated according to the law of supply and demand. The resulting price levels ensure optimal allocation of resources when certain conditions relating to supply and demand are met. However, these conditions do not always prevail in the area of health care.

First, it is difficult for the market system to ensure an adequate supply of health services because of the very nature of these services, which include types of costs and social advantages which the market system does not take into account. Furthermore, consumers cannot be fully informed, because uncertainty always exists about illnesses and future states of health. Consumers are often unable to determine for themselves the type of health services they need and must therefore delegate their free will in the decision-making process to those who provide health services.

Government intervention in health care is also justified by reasons of social fairness. The most frequently mentioned social inequality is basically economic. In a fee market system, low-income people with health problems pay the same as high-income people. As a result, the economically disadvantaged pay a relatively larger share of their income for health costs.

For these reasons, federal and provincial governments in Canada have preferred public insurance to private insurance. Government intervention in health care cannot, however, be explained entirely by economic and social weaknesses in the market system. This is amply

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(2) Standing Committee on Health and Welfare, Social Affairs, Seniors and the Status of Women, *The Health Care System in Canada and its Funding: No Easy Solutions*, Ottawa, June 1991, p. 17.

(3) For a detailed analysis of the government's role in health care, see Evans (1984) and Rheault (1990) in the select bibliography.

demonstrated by the example of the United States, where health care relies heavily on the private sector. The contrasting levels of government intervention in Canada and the United States are largely explained by the two countries' differing ideal of the proper role of government. In the eyes of some,(4) the omnipresence of government seems to explain why the Canadian system is superior to the American system.

B. The Nature and Mechanisms of EPF Arrangements

Health services are financed through powers shared among various levels of government. The public health insurance system established over the last few decades is based on the distribution of powers in the Constitution, according to which the delivery of health services falls essentially under provincial jurisdiction. The main lever through which the federal government exercises its influence in this area is the "spending power" accorded to it under the Constitution. This power enables the federal parliament to transfer funds to people, organisations or other levels of government in areas over which it does not necessarily have any legislative power.

The federal spending power has therefore prompted the emergence of transfer programs to the provinces. Federal government involvement in the financing of provincial health programs ballooned during the 1960s with the establishment of a national public insurance system covering hospital, diagnostic and medical services. At the time, this expanding federal involvement was seen as responding to both the increased needs of the provinces and the desire to establish an equitable, uniform system across the country.

The mechanisms of federal government financing have, however, changed over the years. Before the adoption of EPF, federal transfers were based on more or less equal cost-sharing formulas for both hospital insurance and medical insurance, but the formulas for calculating provincial entitlements differed for each program.

Payments due to the provinces under the Hospital Insurance and Diagnostic Services Act were calculated as follows: a province's entitlement in a given year was equal to 25% of the average national per capita cost of the insured services, plus 25% of the cost of the

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(4) David W. Conklin, "Why Canada's System is Better and Cheaper," *Policy Options*, Vol. 11, No. 4, May 1990, p. 15-18 and Charles A. Bowsher, *Canadian Health Insurance: Lessons for the United States*, Statement Before the Committee of the House of Representatives on Government Operations, 4 June 1991.

insured services per resident of that province multiplied by the population of that province in that year. Overall, the federal government's contribution was equal to about 50% of the cost of the insured services in Canada, although it was more in the provinces where the per capita cost was lower than the national average and less in the other provinces.

Under the *Medical Care Act,* a province's entitlement in a given year was equal to 50% of the average national per capita cost of insured services multiplied by the population of that province in that year. As a result, all provinces received equal per capita transfers, although the federal contribution as a proportion of total provincial expenditures varied from one province to another.

Since the establishment of EPF in 1977, the total entitlements paid to the provinces for hospital insurance, medical insurance and extended health care have been based on the average federal per capita contribution paid out in the 1975-76 financial year, cumulatively increased year by year according to an escalator. This escalator corresponds to a moving average of the gross per capita national product over three years. The use of a moving average makes it possible to moderate any overly sharp fluctuations in the GNP so that the escalator reflects the average trend.

The EPF arrangements between the federal and provincial governments have both a financial aspect and a fiscal aspect. Cash transfers to the provinces are made periodically by cheque, while the federal government also accords a certain tax room to the provinces through the transfer of tax points. For this to happen, the federal government reduces its tax rates while the provinces raise theirs by an equivalent amount. The fiscal burden falling on taxpayers remains the same, although they pay more provincial tax and less federal tax. The amount of revenue thus foregone by the federal government is deducted from the cash transfers to which the provinces would otherwise be entitled. The fiscal transfer is 13.5 tax points on individual income tax and one tax point on corporate tax. As part of its opting-out agreements, Quebec receives a special reduction of 8.5 points on individual income taxes. In comparison with the other provinces, Quebec therefore receives a larger share of its federal contribution in the form of cash transfers. In total, however, Quebec's per capita entitlements under EPF are exactly the same as those of the other provinces.

There are various other interesting aspects of the financing mechanisms established under EPF:

a) The formula used to calculate provincial entitlements is based on the expansion of Canada's collective wealth. When an economy has a large capacity to produce goods and services, governments can easily raise revenues on the commercialization of those goods and services in order to finance health services.

b) The performance of the Canadian economy affects the size of the transfers which the federal government makes to the provinces in tow ways: first, economic growth affects the calculation of the escalator and second, it has a direct influence on federal individual and corporate tax revenues. When the economy turns down, the escalator used to adjust the total amount of transfers also decreases. Poor economic growth also reduces federal government tax revenues, resulting in lower total point transfers.

c) The federal contribution depends not only on economic growth but also on any changes that might be made to federal tax law and to the legislation governing fiscal arrangements. For example, changes to the income tax system which allowed the federal government to increase its general revenues would result in decreased transfers to the provinces because this tax increase would increase the value of a tax point. Any expansion of the federal income tax base or increase in tax rates would have a similar effect.

d) There is a redistributive aspect to the provincial entitlements under EPF. Entitlements are equalized on the level of a representative five-province standard under the general equalization formula. The provinces whose fiscal strength (i.e. capacity to raise revenues) is lower than this standard benefit from equalization. The provinces which make up the standard are Quebec, Ontario, Manitoba, Saskatchewan and British Columbia. As stated by the National Council of Welfare,(5) the EPF entitlements paid by the federal government "play a vital role in offsetting regional disparities and the difficulties poorer provinces have in providing a full range of programs and services to their residents."

e) In contrast to the cost-sharing formula before 1977, EPF provides for block funding. The provinces can use EPF funds according to their own priorities.

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(5) National Council of Welfare, *Funding Health and Higher Education: Danger Looming*, Spring 1991, p. 5.

Because it reflects economic growth and can be changed by a unilateral decision of the federal government, the formula used to calculate federal contributions contains an element of uncertainty regarding both the total amount of transfers and their rate of growth. EPF provides an equitable financing mechanism: provinces receive equal per capita transfers, so that the amount of help they receive depends on the size and growth rate of their populations.

In order to receive all their health entitlements, the provinces must, however, comply with certain criteria, which are as follows:(6)

universality:	all insured persons must be entitled to the services
comprehensiveness:	all necessary insured services must be covered
accessibility:	services must be offered on uniform terms and conditions; no measure may be taken which would impede reasonable access to these services
portability:	individuals must remain insured when they are temporarily absent from their home province or from Canada
public administration:	health plan must be administered by a public authority on a non-profit basis

These criteria are considered to be "national standards" and are stipulated in the Canada Health Act, which also sets out the financial penalties to be imposed on provinces that allow extra-billing or user charges. The penalties for provinces that contravene the provisions of the Act are limited to cash transfers. The adoption of Bill C-20 could increase the penalties on non-complying provinces.

C. Developments in Provincial Entitlements

It is often said that the size of EPF transfers to the provinces for health care gives only a very general impression of federal financial support. Since EPF is a block-funding program, the distribution of funds between health and post-secondary education (67.9% and 32.1% respectively) is very arbitrary. These percentages do not necessarily reflect equal apportionment at the provincial level, since the provinces may use the transfers they receive under EPF according to their own priorities. Furthermore, the federal government's financial

(6) Health and Welfare Canada, *Canada Health Act: Annual Report* 1989-1990, p. 9-10.

contribution to health care is not limited to the resources made available under EPF. For example, some expenses incurred under the Canada Assistance Plan are directed toward health care.

In addition to the points addressed above, developments in EPF entitlements for health care merit close examination because of their political aspects. The federal contributions that were used to calculate entitlements in the first year that EPF was introduced are shown in Table 1.

TABLE 1

FEDERAL CONTRIBUTIONS TO HOSPITAL INSURANCE AND MEDICAL INSURANCE IN THE 1975-76 BASE YEAR

PROVINCE	Millions of Dollars	$ Per Capita	% of Costs
Newfoundland	76.4	139.14	56.3
Prince Edward Island	14.8	126.39	62.2
Nova Scotia	111.6	136.18	54.2
New Brunswick	92.8	139.50	57.1
Quebec	914.5	148.00	47.7
Ontario	1, 181.7	144.60	50.2
Manitoba	148.8	146.80	55.2
Saskatchewan	127.6	140.62	54.1
Alberta	257.3	144.69	50.4
British Columbia	341.4	140.31	48.5
TOTAL	3, 256.9	144.25	50.2

Source: Allan J. MacEachen, *Federal-Provincial Fiscal Arrangements in the Eighties*, April 1981, p. 76-77.

It is evident that federal contributions to health care during the last year in which the old agreements were in effect varied considerably from one province to another. The per capita contribution of the federal government varied between $126 in Prince Edward Island and $148 in Quebec. Table 1 also shows that some of the wealthiest provinces received greater per capita transfers than other provinces under the old agreements. In the first year in which EPF was in effect, the average federal per capita contribution of $144 was increased by the escalator

calculated at 14.85%. As a result, all provinces received a per capita transfer of about $166. With the introduction of EPF, therefore, all provinces received the same per capita amount for health care. The provinces which had received relatively lower per capita transfers under the old shared-cost arrangements–in fact the poorer provinces–received much larger payments under EPF. This is because the EPF provisions contain a certain amount of equalization. In addition, a $20 per capita supplement was offered, beginning in 1977-78, to help finance extended health services. Since then, the federal contributions to the provinces in the base year were supposed to have risen cumulatively from year to year, reflecting the rate of increase in the GNP and population, i.e., according to adjustments in the escalator.

However, federal EPF transfers have in fact been reduced since 1986 in an attempt to reduce the federal deficit. First, in 1986, the Canadian parliament adopted Bill C-96, reducing the growth of EPF transfers. The payments were still tied to economic and demographic growth, but their annual per capita growth rate was 2% lower than it would have been under the old formula. Then Bill C-69, adopted in 1991, froze per capita EPF transfers at their 1989-90 levels for two year. Finally, Bill C-20, which received first reading on 31 May 1991, extends the freeze on per capita transfers to the provinces for three years. The provincial entitlements will therefore continue to increase at the same rate as the population. Bill C-20 also states that beginning in 1995-96, the rate of increase in EPF entitlements will be limited to the per capita rate of increase in the GNP minus 3%.

Figure 1 shows the changes in total federal EPF contribution for health care in budget-year and constant dollars. If transfers to the provinces are studied over a period of about 20 years, the rate of growth in real terms seems to go through three different phases. Over the decade from 1977 to 1987, transfer payments increased steadily, and then flattened out between 1987 and 1990. Finally, federal transfers for health care are expected to begin to decline in real terms in 1990-91.

Because of its deficit and desire to reduce expenses, the federal government wished gradually to level off or even reduce its contribution to health care. In the long run, the federal cutbacks will result in sharply reduced revenues for provincial governments,[7] leading some people to say that the federal government is “vacating” the health sector.

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(7) For a quantitative assessment of the effects of limitations on the growth of transfer payments, see the information published by the National Council of Welfare, Spring 1991, or the Health Action Lobby, June 1991, which appears in the select bibliography.

Figure 2 shows clearly the diverging paths of transfers in the form of cash and tax points. The monetary part of the total transfer is declining because the overall rate of EPF growth has slowed as a result of the federal government's budgetary restraint and because there has been relatively rapid growth of fiscal transfers.

In the medium term, the constraints on the growth rate of EPF transfers will cause the conditional cash payments to disappear. As a result, the federal government may no longer have the necessary means at its disposal to ensure maintenance of the standards of health care set forth in the Canada Health Act.

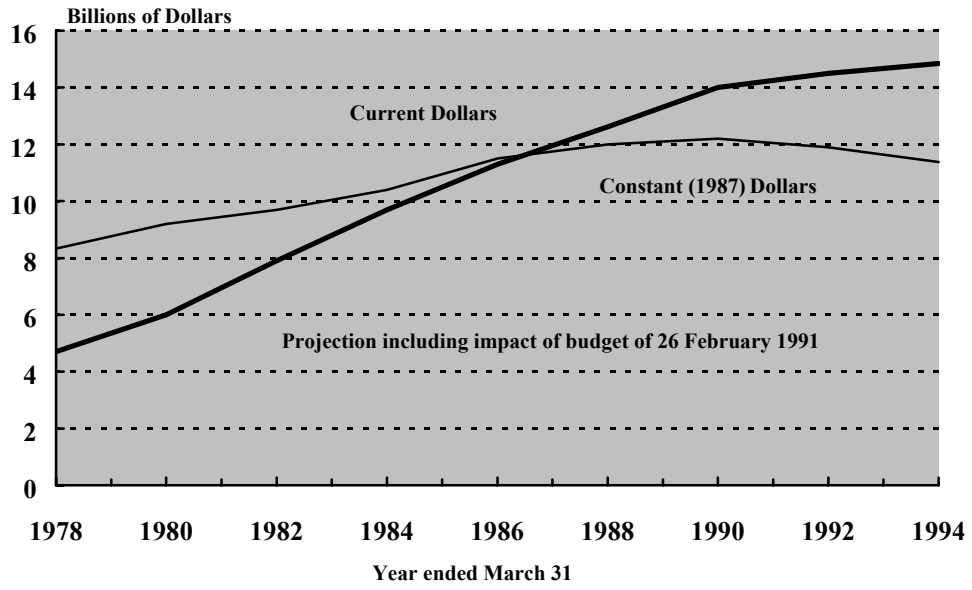
D. Consequences of Limiting the Rate of Growth of Transfer Payments

The numerous modifications to the system made by the federal government since 1986 have considerably affected the growth rate of transfer payments to the provinces and aggravated the financial imbalance in some provinces. What is more, these changes threaten to compromise the very nature of the arrangements made under EPF.

1. Provincial Finances

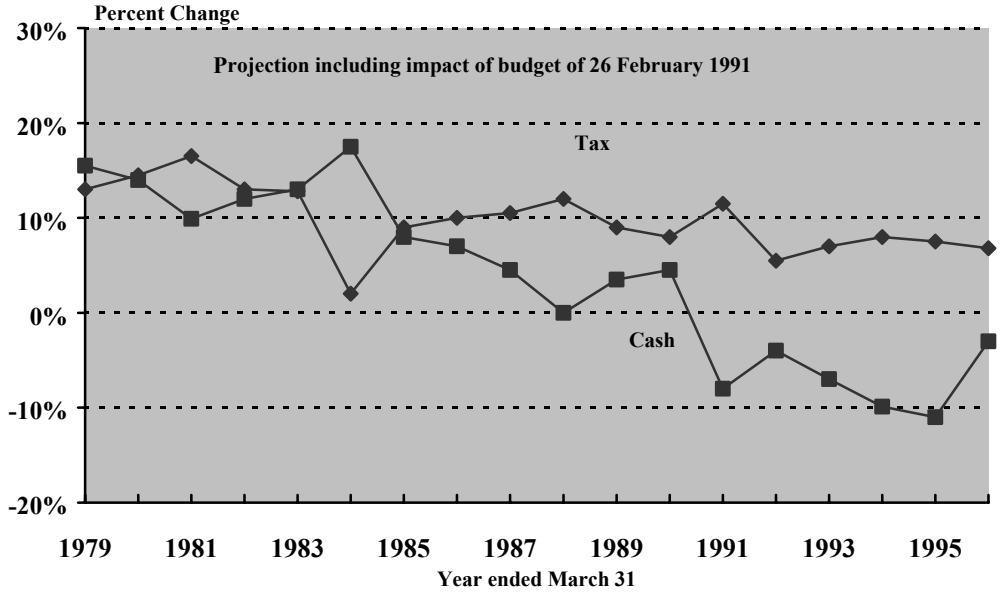
The aim of the limits placed on the growth rate of EPF transfers is to reduce the federal deficit, which is now causing numerous distortions in the Canadian economy. A substantial cut in the size of the budget deficit would make it possible to stabilise the debt : GDP ratio. If the growth rate of the debt were brought down to that of the economy as a whole, it would be possible to maintain at a constant level the share of our collective wealth devoted to servicing the debt, which in turn would diminish the vulnerability of public finances to an economic downturn.

Figure 1
Federal EPF Transfers for Health
(Billions of Current and Constant Dollars)



Source: Department of Finance

Figure 2
EPF Transfers for Health
(Year over Year Percentage Change)



Source: Department of Finance

The provinces look askance at the federal government's attempts to stabilise public finances by reducing transfer payments. Provincial governments maintain that the federal reductions are inappropriate because transfer payments to the provinces are not the cause of the deficit. Furthermore, attempts to stabilise the federal budget through cuts in transfer payments to the provinces simply shift costs from one level of government to another, thereby forcing the provinces to reassess their priorities in order to offset the loss of revenues from Ottawa. If the provinces wish to maintain their current levels of health care spending, they must choose between increasing their deficits, increasing revenues through greater taxation, or charging a user fee for health services. The alternative would be to reduce the quality of health care. Ultimately it is the taxpayer or consumers of health care services who will have to bear the brunt of readjustment.

Two points in the debate on cuts to EPF transfers deserve particular attention:

1. EPF transfers include an equalization aspect intended to enable all the provinces to provide their residents with reasonably comparable levels of public health services without having to resort to heavy taxation. In order to be fair to all the provinces, the federal government sought with the introduction of EPF to moderate the sharp differences in per capita contributions from one province to another. As federal transfers are cut back, the poorer provinces are experiencing mounting difficulties in providing a broad array of health services to their residents. At the same time, the governments of these provinces are not in a position to pay an increasing proportion of health care costs from their own budgets.

2. The restrictions on EPF transfers have fuelled the debate about underfunding of the health care system. Most experts maintain, however, that public funding of the health care system is adequate at the present time. The problem, they say, is that the money devoted to health care is not spent in an optimal fashion.(8)

From this point of view, the debate on funding should not focus on staying within the allotted budget but on effects as far as health is concerned. Since a considerable share of public finances is devoted to the health care system, we should at least inquire into the

(8) See for example Robert Evans, "Health Care: Is the System Sick?" in Doern & Purchase (eds.), *Canada at Risk? Canadian Public Policy in the 1990s*, C.D. Howe Institute, 1991, p. 225-244.

possibilities of using the resources more efficiently and improving the effectiveness of the delivery system.

2. National Standards

The provincial entitlements for health care under EPF are covered by the Canada Health Act, which provides financial penalties for provinces that fail to maintain national standards or that authorise extra-billing or user fees. At present, the Governor in Council can hold back or reduce the amounts due under EPF to a province that does not comply with the provisions of the Act. The penalties have been limited, at least so far, to the total amount of cash transfers.

One important result of the constraints on the growth rate of transfer payments is the disappearance in the medium term of cash payments under EPF. Without cash payments, however, the federal government has no means to ensure that the criteria and conditions set forth in the Canada Health Act are upheld.

In order to preserve this power, the federal government, on 31 May 1991, gave first reading in Parliament to Bill C-20, which would allow other federal payments to the provinces to be withheld if the provinces contravened the provisions of the *Canada Health Act*.

This measure is welcomed by those who fear that limitations on cash payments might exacerbate discrepancies between the provinces in the level, quality and accessibility of health care services.(9) Facing those who fear a "dismantling" of the national health insurance system, however, are others who wonder if national standards are still justified.(10)

When the public health insurance plans were established in the early 1960s, national standards were unquestionably very important. These standards justified the federal presence in health care because they made it possible to offer all Canadians comparable and acceptable levels of care.

Some argue that these national standards have now been largely achieved.(11) They maintain that although these standards ensure a certain amount of uniformity in the

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(9) This is the position adopted notably by the National Council of Welfare, Spring 1991.

(10) See for instance Mel Couvelier, *Resolving Canada's Dangerous Fiscal Situation Through Renewed Federation and Fiscal Discipline*, 10 September 1990, p. 3 and 4.

(11) Some authors expressed this opinion even before the adoption of the Canada Health Act. See for example Thomas J. Courchene, *Refinancing the Canadian Federation: A Survey of the 1977 Fiscal Arrangements Act*, C.D. Howe Institute, 1979, p. 20-23.

provincial health care programs, they exacerbate the rigidity of the framework within which provincial governments are attempting to improve their health care systems. As a result, national standards allegedly detract from the efficiency of health care and the effective use of resources. In this view, the provinces are perhaps better placed than the federal government to determine the type of health care program that best suit the needs of their residents.

3. Shared Responsibility

Some analysts emphasize the contradiction in the existence, side by side, of the EPF agreements and the Canada Health Act. While the basic objective of EPF was to provide the provinces with greater latitude in their areas of jurisdiction, the Canada Health Act limits to some extent the full exercise of provincial authority over health care. Ultimately, shared responsibility between the two levels of government continues to be a problem.

Perhaps a new method of distributing financial and fiscal resources, one that would be more instep with the Canadian political and economic system, should be considered. For example, a disentanglement of federal and provincial funding could be achieved by a partial or complete replacement of EPF cash payments with transfers of tax points and some associated adjustments in the equalization program. The Economic Council of Canada has already studied this type of option, and indicated that a separation of this kind would better reflect the division of powers between the two levels of government. According to the Economic council, this option would provide a clearer division of responsibilities and would probably reduce the likelihood of friction between the federal and provincial governments.(12)

The Group of 22 has made a similar proposal.(13) It also suggested that the provinces agree to entrench in the Constitution certain guarantees regarding services so that Canadians will continue to benefit from easy access to health care.

In the present context of constraint on EPF transfers, these options deserve perhaps greater attention than they have received so far. They would satisfy those provinces that want a reassessment of the constitutional division of powers, while at the same time the proposed adjustments in equalization would serve to maintain an adequate level of health services in the poorer provinces.

The complete withdrawal of the federal government from transfer payments for health through a grant to the provinces of tax room equivalent to its contributions (at least what

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(12) Economic Council of Canada, *Financing Confederation Today and Tomorrow*, 1982, p. 139.

(13) Group of 22, *Some Practical Suggestions for Canada*, June 1991, p. 17.

remains of them) would also make the provinces less dependent in regard to one aspect of their health insurance program financing. The federal government's withdrawal would also eliminate the uncertainty about the final determination of the total level of transfers and their rate of growth.

In order for these concessions to be made, the federal government and the provinces would have to come to an agreement on the value of the fiscal transfers.(14) The provinces have always considered the tax points granted by the federal government to be an integral part of their tax structure. The federal government, on the other hand, sees the tax point transfers as representing sums of money that would otherwise be paid in cash, and which therefore reduce its revenues.

Difficult negotiations lie ahead when the two levels of government attempt to establish their priorities in health care funding.

CONCLUSION

Over the years, governments have become ubiquitous in the health care field. Government intervention was intended primarily to correct certain imperfections in the market system and to rectify social inequalities. The various levels of government shared responsibilities in this area. Even though health falls under provincial jurisdiction, the federal government has participated financially in establishing a national system of health insurance and remains a relatively important source of funding for the provincial health systems.

Federal contributions have, however, declined over the recent years. While some provinces wish to acquire greater latitude in health care, others fear a decline in their ability to deliver care.

Since the responsibility for health care is divided between two levels of government, the way in which fiscal and financial resources are divided is a key element in the Canadian economic and political system. Any change to the manner in which health care is financed should therefore be the result of negotiations that take into account the principle of financial and fiscal responsibility and are based on criteria for establishing equity between the provinces. Difficult negotiations are to be expected when two levels of government attempt to set out their EPF priorities for health care.

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(14) For a full analysis of the various interpretations of fiscal transfers, see the paper published by the Parliamentary Task Force on Federal-Provincial Fiscal Arrangements, *Fiscal Federalism in Canada*, House of Commons, August 1991.

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