

Health Care



ALTERNATIVE
FEDERAL BUDGET
2017

HEALTH
CARE

HIGH STAKES

- The federal government is negotiating one-off agreements on health care funding with the provinces.
- Our current fee-for-service payment model is susceptible to billing abuse and drives the “one problem per visit” policies of many family doctors.
- Your postal code or socioeconomic status determines whether you receive necessary medication.
- Provincial governments have been discharging patients from hospitals to long-term care to save money.
- One in five Canadians experience a mental health issue a year, which costs the economy more than of \$50 billion annually.

CLEAR CHOICES

- Ensure that all health care in Canada is consistent with the principles of the Canada Health Act
- Create a health accord that delivers stable, predictable, realistic, and long-term funding.
- Expand primary health care teams paid to keep patients well.
- Implement a universal, national pharmacare plan.
- Cover home and long-term care under the Canada Health Act.
- Create a national mental health strategy and program linked to the Canada Health Act.

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Background

In a public opinion poll conducted just before the 2016 federal budget, Canadians picked “spending more on health care” as their top priority for the new government.¹ The Liberals had promised during the 2015 election campaign to make improvements to home care, palliative care, prescription drugs, the Canada Health Transfer, and the Health Accord. The budget itself, however, made no real commitment to strengthening the public health care system, containing only a scattered collection of smaller funding initiatives. The decline in federal leadership on public healthcare, and the downloading of

costs to people who are ill, continues without substantial change.

At 15.1% of GDP, overall federal spending is at one of its lowest rates in the past 65 years, and only slightly higher than 2014-15’s all-time low level of 14.2%.² Still, the government indicated in the budget it would be maintaining the previous government’s reduction in the Canada Health Transfer (CHT) to the provinces. “Starting in 2017-18,” it said, “the CHT will grow in line with a three-year moving average of nominal GDP growth, with funding guaranteed to increase by at least 3.0% year.”³ The 2004 Health Accord included a fixed 6% escalator to compensate for drastic cuts to federal health transfers in the 1990s.

The Parliamentary Budget Officer (PBO) and the Council of the Federation have stated the cut to the CHT will amount to at least \$36 billion in 10 years, or the equivalent of the entire CHT in 2016.⁴ Other estimates put the shortfall from GDP-based increases to health transfers at \$43.5 billion over the first eight years alone.⁵ The provincial and territorial governments believe the loss could be as high as \$60 billion over the next decade.⁶ Under any scenario, the sustainability of public health care is threatened. Nearly 40% of most provincial budgets go to health spending. And while half of this would at one time have come from the federal government, today federal transfers make up a fifth of provincial spending.⁷ While provincial and territorial governments have contained costs in recent years by deferring capital investments, this is unsustainable in the long-term and will lead to increased expenditures in the future at the cost of reduced operating expenses.⁸

A 3% increase to the CHT, as planned, would shift an increasing burden of nearly \$1.1 billion annually onto the provinces.⁹ In late 2016, provincial and territorial finance and health ministers declined a federal offer of a CHT escalator of 3.5% and about \$11.5 billion over 10 years for home care and mental health, which would decrease the federal share of health funding from 23% today to 20% in the future.¹⁰ (For comparison, the federal government wants to spend \$186 billion on infrastructure over the next 11 years.) The federal government refused to accept a counteroffer from the provinces of a 5.2% escalator — the minimum needed for Ontario to continue to offer its current

basket of public health services, according to the province's Financial Accountability Office — in exchange for provincial commitments to spend on mutual priorities, and walked away from the negotiations.

Over a year into their first term as government, the Liberal party has done little to change the overall course of health care funding from that of the preceding government. In 2016, Fall Economic Statement by the Liberal minister of finance, healthcare was disturbingly absent from any meaningful discussion in the document. What is clear is that the impasse between the different levels of government mirrors historical debates regarding the federal government's role in vertical and horizontal fiscal imbalances. Jurisdictional and financial responsibilities are a tenuous relationship in our federation, but they are responsibilities that should fundamentally be guided by improving the health of the Canadians.

Since then, the government has pursued a divide-and-conquer strategy, signing bilateral health agreements with New Brunswick, Newfoundland and Labrador, Nova Scotia, Prince Edward Island, Saskatchewan, Yukon, Northwest Territories, Nunavut, British Columbia, and Saskatchewan. These provinces and territories will receive the CHT on a 3% escalator, or the rate of growth in nominal GDP (the Harper government's proposal), but with additional money for home care and mental health. If another province is able to negotiate a better deal it will be applied in other jurisdictions as well. If nothing changes, the federal government will impose a similar 3% CHT to the remaining jurisdiction on April 1,

2017, and may or may not provide the additional mental health and home care funding.

New Brunswick will receive a \$230 million deal that included funding dedicated to home care and mental health, but this side deal is around \$649 million less than what would have been transferred if the 6% CHT escalator was maintained. Nova Scotia will receive \$157 million for home care and \$130.8 million for mental health. Newfoundland will receive \$87.7 million for home care and \$73 million for mental health.¹¹ Prince Edward Island will receive \$24.6 million for home care and \$20.5 for mental health initiatives. Saskatchewan will receive \$190.3 million for home care and \$158.5 million for mental health services, the province stated it has received a special agreement for one or two year in regards to its private MRI clinics which violate the CHA.¹² The federal position is it has not put its position aside regarding private user-pay MRI clinics but is willing to work with the province to insure the CHA is upheld.¹³ Regardless of the secret agreement on MRIs, the federal government should be proactively enforcing the CHA and stopping violations and not cutting side deals that allow illegal activities to continue. The three territories will get an additional \$36.1 million in new financial funding for mental health and home care over the next 10 years, beginning in the 2017-18 fiscal year. British Columbia will receive an additional \$1.4 billion over 10 years home care and mental health care initiatives.¹⁴ While these bilateral deals are significant, it is worth remembering that the four provinces holding out for a more sufficient deal represent the vast majority of Canada's population (more than 70%).

Pre-2017 budget discussions about the future of medicare remain inundated with buzzwords like “health transformation,” “less bureaucracy,” “efficiency,” “innovation,” and other empty signifiers. Furthermore, the government has presented a false dichotomy between external economic forces and the health of Canadians that reinforces an artificial and deterministic narrative about universal health care being unsustainable. This spurious framing leads to distorted trade-offs between the universality of well-being and cost containment when, in fact, the publicly funded portion of health care has remained stable as a percentage of GDP for over 30 years. The costs that are out of control are outside the medicare umbrella: pharmaceutical drugs, home care, physiotherapy costs, etc. The problem of cost containment is therefore political, not economic.

AFB Actions

A Robust Health Accord

The federal share of national (provincial and territorial) health expenditures remains below the funding floor of 25% called for by the Romanow commission. With the current funding formula, this share of federal funding will be reduced to 14.3% by 2037.¹⁵ In Canada, lagging behind most countries in Europe, only 71% of health expenditures are financed under the public system.¹⁶ Conversely, the private health sector in Canada has now grown to nearly a third (29%) of total health expenditures.¹⁷

Action: Renegotiate a 10-year Health Accord with a minimum 6% escalator to increase the federal share of health spending while enforcing the CHA.

Result: Increased funding will open the policy door to expand medicare to include pharmacare, home care, long-term care, mental health, dental care, and rehabilitation services. A more solid Health Accord will also reinforce health promotion/prevention and other public health programs that require federal and provincial leadership. We need less political gamesmanship regarding issues like homecare and mental health; these two issues are indeed important, and for that reason should not be proposed with ‘sunset funding’ but should be included in the Health Accord. It is intellectually dishonest to pit health accord funding against funding for these initiatives, and will be detrimental to the overall health of the nation. At the same time, the provinces and territories need to be amenable to areas where more accountability can be achieved and stop turning a blind eye to violations of the CHA. The federal government is within their right to demand accountability, and attach strings to funding. But, these strings need to be negotiated and in place to include public delivery of care for the best outcomes of all patients — not political promises.

Primary Health Care

Investing and advancing the use of primary health care (PHC) is critical to ensuring continuity of care across the health care system.¹⁸ As a first point of contact, PHC ensures short-term health issues are resolved

and chronic conditions are managed through working with community-based teams of health professionals. Effective PHC is also needed to develop long-term strategies to improve health outcomes at the individual and population levels.¹⁹

As PHC reform promotes interdisciplinary team-based care to improve accessibility and comprehensiveness of care, it will change the way physicians are reimbursed.²⁰ Our current fee-for-service payment model is susceptible to billing abuse and arguably drives the “one problem per visit” policies adopted by a number of family doctors.²¹ There are now more than 82,000 physicians in Canada; total payments to physicians increased by 4% from the previous year to reach \$25 billion in 2014–15.²²

Action: Direct part of the new Health Accord funding to continue the transition to PHC, as opposed to piecemeal bilateral agreements, building on best practices from the 2007 Primary Health Transition Fund.²³

Pharmacare

Among countries with a universal national public health care plan, Canada is the only one whose plan does not include prescription drug coverage. As a result, Canadians spent over \$30 billion in 2016 to fill over 600 million prescriptions.²⁴ No other component of Canadian health care has increased in cost as quickly as drug costs.²⁵ In 2015, patented drugs accounted for 61.8% of total drug sales in Canada, earning \$15.2 billion for the brand-name pharmaceutical sector.²⁶

In our fragmented and inefficient system there are 19 publicly funded drug plans (10 provincial, three territorial, six federal).²⁷ Eligibility, coverage, and benefit payment schemes vary in each of these programs. Your jurisdiction of residence or socioeconomic status should not dictate if you receive necessary medication. Of all other OECD countries, only the United States and Poland have a lower percentage of drug costs paid for by public programs, and Canada is second only to the U.S. in the use of private drug insurance.²⁸

Approximately 3.5 million Canadians lack even basic drug coverage.²⁹ Around one in four Canadian families fail to take needed medication as prescribed due to high costs.³⁰ It is believed that 6.5% of hospital admissions in Canada are the result of non-adherence to medications, which itself adds an estimated \$7–9 billion per year to health care costs.³¹ Canada has wasted \$62 billion dollars over the last 10 years by not implementing a universal pharmacare program.³²

Action: Allocate \$2 billion, plus 10% of private expenditures on prescription drugs (\$1.39 billion), in 2017-18 toward a national pharmacare plan (total expenditure: \$3.39 billion). In 2018-19, the AFB will increase the allocation by 13% for a total expenditure of \$3.83 billion. In 2019-20, this amount will increase by 20% to \$4.59 billion. Future savings will offset the program's startup costs.³³

Home Care and Long-term Care

The Romanow commission pointed out nearly 15 years ago that it made no sense to exclude home care from medicare. Still outside the Act,

provincial governments have been discharging patients from acute-care in hospitals (which are covered under the Act) to save money. Patients are transferred to unorganized, privately-funded, for-profit providers. While the Liberal government has pledged to invest about \$11.5 billion over 10 years for home care and mental health, there have been no commitments to guarantee these services would be included under the Act and that an overarching national strategy would be implemented. Further, details remain missing on if the earmarked billion for home care infrastructure would entail public or private investments.

The AFB would amend the CHA to include both home care and long-term care. Provinces will need to comply with the criteria of the Act in order to receive new federal funding transfers for these services. Further, the AFB aims for a total expenditure for home care at 2% of GDP. This would put Canada in line with northern European countries. Provinces that participate in a national home care program will see federal contributions of up to 40% to jurisdictions in compliance with the CHA. The AFB will invest \$2.3 billion in long-term and residential care to enable hospitals to move Alternate Level of Care (ALC) patients currently in acute care beds to a more appropriate setting.³⁴

Mental Health

From medicare's beginnings an inequity between physical and mental health coverage has ignored the important links between psychological, social, and biological health. As a result, we know that one in five people in Canada (close to seven million people) ex-

perience a mental health problem or illness, costing the economy more than \$50 billion (more than 2% of GDP) annually.³⁵ Spending on mental health makes up only 7% of all public spending on health in Canada, below the 10–13% reached by similar countries including the U.K. and New Zealand.³⁶ It is estimated that 9% of GDP (close to \$800 million in Canada's case) is the minimum level of public investment required to improve access to a range of mental health programs and services, and get better health outcomes.³⁷

The federal government has historically avoided responsibility for mental health, leading to major gaps in public coverage and inequalities in access to services. Treatment received is largely decided based on employment benefits (often capped or limited in range) or income levels, not evidence-based best practices.³⁸ Furthermore, mental health problems are even greater than physical health problems for people at lower income levels.³⁹ Our current fee-for-service model of medicare generally covers hospital stays, specialists, or doctors, but excludes psychologists, counselling, other therapists, and community non-profit agency support. Provincial and territorial coverage is generally limited and haphazard.

Action: Implement a mental health program based on the widely hailed U.K. initiative, which trained 3,500 new mental health professionals, and incorporated into the CHA accountability process.⁴⁰ Mental health promotion and the treatment of mental illnesses must be timely, continuous, collaborative, culturally safe and appropriate, and integrated across the life cycle (from chil-

dren to seniors).⁴¹ Dedicated mental health funding needs to be part of the enhanced Health Accord proposed by the AFB (cost: \$350 million over three years).^{42,43}

Notes

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