

MOWAT RESEARCH #125 | SEPTEMBER 2016

# Partnership Renewed

Transforming Canada's Health  
Funding Arrangements

BY ERICH HARTMANN & ALEXA GREIG

## Mowat Centre

ONTARIO'S VOICE ON PUBLIC POLICY



School of Public Policy & Governance  
UNIVERSITY OF TORONTO

# Acknowledgements

The authors would like to thank the anonymous peer reviewers for their valuable feedback on this report. The authors would also like to thank the anonymous interviewees for so generously giving their time and expertise. All content and any remaining errors are the sole responsibility of the authors. The authors would also like to thank Elaine Stam for her design work on this report as well as Sunil Johal, Brad Graham, Reuven Shlozberg and Bill Forward for their helpful contributions.

## Authors

### ERICH HARTMANN

Erich Hartmann is the Mowat Centre's Practice Lead for Intergovernmental Affairs. Erich has a deep knowledge of intergovernmental affairs and federal fiscal issues. Previously, Erich spent 13 years in the Ontario Public Service at the Ministry of Finance in a number of policy and management roles, most recently serving as Manager of Federal-Provincial Relations. Erich holds an MPA and a BA (Hons) from Queen's University.

### ALEXA GREIG

Alexa joined Mowat as a Policy Intern in Summer 2016. She is a Master of Public Policy candidate at University of Toronto and a Junior Fellow at Massey College. Previously, she spent ten months working on Parliament Hill with the Parliamentary Internship Programme. She holds a bilingual Bachelor of Social Science (Honours) in Political Science and Communications from the University of Ottawa.

---

## Mowat Centre

ONTARIO'S VOICE ON PUBLIC POLICY

The Mowat Centre is an independent public policy think tank located at the School of Public Policy & Governance at the University of Toronto. The Mowat Centre is Ontario's non-partisan, evidence-based voice on public policy. It undertakes collaborative applied policy research, proposes innovative research-driven recommendations, and engages in public dialogue on Canada's most important national issues.

MOWATCENTRE.CA

 @MOWATCENTRE

439 UNIVERSITY AVENUE  
SUITE 2200, TORONTO, ON  
M5G 1Y8 CANADA



School of Public Policy & Governance  
UNIVERSITY OF TORONTO

©2016 ISBN 978-1-77259-031-9

# Contents

Executive Summary	1
<b>1</b> Overview	3
<b>2</b> Fiscal Sustainability	5
<b>3</b> Cost Drivers	8
<b>4</b> Health Care Expenditure Trends	15
<b>5</b> What Provinces Are Doing	17
<b>6</b> What Still Needs to Be Done?	22
<b>7</b> Health Care in Canada's Intergovernmental Context	24
<b>8</b> Historical Overview	26
<b>9</b> Recommendations	33
Conclusion	49
Appendix A	50
Appendix B	51
References	54



Transformational  
change in the  
health care  
sector needs a  
transformational  
partnership  
between Canada's  
orders of  
government.

# EXECUTIVE SUMMARY

Canada's universal health care system is both a point of national pride and a defining characteristic of the country. It is also facing significant pressures that can only be addressed through a stronger partnership between the federal government and the provinces.

The establishment of universal medical and hospital care across Canada 50 years ago was accomplished through a cost-sharing partnership between the federal government and the provinces. In the decades following this original bargain, the federal government has moved, often unilaterally, away from the cost-sharing model for health care.

The federal government's current approach to funding health care is agnostic to the cost pressures provinces face and leaves them on their own to confront the challenges facing their health care systems. This is not sustainable. A rapidly aging population will strain provinces' current health care delivery models. Transformation in the sector is urgently needed. Provinces cannot face this challenge on their own, and nor should they have to. Transformational change in the health care sector needs a transformational partnership between Canada's orders of government.

At this summer's meeting of the Council of the Federation, Premiers drew attention to the pressure that the imminent reduction in the Canada Health Transfer (CHT) escalator will place on provincial and territorial health systems. Premiers also called for a meeting with the Prime Minister this fall, dedicated to advancing a long-term agreement on health care funding.

A long-term agreement on health care funding should reflect the bargain to share costs between Canada's orders of government as partners. A federal investment that ramps up to a \$10 billion annual increase in federal health transfers by 2021-22, would achieve the benchmark of sharing the costs of health care. As the federal government renews its role as a funding partner for health care, provinces should lever additional federal support into investments that will adapt their health care systems to respond to the strains an aging population will place on them. Quality outcomes and fiscal sustainability must be the twin goals of reforms to provincial health care systems. Intergovernmental discussions on how to achieve these goals must be informed by facts, underlined by a renewed focus on transparency.

To that end, this paper calls for a transformational health care partnership and puts forward the following recommendations:

## RECOMMENDATION 1

Restore the health care funding partnership by returning, within five years, to the “cost-sharing” levels that were last agreed upon by federal and provincial governments under the Established Programs Financing (EPF) arrangements.

## RECOMMENDATION 2

Enhance provincial efforts to achieve transformational change in the health care sector through a combination of predictable, flexible and fairly allocated federal funding enhancements, transparent provincial action, and effective use of the federal government’s consensus-building power.

## RECOMMENDATION 3

Create a pan-Canadian institution for transparency and accountability in health care, co-funded by — but independent from — the federal, provincial and territorial governments, operating under a clearly-defined mandate to conduct value-for-money assessments with an end goal of promoting both the quality and fiscal sustainability of provincial health care systems.

# 1 OVERVIEW

This year marks the 50th anniversary of the enactment of the *Medical Care Act*. Much of health care in Canada as we know it today was shaped by this legislation. The provisions of the act enabled the federal government to play an instrumental role in the establishment of universal, comprehensive, portable and publicly administered medical and hospital care across the country. This occasion provides an opportunity to both evaluate the success of federal participation in the sphere of health care, and to propose deliberate improvements to the federal role moving forward.

The federal government's entry into health care financing was facilitated by a collaborative approach to the use of its spending power, which resulted in a commitment to share the costs of delivering health care with the provinces roughly equally. Since then, the federal government has retreated from its role as an active participant in the field of health care, becoming little more than a cheque writer – taking little consideration of the actual costs of delivering health care now or going forward.

The federal government's current approach to its role in health care is not completely without merit. Provinces, which have Constitutional jurisdiction over health care, are left to manage their health care systems without an overly intrusive federal presence, provided certain national standards are met. This level of decentralization is a strength of Canada's system. This model has allowed the provinces to experiment with transformational initiatives aimed at bending down the cost-curve in the health care sector. Such initiatives will become increasingly important as a rapidly aging population causes demographic shifts that will challenge the long-term fiscal sustainability of the provinces.

The federal government has largely abdicated its partnership role in the funding of health care. This is not a sustainable approach, as “from the point of view of real politics, however, both levels of government are responsible for the functioning of the health-care system and, ultimately bear the burden for its successes and failures,” (Maioni 2002). A more complete approach to addressing these challenges will require the federal government to renew its role as a reliable funding *partner* for health care. To that end, Canada's orders of government urgently need a genuine discussion about the appropriate sharing of the costs of health care. This conversation must happen with a view to the nature of the intergovernmental health care funding partnership, and to what both orders of government should be trying to achieve together going forward.

Restoring the intergovernmental funding partnership in health care should not be a simple exercise of cutting a series of cheques to the provinces. It should be informed by a collaborative approach between equal partners seeking to facilitate transformational change in the health sector. By drawing upon the comparative advantages of each partner while committing to enhanced transparency, provinces and the federal government can make significant progress toward a pan-Canadian system that achieves quality outcomes in a fiscally sustainable manner.



# 2 FISCAL SUSTAINABILITY

Managing the growth of public health care spending is critical for the provinces' fiscal sustainability. In each province, health care represents the single largest spending area. Between 2000-01 and 2009-10, provincial-territorial spending on health care nearly doubled from \$65 billion to \$121 billion, an average annual growth rate of 7.1 per cent. This rate of growth was higher than growth in gross domestic product (GDP) (4.0 per cent), the implicit price index for government current expenditure (3.0 per cent), or provincial-territorial program spending (5.9 per cent). Spending growth rate trends such as these, if allowed to continue unabated, inevitably leave governments to face the choice of raising taxes, incurring debt or crowding out other services.

The economic downturn, however, brought the need to constrain the rate of growth in health care into much sharper focus. Provinces have been deploying strategies to bend down the cost-curve in the health care sector with some success. In the first five years of this decade, the growth in provincial-territorial spending on health care has been cut in half compared to the previous decade. Transformation in the sector, however, must be continuous and sustainable to ensure Canada's governments will be ready to meet the impending demographic shifts that will challenge the fiscal sustainability of the provinces.

## What is fiscal sustainability?

In simple terms, fiscal sustainability is the main indicator of the health of the public finances of a given jurisdiction. Fiscal sustainability is achieved by maintaining a stable relationship between expenditures and revenues in the long-term.

In technical terms, then, fiscal sustainability is achieved when government debt does not grow faster than the economy as a whole (PBO 2016). To assess whether federal and sub-national governments have achieved fiscal sustainability, the Parliamentary Budget Officer (PBO) publishes an annual report projecting their debt and public pension plan assets over a 75-year period into the future and estimates the fiscal gap. If a government's debt relative to GDP, otherwise known as its debt-to-GDP ratio, is projected to grow above its current level over the long-term, its fiscal situation is considered unsustainable (PBO 2016).

Fiscal sustainability is a helpful analytical tool insofar as a close look at the current fiscal situation sheds light on whether status quo fiscal arrangements and policies can adequately address long-term demographic and economic changes as forecasted. All governments aspire to fiscal sustainability; the earlier a required or suggested policy intervention is correctly identified, the lower the cost of its implementation (PBO 2016).

# Are Canada's federal and sub-national governments fiscally sustainable?

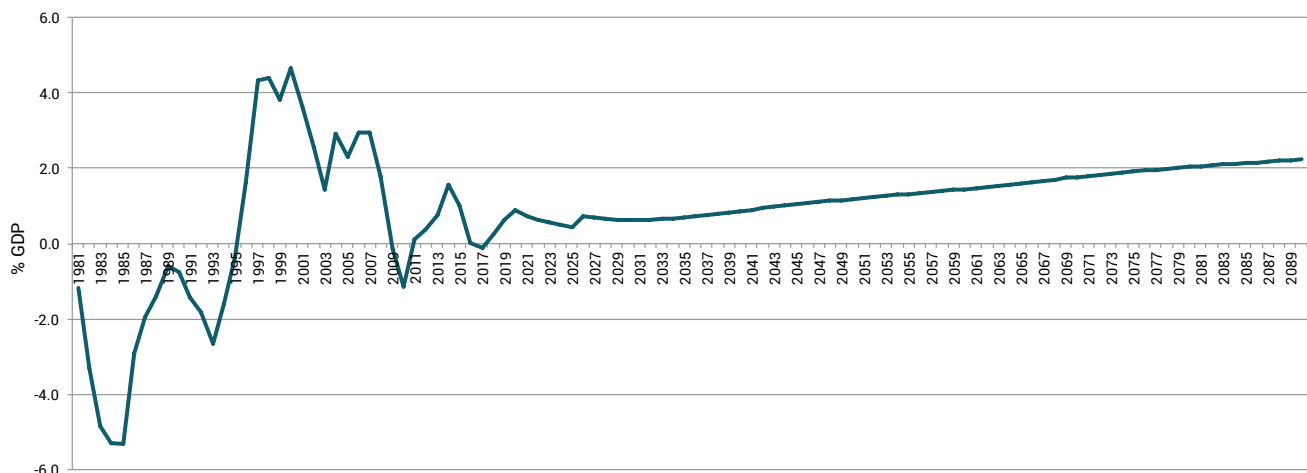
The PBO's Fiscal Sustainability Report 2016 found that the federal government's primary balance – defined as revenues less non-interest spending – is positive over the next 75 years (PBO 2016). This means that the federal government is on a sustainable path, and has the flexibility to increase spending or reduce taxes – or fiscal room. As it stands, federal government net debt is estimated to be eliminated entirely within 50 years (PBO 2016). The federal government has fiscal room of 0.9 per cent of GDP (\$19.2 billion), and could increase spending or reduce revenues by that amount (PBO 2016).

In contrast, for sub-national governments (including provincial, territorial, local, and Aboriginal governments), the primary balance is negative over the 75-year projection period: it is forecast to reach its peak in the medium term at a surplus of 1.6 per cent of GDP in 2020,

followed by a steady deterioration in finances due to population aging and escalating health care costs. The primary balance turns to deficit in 2034 and continues to fall, reaching 3.3 per cent of GDP in the final year of the projection in 2090 (PBO 2016).

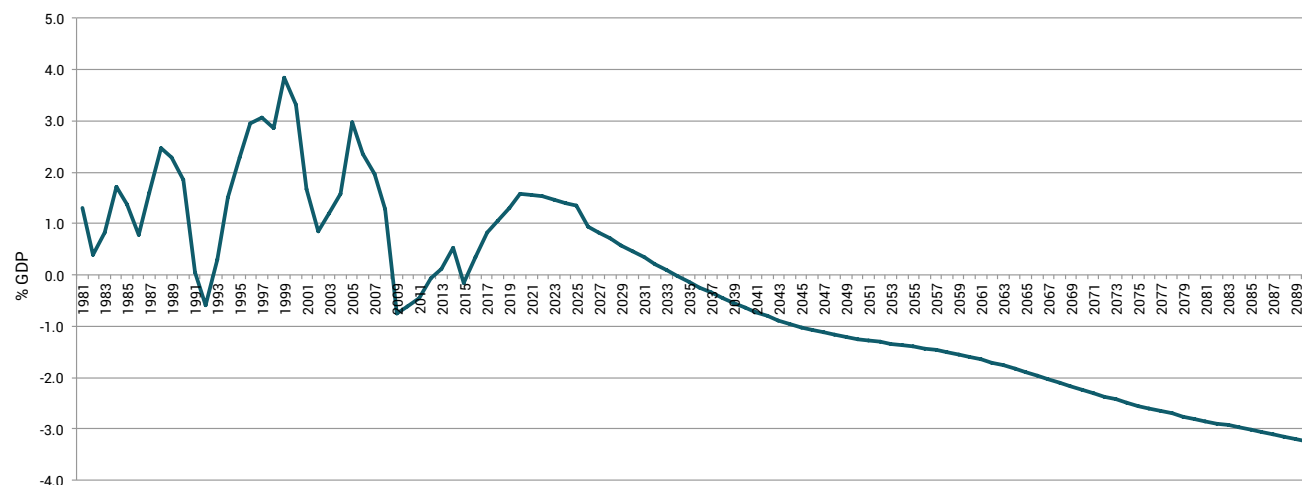
The PBO calculates the sub-national fiscal gap to be 1.5 per cent of GDP. That is, beginning in 2016, the sub-national primary balance would need to increase by 1.5 percentage points of GDP annually – equivalent to \$30.2 billion in current dollars – to achieve fiscal sustainability. This could be achieved by: sub-national governments raising revenues, sub-national governments reducing program spending, increased transfers from the federal government, or some combination of those three.

**FIGURE 1**  
**Federal Government Primary Balance as a Percentage of GDP**



Source: Office of the Parliamentary Budget Officer

**FIGURE 2**  
**Sub-national Governments Primary Balance as a Percentage of GDP**



Source: Office of the Parliamentary Budget Officer

For sub-national governments, unlike the federal government, program expenses are projected to exceed revenues in the long-term. Health care spending is the primary driver of sub-national spending growth as a share of GDP (PBO 2016). Health care spending by sub-national governments is projected to rise from 7.3 per cent of GDP in 2015 to 12.5 per cent in 2090 (PBO 2016).

## The takeaway

Sub-national governments are fiscally unsustainable over the long-term, health care spending is projected to rise, and the federal government has fiscal room.

# 3 COST DRIVERS

## What is driving costs in health care?

A clear picture of the cost drivers in the Canadian health care system is crucial to understand the magnitude of the threat to fiscal sustainability faced by the provinces.

In a 2011 Canadian Institute for Health Information (CIHI) report underlying cost drivers in the health care system in the period from 1998 to 2008 were examined in detail. Physician fee inflation, hospital cost inflation, pharmaceuticals, demographic changes, changes in utilization, and technological advances were identified as major factors contributing to spending growth in that period.

It is important to note that the health care cost drivers described below cannot be treated as excludable realities to be addressed in turn, as they are tightly interwoven – changes in one (or more) almost certainly affect another (or more). Policy changes in health (both at the federal, provincial, and territorial levels) should be considered in terms of the ways they might impact each of these cost drivers, directly or indirectly.

### PHYSICIAN FEE INFLATION

One of the most important areas of price inflation in the health sector is the cost of physician services. Spending on physicians is affected by utilization of physician services and by the fee agreements between provincial medicare agencies and physician associations. Compared to the growth in price of other government goods and services, physician compensation grew much faster between 1998 and 2008 (CIHI

2011b). The rate of average annual growth in physician spending between 1998 and 2008 was 6.8 per cent, of which increases in fee schedules accounted for more than half (3.6 per cent) per year (CIHI 2011b). Physician fee schedules, officially called the “Schedule of Benefits for Physician Services” in Ontario, list the services that physicians can bill for under the fee-for-service system (the fees are negotiated centrally by the Ontario Medical Association in Ontario).

Physician spending is forecast to be \$946 per person in 2015, which represents a growth rate of 2.2 per cent from 2014 (CIHI 2015b). Since 2007, the growth of total public spending on physicians has outpaced the growth in total spending on hospitals or drugs (CIHI 2015b). This could in part be due, according to CIHI, to the rapid growth in supply of physicians – the number of physicians per population has also been rising significantly due to more medical graduates, domestic and

international, entering the workforce (CIHI 2011b). While a greater supply of physicians (as a response to increasing demand or supply) should mean more access and services to the public, it also demands significantly more provincial resources.

## **HOSPITAL COST INCREASES: MORE EMPLOYEES AND PHYSICIANS, AND HIGHER WAGES ACROSS THE HEALTH SECTOR**

Hospital costs have seen their growth impacted by price increases, both via higher salaries and wages for their employees and steadily increasing numbers of staff (CIHI 2011b).

Hospitals are labour intensive: overall compensation makes up 60 per cent of total hospital costs, and although physicians are included in this amount, the largest component of the workforce in hospitals is nurses (CIHI 2011b). The compensation of the hospital workforce overall, separate from fee schedule increases from physicians, has also grown faster than compensation in non-health sectors (CIHI 2011b). Based on data reporting in Statistics Canada's Survey of Employment, Payrolls and Hours, between 1998 and 2008, nominal hourly wages in the health sector grew at an average annual rate of 3.1 per cent in the health and social assistance sector, compared with 2.5 per cent growth in the general economy (CIHI 2011b).

In terms of staff number increases, according to CIHI, the number of people working full time in hospitals increased by a total of 21 per cent between 1999 and 2008, calculated based on earned hours of work in hospitals (2011b).

## **PHARMACEUTICALS: VOLUME AND GENERICS**

In the past few decades, drugs have been the fastest growing cost to health care in Ontario (Institute for Competitiveness and Prosperity (ICP) 2014). Between 1982 and 2013, total real spending per capita in Ontario (inflation adjusted) on pharmaceuticals increased by 312 per cent, while the cost of physician services rose 116 per cent and hospital spending went up 53 per cent in the same period (ICP 2014). Over the same time period, the trend of growing drug costs also held true across provinces. According to CIHI data, the provincial-territorial spending on drugs as a share of total provincial-territorial government health care spending rose from 2.9 per cent in 1982-83 to 7.6 per cent in 2012-13, peaking at 8.5 per cent in 2006-07. Internationally, between 1997 and 2007, Canada's 10.1 per cent average annual growth in per capita drug spending was second only to growth in the United States (CIHI 2012).

Increased spending on drugs is attributable to many factors other than their cost. According to CIHI, the most important factor for the increase in drug spending in Canada between 1998 and 2007 was that Canadians purchased more prescription drugs than ever before (CIHI 2011a). Volume accounted for 6.2 of the 10.1 per cent average annual growth rate. Canadians are using pharmaceuticals more than ever, and demand is likely to increase as new drugs are developed and the population ages.

Generic pharmaceuticals are drugs determined by Health Canada to be bioequivalent to patented pharmaceuticals. The price of generic drugs in Canada has been much higher, and has grown more quickly, than in other countries. In 2008, mean and median prices for generic drugs in France, Germany, Italy, Sweden, Switzerland, the United Kingdom and the United States ranged from 29 per cent to 37 per cent less

than corresponding Canadian prices on average (PMPRB 2011). While cost savings become accessible as generic drugs become increasingly available – when drugs’ patents expire – CIHI points out that when this has happened in the past, the cost savings associated with expired patents appear to diminish fairly quickly over time. Indeed, generic price controls can offer some saving in the short term, but spending growth will continue if volume – that is, increased utilization – continues to be the most important driver of public drug spending (CIHI 2012).

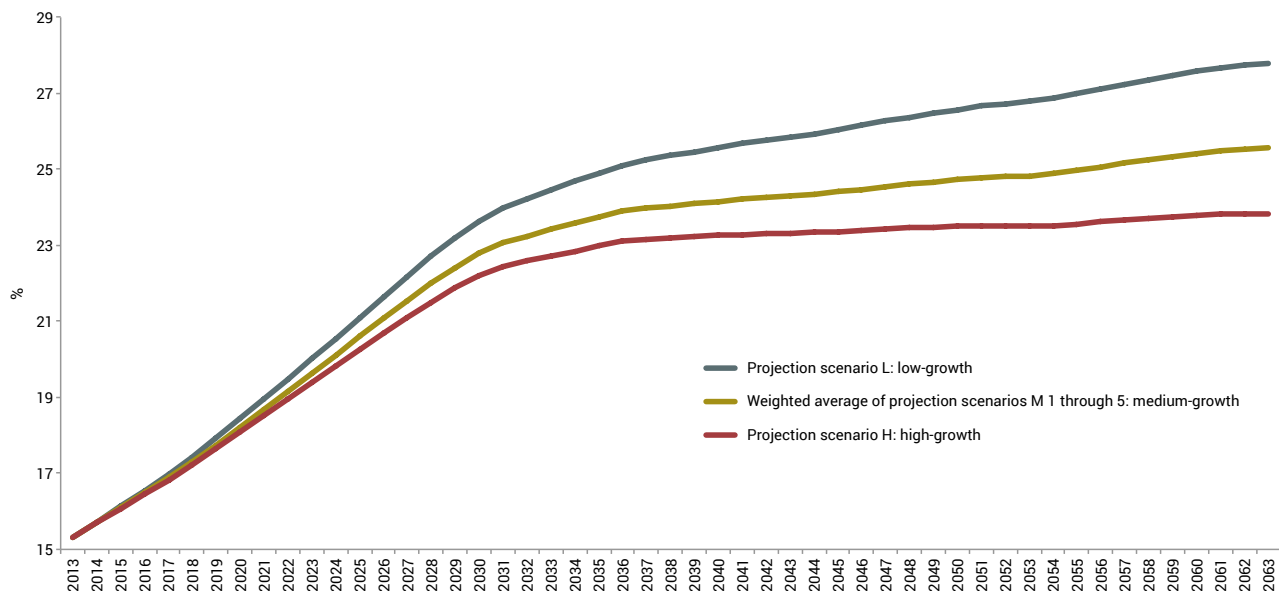
## DEMOGRAPHIC CHANGES: POPULATION GROWTH AND AGING

Between 1946 and 1965, a period otherwise known as the baby boom, the percentage growth in annual births hit an all-time high of 15 per cent (Statistics Canada 2012). The average number of children per woman was 3.7 during the baby boom period, compared to approximately 1.7 in recent years (Statistics Canada 2012).

As has been well-documented, the changing age structure of the Canadian population has significantly affected the country’s demographic snapshot: baby boomers are reaching older age, the Canadian fertility rate is below replacement level, and life expectancy is rising (Statistics Canada 2014).

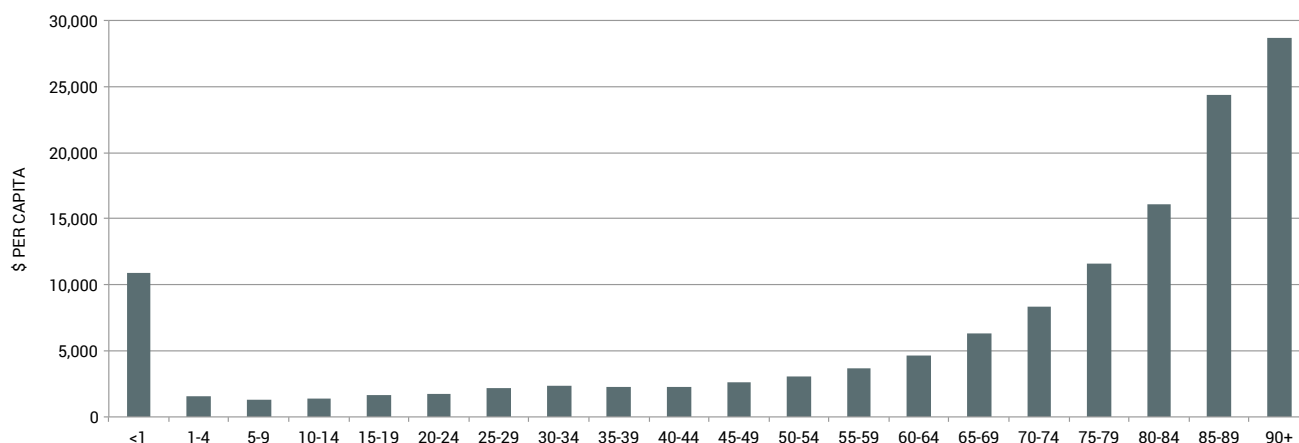
In the year 2015, baby boomers were aged between 49 and 69 years – which means that as of 2011, boomers have started to contribute to the accelerating growth in the population 65 years and older. Partly as a result of this generational shift, Statistics Canada preliminary estimates indicated that as of July 1, 2015, Canada had more people aged 65 and older than children aged 0 to 14 years, with a record number of 5,780,900 people, or 16.1 per cent of Canadians, being 65 years or older in 2015 (compared to 16.0 per cent aged 0 to 14 years) (Statistics Canada 2016). According to Statistics Canada’s medium-growth forecast, this proportion will grow larger as more baby boomers age, projected to reach 20 per cent in 2024 and 25 per cent in 2055, while the

**FIGURE 3**  
Share of the Population 65 Years and Older, Low-, Medium- and High-Growth Projections: 2013 to 2063



Source: Statistics Canada

**FIGURE 4**  
**Provincial-Territorial Health Expenditure Per Capita by Age Group, 2013**



Source: Canadian Institute for Health Information

proportion of children between 0 and 14 years is projected to remain stable at 15 to 16 per cent (Statistics Canada 2016) within that time. These results vary slightly using the low- or high-growth projections, but the story is the same. As a share of the total population, Canada's population of people aged 65 or older will increase rapidly in the coming years.

These demographic trends are not unfolding uniformly across Canada and evolve over time – this has implications for health care delivery priorities in different provinces. For instance, Canada's population is aging more slowly in the Prairies and in the territories than in other provinces (Statistics Canada 2016). Nova Scotia and New Brunswick, on the other hand, were the first two provinces in which the proportion of people aged over 65 exceeded the proportion of people aged between 0 and 14 (Statistics Canada 2016).

Population aging in itself is estimated by CIHI to be responsible for an average of 0.9 per cent of health care costs per year (CIHI 2015a). This being said, while Canadians aged 65 and older represent 16 per cent of the Canadian population,

they account for 45 per cent of all provincial and territorial public sector health care dollars (CIHI 2015a), reflecting their comparatively high health care needs. Canadians aged 65 and older account for the highest average per capita health costs per year of provincial and territorial governments: \$11,598. This is in stark contrast to people aged 15 to 64 (average of \$2,637 per person per year) and for youth aged 1 to 14 (average of \$1,408) (CIHI 2015a).

Going forward, the impact that the aging population will have on the health care sector is not fully understood. While baby boomers on average may be healthier than previous cohorts, "older adults are far more heterogeneous group than previously thought," (Wister and Speechly 2015). Consistent divides in health outcomes across socio-economic status suggest that "the baby boom will have some of the healthiest older humans in history, together with some of the most frail, complex and multiple morbid," (Wister and Speechly 2015). Furthermore, the expectations of the baby-boom generation could be one of the most significant cost drivers in the

# The expectations of the baby-boom generation could be one of the most significant cost drivers in the health system.

---

health system, as “higher levels of education, health literacy, understanding of advocacy and a sense of health care entitlement...could significantly increase costs across virtually all health driver categories,” (Wister and Speechly 2015).

## CHANGES IN UTILIZATION: HIGH-COST USERS

One per cent of Ontarians account for 34 per cent of public health care costs, and five per cent of the population account for 66 per cent of costs (Wodchis et al. 2012). This is not unique to Ontario – in Manitoba, British Columbia, and the United States health care resources are skewed toward a small share of the population (Deber and Lam 2009). As indicated in the previous section, high-cost users of health care tend to be patients at the end of their lives and infants with high health care needs, but also, individuals with chronic conditions or multiple chronic diseases. A better understanding of high cost users of the health care system allows serious consideration for the impact of this reality on fiscal sustainability for provinces moving forward.

Although Canadians have longer life expectancies than previously, an aging population means an increase in the proportional number of people approaching end-of-life and needing the expensive care that, on average, accompanies that life stage.

In long-term care homes, despite the fact that the number of beds per 1,000 seniors remained relatively flat between 2004 and 2008, the intensity in use of beds has increased – there has been a rise in the proportion of residents receiving more intense care (CIHI 2011b). Intense care (otherwise known as level III care) is defined as care “required by a person who is chronically ill and/or has a functional disability” and who “therefore requires a range of therapeutic services, medical management and skilled nursing care plus provision for psychosocial needs” for months or years (CIHI 2011b). Any person with needs above type III usually requires the medical and nursing care that is typically provided in a hospital – from 1998 to 2008, the proportion of long-term care residents requiring this type of intensive care rose from 25 to 33 per cent (CIHI 2011b).

Not only does the care of older seniors cost more because of the delivery expense in the last few months of their lives, but the population living with chronic illnesses tend to require more intensive medical attention with age. In fact, survey data indicates that there is a stronger correlation between multiple chronic diseases and higher utilization of health services than there is between age and utilization (CIHI 2011c).



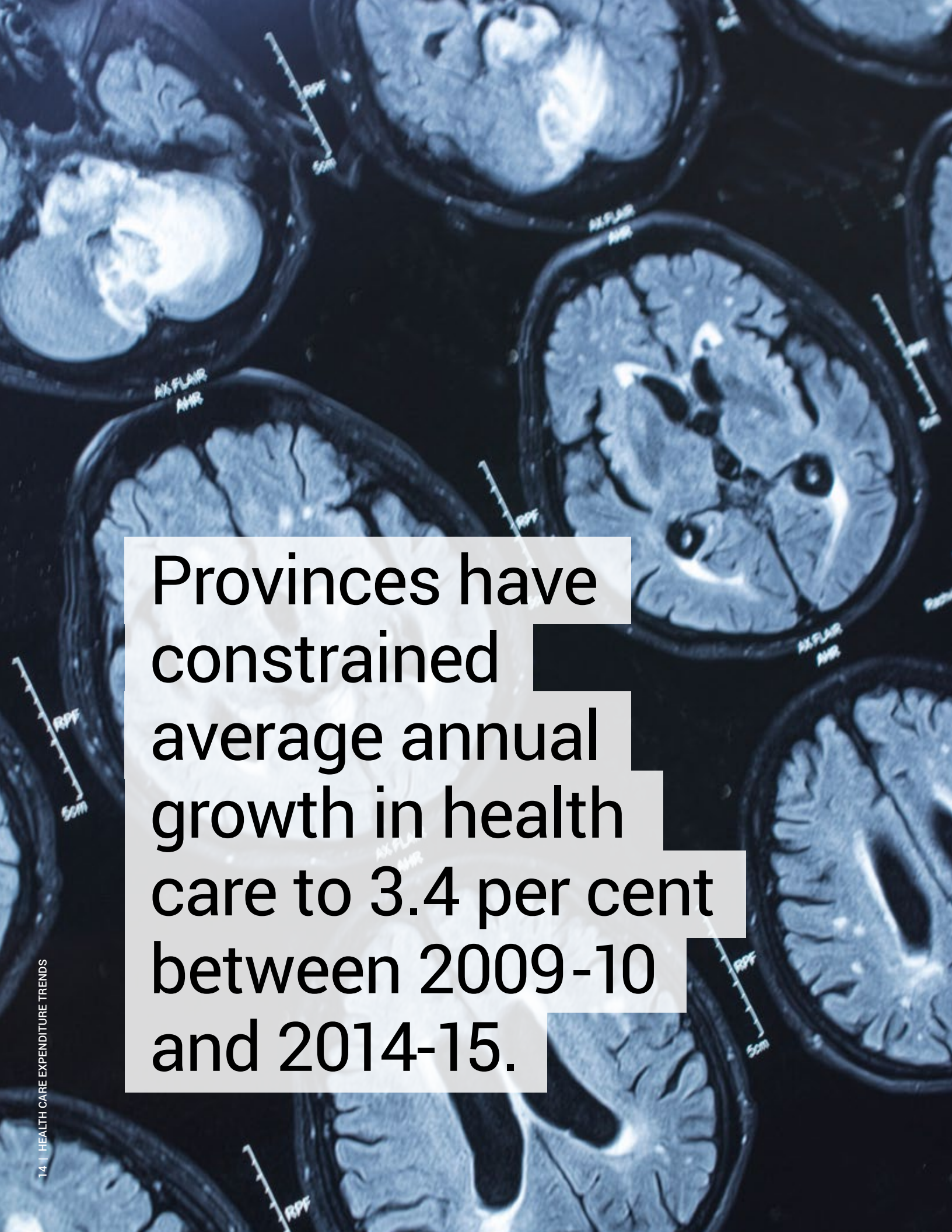
## TECHNOLOGICAL CHANGES AND ENRICHMENT FACTORS

Quantifying the impact of technological changes and advances in the health sector as a cost driver distinct from others is difficult. Technological changes can variously lead to cost increases or decreases. Technological effects are widespread and take into consideration the introduction of new products and new techniques, as well as the changes in practice and demand that emerge due to these changes in products and techniques (CIHI 2011b). “Technology” can include medical devices and equipment, surgical improvements, information and communications technology, and prescription drugs (CIHI 2011b), each of which would have a significant impact on the other key cost drivers noted above, including hospitals, pharmaceuticals, and changes in utilization.

Technological changes are often placed under the category of “enrichment factors,” or factors accounting for spending growth that cannot be accounted for by changes in the age structure, population growth, and the general inflation rate of the economy (ICP 2014).

### The take away

Growth in health care expenditures are driven by a host of interlocking factors such as compensation costs, the size of the health care labour force, pharmaceuticals, demographic changes, complexity of utilization, and technological advances.



Provinces have constrained average annual growth in health care to 3.4 per cent between 2009-10 and 2014-15.

# 4 HEALTH CARE EXPENDITURE TRENDS

This section gives a snapshot of current health expenditure trends. Despite the continued pressure of the cost drivers described above, growth rates in Canada's government health care expenditures are in a unique (but not unprecedented) period of moderation. In each province, average annual growth rates in provincial government health care spending for the 2009-10 to 2014-15 period are lower than they were for the preceding decade. Taken together, provinces have constrained average annual growth in health care to 3.4 per cent over that period.

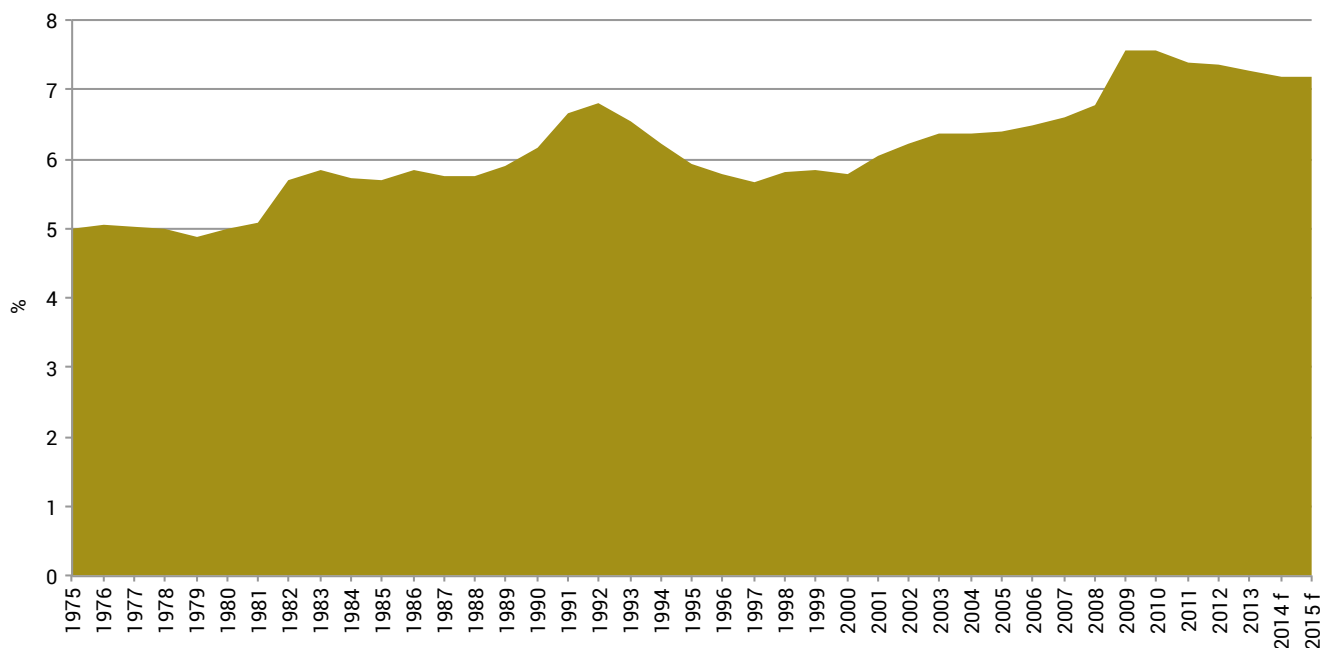
**TABLE 1**  
**Average Annual Growth Rates in Provincial Government Health Care Spending**

	NL	PE	NS	NB	QC	ON	MB	SK	AB	BC	ALL PROV
2000-01 to 2009-10	6.6%	7.7%	7.2%	7.4%	6.3%	7.2%	6.9%	7.3%	9.9%	5.6%	7.1%
2009-10 to 2014-15	3.4%	3.7%	3.7%	1.9%	3.3%	2.3%	4.0%	5.0%	6.2%	3.6%	3.4%

Source: Mowat analysis based on CIHI data

According to CIHI data, provincial-territorial government health expenditures were projected to reach \$144.3 billion in 2015. As a share of GDP, provincial-territorial government health spending has been in gradual decline in the years following the 2009 recession, declining from 7.6 per cent in 2009 to an estimated 7.2 per cent in 2015. The consistent upward trend of health expenditure growth since 1975, including sharper growth in the period from 1975 to the early 1990s as well as from the late 1990s to 2010, has been punctuated by two periods of fiscal restraint in the mid-1990s and in the period from 2010 to the present.

**FIGURE 5**  
**Provincial-Territorial Government Health Spending as a Percentage of GDP**



Source: Canadian Institute for Health Information

In the broader context of the past 40 years, the 0.4 percentage point decrease in provincial-territorial health spending as a share of GDP since 2010 is less pronounced than the decreases in the mid-1990s period.

The largest shares of provincial-territorial health spending are attributable to hospitals (40.1 per cent), physician services (22.9 per cent), and pharmaceuticals (7.4 per cent), together making up over 70 per cent of total health spending in Canada. Although spending levels continue to grow in all of these areas, the pace of growth has noticeably slowed in recent years (CIHI 2015a). For instance, growth in spending on hospitals has moderated considerably in the last five years compared to the previous decade.

**TABLE 2**  
**Average Annual Growth Rates in Provincial Government Spending on Hospitals**

	NL	PE	NS	NB	QC	ON	MB	SK	AB	BC	ALL PROV
2000-01 to 2009-10	7.3%	6.2%	6.6%	6.7%	5.9%	6.0%	7.3%	7.2%	10.2%	5.9%	6.6%
2009-10 to 2014-15	3.1%	5.7%	2.1%	0.8%	1.9%	2.0%	2.1%	4.7%	6.7%	6.6%	3.4%

Source: Mowat analysis based on CIHI data

# 5 WHAT PROVINCES ARE DOING

Health care sustainability and fiscal sustainability in Canadian provinces and territories are inextricably linked.

According to CIHI, the current expenditure trends reflect Canada's slow economic growth, as well as the fiscal restraint exhibited by federal and sub-national governments' intent on balancing budgets and controlling cost growth (CIHI 2015a). Given slower-growing economies, provinces are moving to both control costs in the key areas identified above and to promote the transformative change needed to improve health outcomes, deliver more efficient and patient-centred care, and to meet the current and emerging challenges faced by their respective provincial health systems as described above. The flexibility and decentralization with Canada's system of fiscal federalism is a strength that allows for the seeds of innovation to be sown and to grow. Provinces are taking action with a view to lowering the growth in costs of health delivery, and are having many important successes that tend to get overlooked.

One need not look far to see current examples of provinces and territories engaging with such transformative health care policy initiatives. In its 2016 budget, the Ontario government re-emphasized its commitment to pursue systemic change, modernize health care and maximize the value of health care investments (MOF 2016a). For instance, the Ontario government is in the process of making changes to integrate primary care with home and community care under Local Health Integration Networks (LHINs) (MOF 2016a).

While transformational initiatives are occurring across the country (see Select Health Care Transformation Initiatives text box), this section will outline three Ontario-specific examples that demonstrate the kinds of reforms that are taking place right now. These initiatives show a move to save public money in health care by moving toward a more affordable, accessible, equitable and, ultimately, fiscally sustainable health care system.



## Select Health Care Transformation Initiatives

### BRITISH COLUMBIA – BETTER AT HOME

Established in 2013, Better at Home is province-wide program funded by the Government of British Columbia and managed by the United Way of Lower Mainland to help seniors continue living at home independently and remain connected to their communities. Through Better at Home, seniors can access a wide range of non-medical home support services including housekeeping, grocery shopping, snow shovelling, and transportation to medical appointments. Seniors are charged a fee for services on a sliding scale based on income level (Government of British Columbia 2016).

According to their 2014-15 Annual Report, Better at Home currently includes 61 core programs delivering services, and is growing very quickly (United Way of Lower Mainland 2015). There were 6,058 seniors enrolled in the program by March 2015, doubling the enrollment in the previous fiscal year (United Way of Lower Mainland 2015). Of the 6,058 seniors enrolled from April 2014 to March 2015, 63 per cent were living alone (United Way of Lower Mainland 2015).

### NEW BRUNSWICK – EXTRA-MURAL PROGRAM

The Extra-Mural Program is designed to provide comprehensive hospital services to patients in their homes and communities when their needs can be safely met there. This includes long-term continuous, acute, chronic, rehabilitative or palliative health care services (Government of New Brunswick 2012). Other services include access to medical, occupational therapy, physiotherapy, respiratory therapy and pharmacy, to name a few (Government of New Brunswick 2012).

The Extra-Mural Program, or the “hospital without walls,” was established in 1981, and is currently managed by New Brunswick’s Regional Health Authorities. The Program operates on a client- and family-centred model, bringing together the coordinated efforts and partnerships of clients and families, physicians, agencies, departments, and other service providers to ensure the needs of the client and family are met according to a mutually agree upon plan for care.

### PRINCE EDWARD ISLAND – HEPATITIS C MANAGEMENT STRATEGY

In 2015, the Government of Prince Edward Island (P.E.I.)’s Health and Wellness Minister announced a new partnership between the province and the Quebec-based pharmaceutical company AbbVie that implemented a hepatitis C (HCV) management strategy unique to PEI. The announcement was made following Health Canada’s 2014 decision to approve new treatments that can cure the HCV Hepatitis C genotype 1, the most difficult genotype to treat (CBC News 2015).

Taking advantage of their small size, PEI is able to closely monitor patients with Hepatitis C and to coordinate their health resources in order to, with AbbVie, offer services which include patient referral, assessments, treatment support, education, and follow-up. All of this treatment happens outside of P.E.I. emergency rooms, addiction services and primary care centres (CBC News 2015).

# Generic Drug Pricing

Drug coverage in Canada varies widely across the provinces as each hosts a different combination of public and private drug insurance programs. Public and private plans across provinces vary widely based on eligibility, benefit payment structures, and drug formularies.

As discussed in the above section on pharmaceuticals, Canada has faced some of the highest drug prices in the world (PMPRB 2011). In 2006, Ontario introduced *Bill 102: the Transparent Drug System for Patients Act*, a law that took aim at generic drug pricing structures. In 2010, the Ministry of Health and Long-Term Care built on those changes, introducing further reforms to the prescription drug system designed to ensure the wider availability of more affordable drugs by, among other changes, legislating a reduction in the price of generic drugs. The 2010 Act reduced the amount the government was willing to pay pharmacies for generic drugs from 63 to 50 per cent of the price of the original drug (ICP 2014).

It is estimated that these reforms successfully reduced the cost of generic drugs and produced annual savings of approximately \$500 million (MOHLTC 2011a). Ontario led the way on this file, and other provinces, including British Columbia,

have now adopted similar models in their attempts to curtail exponential increases in public spending on drugs. This has resulted in an across the board decrease in drug spending in Canada.

Also in 2010, Ontario joined with participating provinces and territories in an effort to collaborate to achieve greater value for brand and generic drugs for publicly-funded drug programs (MOHLTC 2015). These initiatives, now exist under the title of pan-Canadian Pharmaceutical Alliance (pCPA), and an Office of the pCPA was established to support their work in 2015. By March 2015, the pCPA had completed negotiations for 63 products, resulting in yearly savings for all pCPA members of approximately \$300 million. In January 2016, the federal government joined all provinces and territories as a participant in the pCPA.

These and other provincial initiatives have played a key role in drastically reducing the growth rate in the public cost of drugs, as demonstrated in the following table:

**TABLE 3**  
**Average Annual Growth Rates in Provincial Government Spending on Drugs**

	NL	PE	NS	NB	QC	ON	MB	SK	AB	BC	ALL PROV
2000-01 to 2009-10	7.1%	9.7%	8.7%	9.2%	8.0%	9.3%	8.6%	12.8%	11.4%	4.2%	8.7%
2009-10 to 2014-15	2.0%	0.5%	1.2%	0.9%	0.2%	0.3%	2.5%	1.0%	4.1%	0.4%	0.8%

Source: Mowat analysis based on CIHI data

# Physician Fee Schedules

Since 2007, physician spending as a share of provincial government health care spending has increased, and the estimated share for 2015-16 (22.9 per cent) has recovered to levels comparable to those in the late 1980s.

As mentioned in the previous section, technological advancements have had major impacts on the cost and nature of health services and procedures provided by physicians. The result is a rate of physician compensation that has grown dramatically without a principles-based rationale (Falk et al. 2011). Given the physician fee-for-service compensation system of Canadian health care, areas where technology has improved most quickly have seen physician remuneration grow dramatically, and these costs have been incurred by the government.

Ontario has sought to address this issue by pursuing big policy changes and decision-making that aligns physician fee schedules (prices) with actual cost trends. In 2011, the province and the Ontario Medical Association (OMA) agreed to make adjustments in the final year of the four-year Physician Services Agreement (agreed to in 2008) that recognized the reality of the way in which technology is changing health care. The changes introduced a new fee accord for a number of services and procedures, including reducing ophthalmology fees (including those for cataract surgery) and reducing the cost of screening endoscopy services (MOHLTC 2011b). The move resulted in \$223 million in public savings (MOHLTC 2011b).

In 2012, the OMA and the Ontario government reached a new Physician Services Agreement (PSA) after a year of disputes that saw negotiations suspended for a time. In May 2012,

the government attempted to make unilateral regulatory changes to fees for 37 physician services, with a focus on specialists such as radiologists, ophthalmologists, and cardiologists (MOHLTC 2012). Further negotiations led to a PSA which included amendments to six of 37 fee reductions, some of which reversed reductions or restored fees that had been removed (Yu 2012). Nevertheless, the Minister of Health and Long-Term Care stated at the time that the additional compensation, as negotiated in the final agreement, would be offset by savings in other areas to the tune of \$400 million in savings (Yu 2012).

Following these negotiations, in 2013-2014, gross clinical payments to physicians in Canada reached \$24.1 billion. Despite representing an increase of 5.7 per cent over the previous fiscal year, this was the lowest increase since CIHI started collecting this payments data in 1999-2000 (CIHI 2015b).

Other provinces, including British Columbia, have mimicked the Ontario government's negotiation efforts with physician groups to achieve similar results.



# Ontario Telemedicine Network (OTN)

The Ontario Telemedicine Network (OTN), a merger of three independent regional networks, was formally established in 2006 with the support of the provincial government. Its goal was to serve the entire population of Ontario by providing access to care for those in less populated and developed regions over time, the OTN has been expanded to urban areas with a need for improved access to care (Brown 2013).

Virtualization via two-way videoconferencing enables patient-to-provider and provider-to-provider communication such that access to health care services can be improved and delivered both effectively, quickly, and at a fraction of the cost. This system is designed to address issues of accessible and quality of care in Ontario's health care system. Between 2012 and 2015, total telemedicine activity in the OTN has grown an average of 37.6 per cent annually, as measured by the number of connections made to a telemedicine activity (OTN 2016).

The OTN is a stand-out example of health sector transformation that is changing the way in which providers and patients interact, monitor care, and manage care. It reduces the necessity to travel and the costs associated with traveling, and it avoids infection and reduces admittance and re-admittance to hospitals. When possible, this initiative shifts care away from high-cost hospitals toward communities and homes, and gives patients more opportunities to manage their health through different innovative technologies.

# 6 WHAT STILL NEEDS TO BE DONE?

Provinces are taking action to address the cost pressures facing their health care systems. Despite these actions, however, an aging population will create further challenges that, left unaddressed, will lead to higher health care costs. Cost escalation in the health care sector is projected to have significant long-term negative effects on provinces' fiscal sustainability.

As Canada's population ages, the volume of older adults with high per unit needs will enter the provinces' health care systems will increase. Greater prevalence of chronic conditions among a growing cohort of older adults combined with higher expectations around the quality of care suggests provinces should have in place patient-centred health systems with a strong focus on integrated continuing care. They do not.

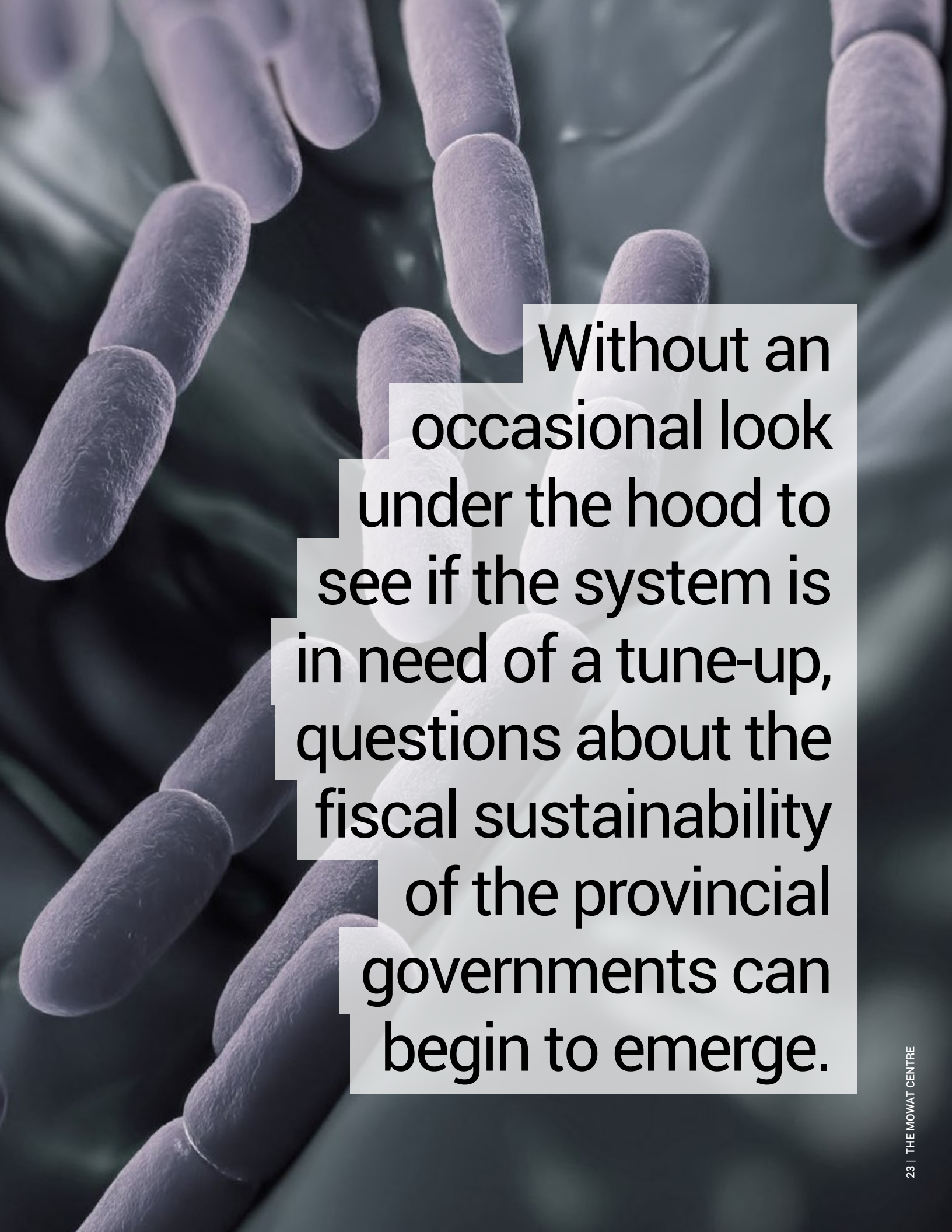
The physician- and hospital-centric model of health care in Canada was not designed to help patients with chronic conditions (CFHI 2014). As noted by Dr. David Walker in his 2011 report *Caring For Our Aging Population and Addressing Alternate Level of Care*, current models of care rely too heavily on acute care hospital resources, where admission to a hospital Emergency Department becomes the default, resulting in a substantial misdirection of resources (Walker 2011). This misdirection of patients to costly acute care settings often occurs because less expensive community supports like home care, residential care or assisted living are not available (CFHI 2014). These issues are often compounded by the fact that Canada is seriously lagging behind the rest of the OECD in the implementation of electronic health records (CFHI 2014).

Investments in models of care that shift the locus of care away from high-cost delivery mechanisms, such as hospitals, and toward more appropriate,

community-based care for patients without acute-care needs will be key contributions to creating a fiscally sustainable transformation of the health sector.

While the baby-boom generation is only just beginning its transition into older-adult status, transformational changes need to begin now so a cost-effective health care system that appropriately deals with the needs of that cohort is operational when needed. Building that system will take time and resources.

To most effectively rise to this challenge, a collaborative approach between provinces and the federal government that builds on the comparative advantages of both partners is required. Transformational change in the health care sector needs a transformational partnership between Canada's orders of government. That partnership will be informed by how health care is situated in Canada's intergovernmental context.

A microscopic image showing numerous purple, rod-shaped bacteria, likely Bacillus anthracis spores, against a dark background. The bacteria are arranged in various orientations, some in chains and others individually.

Without an occasional look under the hood to see if the system is in need of a tune-up, questions about the fiscal sustainability of the provincial governments can begin to emerge.

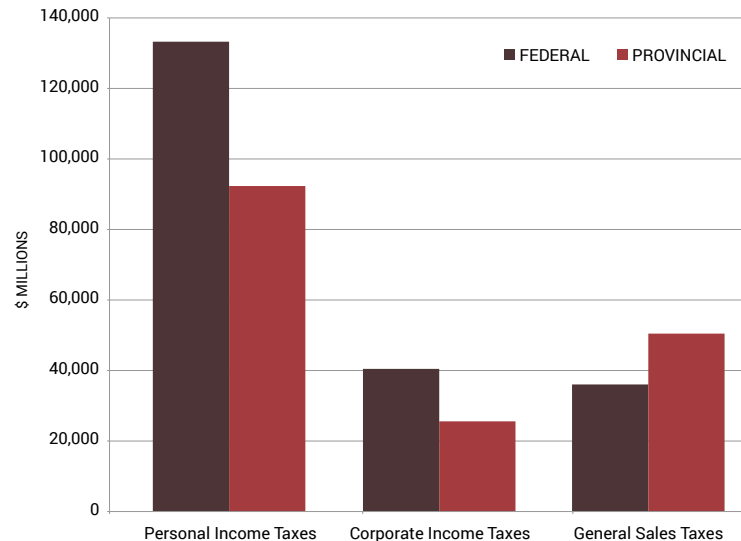
# 7 HEALTH CARE IN CANADA'S INTERGOVERNMENTAL CONTEXT

In a federal system like Canada, how governments divide responsibilities, taxing authority and tax room to ultimately pay for things, matters a lot. The constitutional responsibility for the provision of publicly-funded health care resides with the provinces. For each provincial government, it is the single largest area of spending. A complex system of fiscal interactions forms the foundation on which the funding of government programs, such as health care, rests. Each order of government has access to a broad array of taxing powers, with only a few restrictions in the area of indirect taxation placed upon the provinces.

However, as is generally the case in federal systems, the federal government occupies a much larger share of tax revenue than it needs to carry out its constitutional responsibilities. There are good economic efficiency reasons to recommend a strong federal role in the area of revenue collection. In an open economy, labour, capital and income can flow relatively freely across provincial borders, making it more difficult for provincial governments to tax all of the economic activity that occurs within their borders.

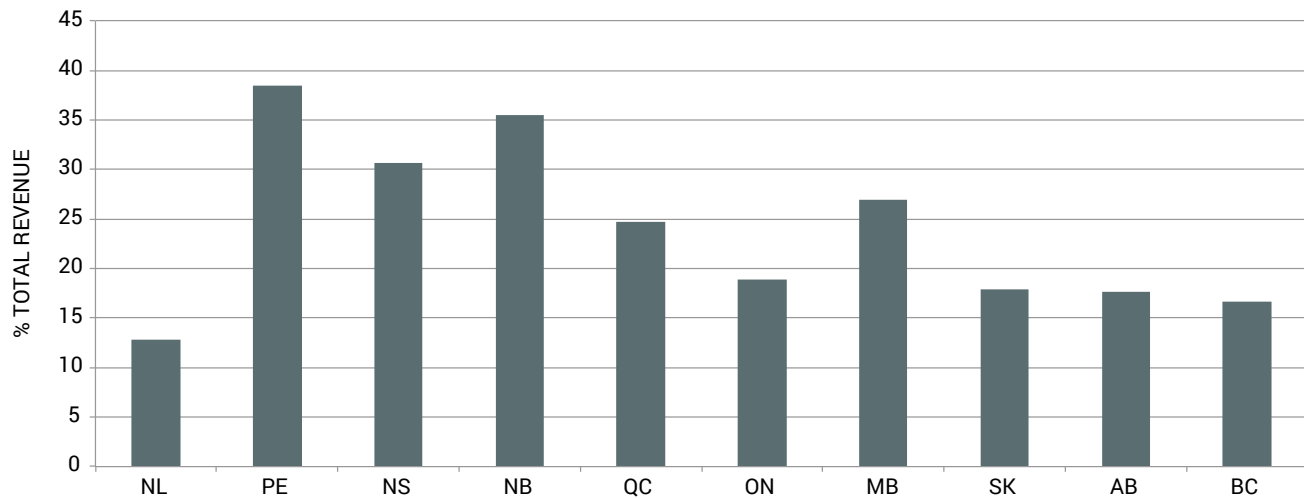
The central role federal governments play in revenue collection results in the federal government having the power to spend in areas outside its jurisdiction, through transfers to the provinces. Conversely, provinces generally raise less own-source revenue than what is required to fund their spending

**FIGURE 6**  
Federal and Provincial Occupation of Select Tax Bases



Source: Statistics Canada

**FIGURE 7**  
**Federal Transfers as a Percentage of Total Revenue**



Sources: 2016 Provincial Budgets; 2016 Report on Federal Tax Expenditures

Note: The Quebec Abatement is added to federal transfers for Quebec, but does not affect its total revenue. Estimate for the Quebec Abatement is taken from the 2016 Report on Federal Tax Expenditures.

responsibilities and rely – to varying degrees – on federal transfers to make up the difference. This system of fiscal federalism underpins the financing of many of Canada’s key social programs.

Canada’s federal approach to governance and program delivery is one of its inherent strengths. It gives provinces the freedom to act with *relative* independence in their spheres of jurisdiction and to respond to local needs and preferences. The concentration of fiscal resources at the federal level also allows the federal government to help the provinces provide more and better services than they could otherwise afford on their own. In exchange for the money it transfers to the provinces, the federal government typically expects a voice in setting priorities and provincial adherence to national standards and conditions. Health care is perhaps the best example of this relationship in the Canadian context.

A key weakness of Canada’s federal system, however, is that it can lead to fiscal imbalances between orders of government. Over time, without

an occasional look under the hood to see if the system is in need of a tune-up, questions about the fiscal sustainability of the provincial governments can begin to emerge. Evidence suggests that we are now at such a juncture given that the provincial-territorial governments are on a fiscally unsustainable track for the long-term (PBO 2016). Contributing to this problem is the fact that Canadian governments have successfully dodged having a serious conversation about the appropriate level of support each order of government contributes to health care for generations. It is time to re-evaluate:

- » the nature of the intergovernmental health care funding partnership; and
- » what both orders of government should be trying to achieve together going forward.

An examination of the history of how Canada’s intergovernmental health care funding partnership developed can inform both of these discussions.



# 8 HISTORICAL OVERVIEW

The adoption of publicly-funded health care across the provinces can be characterized as an example of the use of both the federal spending power and collaborative federalism. Cost-sharing mechanisms and considerable dialogue were instrumental in incenting all provinces to adopt public health care.

Federal use of its spending power through a commitment to cost-sharing was a key contributor in facilitating the establishment of publicly-funded health care across the country in the 1950s and 1960s. Through the *Hospital Insurance and Diagnostic Services Act (HIDSA)* of 1957, the federal government agreed to provide provinces with approximately 50 per cent of the costs of making insured hospital services available without charge to residents. The Medical Care Act of 1966 further extended this cost-sharing offer to cover universal access to eligible basic physician services. With the cost-sharing provisions of both of these Acts came the requirement to meet standards and conditions such as universal coverage, portability and public

administration. As a result, by 1971 each province had a publicly-funded “single-payer” insurance system that covered necessary hospital and physician services. Of key importance to the establishment of the systems was the idea that the sharing of eligible health care costs equally between the two orders of government was seen as the fairest way to set the funding contribution levels between equal partners (Provincial-Territorial Ministers of Health 2000).

The use of collaborative federalism to broker this understanding between the federal and provincial partners was also a key feature of the development of the systems. The enactment of both HIDSA and the Medical Care Act were followed by considerable deliberation between federal and provincial ministers at formal federal-provincial conferences followed by general agreement among partners. That is not to suggest that agreement was arrived at easily. As outlined by Lazar et al., “The model of federal-provincial fiscal relations from the 1950s-70s era was characterized by tough negotiations but with a determination to reach agreement,” (Lazar et al. 2004a).

## Collaborative Federalism:

Collaborative federalism is best understood as “a partnership between two equal, autonomous and interdependent orders of government that jointly decide national policy,”

Cameron and Simeon 2002.

Into the 1970s, the federal and provincial governments continued to follow the collaborative federalism model to address emerging problems with the early cost-sharing arrangements. The federal government's main concern with cost-sharing was that it retained no effective control over the ultimate size of the payouts it made. The provinces, for their part, were concerned with the lack of flexibility in cost-sharing arrangements. Cost-sharing, in the provinces' view, reduced the fiscal incentive to redirect spending to lower-cost services that weren't covered by cost-sharing provisions.

After multiple rounds of extensive negotiations – including three Federal-Provincial Finance Ministers' Conferences and two First Ministers' Conferences – it was agreed that fundamental changes would be made to the cost-sharing provisions that governed federal support for both health care and post-secondary education through the *Established Programs Financing (EPF) Act of 1977*. Though the negotiations were often difficult, “for those who viewed the outcome as involving important compromises by both sides, the exercise offered a good example of successful intergovernmental negotiation,” (Kom 1978). Neither side achieved exactly what they had hoped to, but both partners did realize important redress of their major concerns.

The federal government's concerns over the lack of control over its spending requirements brought about by explicit cost-sharing were addressed by the new arrangements. The vehicle for federal support was transformed into a regime whereby the federal government transferred tax room to the provinces (13.5 points of personal income tax and one point of corporate income tax) accompanied by a largely unconditional block transfer of approximately the same value – although at the outset, the actual split was closer to 60 per cent cash and 40 per cent tax. The value

of the tax points would grow along with the tax base, whereas the growth in the cash transfer would be subject to a Gross National Product (GNP) escalator.

The provincial aim for the new set of arrangements was to create a less federally intrusive, more administratively efficient system which also maintained a commitment to a rough splitting of costs. The extent to which the arrangements accomplished these goals can be measured in a number of ways.

From a systems-planning perspective, the EPF came with major advantages with respect to the flexibility and predictability it created for both orders of government. The move away from explicit cost-sharing to a block transfer gave the federal government a much greater degree of cost-certainty. For provinces, the block funding arrangements meant reduced administrative burdens, coupled with “long-term stability, which enabled them to make their own long-range plans,” (Lazar et al. 2004b).

The new arrangements also moved the federal government a degree closer to sharing the full costs of the health care system. A look at the numbers demonstrates that federal transfers as a share of provincial-territorial health spending increased in the first five years of the EPF regime. It is worth mentioning that the cost-sharing regime before the EPF did not cover half of the costs of all provincial-territorial health spending, only the spending covered by the agreements. In the five years leading up to the EPF, federal support for provincial-territorial health care spending averaged about 37 per cent. In the five years following the EPF agreement, federal support increased to an average of 41.6 per cent support (cash and tax) over the 1977-82 period that this set of arrangements covered.

## Early Assessments of the EPF Arrangements

Opinion at the time on whether the federal government or the provinces stood to gain more from the new arrangements was mixed, yet it indicates that both partners stood to gain from the new arrangements. Tom Courchene characterized the windfall gain that some provinces experienced as a result of the new arrangements as “a replacement or quid pro quo for the shared-cost programs,” (Courchene 1979).

Les Kom of the Institute for Intergovernmental Relations observed that, “in overall monetary terms, the agreement appears as a saw-off, or perhaps appropriately, as a mutually satisfactory trade,” (Kom 1978). Perhaps most surprisingly by today’s standards, the 1977 Ontario Budget lauded the result of the negotiations, calling the EPF “proof that substantial progress can indeed be made in terms of streamlining the relationships between the federal and provincial governments,” (MTEIA 1977).

It can be argued, however, that this was the price of greater cost-certainty for the federal government. This was also the result of a negotiated settlement between funding partners about the appropriate level of funding for each. While not a formal contract, the EPF was “the product of prolonged and intensive federal-provincial negotiations in which Ottawa worked hard to achieve agreement with the provinces,” (Lazar et al. 2004b).

The next 30 years marked a departure from the collaborative approach to resolving intergovernmental health care funding issues, and was instead defined by federal unilateralism. Throughout the 1980s and 1990s, the federal government introduced a series of unilateral adjustments, freezes and funding cuts to the EPF arrangements. In stark contrast with the establishment of federal cost-sharing plans for health care, which were “enacted after considerable dialogue with the provinces and formal federal-provincial conferences,” these funding reductions were generally made “on a unilateral basis, arguably in the context of short-term decisions about public spending rather than on the basis of longer term analyses of the sustainability of the public health-care system,” (Maioni 2002).

Amid the ongoing reduction in the federal level of support for provincial health care spending these changes to the EPF formula brought about, the federal government introduced the *Canada Health Act (CHA)*. The CHA required provinces to uphold the principles of public administration, comprehensiveness, universality, portability and accessibility in their health care systems. It also enabled the federal government to claw back, dollar for dollar, transfers from provinces that allowed extra-billing. The new conditions in the act highlighted a disconnect between the role of



the federal government as a funder of the health care system and the role it saw itself playing as the defender of the public health care system through the provisions of the CHA.

However, it was with the unilateral introduction of the Canada Health and Social Transfer (CHST) in 1996-97 where the role of the federal government as a funder of health care came most seriously into question. With the CHST, the federal government fundamentally changed how it supported provincial expenditures in the areas of health care, post-secondary education and social assistance. First, funding for all three of these programs was bundled together into a single, largely unconditional block transfer, citing flexibility for provinces as the key benefit. Second, the federal government cut its support for the CHST by a third between 1994-95 and 1997-98. This led to accusations from provinces that the federal government was balancing its books on the backs of the provinces. The original design of the CHST, whereby the size of the total program – both cash and tax points – was fixed, inadvertently sent the message that “Ottawa might be willing to see its cash contributions to medicare gradually cease,” (Cohn 1996) as natural growth in the tax points would eventually crowd out the cash transfer altogether. While the eventual introduction of CHST cash floors prevented that scenario, by 1998-99, federal support for provincial health spending nonetheless cratered to less than 10 per cent (cash) or 27.5 per cent (cash and tax).

This state of affairs proved to be unsustainable as the federal cuts began to both exacerbate the pressures on provincial health care systems and lead to further deterioration in intergovernmental relations.

The era of brief federal re-engagement in the mid 2000s at best represented an effort to shore up the system of fiscal arrangements to partially undo the damage caused by the era of unilateral cuts that preceded it.

---

At the time of the large federal cuts to the CHST, the provinces were undergoing a series of reforms to address the challenges facing their health care systems. Among the issues provinces were facing were: challenges in recruitment and retention of health human resources; access to primary care; working toward shifting the locus of care away from institutional providers to more community-based care; investing in new technologies; and reducing wait times for critical services.

Unpredictable and unilateral cuts to federal transfers did not make confronting these challenges any easier. Many of these issues were helpfully highlighted in the Romanow and Kirby Commissions, both of which made compelling cases for increased and predictable federal funding to help provinces see through the changes necessary to reform the health care sector.

With the federal government’s return to budgetary balance, it began to reinsert itself into discussions about renewing the publicly funded health care system. These discussions

manifested themselves most notably in the form of three First Ministers' Meetings in 2000, 2003 and 2004. Broadly, these discussions resulted in: a national focus on issues provincial health care systems were confronting; increases in federal transfers for health care; and the creation and invigoration of national health care institutions.

The federal government did gradually return to the table with funding increases for health care. This process began first with a mix of one-time money, dedicated funds to spur reform and modest increases to the CHST base. The 2004 First Ministers' Meeting ultimately led to the creation of a more predictable federal funding framework for health care, composed of a dedicated Canada Health Transfer (CHT) and a commitment to a six percent escalator for the CHT through to 2013-14. As a result, the seed for the restoration of the federal share of provincial health care spending to a more meaningful level had been planted.

The federal re-engagement in the national discussions on health care also led to a greater national focus on transparency and accountability and the institutions to support those goals. This included significant new funding for CIHI to broaden and enhance pan-Canadian health data, and the establishment of the Health Council of Canada. The Health Council was initially set up in 2003 to monitor and make annual public reports on the implementation of the priorities laid out at the 2003 First Ministers' Meeting, particularly its accountability and transparency provisions. Its mandate was expanded following the 2004 First Ministers' Meeting to provide information on the performance of the Canadian health care system and to report more broadly on health status and outcomes in Canada. This expansion of the Health Council's mandate filled an information gap through increased transparency and accountability.

Despite these largely positive outcomes – especially compared to what had preceded them – this era of brief federal re-engagement at best represented an effort to shore up the system of fiscal arrangements to partially undo the damage caused by the era of unilateral cuts that preceded it. These national discussions did help to build consensus on the need for reform and the need to address specific issues such as wait times. Important steps were likewise taken to enhance a nation-wide system of accountability and transparency. However, the federal investments made at the time did not represent a genuine dialogue between equal partners regarding the appropriate level of support for health care each government should provide. Those were not the pretenses under which these discussions occurred. At best, federal reinvestments in health transfers during this period can be seen as redress for previous federal cuts aimed at addressing short-term issues.

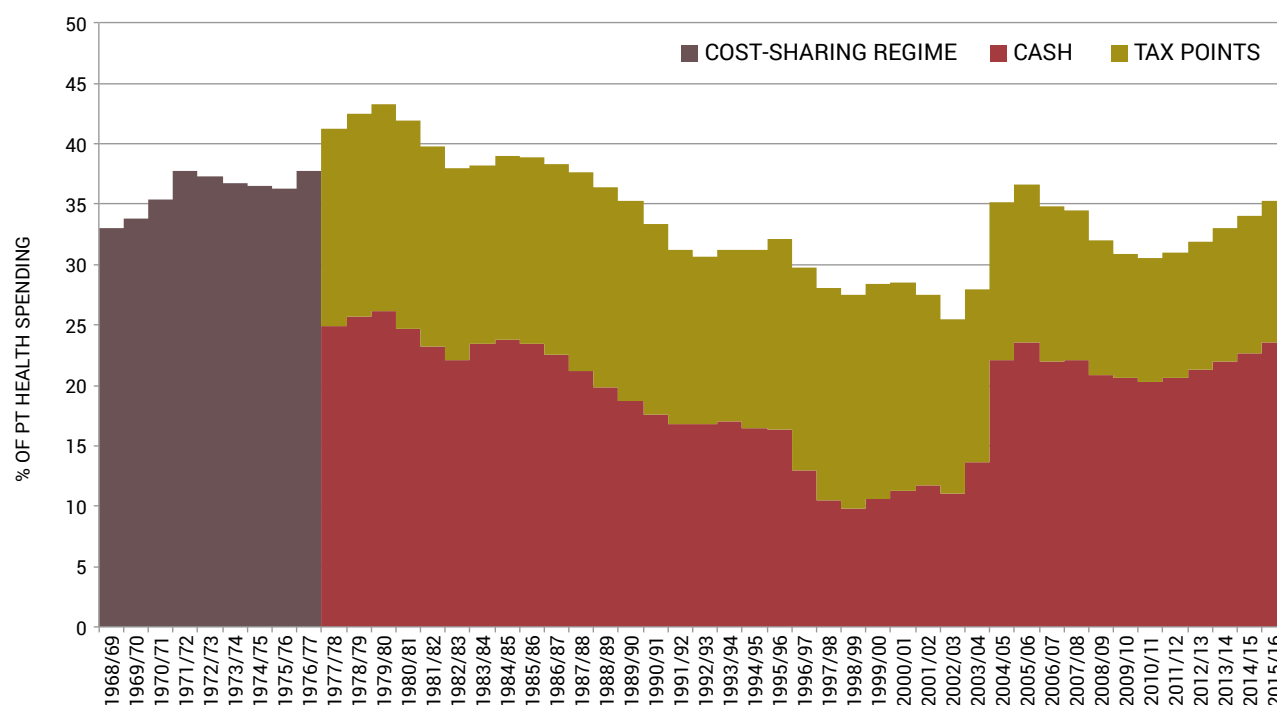
The federal government's most recent foray into issues surrounding the fiscal arrangements that support provincial health care spending came in 2011. At that time, the federal government unilaterally announced that as of 2017-18, the CHT would no longer grow at six per cent but at a growth rate tied to growth in nominal GDP, and that these arrangements would continue until 2023-24. This decision came as a complete surprise to the provinces and reflected no preceding intergovernmental discussions to inform it.

This approach did nothing to build trust between the federation's partners. The system the federal government currently uses to support provincial health care spending was unarguably implemented through an unpredictable and unilateral approach.

The deficiencies of that system, however, do not rest with the December 2011 announcement alone. The entire system is a legacy of arrangements cobbled together and layered on top of one another, each reflecting varying degrees of collaboration at various points in history. It is not reflective of a discussion between equal partners on how the cost burden of health care should be shared. When governments have approached the issue of intergovernmental financing of health care collaboratively, the solutions they have agreed upon have always been variants of cost-sharing.

Currently, federal support is nowhere near that mark. In 2015-16, federal support for provincial-territorial health care spending is forecast to be 23.5 per cent (cash) or 35.2 per cent (cash + tax). Canadian governments have successfully dodged a serious conversation about the appropriate level of support each order of government contributes to health care for generations. The “set it and forget it” approach will not help address some of the key challenges that health care is facing, such as the prospect of increasing costs which are calling into question the long-term fiscal sustainability of the provinces as discussed in the previous section. A collaborative approach is needed going forward.

**FIGURE 8**  
Federal Cash and Tax Point Transfers as a Share of Provincial-Territorial Health Spending



Note: see Methodological Appendix A for sources and methodology



Re-establishing the intergovernmental health funding partnership presents an opportunity for the federal government to facilitate transformation in the health sector.

# 9

## RECOMMENDATIONS

The question around the fiscal sustainability of the provinces is not an issue that will necessarily have immediate consequences, but is one that requires immediate and focused attention. Two key variables in the equation for fiscal sustainability will be restoring the federal partnership in health care and transformational change in the health sector. Provinces have already begun to initiate changes in an effort to bend down the cost-curve in the health sector. Further transformational reforms toward patient-centred health systems and community-based care, however, will be necessary to make provincial health systems more sustainable.

Re-establishing the intergovernmental health funding partnership presents an opportunity for the federal government to facilitate transformation in the health sector. The federal government has several comparative advantages that it can bring to bear to help provinces buy more change than they could otherwise afford to do on their own, including; the federal spending power underpinned by a sustainable fiscal structure; the ability to build consensus and drive change; and the capacity to enable pan-Canadian institutions to promote national goals such as enhanced accountability frameworks and the diffusion of innovation. This should be informed by a collaborative approach between equal partners, with a focus on fiscal sustainability and improving the quality of care.

### Renewing the Intergovernmental Health Funding Partnership

Much of the recent focus regarding federal support for health care has been on the fact that the annual growth rates of the CHT (six per cent until 2016-17) have exceeded recent growth rates of provincial health spending (under three per cent). This has been used at times to suggest that the federal government need not engage in any further increases in health care funding. This argument, however, does not answer the question of whether the federal government is pulling its weight in Canada's health care funding partnership, or whether the costs of delivering health care are being appropriately shared between orders of government.



# The bar for a collaborative approach to funding of the system has been set and it is cost-sharing.

---

So what is the appropriate level of federal support for health care? That is partly a political question, but not one that is divorced from historical bargains or answers that were arrived at when collaborative approaches between the orders of government were previously taken. Universal health care in Canada was established through collaboration and intergovernmental partnership between the provinces and the federal government. Through the intergovernmental bargaining process that created pan-Canadian health care, the bar for a collaborative approach to funding of the system was set and it is cost-sharing, albeit in its idiosyncratic Canadian form. An approach to restoring the intergovernmental health care funding partnership should take the results of that bargaining process strongly into account.

The last serious intergovernmental conversation about how the provinces and the federal government should share the costs of health care was in 1977, which led to the creation of the Established Programs Financing (EPF). The provisions of that agreement are indicative of the results that a collaborative approach to determining the appropriate division of the costs of health care between orders of government should produce. While the result may not have been fair “based on some objective

measure of fairness, it did reflect thirty years of intergovernmental bargaining that dated back to the federal government’s postwar planning,” (Lazar et al. 2004a), which stands in stark contrast to the unilateral approach to health care funding that the federal government has taken since.

As noted in the previous section, the level of federal support for provincial-territorial health spending that resulted from the EPF arrangements averaged 41.6 per cent over the five years those arrangements were in place. A reasonable “cost-sharing” benchmark to reset a true collaborative approach, whereby equal partners share in costs, should seek to achieve this level of support. This was the benchmark established by the last true conversation about how the orders of government should share the costs of health care.

In 2015-16, the level of federal support for provincial-territorial health care spending stood at 35.2 per cent, when the value of cash and tax point transfers are taken into account (federal cash support represents 23.5 per cent of provincial-territorial health spending and tax points 11.7 per cent). This would suggest that the federal government is not holding up their end of the health care partnership bargain. To return to “cost-sharing” immediately would cost the federal government in the order of a \$9 billion increase to the CHT base in 2015-16. Given the federal government’s short-term fiscal situation, and the need to balance other priorities, this may be an ambitious target. However, a commitment on the part of *both partners* to a process to achieve a level of federal support that represents “cost-sharing” in the medium term is reasonable.

The relatively unique period of low growth the provinces are currently maintaining in the health sector offers a potentially unique opportunity to the federal government. Given the low growth of provincial-territorial health care spending and steady growth in federal transfers, restoring the intergovernmental health funding partnership has never been so attainable. That is not to suggest that the federal government ought to simply do nothing and hope that the growth in the CHT will gradually outstrip the growth rates in health spending until the desired share is reached. This would certainly not be in the spirit of collaboration or restoring trust between partners on the health funding file.

Restoring the intergovernmental health funding partnership can address two key drivers of provincial fiscal sustainability: increasing the share of federal support for health care by re-establishing “cost-sharing” and facilitating transformational change in the health sector. This renewed partnership should pay **equal attention to both goals**.

What will make this work? First, the mechanism for delivering increased federal support will be important. Increases to either the level of the CHT or the CHT escalator, while desirable from a flexibility perspective, will inhibit transparent measurement of whether the new federal funding is achieving its intended purpose. It is therefore recommended that these federal funding increases be delivered as dedicated transfers, outside of the CHT envelope, earmarked for pan-Canadian health transformation and innovation agenda. We discuss proposed transparency and accountability mechanisms around these funds later in this section.

## Why Include Tax Points?

Provinces have long argued that the tax points transferred to the provinces as part of the 1977 EPF arrangements should not be counted as federal contributions to provincial health care spending (Provincial-Territorial Ministers of Health 2000). The reasons they cite for this argument include:

- » the tax point transfer was a one-time transaction;
- » many independent experts dispute designating tax points as a federal contribution to health care;
- » the tax transfer does not appear as federal revenue in its Public Accounts; and
- » the tax room transferred to provinces is provincial own-source revenue, representing provincial tax effort.

These arguments are not without merit. However, the validity of those arguments is not challenged by including the value of the tax points to set a benchmark for the appropriate sharing of costs between orders of government. The EPF represents a landmark in collaborative federalism, and the value of the tax points is an important consideration in any discussion of whether the current level of federal support for provincial health care spending is meeting the sharing of costs the 1977 arrangements were designed to achieve.

Once the objective of “cost-sharing” is met, an explicit cost-sharing agreement, similar to the pre-EPF arrangements, is not recommended. A benchmarked block transfer approach would be preferable.

The potential for both an increased administrative burden and moral hazard of the provinces spending “cost-shared” dollars could both produce sub-optimal outcomes. More desirable still would be further discussions at the end of the proposed new set of arrangements to assess whether the goals identified at the outset were on track to being addressed. These discussions should be informed by facts. The following sections will discuss a proposal for a neutral body that could play the role of providing facts for those discussions.

Recognizing the current short-term fiscal constraints but long-term fiscal sustainability of the federal government, the restoration of the intergovernmental health funding partnership to a “cost-shared” basis should be undertaken within a five-year period – that is, the typical length of a renewal period for fiscal arrangements legislation.

Provinces must also be willing to commit to a process that will ensure new federal funding is used to facilitate ongoing systemic changes to provincial health care systems to ensure they can remain sustainable. Building robust community-based care systems that are patient-centred will come with upfront costs.

Many variations and permutations of how to achieve the 41.6 per cent benchmark for cost-sharing are possible. The following is a model that attempts to pay equal attention to both increasing the share of federal support for health and facilitating investments in transformational change in the health sector. Other models are

possible, and two alternative scenarios are discussed in Methodological Appendix B.

This model makes the assumptions that:

- » No changes are made to the CHT GDP growth escalator;
- » CHT tax points grow in line with GDP;
- » Provincial and territorial governments can continue to hold their annual growth in their collective health spending to 3.4 per cent as they have for the last five years;
- » Provinces spend half of the new federal funding on new investments; and
- » Half of the new investment contributes to increasing the share of federal support for health growing the federal contribution.

Under these assumptions, a federal investment that ramps up to a \$10 billion annual increase in federal health transfers by 2021-22, roughly achieves the benchmark for “cost-sharing” (see Table 3.A).

This approach recognizes the short-term fiscal situation that the federal government is in but would still be well within the fiscal room available to it. Using the federal fiscal room to restore Canada intergovernmental health funding partnership will help provinces buy more change than they would otherwise be able to afford on their own. While this approach may lead to higher growth in health care spending in the short-term, these investments in transformational change are meant to contribute to long-term sustainability. The process by which this change is achieved must be informed by collaborative federalism and build on the comparative advantages of both orders of government.



**TABLE 4**  
**Proposed Approach to Restoring the Health Care Funding Partnership (\$ millions)**

	2015-16	2016-17	2017-18	2018-19	2019-20	2020-21	2021-22
STATUS QUO							
CHT Cash	34,026	36,068	37,149	38,549	40,232	41,922	43,682
CHT Tax	17,005	17,931	18,391	19,084	19,917	20,753	21,625
CHT Total	51,031	53,999	55,540	57,632	60,149	62,675	65,307
PT Health Spending	144,802	149,760	154,888	160,192	165,678	171,351	177,218
Federal Share	35.2%	36.1%	35.9%	36.0%	36.3%	36.6%	36.9%
PROPOSAL							
Increased Federal Support			1,000	2,000	5,000	7,500	10,000
Incremental New PT Health Spending			500	1,000	2,500	3,750	5,000
New Federal Support	51,031	53,998	56,540	59,632	65,149	70,175	75,307
New PT Health Spending	144,802	149,760	155,388	161,192	168,178	175,101	182,218
New Federal Share	35.2%	36.1%	36.4%	37.0%	38.7%	40.1%	41.3%

Note: See Methodological Appendix B for sources, assumptions and alternative scenarios

## Recommendation 1:

Restore the health care funding partnership by returning, within five years, to the “cost-sharing” levels that were last agreed upon by federal and provincial governments under the Established Programs Financing (EPF) arrangements.

# A Collaborative Approach to Building Consensus and Buying Change

Leveraging the restoration of the intergovernmental health funding partnership to further drive transformational change in the health sector is a key element in the equation for fiscal sustainability. That is not to say that the answer for the long-term sustainability of the provinces' health care systems will necessarily be found at an intergovernmental table. However, intergovernmental partnership can contribute to the solution through the use of a collaborative approach that recognizes the comparative advantages that both partners bring to bear.

The comparative advantage of the federal government is not found in dictating the terms and conditions for health care reform. Because of their first-hand relationships with health care service providers, the keys to containing health care costs are held by provinces. That would suggest an overly intrusive policy role for the federal government is not warranted. So what is the appropriate federal role?

In addition to leveraging the federal spending power to re-establish an appropriate funding partnership, the federal government can be an effective partner in building consensus for change if collaborative federalism is embraced. As noted by Lazar et al., "Ottawa has extensive research, communications, and political resources that can be mobilized to help provinces overcome resistance to needed change," (Lazar et al. 2004a). The federal government can deploy these resources to help build a compelling case for a transformation of the health sector.

The size and shape of health care transformation, however, will be different in every province. A top-down "one-size-fits-none" approach is not likely to succeed. A sophisticated approach to priority setting that is open to bilateralism is needed. As such, the federal government should use the increased funding committed to restoring the health partnership not to skew provincial investments to one particular area or another, but to drive a pan-Canadian health transformation and innovation agenda.

Examples of initiatives that could fit this bill are wide-ranging. In provinces where chronic conditions are still primarily dealt with in hospital settings, increasing access to home care services or enhancing the level of services provided in the home care basket might be most appropriate. Where access to doctors is a greater issue, investments in primary care or the deployment of virtual medicine solutions may have the greatest impact. In provinces where fragmented and paper-based health records are creating issues around continuity of care, investments in health information technology can help manage chronic conditions and prevent unnecessary costs. In most instances, a multi-pronged approach where many policy levers must be simultaneously pulled will most effectively bend down the cost-curve.

In any event, the first best use of an increase in federal health transfers would not be to support the system as it looks today, but to further transform provincial health systems with a view to fiscal sustainability that would prepare them for the impending demographic challenge.

What will make this work? First and foremost, **predictability**: a predictable policy and funding framework will be instrumental to success. Both the federal government and the provinces need to commit to collaboratively establishing the parameters of the pan-Canadian health transformation and innovation agenda and what types of provincial initiatives would qualify for funding. The federal government must also clearly establish a predictable multi-year funding envelope, tied to its commitment to the goal of achieving “cost-sharing”. For a collaborative approach to be effective, the collaborating partners must have “some minimal level of trust” and “entail a measure of predictability about the behaviour of the partners,” (Lazar 2000). Predictability, therefore, is a key to earning that trust. Provinces are not likely to genuinely buy into such an intergovernmental project if they do not have confidence that the federal government will hold up its end of the funding bargain. The reintroduction of the notice provisions that used to accompany fiscal arrangements legislation, which essentially guaranteed five-year terms for the parameters of those arrangements, would go a long way toward re-establishing that trust.

Provinces must also recognize that trust goes both ways. For the federal government to have confidence that the significant dollars it puts up will fund a pan-Canadian health transformation and innovation agenda, it would need some degree of certainty that value will be achieved with its money. A provincial commitment to transparency would be extremely important in that regard. To that end, each province would need to transparently and publicly lay out a plan, including details about what it would do with the money, how the plan fits into the mutually agreed-upon parameters for the health transformation and innovation agenda, and results it would hope to achieve.

## A sophisticated approach to priority setting that is open to bilateralism is needed to drive a pan-Canadian health transformation and innovation agenda.

---

This approach would stop short of strict conditionality, but would require provinces to be held accountable for how the money is being used. An asymmetrical arrangement for Quebec, however, would need to be considered in this regard should it wish. Recognizing the principles of asymmetrical federalism, many previous intergovernmental arrangements have been adapted to Quebec’s specificity and there is no compelling case to diverge from that practice.

Other considerations would need to be factored in as well. **Flexibility** around provincial transformation plans and initiatives, for example, would be useful. In the event that a province’s initial plan as laid out at the early stages of this process is demonstrated to not be achieving the outcomes it had hoped to, an opportunity to change course and reallocate the funding to more effective measures ought to be made available. In such an instance, a province should not be required to justify such a reallocation to the federal government, but would be expected to transparently and publicly disclose why it is changing course and what it plans to do instead.

In the context of fiscal arrangements, **fairness** in the allocation of funds cannot be overlooked. Currently, the CHT is distributed among provinces and territories on equal-per-capita basis. Per-capita allocations are fair and clear, tend to do a reasonably good job of ensuring that provinces can provide comparable levels of service – and while not their defining feature – they have equalizing effects (Zon 2014). For federal-provincial transfers, an equal-per-capita allocation is “the starting point for a principled approach from which any deviation should have a clear and defensible rationale,” (Zon 2014).

It has been argued by some provinces that, given an aging population and the fact that these demographic trends are not unfolding uniformly across Canada, an age-based distribution of some or all of federal health transfers is more appropriate. According to this argument, federal transfers should be allocated according to provincial shares of the population over 65 years of age. Provinces with relatively older populations would tend to fare better under this scenario than under a per-capita allocation, whereby a province’s share of the seniors’ population stands in as shorthand for expenditure need. While an aging population will place pressure on provincial health systems and is a key motivation for the transformation, it is not the only determinant of expenditure need in the health care sector.

A principled approach to a needs-based allocation of federal transfers should attempt to measure all of the factors that contribute to provinces’ expenditure needs. Broadly, these factors can be categorized into differences in volume of service or workloads, differences in costs, and geographic circumstances (Gusen 2012). Provinces with older populations (Quebec, British Columbia and the Atlantic Provinces) face greater workload demands on their health care systems, whereas higher wage provinces (Alberta and Ontario)

face higher costs. The costs faced by provinces where much of the population is remote from health care providers, such as Newfoundland, also contribute to differences in expenditure need (Gusen 2012). A needs-based allocation of all or part of federal health transfers, derived from a comprehensive measure of expenditure need, is not entirely without merit. If Canada’s orders of government agree to recognize the principle of expenditure need in federal transfers, however, a fairer approach would be to recognize differences in expenditure need across all provincial spending. To accomplish that task fairly, “Equalization is a more promising candidate than targeted transfers,” (Gusen 2012).

The 2015 Report of the Advisory Panel on Healthcare Innovation, chaired by David Naylor, has proposed a Healthcare Innovation Fund that would be distributed using a project-based approach. The proposed fund would be used “to support high-impact initiatives proposed by governments and stakeholders,” and “will be allocated on the basis of rigorous adjudication against transparent specifications,” (Canada 2015). An application-based allocation to meet specific goals based on merit is consistent with a principles-based approach to distributing federal transfers (Zon 2014). The proposed approach meets the fairness test, is not incompatible with the per-capita-based approach recommended by this paper, and could in fact complement it. The size and scope of the provincially-driven initiatives proposed by this paper and their intrinsic link to the fiscal arrangements, however, would render project-based funding both impractical and inconsistent with the principle of fairness. The fairest, most predictable and most practical allocation method for the new federal funding recommended in this paper would therefore be to mirror the current per-capita allocation method for federal health transfers.

While the need to embark upon a pan-Canadian health transformation and innovation agenda is immediate, the federal role of consensus-building should not be time-limited. Intergovernmental conversations on health care, including discussions on the appropriate division of costs between orders of government, should be ongoing. Continued discussions on goals and outcomes will be important not only to evaluate the successes of transformation initiatives but also to measure whether the goal of “cost-sharing” is being met.

These conversations may often be difficult ones, not permanently imbued with the spirit of collaborative federalism. That is to be expected in a federal system, especially in a policy sphere coloured by joint stewardship and somewhat blurred accountabilities. To that end, an independent arbiter of facts, mandated to play a transparency and accountability role, could furnish those conversations with evidence-based information, best practices, and forward-looking recommendations.

## Recommendation 2:

Enhance provincial efforts to achieve transformational change in the health care sector through a combination of predictable, flexible and fairly allocated federal funding enhancements, transparent provincial action, and effective use of the federal government’s consensus-building power.

# A Pan-Canadian Institution for Transparency and Accountability in Health Care

The shift from federal unilateralism to collaborative federalism, if realized, is not likely to sustain itself indefinitely of its own accord. A look back at the past few decades “indicates that harmony and discord in federal-provincial relations for health care are linked, first and foremost, to funding issues,” (Redden 2002). However, some of the friction inherent in a decentralized federal system with shared policy space can be mitigated, at least partially, by transparency. To maintain a collaborative approach based on partnership, more robust intergovernmental institutions mandated both to promote transparency and to serve as neutral and impartial arbiters of facts can help sand off some of the rough edges that cause this friction. The work of building such an institution, however, must be conducted thoughtfully – it must draw from past lessons and leverage the complementary work of other players in the sector, all without stepping on the jurisdictional competencies of either order of government.

In 2002, The Romanow Report called for the creation of an intergovernmental mechanism to “drive reform and speed up the modernization of the health care system by ‘de-politicizing’ and streamlining some aspects of the existing intergovernmental process,” (Canada 2002). Since then, the Health Council of Canada, the organization created to play that role, has come and gone. What can be learned from this experience? Can the promise of a pan-Canadian institution for transparency and accountability in health care be realized?

The obstacles are non-trivial. First and foremost, while elected officials generally support the goals of transparency and accountability, they, like most human beings, do not necessarily enjoy the process of being held accountable. This attitude is understandable since, in areas such as health care, much is at stake and governments are already subject to constant criticism at every turn. Furthermore, in the context of Canada’s federal system, provinces have a particular allergy to any implication that they might need to be accountable to the federal government in their fields of jurisdiction.

External organizations play a critical role in holding governments to account and evaluating performance. In this context, much good and important work is being done in the health sector by organizations such as CIHI, the Canadian Federation for Healthcare Improvement, and the Canadian Patient Safety Institute. This work is being further supplemented by the emergence of provincial health quality councils.

However, when it comes to systematic monitoring and performance evaluation of the health sector, “there is a vacuum in Canada,” (Marchildon 2014). This is especially true when it comes to performing robust value-for-money assessments of health systems from a pan-Canadian perspective. This is no small task. From a practical stand-point, only a well-funded, intergovernmental organization with a mandate to perform these assessments would be able to deliver such a result. The intent behind the establishment of the Health Council of Canada was to deliver on such a mandate; however, it could be argued that the institutional framework beneath it did not set it up well for success in that regard.



## Selection of Independent Not-For-Profit Pan-Canadian Health Organizations

### » Canada Health Infoway

FOUNDED IN 2001

Via partnerships and monetary investments, accelerates and supports the development and adoption of digital health technologies.

### » Canadian Blood Services

FOUNDED IN 1998

Funded in large part by provincial and territorial ministers of health, manages the national supply of blood, blood products and stem cells, and related services for all provinces and territories (excluding Quebec).

### » Canadian Foundation for Healthcare Improvement (CFHI)

FOUNDED IN 1996

Collaborates with sector partners to spread evidence-informed and patient-centred health care innovations across Canadian jurisdictions by supporting organizational capacity and implementation efforts.

### » Canadian Partnership Against Cancer (CPAC)

FOUNDED IN 2006

Facilitates collaboration and action across health sector groups aimed at implementing Canada's cancer control strategy.

### » Mental Health Commission of Canada (MHCC)

FOUNDED IN 2007

Catalyzes mental health system improvement in Canada via partnerships across the health sector, making recommendations specifically aimed at systems and organizations that deal directly with mental health.

### » Canadian Agency for Drugs and Technologies in Health (CADTH)

FOUNDED IN 1989

Conducts evidence-based analysis and writes recommendations aimed at helping organizations and governments make informed decisions about the optimal use of drugs and medical devices.

### » Canadian Centre for Substance Abuse (CCSA)

FOUNDED IN 1988

Consolidates and produces research on the harms of drugs and alcohol, facilitates information-sharing in this field of study, and provides policy advice aimed at reducing harm.

### » Canadian Institute for Health Information (CIHI)

FOUNDED IN 1994

Houses most data on Canada's health care system and the health of Canadians, and produces reports and analysis on health system performance.

### » Canadian Patient Safety Institute (CPSI)

FOUNDED IN 2003

Works with organizations, governments, and providers to develop tools and resources that facilitate and promote patient safety in Canadian health care systems.

In building a new pan-Canadian institution for transparency and accountability in health care, important lessons can be learned from the case of the Health Council. The design of the key elements of the framework for this new institution, such as the mandate, structure, reporting, relationships with partners, and funding arrangements can improve upon that model.

## MANDATE

For any organization to be successful, it must have a well-defined sense of purpose which is clearly understood by its stakeholders. The Health Council was initially created to monitor and make annual public reports on the implementation of the 2003 and 2004 Health Accords. The 2004 Health Accord further expanded the role of the Health Council to report on the “health status of Canadians and health outcomes,” (Canadian Intergovernmental Conference Secretariat 2004) Following a strategic review in 2010 aimed at increasing its effectiveness and relevance, it was agreed the Health Council’s mandate should be expanded to place greater emphasis on “identifying, reporting and disseminating best practices and innovation in its public reports,” (Health Council of Canada 2010). Despite the Health Council’s efforts to strategically re-orient itself, the federal government referenced the completion of the Health Council’s original mandate in its justification for winding down federal funding for the organization:

*As you are aware, the Council was established to monitor and report on progress in relation to the commitments made in the 2003 and 2004 Health Accords. With the 10 year term of the 2004 Accord coming to a close in 2014, the Council will have completed its primary mandate once it releases its final report on progress under the Accords. In this context, and given the fiscal environment, the federal government has decided to wind down funding for the Council.*

Aglukkaq. 2013

# Important lessons can be learned from the case of the Health Council of Canada.

---

A lesson then for a new institution to promote pan-Canadian agenda for transparency and accountability in health care is that its role ought to be explicitly outlined as ongoing. As the Health Council itself came to realize, such an organization should also have a mandate broader than monitoring the implementation of a specific agreement if it is to have enduring relevance. The mandate of the new institution should also seek to overlap as little as possible the mandates of Canada’s other pan-Canadian health organizations, and where possible, should seek to complement them. As such, an appropriate mandate ought to strive for the institution to play a broad and ongoing role in the performance of value-for-money assessments of Canada’s health systems with an end goal of promoting both quality and fiscal sustainability.

## STRUCTURE

In calling for the establishment of a Health Council, both the Romanow and Kirby reports recommended that it be independent of government. The ultimate structure of the board of the Health Council that governments agreed to, however, was one in which – apart from the chair who was a consensus nomination of federal, provincial and territorial ministers of health – half of the other 26 board members sat as “direct representatives of participating governments,” (Fafard 2013). It is debatable as to whether this board structure would meet the test of independence from government as envisioned by both Romanow and Kirby.

As noted by Greg Marchildon, “there are good structural reasons why governments will never be able to critically evaluate their own reforms or performance,” (Marchildon 2014). An institution tasked with promoting accountability and transparency, therefore, must be well and truly arm’s length from government. Likewise, its board should be composed of sector experts, not government representatives. Government representatives are, perhaps understandably, too concerned with the day-to-day and defending status quo. It is important to recognize that Canada’s health care system is comprised of 13 separate provincial and territorial systems, in addition to federally run health programs. As such, consideration to regional representation should be given in board membership though it need not be the over-riding factor.

## REPORTING

A key element to replicate from the Health Council model would be the nature of its reporting structure. In the Canadian context, it is not appropriate for provinces to be accountable to the federal government as neither order of government is subordinate to the other (Watts 1999). Provinces would therefore be reluctant to support an institution that was perceived as a Trojan horse for making them accountable to the federal government.

As a result, any pan-Canadian institution aimed at promoting transparency and accountability should take care to disabuse its stakeholders of any notion that it would play an audit function. As noted by Julie M. Simmons and Amy Nugent, “in policy areas where intergovernmental relations are particularly conflictual, ministers engaged in drawn-out, dense, tit-for-tat power plays with their jurisdictional opponents will also be unlikely to submit to audits,” (Simmons and Nugent 2013). The appropriate role would be to perform value-for-money assessments, not audits.

The other important step in ensuring one order of government is not accountable to another would be to ensure that the primary accountability relationship for the institution is to the public. “Public reporting as a means to hold provincial governments to account for federal spending has become increasingly popular since the 1990s,” (Graefe et al. 2013). Such an approach would mitigate provincial concerns about being directly accountable to federal government, while giving Ottawa comfort that its money is being put to good use.

## RELATIONSHIPS WITH PARTNERS

One of the main challenges the Health Council faced was uneven compliance from its government partners. Because the Health Council did not have consistent access to “comprehensive performance information from provinces, the council [was not] able to fulfill its role as an independent arbiter of the performance-reporting regime created by intergovernmental agreement,” (Fafard 2013). While a return to “cost-sharing” for health care should buy an all-government commitment to a pan-Canadian accountability framework, the institution charged with this task is still likely to have its work cut out for it.

To be successful, the institution will need to find ways of drawing upon existing expertise and capacity in the system. Part of this can come from networking other pan-Canadian health organizations, provincial health quality councils and academics in the formation of its agenda. Its relationship with CIHI in particular will be fundamental. To avoid duplication, CIHI should be the ultimate source of the new institution’s data, and CIHI’s established relationships with provinces with respect to data gathering should be leveraged to the greatest degree possible. To make this possible, increased funding for CIHI may be required.

Relationship management will also be an important element to ensure that all governments are answer to the new institution. Through its strategic review conducted in 2010, the Health Council recognized the need to “increase government engagement in the planning and development of its public reports.” (Health Council of Canada 2010). As the new institution releases its assessments and makes recommendations,

governments should be expected, if not self-compelled, to answer the recommendations, address whether or not they are accepting them, and if not, what they are doing instead.

Many different models are possible to elicit responses from governments. A provision in a new health accord whereby each government agrees to pass legislation requiring it to respond to the institution’s reports would be a gold standard.

However, the approach deployed by many Auditors-General might be a less intrusive one with a higher likelihood of being implemented. For example, the Office of the Auditor-General of Ontario takes the approach of sharing preliminary reports and recommendations with auditees, who are given the chance to respond to the recommendations in writing. These responses are subsequently included in the Auditor-General’s reports (Ontario 2015). This approach of sharing findings upstream limits surprises and removes at least one potential excuse for not responding.

## FUNDING

The Health Council of Canada was funded by the federal government. Having a single funder increased the risk that the Health Council would succumb to the whims of a single decision. In the creation of a new pan-Canadian institution for transparency and accountability in health care, it would be extremely desirable for it to be co-funded by federal, provincial and territorial governments. Similar to their contributions to the Council of the Federation, provincial-territorial funding could be divided on a pro rata basis formula according to their respective populations. Should any province or territory be unwilling to meet its funding commitment, their contribution could be deducted from the new federal funding for health transformation and innovation.

## COMMON UNDERSTANDING OF GOALS

Getting the mechanics right for a new pan-Canadian institution for transparency and accountability in health care will be important, but just as important will be a common understanding of its goals. In addition to the benefits of pan-Canadian value-for-money assessments of health systems, there is inherent benefit to the existence of a respected, expert, neutral body Canadians can turn to for facts. Disagreement over the interpretation and relevance of facts can lead to and fuel intergovernmental bickering. An independent arbiter of those facts can help adjudicate through some of that strife. Such an institution could be turned to by provinces to assess and validate whether or not the federal government is upholding its funding commitments. The federal government could similarly access information on whether the investments it is supporting are achieving the fiscal sustainability goals they are meant to facilitate. Through the institution's public reports, Canadians will be able to assess whether provincial health transformation and innovation initiatives are coming at the cost of quality care.

By supplanting facts for rhetoric, the institution can facilitate and help sustain intergovernmental collaboration and promote the federal consensus-building role. The value added by this function could at some point in the future also serve as a potential gateway to enhancing the federal role in health care in such a way that leverages its comparative advantage from a collaborative base.

## Recommendation 3:

Create a pan-Canadian institution for transparency and accountability in health care, co-funded by — but independent from — the federal, provincial and territorial governments, operating under a clearly-defined mandate to conduct value-for-money assessments with an end goal of promoting both the quality and fiscal sustainability of provincial health care systems.





Canada's governments will increasingly need to look for new ways to collaborate in health care, but that requires trust.



# 10 CONCLUSION

The complex challenges faced by modern governments are not likely to be solved in silos. In the Canadian context, that reality will extend to how intergovernmental relations are practiced. As Ronald L. Watts pointed out, while there may be a seductive appeal to complete disentanglement and independent jurisdiction between orders of government, “in practice it has proved simply impossible to divide functions in federations into watertight compartments,” (Watts 1999).

Canada’s governments will increasingly need to look for new ways to collaborate, but that requires trust. With respect to health care, a great deal of that trust can be re-established through the restoration of the health care funding partnership between the orders of government. While a more appropriate division of costs can be informed by the original bargain that led to the creation of universal health care in the pan-Canadian context, the collaborative approach governments take now should be forward-looking in intent. Through a collaborative approach informed by the comparative advantage of each order of government, underlined by a commitment to transparency, provinces and the federal government can make significant progress toward both a pan-Canadian health care system that achieves quality outcomes and the fiscal sustainability of the provinces.

# APPENDIX A

The federal share of provincial-territorial health spending was calculated according to the methodology outlined in Appendix E of the Commission on the Future of Health Care in Canada: Final Report (Romanow Commission).

Between 1968-69 and 2001-02, federal cash transfer and tax point values reflect the amounts outlined in Column M of Appendix E.1. Total federal health transfers as a proportion of total provincial-territorial health expenditures reflect the percentage shares outlined in Column L of Appendix E.2 over the same period.

For the years 2002-03 and 2003-04, the methodology outlined by the Romanow Commission has been replicated and updated for increases in federal transfers subsequent to the release of the report. The notional health allocation of the CHST (Canada Health and Social Transfer) tax point transfer for those years was calculated using 67.9 per cent allocation of the total transfer of tax points under the Established Programs Financing (EPF), as described in the notes for Column L of Appendix E.1. The notional health allocation of the CHST cash transfer for those years was calculated by applying a 43 per cent share to the base CHST less funding for Early Childhood Development (\$18.7 billion in 2002-03 and \$19.3 billion in 2003-04) and subsequently adding all health specific transfers, including the Primary Health Care Transition Fund, the 2003 and 2004 CHST Supplements, the Health Reform Transfer and the Diagnostic/Medical Equipment Trust as federal support for health. Time-limited trusts were accounted for according to their notional drawdown schedules and not in the year they were booked by the federal government, as this more closely approximates when the funds were spent by provincial-territorial governments.

From 2004-05 and onward, total federal support for provincial-territorial health spending is made up of the Canada Health Transfer cash and tax points, as well as various time-limited funding, including those mentioned in the paragraph above and the 2004 Medical Equipment Fund, the Wait Times Reduction Fund/Trust, the Patient Wait Times Reduction Fund, the Human Papillomavirus Immunization Trust, and CHT Transition and Protection Payments made to various provincial-territorial governments.

It should be noted that upon splitting the CHST into the CHT and the Canada Social Transfer (CST) in 2004-05, the federal government opted to allocate 62 per cent of the CHST to the CHT, not 43 per cent as outlined by the Romanow Commission. The federal rationale at the time was that the 62 per cent /38 per cent split between the CHT and CST “reflect[ed] the percentage of health spending within overall provincial spending in the health and social sectors supported by federal transfers,” (Investing in Canada’s Health Care System: Addendum to the 2003 federal budget). Of the almost \$9 billion year-over-year increase in the federal support for provincial-territorial health spending between 2002-03 and 2003-04 outlined in this report, over half of it can be attributed in the change of the allocation of the CHST from 43 per cent to 62 per cent.

Data for federal cash transfers were taken from federal budgets and public accounts. Data for tax points were taken from federal Tax Expenditure Reports and converted to a fiscal year basis by the author. Data for the Associated Equalization portion of the tax points were provided by the Ontario Ministry of Finance for 2002-03 to 2013-14. For 2014-15 and 2016-17, Associated Equalization was assumed to grow by the same rate as the overall Equalization program.

## APPENDIX B

The numbers underlying the funding proposal outlined in Recommendation 1 were composed of data and forecasts for nominal GDP, CHT cash transfers, CHT tax points, and provincial-territorial health spending.

The forecast for nation-wide nominal GDP growth was taken from Table A1.1, Annex 1 of the 2016 federal Budget.

CHT cash transfer levels for 2016 were taken from the Transfer Tables on the Department of Canada website <http://www.fin.gc.ca/fedprov/mtp-eng.asp>.

Data for tax points were taken from federal Tax Expenditure Reports and converted to a fiscal year basis by the author. Data for the Associated Equalization portion of the tax points were provided by the Ontario Ministry of Finance for 2002-03 to 2013-14. For 2014-15 and 2016-17, Associated Equalization was assumed to grow by the same rate as the overall Equalization program.

The forecast for 2015-16 provincial-territorial health spending CIHI's 2015 National Health Expenditure Trends Tables: Table F.1.1.1: Provincial/Territorial Government Health Expenditure, by Province/Territory and Canada, 1974–1975 to 2015–2016—Current Dollars.

The five-year growth rate between 2009-10 and 2104-15 was also computed from data in the table referenced above table.

## ALTERNATIVE SCENARIOS

A number of alternative scenarios were also considered and are outlined below.

Alternative Scenario #1 contemplates provincial-territorial governments flowing through all new federal support to increased investments. The amount of new federal funding required to meet the “cost-sharing” benchmark under this scenario would be roughly \$14 billion by 2021-22.

### Proposal for Increased Federal Support: Alternative Scenario #1 (\$ millions)

	2015-16	2016-17	2017-18	2018-19	2019-20	2020-21	2021-22
STATUS QUO							
CHT Cash	34,026	36,068	37,149	38,549	40,232	41,922	43,682
CHT Tax	17,005	17,931	18,391	19,084	19,917	20,753	21,625
CHT Total	51,031	53,999	55,540	57,632	60,149	62,675	65,307
PT Health Spending	144,802	149,760	154,888	160,192	165,678	171,351	177,218
<b>Federal Share</b>	<b>35.2%</b>	<b>36.1%</b>	<b>35.9%</b>	<b>36.0%</b>	<b>36.3%</b>	<b>36.6%</b>	<b>36.9%</b>
PROPOSAL							
Increased Federal Support			1,000	2,000	6,000	10,000	14,000
Incremental New PT Health Spending			1,000	2,000	6,000	10,000	14,000
New Federal Support	51,031	53,999	56,540	59,632	66,149	72,675	79,307
New PT Health Spending	144,802	149,760	155,888	162,192	171,678	181,351	191,218
<b>New Federal Share</b>	<b>35.2%</b>	<b>36.1%</b>	<b>36.3%</b>	<b>36.8%</b>	<b>38.5%</b>	<b>40.1%</b>	<b>41.5%</b>

Sources: Finance Canada, CIHI

Alternative Scenario #2 contemplates provincial-territorial governments flowing through none of the new federal support to increased investments. The amount of new federal funding required to meet the “cost-sharing” benchmark under this scenario would be roughly \$8 billion by 2021-22.

### Proposal for Increased Federal Support: Alternative Scenario #2 (\$ millions)

	2015-16	2016-17	2017-18	2018-19	2019-20	2020-21	2021-22
STATUS QUO							
CHT Cash	34,026	36,068	37,149	38,549	40,232	41,922	43,682
CHT Tax	17,005	17,931	18,391	19,084	19,917	20,753	21,625
CHT Total	51,031	53,999	55,540	57,632	60,149	62,675	65,307
PT Health Spending	144,802	149,760	154,888	160,192	165,678	171,351	177,218
<b>Federal Share</b>	<b>35.2%</b>	<b>36.1%</b>	<b>35.9%</b>	<b>36.0%</b>	<b>36.3%</b>	<b>36.6%</b>	<b>36.9%</b>
PROPOSAL							
Increased Federal Support			1,000	2,000	4,000	6,000	8,000
Incremental New PT Health Spending			0	0	0	0	0
New Federal Support	51,031	53,999	56,540	59,632	64,149	68,675	73,307
New PT Health Spending	144,802	149,760	154,888	160,192	165,678	171,351	177,218
<b>New Federal Share</b>	<b>35.2%</b>	<b>36.1%</b>	<b>36.5%</b>	<b>37.2%</b>	<b>38.7%</b>	<b>40.1%</b>	<b>41.4%</b>

Sources: Finance Canada, CIHI

The effect of continuing the six per cent CHT escalator was also examined. Assuming provincial-territorial governments flowed through none of the new federal support resulting from the continuation of the six per cent escalator to increased investments; an additional \$3.9 billion would still be required in 2021-22 to meet “cost-sharing” benchmark.

#### Net Impact of Continuing Six Per Cent Escalator (\$ millions)

	2015-16	2016-17	2017-18	2018-19	2019-20	2020-21	2021-22
STATUS QUO							
CHT Cash	34,026	36,068	37,149	38,549	40,232	41,922	43,682
CHT Tax	17,005	17,931	18,391	19,084	19,917	20,753	21,625
CHT Total	51,031	53,999	55,540	57,632	60,149	62,675	65,307
PT Health Spending	144,802	149,760	154,888	160,192	165,678	171,351	177,218
<b>Federal Share</b>	<b>35.2%</b>	<b>36.1%</b>	<b>35.9%</b>	<b>36.0%</b>	<b>36.3%</b>	<b>36.6%</b>	<b>36.9%</b>
INCREMENTAL NEW FEDERAL FUNDING FROM CONTINUING SIX PER CENT ESCALATOR							
Increased Federal Support			1,082	1,977	2,725	3,612	4,584
Incremental New PT Health Spending			0	0	0	0	0
New Federal Support	51,031	53,999	56,622	59,609	62,874	66,288	69,891
New PT Health Spending	144,802	149,760	154,888	160,192	165,678	171,351	177,218
<b>New Federal Share</b>	<b>35.2%</b>	<b>36.1%</b>	<b>36.6%</b>	<b>37.2%</b>	<b>37.9%</b>	<b>38.7%</b>	<b>39.4%</b>
<b>Additional Amount Required to Achieve “Cost-Sharing”</b>							<b>3,868</b>

Sources: Finance Canada, CIHI

# REFERENCES

- Aglukkaq, Leona. 2013. "Letter to Health Council of Canada Corporate Members, April 8, 2013."
- Brown, Edward M. 2013. "The Ontario Telemedicine Network: A Case Report." *Mary Ann Liebert Inc. (Telemedicine and E-Health)*: Vol 19, No 5: 373-376.
- Cameron, David and Simeon Richard. 2002. "Intergovernmental Relations in Canada: The Emergence of Collaborative Federalism." *Publius: The Journal of Federalism*, Vol 32, No. 2, Oxford University Press, pp. 49-71.
- Canada. 2002. *Building on Values: The Future of Health Care in Canada*. Royal Commission on the Future of Health Care in Canada.
- Canada. 2015. *Unleashing Innovation: Excellent Healthcare for Canada*. Report of the Advisory Panel on Healthcare Innovation.
- Canadian Institute for Health Information (CIHI). 2011a. "Drivers of Prescription Drug Spending in Canada." *Canadian Institute for Health Information (CIHI)*. [https://www.cihi.ca/en/drug\\_spend\\_drivers\\_en.pdf](https://www.cihi.ca/en/drug_spend_drivers_en.pdf).
- Canadian Institute for Health Information (CIHI). 2011b. "Health Care Cost Drivers: The Facts." *Canadian Institute for Health Information (CIHI)*. [https://secure.cihi.ca/free\\_products/health\\_care\\_cost\\_drivers\\_the\\_facts\\_en.pdf](https://secure.cihi.ca/free_products/health_care_cost_drivers_the_facts_en.pdf).
- Canadian Institute for Health Information (CIHI). 2011c. "Seniors and the Health Care System: What is the Impact of Multiple Chronic Conditions?" *Canadian Institute for Health Information (CIHI)*. [https://secure.cihi.ca/free\\_products/air-chronic\\_disease\\_aib\\_en.pdf](https://secure.cihi.ca/free_products/air-chronic_disease_aib_en.pdf).
- Canadian Institute for Health Information (CIHI). 2012. "Drivers of Prescription Drug Spending in Canada." *Canadian Institute for Health Information (CIHI)*. [https://www.cihi.ca/en/drug\\_spend\\_drivers\\_en.pdf](https://www.cihi.ca/en/drug_spend_drivers_en.pdf).
- Canadian Institute for Health Information (CIHI). 2014. "Prescribed Drug Spending in Canada, 2012: A Focus on Public Drug Programs." *Canadian Institute for Health Information (CIHI)*. <https://www.cihi.ca/en/types-of-care/pharmaceutical-care-and-utilization/generic-drugs-slow-spending-growth>.
- Canadian Institute for Health Information (CIHI). 2015a. "National Health Expenditure Trends, 1975 to 2015." *Canadian Institute for Health Information (CIHI)*. October 2015. [https://secure.cihi.ca/free\\_products/nhex\\_trends\\_narrative\\_report\\_2015\\_en.pdf](https://secure.cihi.ca/free_products/nhex_trends_narrative_report_2015_en.pdf).
- Canadian Institute for Health Information (CIHI). 2015b. "Summary Report: Physicians in Canada, 2014." *Canadian Institute for Health Information (CIHI)*. September 2015. [https://secure.cihi.ca/free\\_products/Summary-PhysiciansInCanadaReport2014\\_EN-web.pdf](https://secure.cihi.ca/free_products/Summary-PhysiciansInCanadaReport2014_EN-web.pdf).
- Canadian Intergovernmental Conference Secretariat. 2004. "A Ten-Year Plan to Strengthen Health Care." [http://scics.gc.ca/CMFiles/800042005\\_e1JXB-342011-6611.pdf](http://scics.gc.ca/CMFiles/800042005_e1JXB-342011-6611.pdf)
- CBC News. 2015. "\$5M hepatitis C strategy announced by P.E.I. government." *CBC.ca*. <http://www.cbc.ca/news/canada/prince-edward-island/5m-hepatitis-c-strategy-announced-by-p-e-i-government-1.2954701>.
- Cohn, Daniel. 1996. "The Canada Health and Social Transfer: Transferring Resources or Moral Authority Between Levels of Government?" *Canada: State of the Federation 1996*. Institute for Intergovernmental Relations.
- Courchene, Tom. 1979. *Refinancing the Federation: A Survey of the 1977 Fiscal Arrangements Act*. C.D. Howe Research Institute.
- Deber, Raisa Berlin and Kenneth Cheak Kwan Lam. 2009. "Handling the High Spenders: Implications of the Distribution of Health Expenditures for Financing Health Care." Paper presented at the 2009 American Political Science Association Annual Meeting. [http://papers.ssrn.com/sol3/papers.cfm?abstract\\_id=1450788](http://papers.ssrn.com/sol3/papers.cfm?abstract_id=1450788)
- Fafard, Patrick. 2013. "Intergovernmental Accountability and Health Care: Reflections on the Recent Canadian Experience." In Graefe, Peter, Julie M. Simmons and Linda A. White (editors). *Overpromising and Underperforming?* University of Toronto Press, pp. 31-55.
- Falk, Will, Matthew Mendelsohn & Josh Hjartarson. 2011. "Fiscal Sustainability and the Transformation of Canada's Healthcare System: A Shifting Gears Report." *The Mowat Centre*. [https://mowatcentre.ca/wp-content/uploads/publications/38\\_fiscal\\_sustainability\\_and\\_transformation\\_canada.pdf](https://mowatcentre.ca/wp-content/uploads/publications/38_fiscal_sustainability_and_transformation_canada.pdf).
- Graefe, Peter, Julie M. Simmons and Linda A. White. 2013. *Overpromising and Underperforming? Understanding and Evaluating New Intergovernmental Accountability Regimes*. University of Toronto Press.
- Government of British Columbia. 2016. "Health Care Programs and Services: Better at Home." *Gov.bc.ca*. <http://www2.gov.bc.ca/gov/content/family-social-supports/seniors/health-safety/health-care-programs-and-services/better-at-home>.
- Government of New Brunswick. 2012. "The New Brunswick Extra-Mural Program Strategic Plan 2013-2016." *Gnb.ca*. [https://www.gnb.ca/0051/0384/pdf/strategic\\_plan-e.pdf](https://www.gnb.ca/0051/0384/pdf/strategic_plan-e.pdf).
- Gusen, Peter. 2012. "Expenditure Need: Equalization's Other Half." *The Mowat Centre*. [https://mowatcentre.ca/wp-content/uploads/publications/46\\_expenditure\\_need.pdf](https://mowatcentre.ca/wp-content/uploads/publications/46_expenditure_need.pdf)
- Health Council of Canada. 2010. *Strategic Directions 2011, Five-Year Strategic Plan*. Health Council.
- Institute for Competitiveness and Prosperity. 2014. "Building Better Health Care: Policy opportunities for Ontario." *Institute for Competitiveness and Prosperity*. [http://www.competeprosper.ca/uploads/WP20\\_BetterHealthCare\\_FINAL.pdf](http://www.competeprosper.ca/uploads/WP20_BetterHealthCare_FINAL.pdf)
- Institute of Medicine. 2012. *Living Well With Chronic Illness: A Call for Public Health Action*. National Academies Press.
- Kom, Les. 1978. *The Federal Year in Review, Volume I*. Institute for Intergovernmental Relations.
- Lazar, Harvey. 2000. "In Search of a New Mission Statement for Canadian Fiscal Federalism." *The State of the Federation 1999-2000*. Institute for Intergovernmental Relations, pp. 3-40.
- Lazar, Harvey, Keith Banting, Robin Boadway, David Cameron, and France St-Hilaire. 2004a. "Federal-Provincial Relations and Health Care: Reconstructing the Partnership." *Money, Politics and Health Care*. Institute for Research on Public Policy, pp. 251-286.
- Lazar, Harvey, France St-Hilaire and Jean-François Tremblay. 2004b. "Federal Health Care Funding: Toward a New Fiscal Pact." *Money, Politics and Health Care*. Institute for Research on Public Policy, pp. 189-249.



- Maioni, Antonia. 2002. "Federalism and Health Care in Canada" in Banting, Keith and Stan Corbett, (editors). *Health Policy and Federalism: A Comparative Perspective on Multi-Level Governance*. McGill-Queen's University Press, pp. 173-199.
- Marchildon, Gregory. 2014. "Evaluating Health Policy and System Performance: Are We Moving to a Network Model? White Paper-Working Draft." Presented at Creating Strategic Change in Canadian Healthcare Conference, Queen's University, Kingston, ON. May 2014.
- Office of the Parliamentary Budget Officer (PBO). 2016. "Fiscal Sustainability Report 2016." [http://www.pbo-dpb.gc.ca/web/default/files/Documents/Reports/2016/FSR\\_2016/FSR\\_2016\\_EN.pdf](http://www.pbo-dpb.gc.ca/web/default/files/Documents/Reports/2016/FSR_2016/FSR_2016_EN.pdf).
- Ontario. Office of the Auditor General of Ontario. 2015. "The Office of the Auditor General of Ontario." In *Annual Report 2015*. Office of the Auditor General of Ontario.
- Ontario Ministry of Health and Long-Term Care (MOHLTC). 2006. "Legislation: Transparent Drug System for Patients Act, 2006." Last modified: 2015 December 14. <http://www.health.gov.on.ca/en/common/legislation/bill102/>.
- Ontario Ministry of Health and Long-Term Care (MOHLTC). 2010. "Backgrounder: Reforming Ontario's Drug System." <https://news.ontario.ca/mohltc/en/2010/04/reforming-ontarios-drug-system.html>.
- Ontario Ministry of Health and Long-Term Care (MOHLTC). 2011a. "News Release: Historic Drug Reforms Delivering Better Health Care For Ontarians." Last modified: 2011 June 7. <https://news.ontario.ca/mohltc/en/2011/06/historic-drug-reforms-delivering-better-health-care-for-ontarians.html>.
- Ontario Ministry of Health and Long-Term Care (MOHLTC). 2011b. "News Release: Improving Publicly-Funded Health Care For Ontarians." Last modified: 2011 August 12. <https://news.ontario.ca/mohltc/en/2011/08/improving-publicly-funded-health-care-for-ontarians.html>.
- Ontario Ministry of Health and Long-Term Care (MOHLTC). 2012. "Backgrounder: Physician Compensation and Ontario's Action Plan for Health Care." <https://news.ontario.ca/mohltc/en/2012/05/physician-compensation-and-ontarios-action-plan-for-health-care.html>.
- Ontario Ministry of Health and Long-Term Care (MOHLTC). 2015. "Working Together for Change: Ontario Public Drug Programs Annual Report 2014-2015." <http://www.>
- Ontario Ministry of Finance (MOF). 2016a. "News Release: Ontario Freezing Doctor Pay to Invest In More Community Care For Families and Seniors." <http://www.fin.gov.on.ca/en/budget/ontariobudgets/2016/ch1d.html>
- Ontario Ministry of Finance (MOF). 2016b. "2016 Ontario Budget: Jobs for Today and Tomorrow." 2016 March 16. <https://news.ontario.ca/mohltc/en/2012/05/ontario-freezing-doctor-pay-to-invest-in-more-community-care-for-families-and-seniors.html>.
- Ontario Ministry of Treasury, Economics and Intergovernmental Affairs. 1977. "Ontario Budget 1977."
- Ontario Telemedicine Network (OTN). 2016. "How OTN Is Making a Difference: OTN Year in Review." <https://otn.ca/how-is-otn-making-difference-in-ontario/year-in-review/>.
- Patented Medicine Prices Review Board (PMPRB). 2011. "Generics Drugs in Canada: International Price Comparisons and Potential Cost Savings." *The Patented Medicine Prices Review Board (PMPRB)*. <http://www.pmprb-cepmb.gc.ca/CMFiles/Publications/Analytical%20Studies/NPDUIS-GenericDrugs-IPCs-e-sept30.pdf>.
- Provincial-Territorial Ministers of Health. 2000. "Understanding Canada's Health Care Costs: Final Report." [http://www.health.gov.on.ca/en/common/ministry/publications/reports/ptcd/ptcd\\_mn.aspx](http://www.health.gov.on.ca/en/common/ministry/publications/reports/ptcd/ptcd_mn.aspx).
- Redden, Candace Johnson. 2002. "Health Care Politics and the Intergovernmental Framework in Canada: Discussion Paper No. 21" In *Building on Values: The Future of Health Care in Canada*. Royal Commission on the Future of Health Care in Canada.
- Simmons, Julie M. and Amy Nugent. "Panacea or Peril? Intergovernmental Accountability and the Auditor General." In Graefe, Peter, Julie M. Simmons and Linda A. White (editors). *Overpromising and Underperforming?* University of Toronto Press, pp. 284-303.
- Statistics Canada. 2012. "Census in Brief: Generations in Canada." *Statistics Canada*. [https://www12.statcan.gc.ca/census-recensement/2011/as-sa/98-311-x/98-311-x2011003\\_2-eng.cfm](https://www12.statcan.gc.ca/census-recensement/2011/as-sa/98-311-x/98-311-x2011003_2-eng.cfm).
- Statistics Canada. 2014. "Daily: Ninety years of change in life expectancy." *Statistics Canada*. <http://www.statcan.gc.ca/daily-quotidien/140717/dq140717d-eng.htm>.
- Statistics Canada – Demography Division. 2016. "Canadian Demographics at a Glance: Second Edition." *Statistics Canada*. <http://www.statcan.gc.ca/pub/91-003-x/91-003-x2014001-eng.pdf>.
- United Way of Lower Mainland. 2015. "United Way's Better at Home: A Year in Review – April 1, 2014-March 31, 2015." *UWLM.ca*. [http://www.betterathome.ca/sites/default/files/Better%20at%20Home%20Annual%20Report%202015%20FINAL.compressed-1\\_2.pdf](http://www.betterathome.ca/sites/default/files/Better%20at%20Home%20Annual%20Report%202015%20FINAL.compressed-1_2.pdf).
- Walker, Dr. David. 2011. "Caring For Our Aging Population and Addressing Alternate Level of Care." *Report Submitted to the Minister of Health and Long-Term Care*. <http://www.eriectclairhin.on.ca/page.aspx?id=5C136F8AD6124428AA3B5766E7F10A68>
- Watts, Ronald L. 1999. *The Spending Power in Federal Systems: A Comparative Study*. Institute of Intergovernmental Relations.
- Wister, Andrew and Mark Speechly. 2015. "Inherent Tensions Between Population Aging and Health Care Systems: What Might the Canadian Health Care System Look Like in Twenty Years?" *Journal of Population Ageing*, 8(1&2).
- Wodchis, Walter P., Peter Austin, Alice Newman, Ashley Corallo, and David Henry. 2012. "The Concentration of Health Care Spending: Little Ado (Yet) About Much (Money)." Presentation at the Canadian Association for Health Services and Policy Research Conference. <https://www.cahspr.ca/en/presentation/5244423937dee8014bee024>.
- Yu, Jack. 2012. "Health Bulletin: OMA and Provincial Government Reach Agreement." *Fasken Martineau*. <http://www.fasken.com/oma-and-provincial-government-reach-agreement/>.
- Zon, Noah. 2014. "Slicing the Pie: Principles for Allocating Transfer Payments in the Canadian Federation." *The Mowat Centre*. [https://mowatcentre.ca/wp-content/uploads/publications/90\\_slicing\\_the\\_pie.pdf](https://mowatcentre.ca/wp-content/uploads/publications/90_slicing_the_pie.pdf)

