



## **KEY ISSUES IN HEALTH:**

### **A PRESENTATION TO THE *ROYAL COMMISSION ON OUR PLACE IN CANADA***

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## **1 Introduction**

The Newfoundland and Labrador Health Boards Association (NLHBA) welcomes the opportunity to contribute to the Royal Commission on Our Place in Canada's discussions. The NLHBA is the federation of regional health boards that serve Newfoundlanders and Labradorians across the province. Through our membership, the NLHBA represents the six regional Institutional Health Boards, the two regional Integrated Health Boards, the four regional Health and Community Services Boards, the St. John's Nursing Home Board and the Newfoundland Cancer Treatment & Research Foundation. These Boards are governed by voluntary trustees, who are appointed by the Minister of Health and Community Services and serve in the public interest.

Health Boards are ready to take an active role in working towards solutions. We believe that the focus on wellness and needs-based population health principles in the Strategic Health Plan outline a bright future for the health of our Province. The time has come to move from rhetoric to action and we look to the Federal Government for leadership and a return to sustainable funding. This is our opportunity to engage all stakeholders in this important process and to urge the Royal Commission to review the following analysis of Newfoundland and Labrador's place in Canada with respect to the publicly-funded health system.

## **2. Provincial Support for the values of the Canada Health Act: comprehensiveness, universality, portability, accessibility, public administration**

*Polling shows that the population in this province strongly supports the public health system and does not support the introduction of further privatization initiatives such as user fees.*

The values of the Canadian public health system as defined in the *Canada Health Act* (CHA) are widely supported in the province of Newfoundland and Labrador and are seen as key in terms of the "social safety net" and social equity. Public policy that compromises the public aspect of the health system is therefore not supported in this province. This is reflected on the national scene: the *Health Care in Canada Survey 2001* found that Canadians do not support paying for health services at the point at which care

is delivered, and do not support requiring patients to contribute a portion of the costs of the care and services they use based on income, although there was support for an additional public insurance program, funded by premiums, to cover what is not included in the current government-funded health system. In this province, the NLHBA polling has found that six out of ten Newfoundlanders and Labradorians are either strongly or generally opposed to the introduction of small user fees. In addition, close to two-thirds of residents of the province strongly or generally oppose legislation that would require people to pay for their own medical costs if they become ill or develop a disease as a result of lifestyle choices. Where there are user fees in this province, such as for ambulance use, the cost incurred by recovery of fees owed often exceeds the recovered financial amounts.

In view of the lack of public support for most aspects of private funding for health services and the rock-bottom average income, how is Newfoundland and Labrador, a province with a small economy and geographic and demographic challenges, going to pay for a health system that compares with that offered by other provinces?

### ***2.1 Jurisdiction***

Even though provinces claim jurisdiction over the health system, section 92(7) of the Canadian Constitution explicitly assigns exclusive provincial control over hospitals and psychiatric institutions only. This reflects the nineteenth-century conception of health care in terms of disease and hospitals alone. Provincial authority over other parts of the health system is gained through a broad interpretation of the subsections dealing with local works and undertakings, property and civil rights in the province, all matters of a merely local or private nature, education and immigration. The CHA governs the overall policy and framework of the public health system in the country through the provision of funding by the federal government which is conditional upon following the CHA principles and values. Since the CHA also covers only medical and hospital services, other health programs and services are funded by the provinces, including the early intervention and health promotion services that are now recognized as crucial in reducing the need for acute care services.

Jurisdictional conflict is an inevitable part of the debate as provinces look for more funding for their health programs and services, and the federal government attempts to maintain its legislated role of overseeing the national public health system in the interests of the Canadian population.

## **2.2 Funding**

The Federal Government provides funding for health systems to provinces in two ways, through the equalization program and as part of the Canada Health and Social Transfer (CHST). Newfoundland and Labrador has been hard hit by the changes in equalization transfers and federal health funding in the 90s.

### **(a) Equalization**

Equalization is a constitutionally-mandated federal program intended to ensure that reasonably comparable services can be provided across the country at reasonably comparable levels of taxation. This program is the framework through which Canadian citizens are given the guarantee that economic disparities among Canadian provinces will not deprive Canadian citizens in less prosperous provinces of services, including health services, enjoyed by Canadians in other, more prosperous provinces. The provisions for equalization and regional disparities appear as Part III of *Schedule B, Constitution Act 1982*:

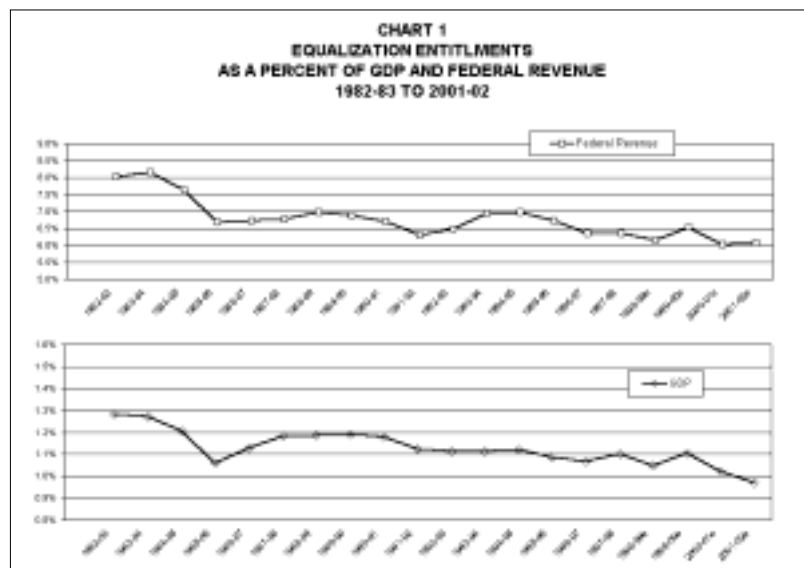
**36.** (1) Without altering the legislative authority of Parliament or of the provincial legislatures, or the rights of any of them with respect to the exercise of their legislative authority, Parliament and the legislatures, together with the government of Canada and the provincial governments, are committed to

- (a) promoting equal opportunities for the well-being of Canadians;
- (b) furthering the economic development to reduce disparity in opportunities; and
- (c) providing essential public services of reasonable quality to all Canadians.

(2) Parliament and the government of Canada are committed to the principle of making equalization payments to ensure that provincial governments have sufficient revenues to provide reasonably comparable levels of public services at reasonably comparable levels of taxation

A report on the equalization program **Report** <http://www.gov.nf.ca/ag/reports.htm> by the Atlantic Provinces Economic Council (APEC) released in winter, 2001, points out that the equalization program has been an essential component of Canada's federal-provincial transfer mechanisms for over 40 years and until recently was widely supported as an essential mechanism to distribute the benefits of growth across the country and a building tool for all Canadians to access improved health and education services. Some provinces persist in describing this particular transfer from the Federal Government as a system where wealthier provinces pay in to equalization and poorer provinces draw out. In reality, this constitutionally-mandated federal program is funded by the general revenue collected from every taxpayer in the country, like all federal programs, to ensure that Canada functions in the best interests of all of its people as a country, not as a collection of loosely-connected sub-nations with very different economic bases.

How is this working in practice? Currently the more vulnerable provinces are concerned that the overall decline in federal transfers since 1995 is gradually downgrading the ability of these provinces to deliver essential services (See Chart 1).



Department of Finance, Government of Newfoundland and Labrador, 2002

This needs to be revisited by the Federal Government so that the program can resume its intended role in our country as laid out in our Constitution. It is promising that Federal Finance Minister John Manley recently agreed in St. John's (p. D1, *The Telegram*, November 22, 2002) that it is important to take into account how to apply the formula to all parts of Canada. At the same time he recognized that equalization transfers are also becoming an increasingly important means of ensuring that common services are funded adequately in have-not provinces. However, he also cautioned that he is not interested in singling out provinces for special treatment.

Without a thorough overhaul of the federal equalization payment formula, it is hard to see how the federal government can fulfill the section 36 constitutional mandate for Parliament and the government of Canada. The crucial question remains "How to ensure that essential services are funded for equitable participation in the system?" The public are already paying for some health services that they want – the key is to make sure that services that are needed are equally available to all.

### **(b) The Canada Health and Social Transfer (CHST)**

Efforts to keep up the federal profile in the Canadian health system were hampered by the early 1990s federal fiscal restraint and the decision to change the funding for the social sector from a model where funding was targeted towards a particular sector (health, education etc.) to the current global model, the CHST, where all health and social funding is handled as a single amalgamated whole. At the same time, transfers were significantly reduced, leaving provinces to fund a far greater share of the cost of delivering health services to the population.

The global CHST model has made it extremely difficult, if not impossible, for the anyone to identify what funding is actually going to the health system and has provided rich material for federal/provincial debate. Initially, the federal government covered 50% of the provincial medical insurance plans covering physician and hospital services. Current estimates of the federal cash share of health costs vary

from 11% to 14% of the total, with by far the lion's share having been downloaded to the provincial governments, resulting in inequities in the health system from province to province according to individual provincial economies. The provincial share of health costs has risen to levels unsustainable for smaller provinces, while the transfer funds from the federal government have not even regained the level of the early '90s. This trend has been a significant disadvantage to Newfoundland and Labrador.

There are two aspects of the CHST funding allocation method which have a particularly negative effect on Newfoundland and Labrador and have also contributed to adversarial relationships among provinces:

**(i) Tax Points**

Relationships among provinces have been strained because the Federal Government wants to be credited for the value of tax points ceded to the provinces in the '70s as part of the CHST health funding. From the Federal Government's point of view, this is a cost-effective method of allocating funds where no actual dollars need to change hands. Provinces with growing economies and large tax bases strongly support this method of calculation, as it gives them a larger share of the pie. The federal government has attributed an average value to the tax points which cannot be supported as meaningful, since the value of a tax point varies widely from province to province according to the health of the provincial economy. In 1999/2000, for example, the value of a tax point was calculated by Finance Canada to be \$16 in Newfoundland and Labrador and \$31 in Ontario (found on the website for Finance Canada, June 2000). Fewer federal health dollars therefore go to Newfoundland and Labrador using this allocation method than to Ontario. Both the Romanow Commission and the Kirby Commission have recommended abandoning the inclusion of this transfer of tax points in the CHST calculation in favour of cash-only transfers, pointing out that this will enhance accountability of both levels of government to the Canadian public.

**(ii) Per Capita Calculation**

The allocation formula for CHST funds is now based on a per capita calculation. This has driven the provinces even further apart. For those provinces with a shrinking population (generally the same provinces as those with a smaller tax base) this has logically resulted in less funding for health services. Newfoundland and Labrador have the dubious distinction of being the only province with a consistently diminishing population over a period of some eight years.

Unfortunately, health services have to be offered in every province however small the population. The large land mass of a province such as Newfoundland and Labrador has an extra impact, in that providing health services to the shrinking population is much more costly than it would be if the same number of people were clustered in an urban centre. Demographically speaking, most people leaving fall within the most healthy age category, below the age of fifty, leaving the frail and elderly without adequate family support and having to rely heavily on the services of the provincial health system.

It is clear from the above discussion that the two major sources of federal funding have been drastically reduced during the last decade in a manner that particularly affects Newfoundland and Labrador, leaving our province struggling to fund needed health services. This year the CHST cash for Newfoundland and Labrador is still \$80 million below the pre-CHST transfers in 1995. Since the Provincial and Territorial Ministers of Health in *Understanding Canada's Health Care Costs* (August 2000) estimated a very conservative 5% annual growth rate for health costs, it is not difficult to see why Newfoundland and Labrador is finding it extremely challenging to keep up with the provision of health services.

**2.3 Is Canada already spending too much on health?**

Canadian spending on health is one of the lowest amongst OECD countries, ranking 21<sup>st</sup> among the 27 OECD countries in public spending on health. As a percentage of the GDP, Canada's health spending ranks only 9<sup>th</sup> among OECD countries and represents a

smaller percentage of the Canadian GDP than it did ten years ago. It is significant in this regard that both federal and provincial governments, in showcasing their contributions to health costs, tend to calculate spending in current dollars without taking inflation or the increase in GDP into account. This gives the impression that health expenditures are rapidly expanding. The reality is that in constant dollars, the average annual increase in total (public+private) per capita health spending has nationally averaged only 1.5% from 1992 – 2000, and the recent increases in public funding projected for 1997-2000 in constant dollar per capita terms (ranging from 1.9% to 5.4%) should be seen in the context of the decreases in public funding from 1993 – 1996 (-1.2% to -2.0%).

A major difficulty in supporting the values of the CHA and sustaining the health system in a equitable way among provinces lies in the withdrawal of the federal government from its leadership role supported by the provision of funding. This withdrawal has significantly disadvantaged Newfoundland and Labrador in its challenge to provide health services based on the values of the CHA comparable to those provided in other Canadian provinces.

### **3 The Need for Federal Leadership**

The province is already on record as supporting the principles of the CHA. In addition, the vision articulated in the provincial Strategic Social Plan of “a healthy, educated, distinctive, self-reliant and prosperous people living in vibrant, supportive communities within sustainable regions” brings a high level strategic direction to public policy in this province. The recently-released provincial Strategic Health Plan also supports and expands the same concepts in the health context. Canada-wide support for basing health systems on similar, population health principles is reflected in the recently-released reports from the Romanow Commission and the Kirby Commission, and in health reports from national organizations such as the Canadian Institute for Health Information and the Canadian Public Health Association. The Canadian Institutes of Health Research and the Canadian Health Services Research Foundation also have broadened their mandate, allocating funding for health research according to broader population health principles as well as for pure biomedical research.

The August 2000 Final Report of the Provincial and Territorial Ministers of Health, *Understanding Canada's Health Care Costs*, identified the cost-drivers and cost-accelerators that are always present in the prevention and treatment of disease. There is a clear role for the Federal Government to address these, and other potential cost-drivers such as gene patents, at the national and international level to make decisions that control these costs. Without strategically addressing matters largely under federal control, these costs will continue to increase. Again the provinces, and particularly Newfoundland and Labrador, face the consequences of rising costs, where only the Federal Government can make the requisite changes.

We now need the Federal Government to recognize that principles alone are not enough; federal leadership is required in order to continue to develop the publicly-funded health system to meet the needs of the population. The NLHBA supports a strong national health system based on national values with national programs and standards, in order to ensure access for all Canadians to health services, and particularly those Canadians living in small provinces. The only way to achieve this is through a thriving federal-provincial partnership, built on shared values, collaboration and cooperation with all stakeholders. We as a province need to focus on fostering a strong federal-provincial relationship in order to maintain the principles of the Canada Health Act.

Newfoundland and Labrador has done its part within the limits of its administrative and fiscal capacity: it is time for the Federal Government to fulfill its intended role in the Canadian health system in order to support and develop the system in the most innovative and equitable manner.

#### 4. Conclusion

Newfoundland and Labrador is already contributing the highest per capita provincial health funding amongst Canadian provinces, and is amongst the highest of the provinces with respect to the proportion of its annual budget devoted to health. This situation is not forecast to improve in the near future (Canadian Institute of Health Information, *Health Expenditure Estimates*). It is unlikely that next year's provincial budget will be offering further increases to the health budget because there is little funding available. Our Province has already undertaken very significant reform in the health system, and has completed a Strategic Health Plan in consultation with all the key health stakeholders.

It is imperative for the Federal Government to step up to the plate, resume its leadership and support our national health system with renewed funding that ensures a strong, consistent health services delivery right across our nation. In the absence of such national action from the Federal Government, medicare is in danger, as Roy Romanow recently pointed out in calling for a floor to federal health funding, of fragmenting “into 13 or more separate health care systems, each with differing methods of payment and each with its own list of covered services. The most important point of all is this: quality care for all Canadians may be compromised” (Notes for Speech at the Canadian Club of Winnipeg, November 20, 2002).

Thirteen separate health systems offering various services at various levels. Does this sound like a country to you? 