

The Forum Presents:

## Health Care Funding and Sustainability in Canada

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## Introduction

In a Commonwealth Report comparing OECD country healthcare systems, Canada ranked 10 out of 11 countries for performance of their healthcare system; second only to the United States (Davis et al., 2014). This is despite the fact that as a country we are expected to spend \$219.1 billion or \$6,105 per Canadian in 2015 which translates into 10.9% of our GDP, putting us in the top quartile of per capita health spending internationally (CIHI, 2015). Therefore, in the recent report released by the Advisory Panel on Healthcare Innovation noted that despite our high per capita spending and the talents of dedicated healthcare professionals and researchers, the Canadian healthcare system is being held back (Advisory Panel on Healthcare Innovation, 2015). Therefore, this brief explores the literature surrounding three challenges affecting our healthcare system: the renegotiation of the health accord between the federal and provincial-territorial governments, the creation of a national pharmacare strategy and the improvement of long-term care and home care.

## A New Health Accord

The jurisdiction of healthcare in Canada is a shared responsibility between the provincial and federal governments: while provinces are responsible for healthcare delivery to all but federal populations (Aboriginal people, the Canadian Armed Forces and refugees), the federal government is responsible for areas such as public health and health research and provides approximately 25% of the provincial governments' healthcare budgets (Picard, 2012). In order for the healthcare system to be more effective, Picard argues that there needs to be more cooperation between all levels of government.

The newly elected federal government has pledged to renegotiate a health accord with the provinces and territories as the original agreement expired in 2014 (Prime Minister's Office, 2015). While the previous accord increased transfer payments to the provinces for healthcare, there was arguably little quantifiable change that came out of it. Gardner et al. state that Canadians deserve "better value" in their healthcare system through improved health outcomes, health equity and patient experience which can be achieved through meaningful engagement among all levels of government (2014).

Additionally, a health accord at its core, addresses the relationship between the provincial-territorial governments and the federal government. The new health accord will require a debate as to the roles of the different levels of government as well as highlight

areas for cooperation. The previous federal government did not “intervene in the health sector” as much as previous Canadian governments and had a more bottom up approach with the provinces leading healthcare reform (Forest, 2014; Gardner et al., 2014). Forest argues that the provinces should be able to continue this process and take the lead on “crucial files such as pharmaceuticals” and work together among themselves for joint initiatives (2014). Criticizing the bottom-up approach as ineffective, Picard and others state that in order to be successful, this new accord must take a top-down approach and must ensure that any fiscal change in the Canadian healthcare system, including the Canada Health Transfer, must have conditions attached to any increase in funding and must establish measurable outcomes to evaluate progress. (2012; Gardner et al., 2014). Gardner et al. take the middle ground as they argue that the provinces do not have incentives nor the fiscal resources to achieve and maintain better value and they see it as difficult for best practices to be expanded across jurisdictions without some federal leadership and intervention. Yet they also state that provinces need flexibility to pursue different policy options to achieve an objective (2014).

Finally, the current formula for federal funding to the provinces for healthcare through the Canada Health Transfer (CHT) will be a major challenge for governments during the negotiations and it is likely needed to be renegotiated before a new health accord can come into an effect. According to the Innovation Panel’s report, the federal government does quite a lot of spending without much power attached to it (2015). They use this to partly explain the change to the CHT escalator; tying it to nominal GDP growth with a floor of 3% and at the same time not imposing any conditions beyond meeting the requirements of the *Canada Health Act* (Advisory Panel on Healthcare Innovation, 2015). The Parliamentary Budget Officer released a report about the change which was concerned that the provincial governments will no longer be able to sustain their healthcare systems as the fiscal gap between the provinces and federal government continues to rise (Office of the Parliamentary Budget Officer, 2013). The provinces are therefore concerned with the announcement and feel that they need more federal funding to maintain their respective healthcare systems (Levy et al., 2014).

## Pharmacare

Canadians are increasingly spending more of their income on drugs, representing 15.7% of the total healthcare spending in 2015, yet Canada is the only country in the world with healthcare coverage that does not include prescription drugs (Morgan et al., 2013). It is expected that in 2015, 63.4% of all drug costs are paid for by the private sector, meaning that most Canadians are paying for these drugs either out-of-pocket or through private insurance coverage. Yet despite this large amount of expenditures, one in ten Canadians

cannot afford their prescription medications and therefore do not fill them, increasing the burden on other healthcare services (Morgan et al., 2015b) The 36.6% paid for by the public sector accounts for the drugs used in hospitals as well as those used by certain populations covered by provincial pharmacare programs which are usually dependent on age, income or employment and the federal government health insurance program that covers First Nations peoples (Canadian Institute for Health Information, 2015; Morgan et al., 2013).

The discrepancies in coverage have led many organizations and academics to call for a national pharmacare plan to address the inefficiency, inequity and unsustainability (Gagnon, 2014). The design of such a program will have to take into account who is covered, what is covered and how it will be financed. However, having public drug insurance will ensure that all Canadians are adequately covered and will increase the purchasing power of governments (Morgan and Daw, 2012).

As the provinces already have drug plans in place for certain sections of their citizenry which differ in both eligibility requirements and subsidy structures, the implementation of any national pharmacare strategy will be challenging (Morgan et al., 2013). If the national pharmacare strategy does not provide coverage for all Canadians, then the federal and provincial-territorial governments will need to take into account which segments of the population the national pharmacare plan would cover. Whether that means adopting eligibility requirements like British Columbia, Manitoba and Saskatchewan, which have an income-based model for universal catastrophic drug coverage where everyone is eligible to apply for subsidies but the amount given is determined by the income level of the applicant; or like Ontario, which is a hybrid model that includes an income-based model for non-senior residents and comprehensive coverage for seniors over 65; is one of the questions that will need to be answered during the creation of a national strategy (Morgan et al., 2013).

In addition to coverage eligibility, the other large challenge facing the creation of a national pharmacare strategy is how it should be financed. If provinces were to expand their provincial health coverage to include prescription drugs, they would need to negotiate the amount of federal funding they would receive. A group of academics published a *Pharmacare 2020* strategic document which has suggested the federal funding be capped at 25% (Morgan et al., 2015a). However, there is another financing possibility that would allow for provincial governments to keep their provincial health insurance largely as is. This pharmacare strategy would have to use a social insurance model where people who are able to work pay into the pharmacare insurance pool and then draw out of it when they require (Gagnon, 2014).

## Long-Term Care and Home Care

Finally, like many OECD countries, Canada has an aging population which will need more and more support. Therefore, long-term care options including home and community care need to be strengthened (Torjman, 2013). Home care allows for people to have more autonomy over their health and allows for a reduction of wait times and a slowdown of rising costs in the healthcare system (Cote and Fox, 2007). However, home care is not included in the Canada Health Act and as such there is a myriad of programs run by the provinces in the absence of an overarching national strategy (Hirdes, 2001).

Alberta and the territories have a per diem model to help cover or contribute to costs while BC, SK, MN, ON and QC all have per diem models but recognize that contribution levels should depend on the person's income. The Maritime Provinces have an income/asset based model where the per diem rate set by nursing homes and government agencies which also includes the cost of care but those who cannot afford this may apply for a subsidy (Stadnyk, 2010; 10-11). According to Stadnyk, the income/asset-based model places financial burden on those who are ill as they are responsible for their costs (2010). This variety in programmes has led to a call for a national strategy on home care that would incorporate national standards and clarify eligibility requirements for home care services (Coyte, 2000). Through this national strategy, the provincial governments will need to come to an agreement on a system of long-term care and home care with similar eligibility requirements and financing options and the federal government will need to provide the leadership to facilitate and provide support for the implementation of this strategy.

Financing long-term care and home care could be one of the key pillars of such a strategy. As home care is not covered by the *Canada Health Act*, there is a need to bridge the gap between long-term care supports that are deemed medically necessary and therefore covered by medicare, and those that are not, such as room and board, within a national strategy (Silversides, 2011; Stadnyk, 2010; Torjman, 2013). As Torjman notes there are a variety of methods that could be considered including a social insurance model and private savings model coupled with public tax incentives.

## Conclusion

In brief, some of the most pressing issues facing the Canadian healthcare system include affirming the jurisdictional and financial responsibilities of the federal and provincial governments through a new Health Accord, creating a national pharmacare strategy and improving long-term and home care. Due to the brevity of this paper, other important issues such as those concerning health human resources, access to other health professionals, particularly dental care; and Aboriginal healthcare are not able to be

explored. Therefore, it is important to note that while this is by no means a comprehensive analysis of all of the challenges facing the Canadian healthcare system, it does provide a starting point for future research.

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