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Funding of Universal Health Care Coverage: Is it still possible in next Future: Canada Example

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Abstract

After the coronavirus disease 2019 (COVID-19) outbreak takes its course in World, financial pressure mounts on all levels of government across the country, cost-sharing of medical and hospital care covered by the public plan health insurance has once again become a very big conflict.

Following the Canadian constitution in 1867, the door is opened to a national health insurance plan. Succeeding document indicates that the monitoring and delivery of health services is a provincial and territorial responsibility. The provinces have therefore, at different rates, implemented their own public health insurance plans. Government of Saskatchewan got the ball rolling, establishing a provincial universal public hospital insurance plan in 1947 and a provincial universal health insurance plan in 1962. Due to its constitutional reality, the country has 13 relatively distinct health care systems, one for each province and territory. However, these systems have much in common, as they draw their fiscal and legislative origins from the same series of agreements which, since the late 1950s, have defined the terms of cost sharing between the Government of Canada and the provincial governments. and territorial.

This article analyze historical federal government cost shares shows a difference of about $20 billion in current funding depending on whether tax points transferred in 1977 are considered, and results ranging from a surplus of some $15 billion to a deficit of some $23 billion if only the transfer payment is observed.

Key words: Universal Medicare, Uncertain Future, Funding

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Introduction

Nothing in the Canadian constitution of 1867 opened the door to a national health insurance plan. On the contrary, the document indicates that the monitoring and delivery of health services is a provincial and territorial responsibility. The provinces have therefore, at different rates, implemented their own public health insurance plans. Saskatchewan got the ball rolling, establishing a provincial universal public hospital insurance plan in 1947 and a provincial universal health insurance plan in 1962(1).
Due to its constitutional reality, the country has 13 relatively distinct health care systems, 1 for each province and territory. However, these systems have much in common, as they draw their fiscal and legislative origins from the same series of agreements which, since the late 1950s, have defined the terms of cost sharing between the Government of Canada and the provincial governments. and territorial(2).

Overall cost sharing (1957–1976)

The Hospital Insurance and Diagnostic Services Act, which received Royal Assent in April 19573, remitted to participating provinces approximately 50% of the per capita cost of eligible services provided in general hospitals. Basically, cost-sharing meant that wealthier provinces would get more money because they spent more per person on hospital care. To remedy the situation, half of the provincial allocation was determined on the basis of the national average expenditure.
In response to the report published in 1964 by a Royal Commission chaired by Justice Emmett Hall, the Government of Canada in 1966 passed the Medical Care Act. The Act provided for the reimbursement of 50% of the national average expenditure per person for all insured medical services, less the costs of administering the plan and the costs paid by patients. These two federal initiatives are the starting point of the national public health insurance scheme.
In 1976/77, the last year that the amounts paid under the 2 above-mentioned acts are recorded separately in the Public Accounts of Canada, the federal government covered 48% of hospital care expenditures and 49% of medical care expenditures5. It can be said that at that time, the federal government had honored its promise of a 50/50 split(3).

Paradigm shift (1976–1995)

As early as 1970, the federal government began to wonder how it could limit the increase in its share of health spending in proportion to the growth of gross national product (GNP). (Gross national product corresponds to gross domestic product [GDP]—later adopted as a benchmark for cost sharing—to which net revenues received abroad are added.) During a meeting of the first ministers in 1976, Pierre Elliott Trudeau, who then led the country, suggested replacing the 50-50 split with a new regime.
His proposal: that a first half of the 1975/76 payments for three programs (Hospital Insurance and Diagnostic Services Act, Medical Care and Post-Secondary Education Act) as shown in figure 1. be paid as a block grant, which would increase each year

according to the 3-year moving average of the nominal per capita growth rate of GNP, and that the second half should instead be the recovery by the provinces of a reduction in federal tax, which would not cause an immediate change for this which is the taxation of individuals and businesses.

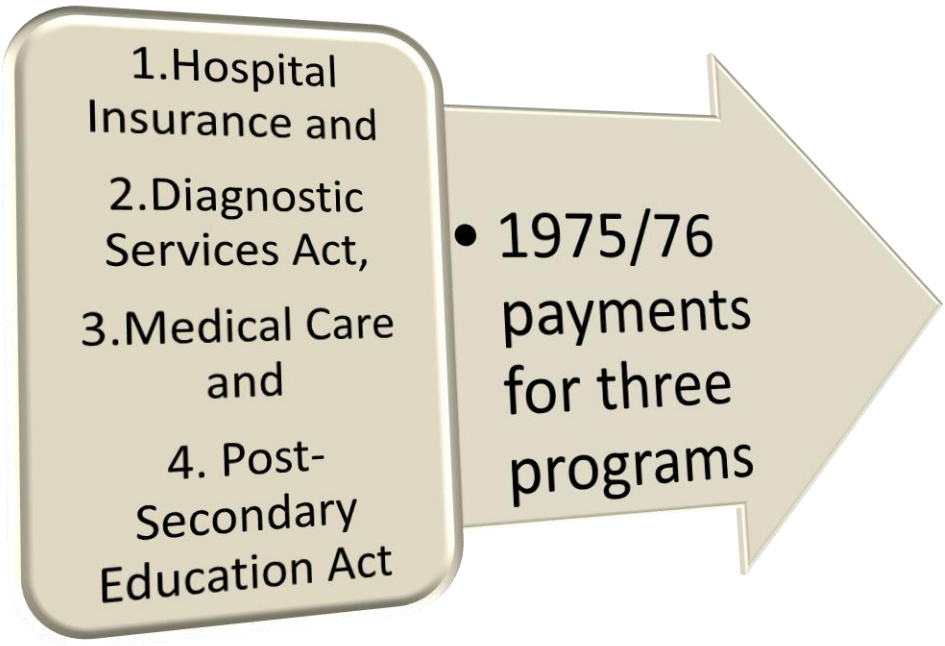

Figure 1. Payments for three programs

Some provinces argued that block grants would expose them to unilateral budget cuts, while others agreed with federal negotiators, who argued that block grants and the clawback of tax points would allow authorities to provincial authorities to limit spending on medical services and general hospitals to invest in more cost-effective services such as home care. Provinces and territories eventually accepted a slightly more generous version of the federal government's proposal, embodied in the Federal-Provincial Fiscal Agreements and Established Programs Financing Act, which came into force in April. 1977(4).

In 1979, the Canadian government asked Emmett Hall to review his 1964 report. The judge's approach led to the creation of the Canada Health Act of 1984, which consolidated existing legislation and, gave the federal government the power to reduce transfers to the provinces by one dollar for every dollar billed to patients for publicly insured services.

Between 1985 and 1995

Six federal budgets each in their own way slowed the GNP-based increase in the Combined Health and Social Transfer or stopped payments altogether. According to calculations made by Alistair Thomson for a background paper published in 1991, total health transfers fell by $30 billion between 1986/87 and 1995/9610. It fell by an additional $11.2 billion to 1998/99, compared to the arrangements made in 1977 (5).

Restitution and health accords (1996–2006)

As the financial health of the federal government improved, the 1999 budget provided for a base increase of $11.5 billion over 5 years in the combined health and social transfer. The scientists were described vertical imbalance as a situation where, on the one hand, subnational governments are under financial pressures that exceed their ability to raise revenues, and where, on the other hand, the national government generates surpluses year after year. year13. Since then, this concept has been a central part of the first ministers' case for increased federal funding.

As the November 2000 election approached, the complaints of provincial and territorial premiers could no longer be ignored: a first ministers meeting led to the first health accord. This agreement increased the combined transfer payment for health and social programs from $15.5 billion in 2000/01 to $21 billion in 2005/06, and included a one-time amount for medical equipment, health information technology and primary health care reform (6).

The Royal Commission on the Future of Health Care in Canada, also known as the Romanow Report, is a committee study led by Roy Romanow on the future of health care in Canada.

After his re-election, the government convened the Romanow Commission on the Future of Health Care in Canada in April 2001. The commissioners found, among other things, that in 2001/02 transfers from the federal government covered only 18 .7% of provincial and territorial spending on medical and hospital care. Given the agreement that led to the terms of the transfer program, called Established Programs Financing, they also recommended "that at a minimum" the federal health transfer payment be equal to 25% of provincial expenditures and territorial(7)

Governments Change, Stakes Remain (2006–2018)

Beginning in the 1950s, the Government of Canada often used its fiscal capacity to encourage the provinces and territories to participate in its social programs. But when the Conservative Party took power in 2006, fiscal federalism became more cautious. As he sought re-election in 2011, Prime Minister Stephen Harper pledged to negotiate a fourth health accord. No negotiations took place. Rather, things went like this: in December 2011, at a meeting of finance ministers from Canada, the provinces and territories, federal minister James Flaherty announced that when the 2004 agreement expired, in 2014, the escalator for the Canada Health Transfer would remain at 6% until 2017, and then equal 3% per year or the 3-year moving average of the nominal GDP growth rate, depending on the the highest amount, for 10 years21. A provincial–territorial task force estimated that by changing the rules, the federal government would spend $36 billion less on health than if it had maintained the 6% factor for the period from 2014/15 to 2023/2422(8).

In July 2015, First Ministers again called on the federal government to increase the Canada Health Transfer to cover 25% of health spending. Soon after, during the election campaign, the Liberal Party criticized the Harper government for its actions on health

funding and promised, if elected, to negotiate a new health accord with the provinces and territories. . The Liberals reiterated their promise in the Speech from the Throne, after being elected to form a majority government in October 201525. Again, no summit took place. In addition, the 2017 budget did include the decrease in the increase factor of the Canada Health Transfer decided under Harper, but allocated term funding of $11 billion over 10 years for home care and mental health(9).

Conclusion

In 2020, with the arrival of COVID-19, they began to be more insistent, seeking to increase the federal contribution to annual provincial and territorial health spending from 22% to 35%.

Federal-provincial-territorial health relations are colored by decades of complex history, fraught with mutual frustration and disappointment. Successive governments at the federal level, regardless of party, have repeatedly abrogated provisions of the 1977 agreement. On the other hand, the provinces and territories have largely failed to implement far-reaching reforms which could have limited long-term cost increases and greatly increased the efficiency of investments in public care services. This journey and the constant disagreements of the order of billions of dollars over the figures to be used in the cost-sharing calculations explain the recurring tensions, but only partially: they also create a difficult climate for the launch of joint initiatives, which require a lot of public funds and new cost-sharing arrangements, such as universal drug insurance, increased funding for long-term care and increased covered costs for mental health. Without a process of agreeing on the federal government's share that would constitute fair cost-sharing between levels of government, there is little hope that long overdue changes in funding can be made, the organization and range of public health services in Canada.

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