Overview - Council of the Federation Meeting January 16-17, 2012

Last July, Premiers agreed "to meet again early in the new year on an integrated approach to sustainable health. Premiers will work together on identifying key principles that should govern a new agreement on health care with the federal government". The communiqué released at the meeting noted that "discussions will also focus on innovations to modernize health care services that will bring savings to be reinvested in health care systems".

The nature of the meeting has changed significantly as a result of the federal government's funding announcement at the Finance Ministers' Meeting in Victoria and the reaction to it by provinces and territories.

Instead of a meeting to set the stage for discussions with the federal government on a new health agreement as originally intended, Premiers will be meeting with the fiscal arrangements, including the Canada Health Transfer, pre-emptively decided by the federal government.

1. Implications and Fallout from the Federal Funding Announcement

The federal announcement (see below for a summary) maintains the status quo for fiscal arrangements for the foreseeable future except for the Canada Health Transfer which as of 2017-2018 will grow at the rate of nominal GDP (economic growth plus the rate of inflation) – anticipated to be around 4%.

The primary benefits of Minister Flaherty's announcement are that it provides funding stability and continued increases in transfers for the foreseeable future without strings attached. S13

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As anticipated, the federal government also announced it will follow through on its commitment to move to an equal per capita cash allocation of the Canada Health Transfer in 2014-2015. S13

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It is expected that the federal government will implement its announcement in the next federal budget expected in late March 2012. S13

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In a recent radio interview, the Prime Minister made the following points:

- The federal government will continue to expand healthcare funding significantly but all governments are going to have to come, and are, frankly, coming to grips with the reality that healthcare funding can't over the long period grow quicker than the economy, because obviously it would bankrupt the system.
- Most provinces are already projecting reductions in their own growth rates and healthcare spending. But the provinces themselves are going to have to look seriously at what needs to be done to make the system more cost effective.

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Speaking Points

Opening Remarks

- **As we grapple with putting health care on a sustainable basis, what role do we envision for the federal government?**

- **The federal government did not impose conditions on the Canada Health Transfer. It no long seems interested in a "Health Accord."**

- **However, following Minister Flaherty's announcement, Federal Health Minister Leona Aglukkaq sent a letter to all our Health Ministers, noting that improvement of the health care system is "the real issue," and suggesting we "consider tasking our officials to start work on an approach to measuring and reporting performance across health systems using common metrics."**

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Fiscal Arrangements

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Key Points

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- As Premiers agreed to, the federal commitments announced in December should not be at the expense of other federal programs such as infrastructure or labour market.

- BC would like to see the continuation of stable and adequate federal funding for transfers outside of the four major programs – CHT, CST, Equalization and Territorial Formula Financing and, in aggregate, to complete the fiscal arrangements picture.
- BC welcomes the federal commitment to work collaboratively to develop a long-term post 2014 infrastructure plan, but it is important to note that the federal government has provided no further details.

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NOTE: Additional detailed information on Equalization is provided in the briefing note immediately following this note.

Issue:	Equalization

Key Points

- Constitutionally mandated, the Equalization Program plays an important role in ensuring that all provinces have the ability to provide Canadians reasonably similar levels of public service at reasonably similar levels of taxation, regardless of where they live in Canada.
- BC is committed to working with the federal government and other provinces to address some of the problems with the current Equalization Program, such as the implication that BC's uniquely high property values means that British Columbians can afford to pay much higher property taxes than residents of any other province.
- Equalization has been growing at a reasonable pace. It grew slightly faster than the CHT between 2006/07 and 2010/11, even with the ceiling and even if you don't count Total Transfer Protection payments.
- The federal government has limited fiscal room to increase transfers, so if we are to ask for increased federal funding, we should focus on areas that will benefit all provinces and territories.

Current Status

- Final Equalization estimates for 2012/13 were released at the Finance Ministers' Meeting. The size of the program, limited to average nominal GDP growth, increased by $764 million (5.2%) to more than $15.4 billion.
- Ontario's Equalization entitlement more than doubled in 2011/12 to $2.2 billion in 2011/12 (up from $972 million) and increased by $1.1 billion (48%) in 2012/13. S16

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- BC has not received Equalization since 2006/07 and is unlikely to receive Equalization for the foreseeable future due to the current design of the Equalization Program and BC's relatively strong fiscal capacity.
- Federal/provincial/territorial finance officials on are working on a broad range of technical and conceptual issues.

Background and Analysis

- The Equalization Program is enshrined in the Constitution. Its purpose is to help ensure provinces are able to provide reasonably similar levels of public service at reasonably similar levels of taxation.

- Equalization transfers are unconditional and can be used for any purpose.
- Every province has received Equalization at some point. BC received $2.5 billion in Equalization transfers between 1999/00 and 2006/07.
- The Equalization formula was fundamentally changed in 2007 as a result of recommendations from a federal panel referred to as the "O'Brien Panel" or the "Expert Panel". Under the 2007 formula, the cost of the Program would have increased from $13.3 billion in 2008/09 to $16.1 billion in 2009/10 and $20.0 billion in 2010/11, primarily as a result of strong natural resource revenues and Ontario's qualifying as a recipient province.
- While the official Equalization Program renewal will not be implemented until 2014, the formula continues to be subject to change:
    - In order to ensure the Equalization Program remained sustainable, **the 2009 federal budget announced changes to the Equalization Program effective in 2009/10. These changes capped entitlements for individual provinces and imposed a ceiling on overall growth in the program that was linked to average nominal GDP growth. Several provinces expressed disappointment with the changes' impact and unilateral nature**.
    - Entitlements in 2009/10 included protection from year-over-year declines in Equalization that came at the expense of other Equalization-recipient provinces. This was replaced in 2010/11 and 2011/12 with Total Transfer Protection payments.
- **The changes that came into effect in 2009/10 reduced the size of the Equalization Program in 2011/12 by $4.0 billion relative to what they would have been under the 2007 formula.** The cumulative impact since 2009/10 has been $11.4 billion, and the provinces most impacted on a per capita basis have been Nova Scotia ($1,281 per capita) and Quebec ($643 per capita); the cumulative impact for the remaining provinces (NB, ON, PE, and MB) have Ontario ($2.5 billion), Quebec ($2.2 billion) and Nova Scotia ($565 million).

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Patrick Ewing (250 387-6090)
Intergovernmental Fiscal Relations Branch
BC Ministry of Finance
January 12, 2011

Appendix – Transfer Subcommittee Workplan

1. Equalization and TFF
    - Consumption tax base – general sales taxes, gasoline taxes, tobacco taxes, insurance premiums taxes, etc.
    - Property taxes – commercial/industrial, farm and residential
    - Corporate Tax Base – overall structure of base, treatment of capital taxes, treatment of GBE profits
    - Equalization of natural resource revenues – resource inclusion rate, economic rent, optimal number of resource bases
    - Payroll taxes, hospital and medical insurance taxes
    - Predictability, stability, and responsiveness of payments
    - Optimal number of tax bases
    - Other topics
2. Expenditure need (working group?)
3. CHT and CST renewal – technical issues
4. Transfers — technical diagnostique
5. Transparency/communication
    - Duane Hayes to organize web seminars
6. Other
    - Macro approach – SK to develop paper/presentation

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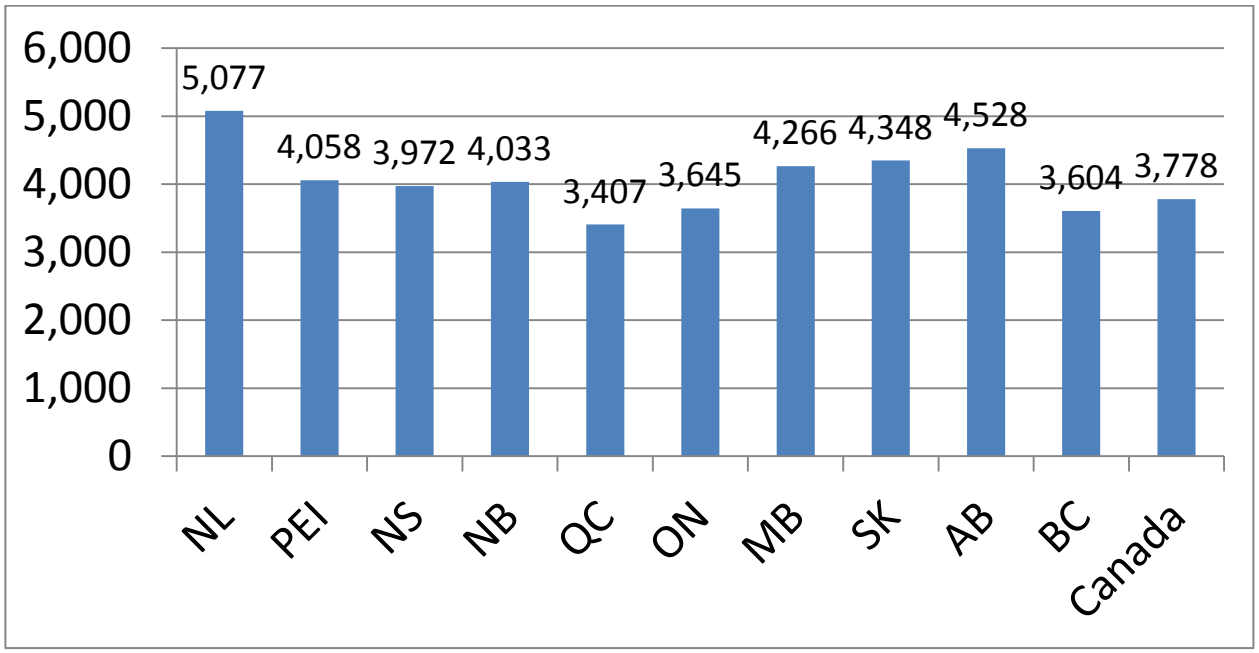
1. British Columbia is one of the country's leaders in keeping health care expenditures in check. BC ranks 2nd lowest in total provincial government health spending per capita. British Columbia's growth in health spending has been consistently one of the lowest in the country.

Total Provincial Government Health Spending Per Capita, 2011



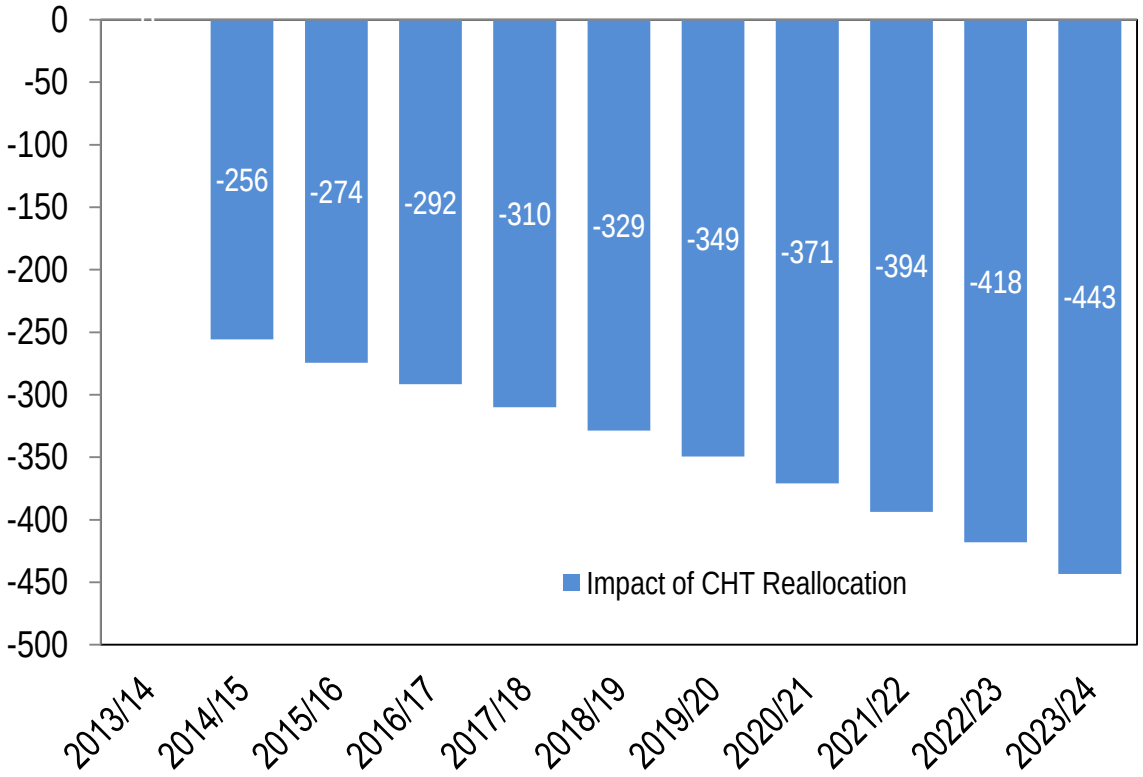
Source: Canadian Institute for Health Information: *National Health Expenditure Trends, 2011* Series E

Annual % Change P/T Government Sector Health Expenditure by P/T - Current dollars

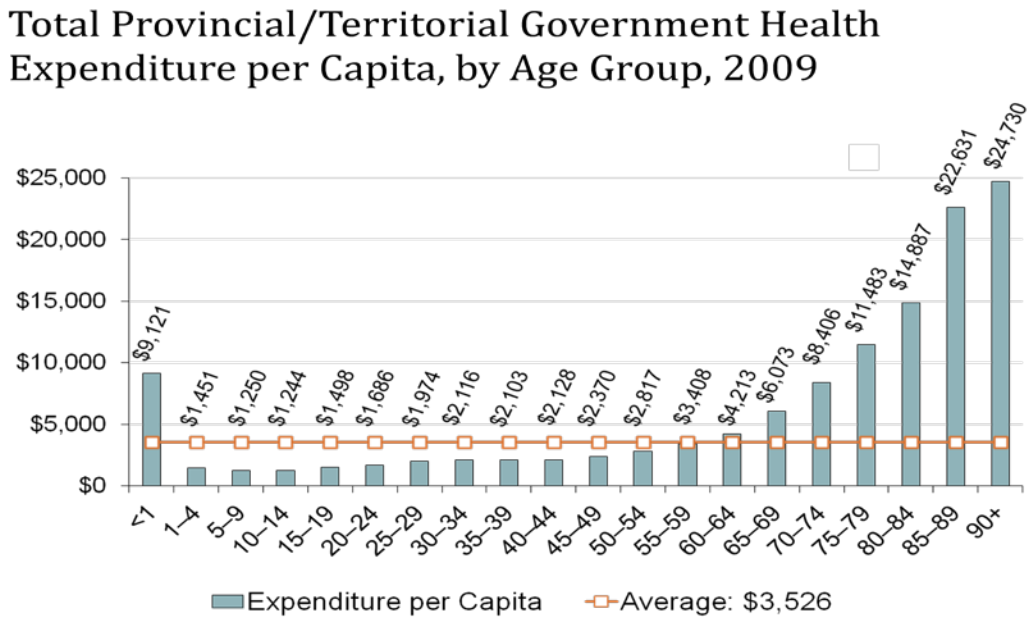
Year	NL	PEI	NS	NB	QC	ON	MB	SK	AB	BC	CAN Avg
2003	5.3	2.9	10.2	6.8	5.2	11.5	8.6	5.9	7.2	3.9	7.9
2004	2.7	-1.9	4.1	8.9	6.5	7.7	6.7	7.9	9.9	2.2	6.7
2005	3.3	6.8	9.1	9.2	5.6	7.0	7.6	9.3	11.9	6.4	7.2
2006	6.3	3.9	12.3	10.0	6.0	6.1	5.6	6.9	10.4	4.3	6.6
2007	8.4	7.4	7.7	5.0	6.0	7.6	5.3	7.6	9.9	5.8	7.2
2008	8.6	9.5	5.7	6.6	7.1	7.0	7.6	9.0	11.6	8.9	7.9
2009	10.7	13.0	2.3	5.9	7.6	6.6	8.7	5.7	5.5	3.7	6.3
2010 f	10.3	10.1	7.8	5.7	3.9	5.3	4.3	8.2	13.7	5.3	6.3
2011 f	6.2	2.6	3.0	3.2	3.9	1.5	6.0	7.4	3.7	4.0	3.2

2. British Columbia has been a strong supporter the federal government's decision to reduce the CHT escalator to nominal growth in GDP, however, because of the CHT allocation change announced by the federal government, BC will lose an estimated 3.4 billion health care dollars over the 10-year period beginning in 2014/15. In 2014-2015. British Columbia will only receive a 0.5% increase, $256 million lower than it otherwise would have if the change in the allocation had not been made.

Impact on British Columbia of Change of the CHT Allocation



3. As Canadians age the average per capita health spending increases considerably particularly for Canadians 65 to 74; 75 to 84 and 85 and over. Seniors as a percentage of BC's population is currently and is projected to be high by comparison to the rest of the country. An equal per capita approach does not recognize the much higher cost of caring for seniors. As a result, provinces with high seniors population, like BC, are disadvantaged as they have higher costs for seniors care but have lower financial support.



Sources
National Health Expenditure Database, CIHI; Statistics Canada.

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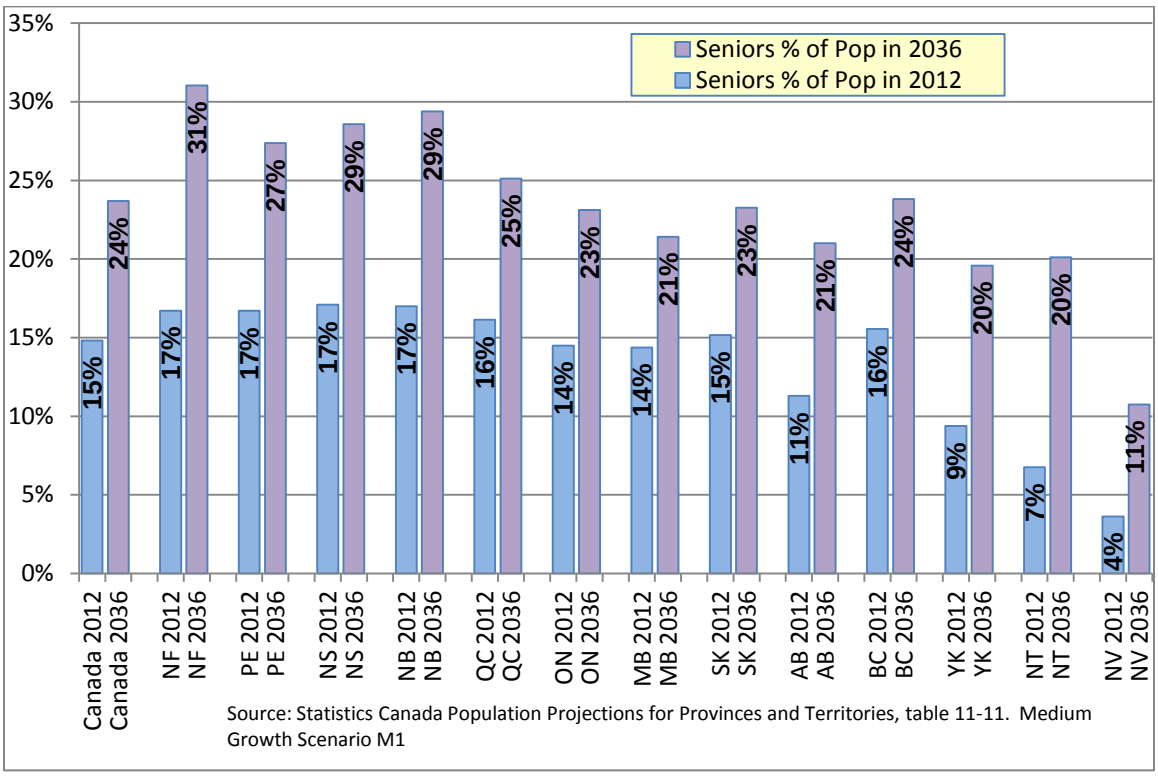

Source: Statistics Canada Population Projections for Provinces and Territories, table 11-11. Medium Growth Scenario M1

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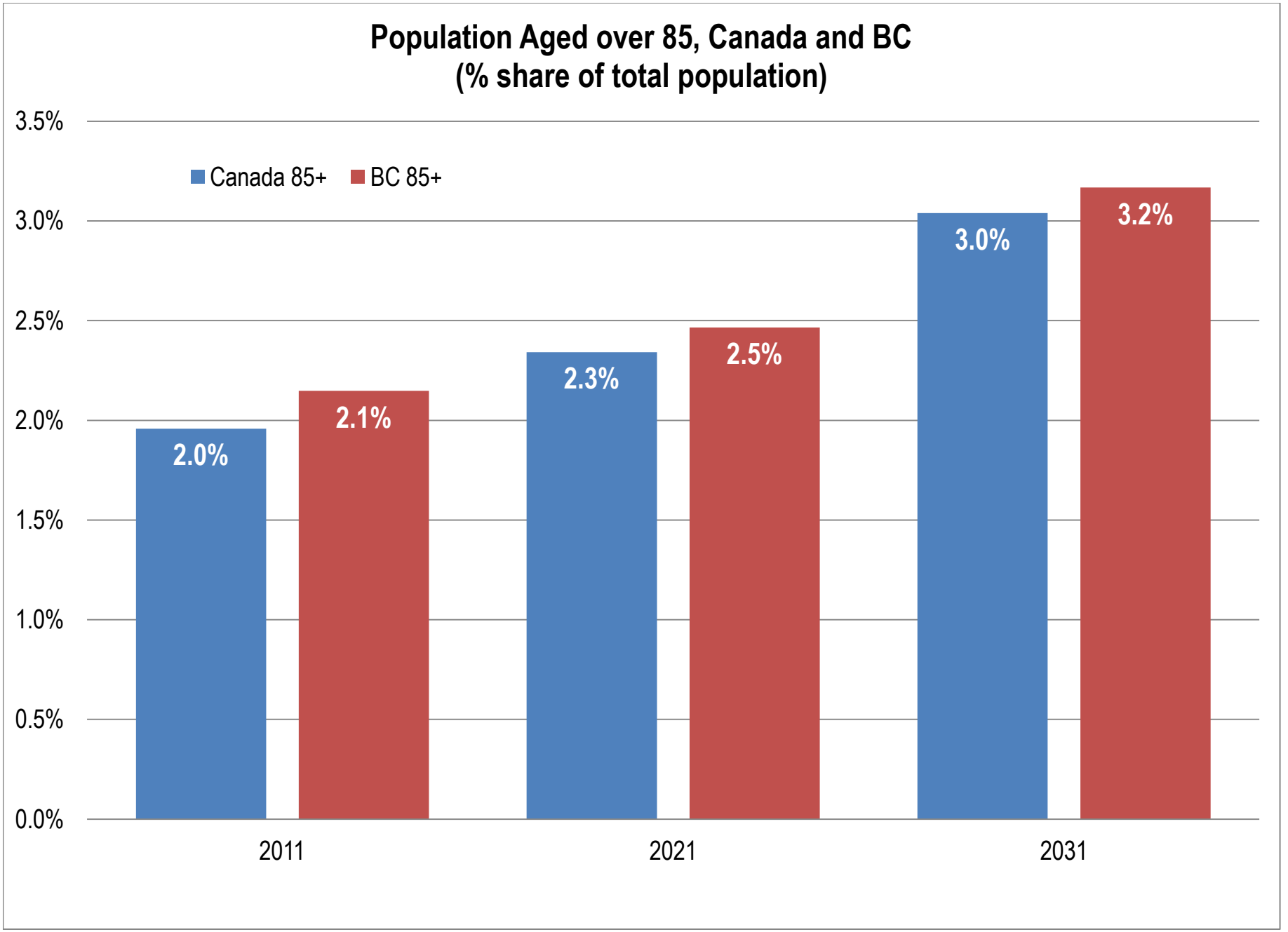
Population Aged over 85, Canada and BC
(% share of total population)
3.5%
3.0%
2.5%
2.0%
1.5%
1.0%
0.5%
0.0%
Canada 85+
BC 85+
2.0%
2.1%
2.3%
2.5%
3.0%
3.2%
2011
2021
2031

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Provinces and territories are pursuing comprehensive strategies within their jurisdictions to improve the health and health care for seniors including:

- Promoting health and disease prevention among seniors through falls prevention programming; promoting active living.
- Seek federal funding for enhancements to community-based transportation systems to help seniors maintain mobility; seniors' parks to encourage active living; and other community spaces to support connectedness.
- Addressing chronic disease and improving condition management for seniors by increasing integrated care and multidisciplinary teams; improving access to primary care, early assessment and treatment for Alzheimer's, dementia, and other mental health conditions, and leveraging of technology to assist with care.
- Ensuring competitive prices for new drugs coming on the market for treatment of Alzheimer's, dementia, and other mental health conditions.

Together provinces and territories will:

- Seek federal funding for a Health and Seniors' Care Innovation Fund of $2 billion per year commencing in 2014-2015 to foster innovation in health care (including innovative approaches to seniors health care. The specific initiatives would be negotiated bilaterally between the federal government and each province and territory.
- Examine how to improve the accessibility and portability of home care and long term care services within and between provinces and territories to ensure seniors can more easily move closer to their families.
- Examine the value of developing core standards for home health services and providers across provinces and territories.
- Examine the development of a common caregiving strategy to focus on the highest level of functioning and abilities of all older adults, with specialized support and services, implemented to optimize their participation in life.[4]

2. Finding Innovative Ways to Improve Health Care Delivery and Patient Outcomes

Clinical Care

- Extend federal funding for Canada Health Infoway funding until 2015 to accelerate Canada's ehealth record development and implementation:
    - $500 million in 3 year funding is set to expire in 2012.
- Direct provincial and territorial Health Ministers to identify priorities and develop 5 lead indicators that could be used as an effective barometer for the measurement of the success of innovation and change within their health care systems.
- Continue work already begun on clinical practice guidelines.

Promoting Public Health and Prevention of Chronic Diseases

- Appoint a Blue Ribbon Panel to report within 6 months on recommendations to provinces and territories on merits of increasing taxes to health limiting products and tax incentives on health promoting products and services.
- Develop and promote 10 common recommendations to help Canadians avoid chronic diseases and other conditions.
- Seek federal support to implement recommendations in the forthcoming report from the Mental Health Commission.

[4] June 2004. Registered Nurses Association of Ontario. http://www.rnao.org/Storage/11/573_BPG_caregiving_strategies_ddd.pdf

Managing Major Cost Drivers

Pharmaceuticals

- Intensify the efforts of the Pan Canadian Purchasing Alliance with a goal of reducing costs through:
    - bulk purchasing for the 100 most commonly prescribed drugs; and
    - expanding the initiative to the bulk purchase of vaccines.
- Seek federal regulatory/policy change to the Patented Medicine Prices Review process to ensure that the prices of patented medicines sold in Canada are not excessive.

Health Human Resources

Labour compensation consumes the majority of health budgets. Premiers agree that managing the growing costs of health compensation is essential to sustainable health care.

- Direct Ministers responsible to cooperate to better manage labour compensation escalation and ensuring the right mix and number of health providers are being trained and deployed in Canada.

Background

1. Proposed Changes to Canada's Pharmaceutical Patent Regime (Comprehensive Economic and Trade Agreement with the European Union)

Canada and the European Union are presently engaged in negotiation of a Comprehensive Economic and Trade Agreement, which is to be finalized by end of 2012. Intellectual property protections fall within the scope of such negotiation and the European Union has proposed that Canada adopt fundamental changes to its current patent regime in respect of pharmaceuticals. Over the next two years, anticipated launches of new generic drugs are expected to generate approximately $40 million in aggregate savings for BC PharmaCare. Delayed entry of new generics due to patent regime changes could eliminate some or all of those savings.

2. Patented Medicine Prices Review Board - Excessive Pricing Determination Methodology

The Patented Medicine Prices Review Board (PMPRB) protects the interests of Canadian consumers by ensuring that the prices of patented medicines sold in Canada are not excessive. It does this by reviewing the prices that patentees charge for each individual patented drug product in Canadian markets. Under the PMPRB's current policy, if there are one or more comparable drug products of the same strength as a new patented drug product, then the highest priced comparable drug product of the same strength determines the Maximum Average Potential Price for the new patented drug product. Prices above this threshold are considered to be excessive.

It may be more appropriate for PMPRB to base the Maximum Average Potential Price for the new patented drug product on the average or median price rather than the highest price of comparable drug product of the same strength. In this manner, patented medicines would be more affordable for Canadians.

Additionally the PMPRB uses the International Therapeutic Class Comparison test to compare the National Average Transaction Price of the patented drug product under review with the prices of comparable drug products that are sold in the seven comparator countries listed in the Regulations (France, Germany, Italy, Sweden, Switzerland, the United Kingdom, and the United States). Adjusting the composition of the seven comparator countries to exclude countries such as Switzerland and include countries like Australia or New Zealand, both of which have greater similarity to Canada with respect to pharmaceuticals, may be worthy of consideration.

It is recommended that the PMPRB convene a group of Provincial and Territorial drug plan representatives to review the current PMPRB methodology and make recommendations for improvement to ensure that the prices for brand name drugs are not excessive.

BC Proposed Outcomes

Jurisdictions are continually making changes and adjustments to the provision of health care services to ensure efficiency, accessibility, and the delivery of quality care. In addition, the shift to health promotion and disease prevention is intended to relieve pressure on the health care delivery system by addressing risk factors at the front end, as well as managing conditions to ensure the healthiest lifestyle possible.

Changes and innovations will help all population age groups, however, the aging population presents unique challenges, and provides opportunities for extra focus on efforts where some of the greatest challenges exist, and perhaps the most significant gains can be made.

Given the pressures presented by the aging population, one of the sections below focuses on senior-specific strategies. S13 S13 Similarly, the second section focuses on more general initiatives which will benefit all citizens, including seniors.

S13

1. Preparing for Aging Populations / Improving Care for Seniors

The Canadian Institute for Health Information (CIHI) states that between 2014 and 2023, the senior population will increase annually by 3.5%. Statistics Canada reports that the proportion of seniors (65+) is to double from 13% to about 25% by 2031. An impact of the increase in the seniors' population is the resulting increase in health care costs. According to CIHI, the current average per capita P/T health spending is as follows:

According to CIHI[1], the average per capita P/T health spending in 2009 was as follows[2]:

- Average per capita: $3,536
- For ages 65 to 69: $6,073
- For ages 70 to 74: $8,406
- For ages 75 to 79 $11,483
- For ages 80 to 84 $14,887
- For ages 85 to 89 $22,631
- For ages 90+ $24,730

The number of chronic conditions is the strongest determinant of the frequency with which seniors use health care[3]. Seniors currently make up 44% of total P/T health care expenditures (31% physicians, 50% hospital, 90% residential care) and CIHI reports that health expenditures for seniors will increase by 6.1% annually. Further, the frail elderly make up one percent of the population yet use 22% of health services.

1 CIHI, (Nov. 2011). National Health Expenditures Highlights Presentation. https://secure.cihi.ca/estore/productFamily.htm?locale=en&pf=PFC1671

2 Average for ages 0 – 64 = $ 2,669.93; ages 1 – 64 = $

3 Rotermann, Michelle (2006). *Seniors Health Care Use*. Health Rep 16:33-45. Health Statistics Division, Statistics Canada, Ottawa

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