

**A FRAMEWORK FOR THE PROSPERITY,  
HEALTH AND WELL-BEING OF CANADIANS**

**Brief Submitted to the  
House of Commons  
Standing Committee on Finance**



**Canadian Healthcare Association  
Association canadienne des soins de santé**

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## **Executive Summary**

This year's Canadian Healthcare Association (CHA) brief to the Finance Committee has necessarily focused on the tax-related questions posed by the committee, which leaves no room for an analysis of subjects raised in CHA's previous briefs. These include the public/private spending and delivery of health services and the need for an evidence-based approach to these issues, the complexity of wait times issues, the need to address the determinants of health and wellness, the challenge of addressing chronic disease management, the need for a pan-Canadian health human resources mechanism which goes beyond a strategy. CHA's point of view on these and other issues can be found on our website ([www.cha.ca](http://www.cha.ca)) in previous briefs to the Finance Committee.

For budget 2008, CHA recommends that the Finance Committee consider funding for the following areas. They are in order of priority, but all are important to meet the health needs of Canadians:

1. **The Electronic Health Record** - To enhance the efficiency and effectiveness of Canada's health system CHA recommends additional investments of \$6.2 billion over five (5) years in order to accelerate the development and implementation of a pan-Canadian electronic health record and to broaden its scope.
2. **A new Medical/Diagnostic Equipment Fund** - CHA recommends a renewed medical/diagnostic equipment fund of \$1 billion over three (3) years linked to the safety of health workers and patients in all settings.
3. **A Health Infrastructure Fund** - CHA recommends the establishment of a national investment program of \$5 billion over five (5) years for capital infrastructure for health, in partnership with the provinces and territories. The investment program should promote and encourage effective delivery models in accordance with the principles of health system renewal.
4. **Dealing with unfinished business**
  - a. **Home, community and long-term care**- CHA recommends as a start a \$1 -billion investment over three (3) years to support a home care program with ongoing /chronic care services linked to pan-Canadian objectives while respecting provincial /territorial jurisdiction regarding the delivery of care. CHA also signals the importance of addressing facility-based long term care on a pan-Canadian basis which remains another area of unfinished business and will, in the future, require additional investments to assure access and quality.
  - b. **Research funds**- CHA recommends an investment in health research of at least 1% of total health spending.
  - c. **GST rebate to not for profit health facilities** - CHA recommends clarification concerning which additional health facilities, agencies and services will now qualify for the 83% GST rebate, applicable in the past to hospitals only. Additionally CHA wishes to ensure that all hospital functions be eligible for the 83% GST rebate including research. CHA also recommends that the interpretive rules determining which health facilities, agencies and services will now be eligible for the 83% rebate be as inclusive as possible. Ideally the health system should have a 100% GST rebate.
  - d. **Pharmaceuticals**- CHA notes the importance of moving ahead expeditiously on the pharmacare strategy and programs with pan-Canadian objectives to address gaps in access, lack of equity and undue financial burden. CHA also advocates for a commitment to develop and support the optimal use of pharmaceuticals.
5. **Providing support for informal caregivers (carers)** - CHA recommends the creation of a provision in the CPP/QPP to allow for elder-care dropout or permit those who leave the labour force to care for a senior to continue to contribute to CPP/QPP. CPP allows parents to drop years of low or no earnings from the calculation of their pension benefits but no provision exists for other types of caregivers. CHA also recommends portability of continuing care services across Canada, thus reducing or eliminating waiting periods for either residential services or community based services so that family caregivers can be close to their loved ones.
6. **Equal per capita funds** -CHA recommends that equal per capita transfers for health should be implemented in next year's budget through increased funding for the CHT in the budget implementation bill.

Much of the spending listed above can be funded through the surpluses identified this year and placed in trust funds as was done for the wait times guarantee projects outlined in the March 2007 budget.

Oliver Wendell Holmes once stated "Taxes are what we pay for civilized society". It's how we use the revenue from these taxes and how we impose these taxes that can make Canada the country that we aspire to be. Comments on taxes and their relationship to health issues will be found in the brief to follow.

The Canadian Healthcare Association (CHA) is the federation of provincial and territorial hospital and health organizations across Canada. Through its members, CHA represents a broad continuum of services provided through regional health authorities, hospitals, facilities and agencies that are governed by trustees who act in the public interest. CHA is a leader in developing, and advocating for, health policy solutions that meet the needs of Canadians and is committed to a publicly funded health system that provides access to a continuum of comparable health services throughout Canada.

### **The myths surrounding health system sustainability**

Concerns continue to be expressed about the funding and sustainability of Canada's health system. Prior to addressing the questions of the committee and discussing CHA's recommendations regarding the needs of the health system, we will address these myths by comparing Canada's health system spending with some OECD countries. We can demonstrate with the latest OECD figures that Canada's health system is both sustainable and efficient.

OECD Health Data 2007<sup>1</sup> commenting on 2005 statistics notes that a growing share of the economy is devoted to health across OECD countries. In 1970, total health spending (public and private combined) accounted for just 5% of GDP. By 1990, this share had increased to nearly 7%. Today, it has climbed to 9%. One in four OECD countries now spends more than 10% of its income on health. The United States leads by a wide margin with a 15.3% share, followed by Switzerland (11.6%), France (11.1%) and Germany (10.7%).

The percentage of GDP that is expended on health services in Canada - public and private spending combined - has remained between 9 and 10% for over 15 years. There appears to be a disconnect between the reality of health spending, which has changed little as a percentage of GDP on the one hand, and concern over health costs being out of control on the other. Every country in the developed world is struggling with health costs and searching for solutions to health system challenges. There are solutions, but there is no magic bullet. One suggested solution - more privatization of funding through private insurance or increased out of pocket expenditures - is based on the premise that shifting health costs to individuals or to their employers makes them less onerous. Cost shifting is not cost savings.

The public sector is the main source of health funding in all OECD countries, except the United States, Mexico and Greece. OECD figures show that in 2005, 70.3% of Canada's health spending was funded by public sources, below the average of 72.5% in all OECD countries

Between 2000 and 2005, health spending per capita in Canada increased in real terms by 3.6% per year on average, a growth rate lower than the OECD average of 4.3% per year. In 2005, after the implementation of the 2004 Health Accord increases, Canada ranked ninth in total per capita health spending, at \$3,326 (U.S.) (down from sixth in 2003 OECD health data). The list of countries with higher spending than Canada includes all of the western European countries that Canada is usually compared to, in addition to the USA. The rise in pharmaceutical spending has been one of the factors behind the rise in total health spending in Canada as well as in many other OECD countries. In 2005, spending on pharmaceuticals accounted for 17.7% of total health spending in Canada, up from 13.8% in 1995.<sup>2</sup>

Canada's publicly funded health system provides a significant competitive advantage to Canadian business due to reduced health benefit costs for Canadian employers. Given the high Canadian dollar, any move to increase health spending by Canadian businesses through transferring more health costs to employers would remove our competitive advantage. "Canada has arguably one of the world's best and most well-run health systems. That knowledge is as exportable and profitable as lumber or oil"<sup>3</sup> "We must see the health sector in a whole new way - not simply as a provider of health but as a generator of wealth for Canada." to quote Henry Friesen.

### **Taxes, revenue and the Canada Health Act**

"Taxes are the price citizens of a country pay for the goods and services they collectively provide for themselves and for each other"<sup>4</sup>. Taxes are an important source of revenue that allows the federal government to help deliver services and fund programs for the health and social well being of Canadians. While the delivery of health services is a provincial/territorial responsibility, the federal government has traditionally used its constitutional spending power to assert the Canada Health Act and achieve pan-Canadian objectives for health. The CHA has long supported this pan-Canadian approach, while recognizing that the provinces and territories require flexibility in responding to their unique situations. Any move to restrict the federal spending power would have a negative impact on future health programs like pharmacare.

The government has a responsibility to the electorate to be fiscally responsible and thus must balance budgetary decisions among debt reduction, tax reductions and expenditures on programs. For a number of years, the

Minister of Finance has amassed large surpluses, often unplanned, that have been used in large part for debt reduction. CHA agrees with the need to reduce the national debt but also identifies the need to set aside a portion of these funds for new programs and for broad based tax reductions that will reduce poverty and the inequities of opportunity.

### Tax cuts

CHA is particularly interested in the question posed by the committee concerning whether taxes should be broadly based or targeted to specific groups. General income tax reductions allow for more tax relief for individuals with below average income and limited discretionary consumption patterns as well as maximize economic growth. It is well known that socio economic status is tied to health status. Thus, improving the financial status of lower income individuals through a reduction in the tax rate of the lowest income bracket will benefit the health system as well as individuals at all income levels.

Budget 2007 announced a Tax Back Guarantee linked to the interest savings resulting from debt reduction. CHA, as noted above, would like to ensure that some surplus money is allocated to trust funds to achieve specific purposes that meet health system needs rather than allocate the entire unplanned surpluses to debt reduction and/or tax cuts.

The following points are worthy of consideration:

1. The latest OECD figures from 2004 indicate that tax revenue in the average industrialized OECD country was 38.3% of GDP while Canada's was 35.9% of GDP.
2. **American style taxes cannot provide European style services.** Brooks and Hwong<sup>5</sup>, compared high-tax Nordic countries and low-tax Anglo-American countries on 50 social and economic measures and found the high-tax Nordic countries score better in 42 categories. The high-tax Nordic countries have: lower rates of poverty, more equal income distribution, higher total labour participation rate; a higher GDP per capita; higher rates of household saving and net national saving; greater innovation, including a higher percentage of GDP spent on research and development; a higher ranking on their growth competitiveness by the World Economic Forum; higher rates of secondary school and university completion; and less drug use, more leisure time, and higher life satisfaction.

Brooks and Hwong also showed that Americans bore severe social costs for living in one of the lowest taxed countries in the world since the US fell near the bottom of the 21 industrialized countries in a number of social indicators. In contrast, Finland ranks near the top of the industrialized world in most of the social indicators and has been named the most competitive country in the world by the World Economic Forum four years in a row.

3. **Do Canadians want tax cuts or services?** A recent poll by the Strategic Counsel for the Globe and Mail<sup>6</sup> taken in mid July showed that only 3% of respondents believed that taxes are the most important issue facing Canadians while 16% identified health care as one issue of concern (as compared to 20% in July 2006). At 16% this was substantially ahead of the economy, tax cuts and other issues.

Earlier polls have shown that Canadians are willing to pay the taxes to get the services. Witness the poll taken in Quebec when Premier Charest indicated that the equalization funds coming from the federal government would provide tax relief. Quebecois indicated that they would rather see these funds go into health and social programs<sup>7</sup>.

CHA is not arguing for higher taxes. It is just noting that taxes pay for needed services and that if there are tax cuts that they should be broad-based so as to enhance economic growth, help low income Canadians and improve their health status.

### Targeted tax relief

The CD Howe Institute has indicated that government reliance on targeted tax credits, which complicate the tax system, does not necessarily improve the prospects for economic growth or fairness.<sup>8</sup> *"If governments remain on this tax reform path, the accumulation of targeted tax relief measures will have a significant fiscal cost which could be better used to finance broad rate reductions. Tax rate reductions encourage greater work effort investment and risk-taking without governments putting themselves in the position of picking winners from losers, a task at which they rarely succeed."*

Using tax credits/tax expenditures or targeted tax cuts as instruments of social policy is not appropriate since it marginalizes Canadians who do not have the financial ability to save or to make use of the credits. Credits for activities such as sports, transit passes, etc. are 'rough justice'. Though tax credits are a way of promoting programs such as children's sport programs to improve their physical health, they will not necessarily meet their

goal because the groups in our society who would most benefit from such programs do not have the salaries that allow them to benefit from the tax credits. In addition, various registered savings plans only benefit those individuals who have the resources to save. Thus the government creates two classes of citizens; the 'haves'- those who have the income to claim the tax credit and the 'have-nots' – the working poor and those who are at the margins of society and do not have the tax room to claim the credit.

All of these measures institutionalize/formalize the inequities faced by low-income or subsistence level wage earners.

The CD Howe Institute concluded that: "*Canadian governments should get back to an agenda of tax reform, looking to reduce personal and corporate rates to internationally acceptable levels while keeping tax bases broad and neutral.....to maximize economic growth while ensuring fairness in the tax system.*"<sup>9</sup>

In many cases the needs of the population are better served through directed programs and not through tax credits/tax expenditures, and this is particularly true of health programs. Tax measures in support of health are not a substitute for positive programs.

### **Beyond tax cuts – where should the surplus be spent?**

CHA over the years has identified areas that require new or additional funding. For budget 2008, CHA recommends that the Finance Committee consider funding for the following areas. They are in order of priority, but all are important:

1. **The Electronic Health Record** - An electronic health record (EHR) is pivotal to moving forward on many of the health renewal priorities established by First Ministers. Improved access to care, high quality services, patient safety and the efficiency and effectiveness of the health system are all linked to an accelerated implementation of an inter-operable, pan-Canadian electronic health record.

**To enhance the efficiency and effectiveness of Canada's health system, CHA recommends additional investments of \$6.2 billion over five (5) years in order to accelerate the development and implementation of a pan-Canadian electronic health record and to broaden its scope.**

2. **A new Medical/Diagnostic Equipment Fund** - During the past decade, there has been rapid growth in the availability of diagnostic technologies such as computed tomography (CT) scanners and magnetic resonance imaging (MRI) units in most OECD countries<sup>10</sup>. The equipment funds from the 2003 and 2004 Accords assisted health authorities and hospitals to increase the number of MRIs and CT scanners but facilities still languish in other equipment that is needed for both patient and worker safety. Renewal of new diagnostic equipment is also an ongoing need. **CHA recommends a renewed medical/diagnostic equipment fund of \$1 billion over three (3) years linked to the safety of health workers and patients in all settings.**

3. **A Health Infrastructure Fund** - Federal investments in recent years eased somewhat the capital financing concerns for medical equipment but this funding did not extend to revitalizing facilities. Budget 2007 indicated that spending by all orders of government on public infrastructure as a proportion of gross domestic product declined over the three decades following the 60s. The cuts in the 90s created increased pressure on Canada's infrastructure. Thus Budget 2007 identified a need in Canada for a modern, world-class infrastructure and provided for an investment of more than \$16 billion over seven (7) years in infrastructure. However, the investment was dedicated to "roads and highways, public transit, bridges, sewer and water systems and green energy".<sup>11</sup> *The plan did not specifically cover funding for new health physical infrastructure although some of the green energy projects are being used for health facilities.*

Many of our healthcare facilities especially hospitals were built in the fifties and sixties with 50 cent dollars provided by the federal government under the National Health grants. Provincial governments face the challenge of an ageing health infrastructure which needs to be renewed, and many have announced the funding of new projects. The federal government should assist in this.

**CHA recommends the establishment of a national investment program of \$5 billion over five (5) years for capital infrastructure for health, in partnership with the provinces and territories. The investment program should promote and encourage effective delivery models in accordance with the principles of health system renewal.**

4. **Dealing with unfinished business** – the following unfinished business still needs to be addressed.

a. **Home, community and long-term care** - CHA has long advocated for a home and community care program that provides both acute care replacement services and ongoing continuing/chronic care. There is a commitment in the Ten-Year Plan to provide post-acute home care on a short-term basis as well as short term

community mental health and end-of-life care; however there is no commitment to continuing/chronic care in the community.

**CHA recommends as a start a \$1 billion investment over three (3) years to support a home care program with ongoing /chronic care services linked to pan-Canadian objectives while respecting provincial /territorial jurisdiction regarding the delivery of care. CHA also signals the importance of addressing facility-based long term care on a pan-Canadian basis which remains another area of unfinished business and will, in the future, require additional investments to assure access and quality.**

b. Research funds-The link between research and economic development is well known. So too is the importance of research for the delivery of efficient, high quality, effective health services. In recent years, Canada has moved ahead in health research through the Canadian Institutes of Health Research, the Canada Foundation for Innovation, research chairs, increased support to funding bodies, etc... It would be unfortunate if momentum is lost due to insufficient future increases in funding. **CHA recommends an investment in health research of at least 1% of total health spending.**

c. GST rebate to not for profit health facilities - **CHA recommends clarification concerning which additional health facilities, agencies and services will now qualify for the 83% GST rebate, applicable in the past to hospitals only. Additionally CHA wishes to ensure that all hospital functions be eligible for the 83% GST rebate including research. CHA also recommends that the interpretive rules determining which health facilities, agencies and services will now be eligible for the 83% rebate be as inclusive as possible. Ideally the health system should have a 100% GST rebate.**

d. Pharmaceuticals - **CHA notes the importance of moving ahead expeditiously on a pharmacare strategy and programs with pan-Canadian objectives to address gaps in access, lack of equity and undue financial burden. CHA also advocates for a commitment to develop and support the optimal use of pharmaceuticals**

5. Providing support for informal caregivers (carers) - Failure to move forward with appropriate support for the informal parts of the health system will negatively affect the formal parts of the health system. A substantial component of home care is provided by informal (family, friends) caregivers with an estimated 2.1 million unpaid informal caregivers providing \$5 billion a year in savings for the health system. Home care does not come without costs to individual Canadians and the Canadian economy. In addition to the loss of income through foregone employment, there is also the loss or reduction of employer-sponsored benefits, Canada Pension Plan credits, training opportunities, experience in one's field and promotions. **CHA recommends the creation of a provision in the CPP/QPP to allow for elder-care dropout or permit those who leave the labour force to care for a senior to continue to contribute to CPP/QPP. CPP allows parents to drop years of low or no earnings from the calculation of their pension benefits but no provision exists for other types of caregivers. CHA also recommends portability of continuing care services across Canada, thus reducing or eliminating waiting periods for either residential services or community based services so that family caregivers can be close to their loved ones.**

6. Equal per capita funds - The equal per capita cash commitment for health is taking too long to realize. The 2007 budget provided for equal per capita funds for the Canada Social Transfer starting in 2008 but indicated that equal per capita funding for the CHT would not take place until the 2004 Accord is over in 2014. The wait times trust funds were based on per capita funding as were the 2007 wait times guarantee funds and previous medical and equipment funds. So the principle is well established. CHA has long supported equal per capita cash transfers in areas where pan-Canadian objectives are important (e.g. health), and this was the principle underlying the 2004 Health Accord. **CHA recommends that equal per capita transfers for health should be implemented in next year's budget through increased funding for the CHT in the budget implementation bill.**

CHA also recognizes the role of an appropriate equalization program to address issues of different fiscal capacities amongst provinces and territories, so that they can deliver comparable social programs with comparable levels of taxation.

This year's brief has necessarily focused on the tax-related questions posed by the committee, which leaves no room for an analysis of subjects raised in CHA's previous briefs. These include the public/private spending and delivery of health services and the need for an evidence-based approach to these issues, the complexity of wait times issues, the need to address the determinants of health and wellness, the challenge of addressing chronic disease management, the need for a pan-Canadian health human resources mechanism which goes beyond a strategy. CHA's point of view on these and other issues can be found on our website ([www.cha.ca](http://www.cha.ca)) in previous briefs to the Finance Committee.

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<sup>1</sup> OECD Health Data 2007 How Does Canada Compare, <http://www.oecd.org/dataoecd/46/33/38979719.pdf>

<sup>2</sup> Ibid

<sup>3</sup>; Alan Bernstein ,We're in a global race with no finish line, , Globe and Mail, May 23, 2007

<sup>4</sup> Brooks and Hwong, The Social Benefits and Economic Costs of High and Low-Tax Countries, , Canadian Centre for Policy Alternatives, December 2006

<sup>5</sup> Ibid

<sup>6</sup> Gloria Galloway; Cutting taxes not top priority, Harper says. Globe and Mail, August 3, 2007

<sup>7</sup> Lysiane Gagnon, Quebecers don't want a tax cut. Globe and Mail, June 4, 2007

<sup>8</sup> Chen, Mintz and Tarasov; Federal and Provincial Tax Reforms: Let's Get Back on Track, CD Howe Institute Backgrounder; No. 102, July 2007

<sup>9</sup> Ibid

<sup>10</sup> In Canada, the number of MRIs also increased over time, to reach 5.5 per million population in 2005 but Canada is still lagging behind the OECD average of 9.8 MRI units per million population. Similarly, the number of CT scanners in Canada stood at 11.2 per million population in 2005, below the OECD average of 20.6.

<sup>11</sup> Honourable James M. Flaherty, P.C., M.P ; Aspire To a Stronger, Safer, Better Canada, The Budget Plan 2007, tabled in the House of Commons by . , March 19, 2007