Health Accord Break Down:

Costs & Consequences of the Failed 2016/17 Negotiations

Canadian Health Coalition & Ontario Health Coalition
October 18th, 2017

Sponsored by:
B.C. Health Coalition, Friends of Medicare (Alberta), Nova Scotia Health Coalition, PEI Health Coalition, Health Coalition of Newfoundland & Labrador, Alternatives North (Northwest Territories)

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By the Canadian Health Coalition and the Ontario Health Coalition

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Introduction

> *Despite our health care system's value and importance, it has been more than a decade since a Canadian Prime Minister sat down with provincial and territorial Premiers to strengthen the program, and ensure that it can meet current needs and the challenges that come with an aging population.*
>
> *We will restart that important conversation and provide the collaborative federal leadership that has been missing during the Harper decade. We will negotiate a new Health Accord with provinces and territories, including a long-term agreement on funding.*
>
> *Liberal Party of Canada Election Platform 2015*

With a wave of optimism, the Trudeau government took office promising new investments in health care, a revitalized federalism, and a freshly-minted Health Accord for Canada. These promises align with what polls consistently report as the wishes of the vast majority of Canadians. They also align with the large social movements on health care across Canada and with the desires of provincial and territorial premiers. But details on funding were sketchy, and during the election campaign there were few, if any, questions asked and answered about the substantive measures that would support the health care promises. Unfortunately, this lack of depth is now all-too evident. In the two years since the election, negotiations towards a new Health Accord have been abandoned in favour of hard-edged bilateralism, the fiscal approach of the previous Harper government has been adopted virtually wholesale, and Canadians have been left with no definitive measures in place to improve health care nationally.

Just prior to the 2017 Federal Budget, the federal government moved to quash what was becoming a contentious debate with provincial and territorial premiers about a new Health Accord and take the issue off the table. In December, after only a cursory effort at negotiations, the Trudeau government tabled an ultimatum that was bound to fail. They then walked away from discussions without the promised Accord. Instead, they opted to push through bilateral funding deals with the provinces and territories one at a time. Having overridden vociferous disapproval from their provincial and territorial counterparts, the Trudeau government has succeeded, for now, in getting the premiers to sign onto the bilateral deals.[1] But since the funding formula in these schemes is not sufficient even to support existing services, it is inevitable that the question of a new Health Accord will be resurrected. While the federal government's approach has been cheered in some quarters as a victory of realpolitik, in fact, the failure of the Health Accord negotiations and the inadequacy of the bilateral schemes contribute to grave long-term problems for Canadians and our governments that will not simply be wished away.

Concerned about the gulf between needed funding levels and the federal governments' proposals, the bilateral deals have been strongly opposed by the majority of the provinces. They are in good company. Repeated polls show that Canadians overwhelmingly support public medicare as a matter of national pride and a policy priority. They are not jumping onto the cost-containment juggernaut. In fact, improved funding for health care ranks as the top issue in the country and a sizeable

[1] Provinces and territories signed onto the deals one at a time, with the last province, Manitoba, signing in late August 2017.

majority of Canadians want our federal government to expand health services and increase funding to health care, not cut and constrain them.[2]

The case for a new Health Accord is also supported by large popular advocacy campaigns across Canada that are working to stem health care privatization and curb the spread of user fees for patients. In at least six provinces, as private clinics have set up shop and taken over services formerly provided in non-profit hospitals, patients find themselves confronted by an increasing array of out-of-pocket fees.[3] Extra charges levied on often elderly patients by private clinics have ballooned to hundreds or even thousands of dollars. Extra-billing is a contravention of Canada's medicare laws and should result in financial penalties for the provinces involved. But inaction by the federal government and complicity by provincial governments have led hundreds of thousands of patients to launch court actions in British Columbia and Quebec.[4] An attempt by the provincial government to systematically cut diagnostics and surgeries from public hospitals in Ontario and expand private clinics was stymied by a volunteer-led referendum in which approximately 80,000 people voted against privatization.[5] In fact, all across the country, growing campaigns from public health advocates are coalescing around demands for our governments to uphold public medicare laws that protect patients, build capacity to meet population need and stop privatization.

Under-reported in the national media, the fiscal approach of the federal government and the process used to achieve it conflicts with the values, priorities, expectations and health care needs of Canadians. The gap is not unsubstantial. In this report the Canadian Health Coalition has calculated the shortfall. On the funding alone, the bilateral deals are $31 billion less than the best evidence of what is needed. There is no plan to bridge this gap. Thus, the provinces will have to grapple with an average of $3 billion per year less than they need to provide health care for Canadians for the next 10 years. Moreover, those provinces with some of the most egregious under-capacity problems in their health systems face the biggest funding shortfalls.

We have also assessed the wider costs and consequences of the Health Accord failure and the process by which the bilateral deals were created. The declining share of federal health care funding not only increases fiscal pressures on provinces to cut needed public health care services,[6] but it also reduces the authority of the federal government to protect and improve medicare.[7] The federal government did not take the time to hammer out actual measures to improve health care with the provinces and territories in return for an attractive funding compact, as Canadians might expect. Instead, problems of under-capacity in public hospitals were completely ignored by the federal Health Minister throughout the perfunctory negotiations, and the so-called "targeting" in the bilateral agreements means nothing in practical terms: it is public relations messaging rather than substance. Further, the bilateral agreements threaten to exacerbate inequities across the country, risking the portability of public medicare. And finally, there is also the "opportunity cost" of the Trudeau government's approach. Canadians have, for now, lost the opportunity to make

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[2] Galloway, Gloria "Canadians differ from Trump view of public health care: poll shows" *Globe and Mail* November 14, 2016; Russell, Andrew, "What are top priorities for Canadians ahead of the federal budget?" *Global News* March 21, 2016, and; The Canadian Press "Canadians are most proud of universal medicare" *CTV News* November 25, 2012.
[3] Mehra, Natalie "Private Clinics and the Threat to Public Medicare in Canada: Results of Surveys with Private Clinics and Patients" *Ontario Health Coalition* June 10, 2017: page 5.
[4] Ibid, pages 19 – 20.
[5] Ontario Health Coalition Media Release *More than 80,000 Ontarians Vote to Stop Wynne Government Plan to Cut Local Community Hospitals and Contract Out Care to Private Clinics: Health Care Advocates Call On the Premier and New Health Minister to Stop the Privatization Plan* July 17, 2014. The Ontario government has since abandoned the plan.
[6] Cameron S, Lao H., Matier, C and Shaw, T. *Fiscal Sustainability Report* Parliamentary Budget Office, 2015: pages 1,10.
[7] Romanow, Roy *Building on Values: The Future of Health Care in Canada* Commission on the Future of Health Care in Canada, 2002: page 68.

progress towards a more comprehensive and modernized public health system with concrete plans to cover critical areas like prescription medication and seniors' care.

A new approach to national health policy is needed. A Health Accord presents an opportunity for governments to come together to set national priorities and markers for advancement. Instead, the Health Accord became an end in itself and the path to it was driven by public relations messages over substance. The federal government has neither built consensus around a vision with clear goals, nor has it set any benchmarks for improvements. Canada's universal health care system requires all levels of government to engage in sound population-based health planning. This has not happened. Once forged, plans must be supported by adequate resources to meet Canadians' projected needs for care. Under-capacity is driving privatization and creating hardship for Canadians who cannot wait for several more years until the failure of the Health Accord becomes an issue too contentious to be ignored. The federal government must listen to the provinces and territories' real concerns about their real health care costs and the seriousness of the under-capacity issues in public hospitals, as well as supporting an enhanced continuum of care. The provinces must accept their accountability for spending health care dollars to improve health care and must commit to clear targets to do so. Both levels of government must recommit to the principles of equity and compassion that underlie our public health care system.

Achieving a new Health Accord is not an easy process, but the tensions that surrounded the 2016-17 negotiations raised important questions of fiscal policy, population needs, and accountability that cannot simply be swept aside. There are ways to make these interests meet, but they require real negotiations. With a commitment to working through them, a Health Accord could unite the country: restoring confidence, recommitting to our shared values, encouraging the scaling up of best practices, and instituting national priorities and standards. No matter where they live Canadians should be able to access high quality public health care, based on our health system's foundational principles of equity and compassion. The failure of the Health Accord negotiations in 2016-17 is a failure for Canadians. These issues require urgent redress in order to protect access to needed care on equitable terms.

$31 Billion Shortfall:
The Bilateral Deals Broken Down

In this report we have calculated -- in financial and health policy terms -- the costs and consequences of the failed 2016-17 Health Accord negotiations. Using the public record, the Canadian Health Coalition has assessed each of the bilateral deals negotiated in recent months. We have calculated the deficit between the level of health funding needed to maintain existing programs and services and the Trudeau government's funding deals, and we have broken down the figures by province. The result, over the 10-years of the deals is a staggering $31 billion shortfall across Canada. For the worst-hit provinces, the gap ranges from $3.4 to $13.6 billion. In every case, the deficiency amounts to significant measurable amounts of lost health services. In the end, the bilateral deals neither contain enough funding to meet population need, nor is there any answer as to how Canada's health system is to grapple with the funding deficit. Despite their pre-election messaging, the funding approach under the Trudeau government varies only marginally from the retrenchment of the previous Harper government and is grounded neither on the principles of public medicare in Canada and a vision for a restored federal role, nor on the fiscal evidence.

In early December 2016, after hasty negotiations and only a few hours of in-person meetings, the federal government tabled a "take it or leave it" proposal with a funding formula that was in actuality less than that of the Harper government.[8] Not surprisingly this plan was unanimously rejected by the provinces. The Trudeau government then called quits on a national Health Accord and began pushing through bilateral deals with individual provinces and territories, starting with governments in the Atlantic. Intergovernmental deals, in the past, have taken days of intense negotiation. Stories surrounding the 2004 Health Accord include 3 a.m. pizza deliveries and exhausting all-night sessions. The 2016-17 negotiations, in contrast, were perfunctory and quickly abandoned. Throughout the process, (then) Federal Health Minister Jane Philpott failed to champion any clear and cogent national standards and measures to address under-capacity and improve access to care. Both on process and policy, the failed Health Accord negotiations of 2016 – 17 place the Trudeau government clearly on the side of retrenchment and a reduced federal role in health care, despite pre-election positioning and commitments to Canadians. Though their own record on health care investments is less than exemplary in a number of cases, the provincial and territorial proposal is supported by the best available evidence of what is needed to maintain existing health care services.

At the December 2016 Federal-Territorial-Provincial Finance Ministers' meeting, the provinces and territories called for a Canada Health Transfer (CHT) escalator at 5.2 per cent. Most of the provinces and territories were quick to speak out against the process of bilateral deals and to voice their concerns that the federal funding proposal of Gross Domestic Product (GDP) or 3.5 per cent flat would not be enough. Ten of thirteen provinces and territories signed onto a joint letter on January 3rd, 2017 calling for the federal government to return to the negotiating table and advocating for a 5.2 per cent funding escalator.[9]

[8] The offer from the federal government was 3.5 per cent per year plus approx. 0.07 per cent in so-called target funding for 10-years. (For calculation of the percentage in target monies please see footnote 11.) This compares to Harper's plan which was nominal GDP growth per year (currently at 4 per cent) or 3 per cent, whichever is higher, for 10 years.
[9] "10 of 13 provinces call for renewed health talks" *CBC News* January 3, 2017.

Following the Trudeau government's departure from united negotiations, between December 2016 and January 2017, five provinces and territories signed onto bilateral deals. These compacts include a funding formula in which federal health care transfers will increase by nominal GDP, or 3 per cent, whichever is higher, with additional "targeted" funding for home and mental health care. Thus, the Trudeau government's funding formula is a floor of 3 per cent increase per year, fluctuating with the rate of economic growth. Despite all the rhetoric about "transformative change", it should be noted that the additional so-called target monies for mental health and home care do not add significantly to the total funding package. To put this in context, the target monies amount to only 2 per cent of the CHT escalator. Thus, if the CHT escalator amounts to 3.5 per cent, the target monies are only 2 per cent of that 3.5 per cent over 10 years, or 0.07 per cent of health care transfers as a whole. They add less than one tenth of one percent to health funding for the provinces. Furthermore, they are back-end loaded, with the majority of the so-called target funds coming in the latter half of the decade, after the next federal election.[10] Unlike in previous negotiations, the full text of the bilateral deals has never been released publicly.

Far from enough to meet population need for care, the funding scheme was panned by the larger provinces. In fact, five provinces, representing 90 per cent of the country's population held out for several months. Then, after British Columbia reluctantly acquiesced in February 2017, the three largest remaining provinces signed bilateral deals just prior to the federal budget. Manitoba remained as the final hold-out, signing on in late August.

Three highly credible and independent organizations -- the Parliamentary Budget Office, the Conference Board of Canada and the Financial Accountability Office of Ontario -- had previously released analyses showing that in order to maintain today's basket of health care services for the next 10- years, a CHT escalator of approximately 5.2 per cent would be required based, roughly, on a projection of 2+ per cent increase needed to meet population growth and aging, and an additional 3 per cent needed for inflation, income growth and enrichment.[11] The 5.2 per cent escalator enjoys a wide consensus: it is based on the best evidence available and is supported by the provinces and territories, by a range of national and subnational organizations, and by Health Coalitions across Canada.

Conversely, the 3 per cent floor adopted by the Trudeau government has never been supported by any publicly-available calculation of population need. Rather, it appears that it is based on the previous Harper government's approach which was always ideologically at odds with the fundamental values and aims of the public health care system. By adopting the Harper government policy, the foundational principle that health care in Canada be provided according to need has been abandoned by the Trudeau government in favour of linking funding (and therefore health system capacity) to GDP growth. The harsh reality of this approach is that in economic downturn, health care funding will shrink, regardless of population need.

Using publicly available information, we have put together what has been negotiated in the bilateral deals between the federal government and provinces/territories. (See Chart 1.) Based on a

[10] Authors' calculations based on Institute of Fiscal Studies and Democracy *CHT Conundrum: Ontario Case Study* February 2017 page 7. Reportedly, the bilateral deals contain target monies for home and mental health care only. As per the IFSD chart, the total for those two target funds over 10-years is $10 billion. The total CHT escalator, calculated at 3.5 per cent here, is $473.8 billion. Thus, the target monies amount to only 2.1% of the 3.5% CHT escalator 2.1% of 3.5% is 0.07% of the total CHT.

[11] Beckman, K., Fileds, D., and Stewart, M. *A Difficult Road Ahead: Canada's economic and fiscal prospects* The Conference Board of Canada, 2014; Bartlett, R., Cameron S, Lao H., and Matier, C. *Fiscal Sustainability Report* Office of the Parliamentary Budget Officer, 2012; Financial Accountability Office *Economic and Fiscal Outlook* Spring 2016, page 39.

projected nominal GDP growth of 4 per cent[12] we have calculated the deficit in each province between the level of funding needed to maintain existing services and what has been negotiated. We have also calculated what the shortfall means in forgone health services. The total shortfall Canada-wide is $31 billion. Ontario suffers the worst blow at $13.5 billion, followed by Quebec ($4.7 billion), British Columbia ($4.13 billion) and Alberta ($3.43 billion) (See Chart 2.) In the end, the bilateral deals advanced by the Trudeau government vary only slightly from the Harper plan – adding only 0.07 per cent over the entire span of 10-years.[13]

[12] See Appendix 1.

[13] Institute of Fiscal Studies and Democracy *CHT Conundrum: Ontario Case Study* February 2017 page 7. See calculations in footnote 10.

Chart 1. Comparison of Funding Plans: Canada Health Transfer (CHT) Plus Additional Health Care Funding 2004 Health Accord to 2017 Bilateral Deals & Amount Needed to Maintain Existing Services					
	2004 Health Accord	**Harper Government Plan (2011)**	**Trudeau Government Ultimatum (December 2016)**	**Trudeau Government Bilateral Deals (Winter 2016 – 2017)**	**Needed to Maintain Existing Services**
CHT Escalator	Annual Increase of 6% for 10 years.	Annual Increase: Nominal GDP growth (est. 3.5 - 4%) for 10 years, with a floor of 3%.	Annual Increase: 3.5% with no fluctuation for growth for 10 years.	Annual Increase: Nominal GDP growth rate (est. 3.5 -4%) for 10 years with a floor of 3%.	5.2% CHT increase per year for 10 years.
Additional Funds for National Priorities	$4.5 billion wait time reduction targeting cancer care; cardiac care; cataracts, hip & knee replacements; MRI & CTs. $16 billion for primary care, home care and drug coverage.	None.	$11.5 billion over 10 years for mental health, home care, prescription drugs innovation. This amounts to 2.4% over 10 years in addition to the 3.5% base escalator.[14]	Approx. $11.5 billion for home care and mental health over 10 years as follows: **New Brunswick:** $229.4 million **Nova Scotia:** $287.8 million **NFLD & Labrador:** $160 million **Saskatchewan:** $348.8 million[15] **Alberta:** $1.3 billion **P.E.I.:** $45.1 million **British Columbia:** $1.4 billion plus $10 million for opioid crisis **Ontario:** $4.2 billion **Quebec:** $2.5 billion.[16] **Territories:** $36.1 million **Manitoba:** $1.1 billion	Plus: Additional funds would be required to establish new or enhanced programs.
Total	6% per year for 10 years + $21.5 billion over 10 years.	Est. 4% per year for 10 years.	3.5% per year for 10 years + $11.5 billion in "target" funds over 10-years amounting to 0.07%.[17]	Est. 4% per year for 10 years plus less than 1/10 of 1 % in target funds over 10 years.[18]	5.2% per year for 10 years plus unspecified amounts for any new programs/enhancements.

[14] The $10 billion over 10-years for home care and mental health funding is divided among 13 provinces and territories. It is also broken down over the 10-years so that the majority of the funding will be transferred in later years. IFSD notes: "In summary, while additional federal funds dedicated to home care and mental health will provide modest support to provincial finances, this agreement is neither sufficient nor transformative in helping the provinces to meet the health care needs of their citizens. And given the back-end loaded nature of additional health funding, the more paramount concern is that health reforms have been largely deferred to beyond the 2019 election." Institute for Fiscal Studies and Democracy *CHT and the Federation Past, Present and Future* Spring 2017, page 6.
[15] The Saskatchewan government claims that the Federal government has allowed them to continue violating the Canada Health Act for one year by billing patients for diagnostic imaging. Aaron Wherry, Susan Lunn,"Saskatchewan and federal government reach deal on health care." *CBC News.* January 17, 2017.
[16] Quebec will retain purview over how these funds are used, extending a principle the province and federal government agreed upon in 2004.
[17] Note: the additional 0.07 per cent is actually back-end loaded and not equally distributed per year. For calculation of this please see footnote 11.
[18] Ibid.

Bilateral Deals: Shortfalls by Province

The Canadian Health Coalition has calculated a province-by-province tally of the financial impacts of the bilateral deals. The totals, shown in Chart 2 below, reveal the difference between the CHT tied to GDP, estimated at a 4 per cent growth rate[19] over the next 10 years, and the best available evidence of the amount needed to continue delivering the public health care services we rely on, at 5.2 per cent. Each bilateral agreement includes a "me too" clause. The Atlantic provinces signed hoping the larger provinces would be able to negotiate a better financial deal, but with the final signing of Manitoba in the summer of 2017, those hopes were dashed.[20]

Chart 2. Bilateral Deals: Canada Health Transfer Funding Shortfall by Province	
Alberta	$3.43 billion
British Columbia	$4.13 billion
Manitoba	$1.1 billion
New Brunswick	$830 million
Newfoundland & Labrador	$580 million
Nova Scotia	$993 million
Ontario	$13.56 billion
Prince Edward Island	$156 million
Quebec	$7.2 billion - $2.5 billion = $4.7 billion[21]
Saskatchewan	$1.1 billion
Canada Total	$31 billion

The provinces that have signed onto the Trudeau government's bilateral deals have acquiesced to the same CHT plan as advanced by the Harper Government in 2011: a CHT tied to nominal GDP growth with a floor of 3 per cent. The provinces determined the deal to be slightly better than the 3.5 per cent flat rate that the Trudeau government proposed in its December 2016 ultimatum, assuming that nominal GDP growth will exceed 3.5 per cent. In addition to the CHT escalator, provinces and territories will receive funding for mental health and home care amounting to an

[19] Nominal GDP growth rate estimate of 4 per cent is based on growth rate for last 20 years. See Appendix 1 for calculations.
[20] Benzie, Robert, Campion-Smith, Bruce, "Ontario welcomes new 10-year health accord with Ottawa," *Toronto Star*, March 10, 2017.
[21] The additional $2.5 billion over 10 years for Quebec is not earmarked specifically for home, mental health care and pharmaceutical innovation as these monies are in other provinces and can be used, like the CHT, for the purposes designated by the province. We have therefore deducted it from the shortfall.

additional 0.07 per cent over 10 years.[22] Some provinces and territories were given small additional incentives to sign: British Columbia, and Alberta were promised money for the opioid crisis, Manitoba will receive a one-time combined lump sum of $5 million for kidney disease and the opioid crisis,[23] and Premier Brad Wall revealed to the press that he was given a one-year reprieve on the Canada Health Act,[24] a claim denied by (then) federal Health Minister Jane Philpott, but no text has been made available to verify either party's claim.[25]

Health Ministers on the Bilateral Health Deals[26]

"Quebecers do understand the simple math of those things. They understand that we are being lured into a deal that really means that it's going to be less care,"
Gaétan Barrette, Quebec Health Minister

"By Ontario's estimates, we'll spend $29 billion over the next five years alone on mental health and home care. The federal government has offered to provide roughly seven per cent of that total, or $1.9 billion. That's simply not sustainable and that's why the premiers have asked the prime minister for a meeting early in the new year."
Eric Hoskins, Ontario Health Minister

"These deals represent massive cuts to federal health funding that will hurt mental health, home care and hospitals and will impact every Canadian,"
Kelvin Goertzen, Manitoba Health Minister

The following tables provide province-by-province calculations of the financial impacts of the bilateral agreements.[27] The report does not include a calculation for any of the territories because of the different funding structure that is used.

[22] IFSD *CHT Conundrum* February 2017 page 7.
[23] "A healthy deal for Manitoba?" *CBC News.* September 12, 2017.
[24] "Feds give Sask. 1 year to make case for private MRIs" *CBC News* January 18, 2017.
[25] Fraser, DC, "Feds holding the line on 2-for-1 MRI scans" *Saskatoon Star Phoenix,* January 19 2017.
[26] "Nova Scotia, Newfoundland and Labrador make deals with federal government on health," *CBC News,* Dec 23, 2016.
[27] See Appendix II for sources and calculations of what the difference could buy in each province.

British Columbia CHT Calculations 2016/2017-2026/2027 (millions)			
Years	Nominal GDP (4%)	**What is needed 5.2%**	Previous escalator 6%
2016-2017	4,723	**4,723**	4,723
2017-2018	4,912	**4,969**	5,006
2018-2019	5,108	**5,227**	5,306
2019-2020	5,312	**5,499**	5,624
2020-2021	5,524	**5,785**	5,961
2021-2022	5,745	**6,086**	6,326
2022-2023	5,975	**6,402**	6,706
2023-2024	6,214	**6,735**	7,108
2024-2025	6,463	**7,085**	7,535
2025-2026	6,722	**7,453**	7,981
2026-2027	6,991	**7,841**	8,451
Total (millions)	63,677	**67,805**	70,727
Difference between what is needed and what is being given $4,128,000,000			

What does $4.13 billion over 10 years buy in health care in British Columbia?

1,514 physicians for 10 years.

300,757 hip and knee replacements.

13,409,090 MRIs.

Alberta CHT Calculations 2016/2017-2026/2027 (millions)			
Years	Nominal GDP (4%)	**What is needed 5.2%**	Previous escalator 6%
2016-2017	4,226	**4,226**	4,226
2017-2018	4,376	**4,446**	4,480
2018-2019	4,551	**4,677**	4,749
2019-2020	4,733	**4,920**	5,034
2020-2021	4,922	**5,176**	5,336
2021-2022	5,189	**5,445**	5,656
2022-2023	5,397	**5,728**	5,995
2023-2024	5,613	**6,025**	6,355
2024-2025	5,838	**6,338**	6,736
2025-2026	6,072	**6,668**	7,140
2026-2027	6,315	**7,015**	7,568
Total (millions)	57,232	**60,664**	63,275
Difference between what is needed and what is being given $3,432,000,000			

What does $3.43 billion over 10 years buy in health care in Alberta?

937 physicians for 10 years.

204,288 hip and knee replacements.

Saskatchewan CHT Calculations 2016/2017-2026/2027 (millions)			
Years	Nominal GDP (4%)	**What is needed 5.2%**	Previous escalator 6%
2016-2017	1,143	**1,143**	1,143
2017-2018	1,182	**1,202**	1,212
2018-2019	1,229	**1,265**	1,285
2019-2020	1,278	**1,331**	1,362
2020-2021	1,329	**1,400**	1,444
2021-2022	1,382	**1,473**	1,531
2022-2023	1,437	**1,550**	1,623
2023-2024	1,494	**1,631**	1,720
2024-2025	1,554	**1,716**	1,823
2025-2026	1,616	**1,805**	1,932
2026-2027	1,681	**1,899**	2,048
Total (millions)	15,325	**16,415**	17,123
Difference between what is needed and what is being given $1,090,000,000			

What does $1.1 billion over 10 years buy in health care in Saskatchewan?

339 physicians for 10 years.

72,935 hip replacements (with trauma).

Manitoba CHT Calculations 2016/2017-2026/2027 (millions)			
Years	Nominal GDP (4%)	**What is needed 5.2%**	Previous escalator 6%
2016-2017	1,310	**1,310**	1,355
2017-2018	1,362	**1,378**	1,436
2018-2019	1,416	**1,450**	1,511
2019-2020	1,473	**1,525**	1,590
2020-2021	1,532	**1,604**	1,673
2021-2022	1,593	**1,687**	1,760
2022-2023	1,657	**1,775**	1,866
2023-2024	1,723	**1,867**	1,978
2024-2025	1,792	**1,964**	2,097
2025-2026	1,864	**2,066**	2,223
2026-2027	1,939	**2,173**	2,356
Total (millions)	17661	**18799**	19845
Difference between what is needed and what is being given $1,138,000,000			

What does $1.1 billion over 10 years buy in health care in Manitoba?

362 physicians for 10 years.

81,355 hip and knee surgeries.

Ontario CHT Calculations 2016/2017-2026/2027 (millions)			
Years	Nominal GDP (4%)	**What is needed 5.2%**	Previous escalator 6%
2016-2017	13,897	**13,897**	13,897
2017-2018	14,331	**14,620**	14,731
2018-2019	14,904	**15,380**	15,615
2019-2020	15,500	**16,180**	16,552
2020-2021	16,120	**17,021**	17,545
2021-2022	16,765	**17,906**	18,598
2022-2023	17,436	**18,837**	19,714
2023-2024	18,133	**19,817**	20,896
2024-2025	18,858	**20,847**	22,150
2025-2026	19,612	**21,931**	23,479
2026-2027	20,396	**23,071**	24,888
Total (millions)	185,952	199,507	208,065
Difference between what is needed and what is being given $13,555,000,000			

What does $13.56 billion over 10 years buy in health care in Ontario?

3,988 physicians for 10 years.

1,133,874 hip and knee replacements.

45,200,000 MRIs.

Quebec CHT Calculations 2016/2017-2026/2027 (millions)			
Years	Nominal GDP (4%)	**What is needed 5.2%**	Previous escalator 6%
2016-2017	8,278	**8,278**	8,278
2017-2018	8,609	**8,708**	8,775
2018-2019	8,953	**9,161**	9,301
2019-2020	9,311	**9,637**	9,859
2020-2021	9,683	**10,138**	10,451
2021-2022	10,070	**10,665**	11,078
2022-2023	10,473	**11,220**	11,743
2023-2024	10,892	**11,803**	12,448
2024-2025	11,328	**12,417**	13,195
2025-2026	11,781	**13,063**	13,987
2026-2027	12,252	**13,742**	14,826
Total (millions)	111,630	**118,832**	123,941
Difference between what is needed and what is being given $7,202,000,000			

What does $7.2 billion over 10 years buy in health care in Quebec?

2,841 physicians for 10 years.

953,769 hip and knee replacements.

New Brunswick CHT Calculations 2016/2017-2026/2027 (millions)			
Years	Nominal GDP (4%)	**What is needed 5.2%**	Previous escalator 6%
2016-2017	753	**753**	753
2017-2018	768	**792**	798
2018-2019	799	**833**	846
2019-2020	831	**876**	897
2020-2021	864	**922**	951
2021-2022	899	**970**	1,008
2022-2023	935	**1,020**	1,068
2023-2024	972	**1,073**	1,132
2024-2025	1,011	**1,129**	1,200
2025-2026	1,051	**1,188**	1,272
2026-2027	1,093	**1,250**	1,348
Total Millions	9,976	**10,806**	11,273
Difference between what is needed and what is being given $830,000,000			

What does $830 million over 10 years buy in health care in New Brunswick?

314 physicians for 10 years.

76,859 hip and knee replacements.

Nova Scotia CHT Calculations 2016/2017-2026/2027(millions)			
Years	Nominal GDP (4%)	**What is needed 5.2%**	Previous escalator 6%
2016-2017	944	**944**	944
2017-2018	967	**993**	1,001
2018-2019	1,006	**1,045**	1,061
2019-2020	1,046	**1,099**	1,125
2020-2021	1,088	**1,156**	1,193
2021-2022	1,132	**1,216**	1,265
2022-2023	1,177	**1,279**	1,341
2023-2024	1,224	**1,346**	1,421
2024-2025	1,273	**1,416**	1,506
2025-2026	1,324	**1,490**	1,596
2026-2027	1,377	**1,567**	1,692
Total (millions)	12,558	**13,551**	14,145
Difference between what is needed and what is being given $993,000,000			

What does $993 million over 10 years buy in health care in Nova Scotia?

396 physicians for 10 years.

75,467 hip and knee replacements.

PEI CHT Calculations 2016/2017-2026/2027(millions)			
Years	Nominal GDP (4%)	**What is needed 5.2%**	Previous escalator 6%
2016-2017	148	**148**	148
2017-2018	152	**156**	157
2018-2019	158	**164**	166
2019-2020	164	**173**	176
2020-2021	171	**182**	187
2021-2022	178	**191**	198
2022-2023	185	**201**	210
2023-2024	192	**211**	223
2024-2025	200	**222**	236
2025-2026	208	**234**	250
2026-2027	216	**246**	265
Total (millions)	1,972	**2,128**	2,216
Difference between what is needed and what is being given $156,000,000			

What does $156 million over 10 years buy in health care in PEI?

66 physicians for 10 years.

4,281 hip replacements (with trauma).

Newfoundland and Labrador CHT Calculations 2016/2017-2026/2027 (millions)			
Years	Nominal GDP (4%)	**What is needed 5.2%**	Previous escalator 6%
2016-2017	528	**528**	528
2017-2018	539	**555**	560
2018-2019	561	**584**	594
2019-2020	583	**614**	630
2020-2021	606	**646**	668
2021-2022	630	**680**	708
2022-2023	655	**715**	750
2023-2024	681	**752**	795
2024-2025	708	**791**	843
2025-2026	736	**832**	894
2026-2027	765	**875**	948
Total (millions)	6,992	**7,572**	7,918
Difference between what is needed and what is being given $580,000,000			

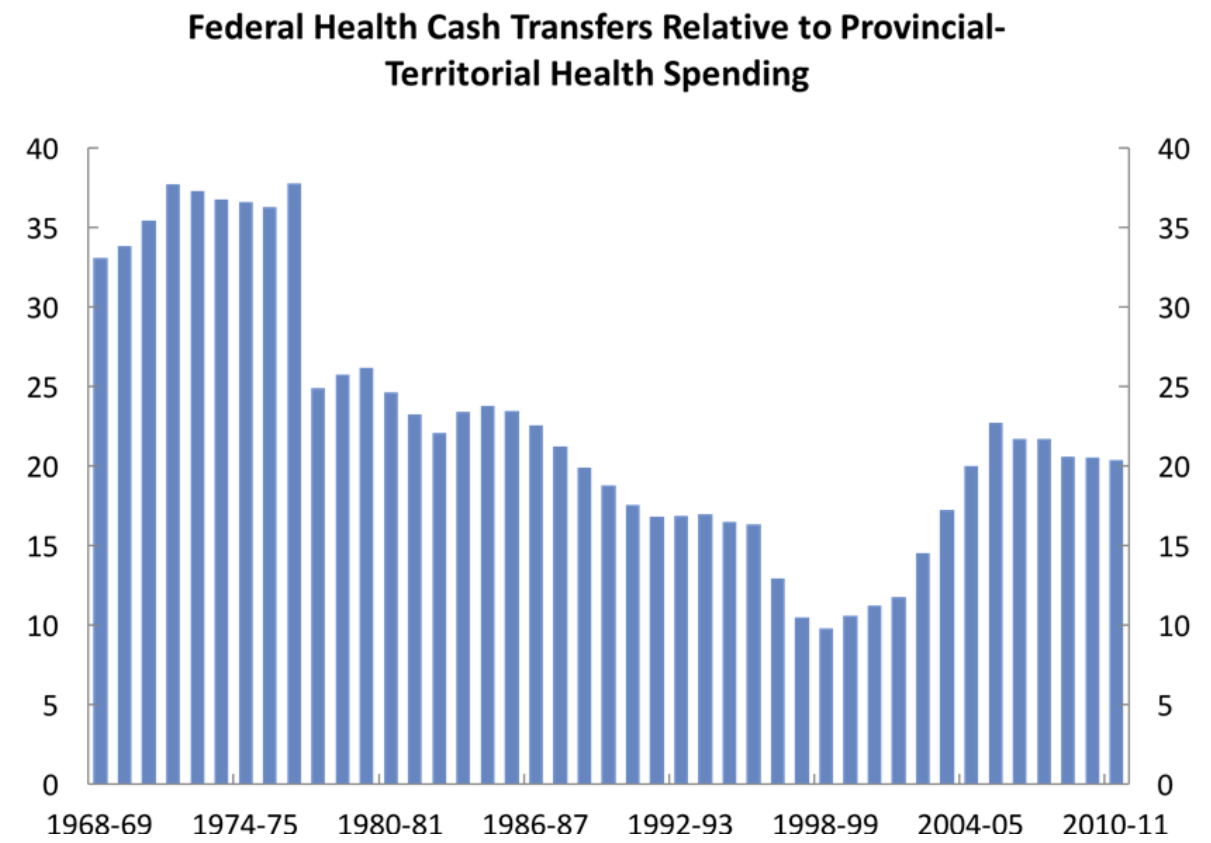
What does $580 million over 10 years buy in health care in Newfoundland and Labrador?

223 physicians for 10 years.

42,616 hip and knee replacements.

Declining Shares:
Breakdown of the Federal Commitment to Health Care

At the creation of public medicare in Canada, the federal and provincial governments split the cost of physician and hospital services 50/50 through a combination of cash and tax point transfers.[28] But by the late 1990s, the federal contribution was in precipitous decline. Federal cash transfers for public health care costs under the Canada Health Act (physicians and hospitals) had fallen to 15 per cent.[29] In subsequent decades, in a series of meetings of the Council of the Federation – including federal, provincial and territorial leaders-- the federal role in health care was slowly improved. In 2017, federal shares had climbed back up to 23.3 per cent – still far from the original cost share



Source: Office of the Parliamentary Budget Officer *Renewing the Canada Health Transfer: Implications for Federal and Provincial-Territorial Fiscal Sustainability* January 2012. Using data from: Commission on the Future of Health Care in Canada (CFHCC); Finance Canada; Canadian Institute for Health Information (CIHI); Office of the Parliamentary Budget Officer.

[28] Romanow, Roy *Building on Values: The Future of Health Care in Canada* Commission on the Future of Health Care in Canada, 2002, page 36.
[29] Ibid, page 66.

agreement, but signaling a restored federal role and providing the opportunity to steer a national approach following years of Health Accord.[30]

Tipping the Balance – First Ministers' Meeting 2000 & the Communiqué on Health

When the federal contribution sank below 15 per cent of their public health costs, Canada's premiers asked the federal government for a roundtable meeting on public health care. Out of these negotiations a Communiqué on Health was developed. In it, federal, provincial and territorial governments reaffirmed their commitment to the principles of the Canada Health Act and agreed upon a set of common goals for health renewal including: improving access to care; primary care reform; attention to the determinants of health, promotion and prevention; supply of health human resources; home and community care; coordination on pharmaceuticals; investments in health equipment and infrastructure. First Ministers agreed to report publicly on a list of health indicators, outcomes and quality of service but there were no definite targets. The federal government gave a commitment to increase the Canada Health and Social Transfer (CHST) by $21 billion over 5-years, and additional funding including $1 billion for medical equipment, $800 million to support primary care reform and $500 million in information technology (such as e-health records).[31] The 2000 agreement marked a change in policy, pivoting the federal government from a shrinking role to incrementally increasing the federal share of public health care costs. It also served as a precursor to the Health Accords which followed.

In 2002, the Commission on the Future of Health Care in Canada, headed by the Honourable Roy Romanow, reported that the provinces were shouldering too much of the health care costs and recommended an increase to the federation contribution.[32] Romanow also recommended that any escalator must be set in advance for five-year periods to provide stable and predictable funding.

Commission on the Future of Health Care in Canada (2002)

RECOMMENDATION 6:
To provide adequate funding, a new dedicated cash-only Canada Health Transfer should be established by the federal government. To provide long-term stability and predictability, the Transfer should include an escalator that is set in advance for five year periods.

[30] Government of Quebec *Budget 2017-18 Health Funding: For a Fair Share of Health Funding*, March 28, 2017. http://www.budget.finances.gouv.qc.ca/budget/2017-2018/en/documents/Budget1718_Health.pdf
[31] News Release – First Ministers' Meeting Communiqué on Health, Ottawa, September 11, 2000 and News Release – New Federal Investments to Accompany the Agreements on Health Renewal and Early Childhood Development, Ottawa, September 11, 2000.
[32] Romanow, Roy Building on Values: The Future of Health Care in Canada Commission on the Future of Health Care in Canada, 2002, page 69.

The 2004 Health Accord: Rebuilding the Federal Role

The goal of the 2004 Health Accord was to "fix health care for a generation". This was an overstatement. But the Accord did offer 10 years of significant federal re-investment in health care with stable and predictable funding, a 6 per cent annual escalator and substantial target funds for national priorities. Building from Romanow's recommendations, the Accord was more than a funding arrangement. It created the Health Council of Canada (HCC), a government organization which was mandated to report annually on progress toward the goals of the Health Accord including: reduced wait times; improved access to home care; primary health care reform; electronic health records; catastrophic drug coverage; prevention and health promotion, and; aboriginal health. It also recommitted First Ministers to universal public health care, set national standards for home care coverage to be implemented within 2-years, targeted improvements in access to primary health teams within 7-years, set a national priority of reducing wait times for targeted procedures, forged an agreement for the creation of benchmarks in targeted health services, and shared best practices. First Ministers also agreed to working groups on pharmacare and home care. Over the decade that followed, results were mixed.

Five priority procedures and diagnostics were agreed upon as targets for wait time reduction: diagnostic imaging, radiation therapy, hip and knee joint replacement, cataract removal surgery, and cardiac bypass surgery.[33] Three years after the implementation of the 2004 Health Accord, the Health Council of Canada reported on progress:

> *"Undoubtedly, there has been progress in reducing wait times for some health care services in some areas of Canada"*[34] with British Columbia, Alberta, Ontario, and Newfoundland and Labrador showing reductions in at least three of the 5 priority areas.

In 2011, the Senate Standing Committee on Social Affairs, Science and Technology reported on the implementation of the 2004 Accord. Regarding the wait times targets, they noted:

> *"…the committee found that governments had, for the most part, met their obligations in relation to the establishment of benchmarks in four of the five priority areas (cancer, heart, sight restoration, and joint replacement) and reporting on progress. In addition, the committee heard that targeted funding had resulted in an increase in the number of surgeries in the priority areas, as well as the number of diagnostic imaging services performed. Moreover, the committee heard that eight out of ten Canadians were indeed receiving treatment within the established time frames. However, the committee also heard from witnesses that there were significant variations among provinces in meeting the benchmarks in some of the priority areas and considers this to be a concern."*[35]

The Canadian Institute for Health Information (CIHI) also reported on progress following the 2008 financial crisis and subsequent fiscal austerity imposed in some provinces. They noted that after initial progress, gains had stalled on wait time reduction. Their data reveals

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[33] Health Council of Canada *Wading Through Wait Times: What do meaningful reductions and guarantees mean?* 2007, page 8 and Health Council of Canada *Progress Report 2013: Health Care Renewal In Canada*, page 12.
[34] Health Council of Canada *Wading Through Wait Times: What do meaningful reductions and guarantees mean?* 2007
[35] The Honourable Kelvin K. Ogilvie Chair, The Honourable Art Eggleton, P.C. Deputy Chair, The Standing Senate Committee on Social Affairs, Science and Technology *Time for Transformative Change: A Review of the 2004 Health Accord*, March 2012 pg viii.

that the number of surgeries, MRIs and CTs performed had increased significantly and it was suggested by CIHI that the demand of an aging population was outpacing system capacity.[36]

The 10-year Health Accord also set the first concrete national standards for home care coverage. In it, the provinces and territories agreed to cover post-acute, mental health, and palliative home care by 2006, as per the recommendations of the Romanow Commission. According to the Senate's review, progress had been made in improving access to these target areas. However, there was little follow-up by the federal government. By 2011 targets and indicators to measure progress in these areas had not yet been agreed upon and national reporting requirements were not implemented.[37]

Other targets and goals were not met, due to failures at both national and provincial/territorial levels. In the Accord, provinces and territories agreed that by 2011, 50 per cent of their populations would have access to multidisciplinary primary health teams. Though the emphasis on primary care reform did support innovations across the country,[38] that target was not met by most provinces. A Ministerial Task Force was created to establish a National Pharmaceutical Strategy. But after initial progress in which the task force built consensus around five priorities,[39] the federal government under Stephen Harper walked away from the table, effectively disbanding it. On 13 September, 2004 First Ministers and the Leaders of the National Aboriginal Organizations agreed to the Communiqué on Improving Aboriginal Health, in which they committed to developing a blueprint to improve the health status of Aboriginal peoples. Almost a decade-and-a-half after the Communiqué was developed, the gap in health status between Aboriginal peoples and the general Canadian population remains.

In the end, the 2004 Health Accord resulted in measurable improvements and a restoration of federal vision and some engagement in the health care system. The funding escalator worked to re-establish a federal role in health care, boosting the federal share of funding by more than 8 per cent. Volumes for MRIs and target surgeries were significantly increased across Canada. Progress was also made in primary care reform, particularly in Ontario, and in access to home care. Measures were implemented for wait times that did not exist prior to the Accord. Important intergovernmental tables were established for pharmacare and home care. The principle that the federation could and should agree upon measures of achievement was established. There were failings too. The most egregious of these has been the lack of progress on closing the health gap for Aboriginal people. As difficult as it is to fairly balance an evaluation of a compact covering such wide and complex policy, it is clear that the 2004 Health Accord was a beginning that could have been built upon. But there was insufficient follow-up. Then, the 2006 election brought a dramatic shift.

The Harper Government Years: Unilateralism and Retrenchment

In 2006, the Canadian federal election ushered in Stephen Harper's government, and with it, a sea-change in health care policy. The Harper government repeatedly described health care as purely provincial and territorial jurisdiction and disengaged from any potential role in ensuring national

[36] Canadian Institute for Health Information *Wait Times for Priority Procedures in Canada*, 2013.
[37] The Honourable Kelvin K. Ogilvie Chair The Honourable Art Eggleton, P.C. Deputy Chair The Standing Senate Committee on Social Affairs, Science and Technology *Time for Transformative Change: A Review of the 2004 Health Accord*, March 2012, page xii.
[38] Ibid, page xiii.
[39] Ibid, page xvii

standards that were set in the 2004 Health Accord were followed up.[40] Under the Harper government, the policy of retrenchment was clear. Harper refused multiple invitations by the premiers to meet and discuss health care.[41] There were no First Ministers' meetings during Harper's tenure and the federal government refused to acknowledge the intergovernmental agreement in the 2004 Accord for a National Pharmaceutical Strategy, walking away from the Ministerial Task Force and stopping all progress.

In December 2011, a surprise announcement was made by federal Finance Minister Jim Flaherty. Far ahead of the 2014 deadline that would have marked the end of the 2004 Health Accord's 10-year agreement, he proclaimed unilaterally that the 6 per cent escalator for public health care through the CHT would be replaced in 2017 with an escalator that was tied to GDP with a floor of 3 per cent.[42] Health care funding was no longer to be tied to population need, but rather to economic growth. If the economy were to fail – likely resulting in more health care need, not less – health care funding would nonetheless go down.

Canada's finance ministers were outraged at both the suggestion to tie the CHT to GDP and the process by which the new funding formula was dictated to them with no notice and little discussion.[43] The following year both the Parliamentary Budget Office[44] and the Council of the Federation calculated the impact of the new funding formula and announced that by tying the CHT to GDP the provinces were being forced to accept a $36 billion cut to federal public health care funding over 10 years and a reduction in the federal share of health care financing from 23 per cent to 18 per cent.[45]

The Harper Government's announcement of a CHT tied to GDP was their only plan for public health care, there would be no new Health Accord, no national standards, no sharing of best practices, and no opportunity to discuss strengthening and expanding public medicare. By 2014, the Health Council of Canada had been defunded and produced its last report on the 2004 Health Accord. While it found that wait times had decreased initially, they stagnated and began to rise by the end of the Accord.[46] The provinces and territories needed federal involvement for the more difficult tasks like creating a National Pharmaceutical Management plan including a national drug formulary and having common reporting mechanisms and benchmarks for wait times. In the absence of federal leadership these plans and mechanisms were never developed.

Summary 2000 – 2015: From Reinvestment to Retrenchment

From 2000 – 2006 the federal government began to reinvest in health care, and with it, began to restore the federal role. The establishment of the Romanow Commission began the process of re-visioning that led to the 2003 and 2004 Accords. Despite its detractors, the evidence supports the 2004 Accord as important, not just because it signaled a new era of federal re-engagement, but also because consensus was built around some clear priorities. Real targets were agreed upon demonstrating that provincial and territorial governments can be persuaded to adopt concrete

[40] Ibbitson, John "One Promise the Tories Won't Keep" *Globe and Mail* July 26, 2006.
[41] CBC. Laura Payton "Roy Romanow urges PM to meet with premiers on health care: Former Saskatchewan premiers says health-care reform will go further with federal support" *CBC* July 24, 2013.
[42] "In a surprise move, Flaherty lays out health-spending plans til 2024." *Globe and Mail*. December 19, 2011.
[43] Ibid
[44] Bartlett, R., Cameron S, Lao H., and Matier, C. *Economic and Fiscal Look Update.* Parliamentary Budget Office, 2012: page 4.
[45] Council of the Federation Working Group on Fiscal Arrangements, *Assessment of the Impact of the Current Federal Fiscal Proposals*, July 2012: page 10.
[46] Better health, better care, better value for all: Refocusing health care reform in Canada. *Health Council of Canada*. September 2013.

measures of performance. Some measurable progress was achieved. Though advances could have been much more substantial and there were significant failings, the Accord shows what federal-provincial-territorial negotiations could accomplish. Further, the 2004 Accord began initiatives that could still be built upon today. With the Harper government's policy of retrenchment, funding continued through to 2017; but the national vision, consensus, targets and new initiatives were all dropped, stalling virtually all progress as a national health system for a decade. In this context, the lost opportunity as a result of the policy approach by the Trudeau government in the 2016-17 Health Accord negotiations becomes clearer.

Beyond Money: The Cost of the Trudeau government's Health Care Retrenchment

When it swept into office with a mandate for change, the Trudeau government had at least two clear policy choices from recent history to guide its approach to health care. It could take as a starting point the 2004 Accord with its path of reinvestment and re-engagement, and build upon it. Or it could adopt the Harper government's programme of funding constraint with the attendant limitations. It opted for the latter. Having signed 10-year bilateral deals, the federal government appears to be hoping that health care, as a major issue of contention, is off the table at least until after the next election. But in so doing, the Trudeau government has adopted a funding formula that will again see a declining federal share; and by attaching funding to economic growth, the federal government has abrogated the principle that health care is to be provided based on need. Since the funding is insufficient to meet population need, the federal government did not establish targets based on sound planning principles. The result is a series of bilateral deals that are guided by short-term public relations concerns. In part because it did not give itself the fiscal room to negotiate seriously with the provinces, the federal government did not champion any meaningful vision nor did it establish concrete targets for improvements to care for Canadians. Leading into the negotiations and throughout the process, its record on upholding the Canada Health Act's prohibition on user fees for patients has been reactive and inequitable.

These policy failings come with a human cost. For Canadians, constrained funding and the lack of a clear national plan means widening inequities. Despite this, our public health system provides excellent quality care to millions of Canadians each year. Our life expectancy has increased significantly in the last decade and is significantly better than in the U.S.[47] Heart attack rates are down and fewer Canadians die of heart attacks each year than they did a decade or two decades ago.[48] Stroke rates are down[49] and cancer survival rates are up.[50] There is much to celebrate. But there are also significant inequities, under-capacity problems and gaps in services. Cuts to public hospitals have effectively rationed and delisted services, particularly in provinces such as Ontario, Quebec and British Columbia. Wait times remain too high for an array of covered tests and procedures, and capacity planning is dramatically uneven across the country. Coverage for home care varies from relatively comprehensive in the prairies to severely rationed in Ontario and the Atlantic provinces. Long-term care coverage is also vastly inequitable, with some Atlantic provinces providing very little and some larger provinces, such as British Columbia and Ontario, steeply rationing access. Primary care has undergone wholesale reform in provinces such as Ontario, but such reforms are in their infancy in some provinces. Mental health care across the continuum from hospitals to primary and community care, can best be described a patchwork of programs that range from public to private, with long waits and inadequacies across the board.

[47] World Bank, September 2017 at: https://www.google.ca/publicdata/explore?ds=d5bncppjof8f9_&met_y=sp_dyn_le00_in&idim=country:CAN:USA:AUS&hl=en&dl=en

[48] Statistics Canada *Changes in causes of death 1950- 2012* at: http://www.statcan.gc.ca/pub/11-630-x/11-630-x2016003-eng.htm

[49] Statistics Canada *Trends in mortality rates 2000* – 2011 at: http://www.statcan.gc.ca/pub/82-625-x/2014001/article/11897-eng.htm

[50] Ellison, Larry F. and Wilkins, Kathryn *An update on cancer survival* Government of Canada, September 2010. Also see *Canadian Cancer Statistics 2016* Statistics Canada at: https://www.canada.ca/en/public-health/services/chronic-diseases/cancer/canadian-cancer-statistics-2016.html

Not only are national standards lacking in the major health sectors, but flagrant violations of Canada's medicare laws are being ignored. Where they have not been enforced, patients, facing hundreds or thousands of dollars in unlawful user fees for public health care services, have undertaken unprecedented advocacy to compel action. In one example, in November 2015, high-profile doctors, nurses and academics in Quebec wrote a public letter pleading for the federal government to intervene to protect patients from exorbitant extra fees charged in private clinics, a practice that they described as "widespread".[51] In May 2016, the Réseau FADOQ, a group of Quebec seniors with 450,000 members, filed an application to the federal court of Canada for a motion of mandamus. This motion aimed to force the federal government to take measures to stop the extra-billing of Quebec patients; a practice which is prohibited by the Canada Health Act. Finally, pressured by patients and their advocates to take action, the federal Health Minister asked the Quebec Health Minister to end all extra-billing practices, specifying that the federal health transfer payment to the province would be reduced if the province did not comply.[52] Conversely, during the 2016 Health Accord negotiations, the Saskatchewan government claimed in the media that their federal counterparts had given them a one-year leave to violate the Canada Health Act – a shocking assertion that, if true, threatens equitable access to health care for all Canadians.[53] Though the federal government denies this allegation, it has not taken enforcement action against Saskatchewan, even while that province's government has widened legislation to usher in more private clinics and expand the use of user fees charged to patients in medical need. In the spring of 2017 the Ontario Health Coalition released an investigation into private clinics across Canada, finding 88 clinics in 6 provinces charging extra user-fees to patients.[54] The Canada Health Act is being upheld, it appears, only when the Trudeau government is forced to do so.

Opportunity cost measures the lost potential gain of choosing one course over another. This lost potential as a result of the failed 2016-17 Health Accord negotiations is impossible to measure, but is nonetheless very real. One foregone opportunity is that Canadians will not see progress on capacity planning and measurable targets for improvement in any part of the health care continuum as a result of any national initiative. There will be no renewal of focus on building capacity and reducing wait times, for instance. Instead, with less national funding and no plan to bridge the gap, provinces will have to raise revenues or decrease spending on health care in whatever ways they choose. In addition, long-promised new programs, such as a national drug plan or a seniors' strategy, that could alleviate suffering and reduce costs, have also been stalled, perhaps for years. The 2004 Accord's targets for home care coverage to include post-acute, mental health and palliative home care could have been dusted off, revived and expanded upon. But instead, the so-called "target" monies for home care and mental health, amounting to 0.07 per cent in addition to the 3-per-cent-or-GDP funding escalator, are not tied to any definitive national standards. Moreover, significant parts of home care and mental health are privatized and there is nothing in the bilateral agreements to direct federal funds to build capacity in services provided on

[51] Brouselle, Astrid and Damien Contandriopolous et al. "Why Trudeau must save medicare in Quebec" *Toronto Star* November 5, 2015.
[52] Montpetit, Jonathan, "Jane Philpott holding Quebecers 'hostage' in spat over user fees, Gaetan Barrette says" *CBC News* September 20, 2016. In addition, last month the Quebec Superior Court authorized a class action lawsuit against the provincial government, doctors and clinics for health care user fees.
[53] Saskatchewan's government has passed legislation that flagrantly violates the Canada Health Act and legislates into being private clinics that are currently charging patients a minimum of $900 for a basic medically-needed MRI. Aaron Wherry, Susan Lunn "Saskatchewan and federal government reach deal on health care." *CBC News* January 17, 2017. The federal government denies that they are allowing Saskatchewan a one-year reprieve and instead claims they are committed to upholding the Canada Health Act, see Fraser, D.C. "Feds holding the line on 2-for-1 MRI scans" *Saskatoon Star Phoenix* January 19, 2017.
[54] Mehra, Natalie. "Private Clinics and the Threat to Public Medicare in Canada: Results of Surveys with Private Clinics and Patients" Ontario Health Coalition June 10, 2017.

an equitable public and not-for-profit basis. Further, after being stopped by the Harper government for a decade, progress on the National Pharmaceutical Strategy was sidelined in the 2016-17 negotiations. A new 2017 Health Accord could have used the 2014 Ministerial Task Force's priorities as a starting point to build toward a national pharmacare program. Instead, it is entirely absent from the bilateral agreements and there is no promise for progress at any point in the foreseeable future.

For patients facing impossible costs for drugs, or lying on a stretcher in a hospital hallway, or unable to get home care, the federal government's bilateral deals will not bring relief. Instead, the failure of federal leadership in 2016-17 damages the federal government's moral authority to uphold public medicare. It fails to address the problems of privatization and under-capacity and offloads these problems to the provinces and territories that have less fiscal room to deal with them. It will, with little doubt, lead to greater inequities across the country. It delays the implementation of much-needed improvements in the scope of medicare, prolonging suffering. A Health Accord is not a magic pill. No Health Accord could answer all needs across the continuum of care -- but the lost opportunity to set standards that would leverage progress in improving capacity and planning to reduce long waits for tests and procedures; the postponement of any movement for the country towards a national drug plan; the failure to establish concrete expansion of home care coverage – these policy choices run against the clear priorities and needs of people in Canada.

Conclusion

Almost two decades have passed since the federal government first turned the corner on declining federal investment – both financial and political – in public health care. The 2003 and 2004 Health Accords set the stage for what should have been ongoing progress. The 2016-17 Health Accord negotiations offered an opportunity for the Trudeau government to seal the Harper era in history as an isolated period of retrenchment bookended by reinvestment and restored vision. But despite initial promises, the federal government has embraced the Harper government's fiscal approach and has limited its ability to meaningfully address the need for national leadership in health care.

A policy rethink is in order. It is inevitable that the question of a new Health Accord will rise again; the inadequacy of the federal funding formula and the priority Canadians place on health care makes this a surety. This time, the federal government must enter talks having listened to the legitimate concerns from their provincial and territorial counterparts. Restored federal leadership means that the federal government focuses on substantive improvements, not public relations messaging and short-termism. Repeated polls support the fact that Canadians will unite in support for effective reinvestment tied to a progressive federal leadership role. With meaningful negotiations, with leadership that grounds itself in the foundational principles of equity and compassion that underlie our public health system, and with a focus on building capacity to meet the real health care needs of Canadians, it is possible for the federal government to inspire all levels of government to work together in the public interest. There is no question that the needs are great. But so are the opportunities.

A Health Accord affords a chance for governments to come together to make our system more comprehensive and fair by expanding public health care to cover critical areas like prescription medication and seniors care for everyone. This requires federal leadership and cooperation. Bilateral agreements are no way to build and promote an equitable national vision and move it forward. Health Coalitions across Canada are calling on the federal, provincial, territorial and First Nations governments to return to the negotiating table. To safeguard public health care for all, the federal government must agree to pay their fair share, and commit to meeting the real costs of health care. This requires at least a 5.2 per cent CHT escalator. To strengthen public health care, the federal, provincial, territorial governments must reaffirm their commitment to the Canada Health Act and the Federal government must properly enforce the Act. Both levels of government must commit that public health care funding is spent on public health care and must implement national standards so people across Canada can access equitable high quality public health care services with reduced wait times. To strengthen health care best practices in our public system must be shared and expanded. To expand public health care, the federal government must work with everyone to create a national drug plan, a seniors' care plan and mental health expansion. A Health Accord should be seen as an opportunity to protect, strengthen and expand our public health care system for all. It is too important to give up for another decade.

Appendix I. CHT Increase

	1996	1997	1998	1999	2000	2001	2002	2003	2004	2005	2006
GDP Nominal	857,023	903,902	937,295	1,004,456	1,102,380	1,140,505	1,189,452	1,250,315	1,331,178	1,417,028	1,492,207
Annual increase		5.47%	3.69%	7.17%	9.75%	3.46%	4.29%	5.12%	6.47%	6.45%	5.31%
3-year MA*, 3% min		5.43%	6.84%	6.76%	5.80%	4.29%	5.29%	6.01%	6.07%	5.43%	6.84%
3-year average, 3% min		5.44%	6.87%	6.79%	5.83%	4.29%	5.29%	6.01%	6.07%	5.44%	6.87%

	2007	2008	2009	2010	2011	2012	2013	2014	2015	2016	Long-term average	10-year average
GDP Nominal	1,573,532	1,652,923	1,567,365	1,662,130	1,769,921	1,822,808	1,897,531	1,983,117	1,986,193	2,027,544	4.40%	3.11%
Annual increase	5.45%	5.05%	-5.18%	6.05%	6.49%	2.99%	4.10%	4.51%	0.16%	2.08%	4.44%	3.17%
3-year MA*, 3% min	5.73%	5.27%	3.00%	3.00%	3.00%	5.16%	4.51%	3.86%	3.00%	3.00%	4.78%	3.95%
3-year average, 3% min	5.73%	5.27%	3.00%	3.00%	3.00%	5.17%	4.52%	3.87%	3.00%	3.00%	4.79%	3.96%

*MA: Moving Average

Source: Statistics Canada. Table 380-0064

Appendix II. Calculations

	Physicians		Hip replacement		Hip and knee replacement		MRIs	
	Cost per unit[55]	Unit per year	Cost per unit[56]	Unit per year	Cost per unit[57]	Unit per year	Cost per unit	Unit per year
BC	$272,795	1,514	--	--	$13,732	30,075	$308[58]	1,340,909
AB	$366,000	937	--	--	$16,790	20,429	--	--
SK	$324,342	339	$15,082[59]	7,294	--	--	--	--
MB	$304,165	362	--	--	$13,521	8,136	--	--
ON	$340,019	3,988	--	--	$11,959	113,387	$300[60]	4,520,000
QC	$253,539	2,841	$7,549[61]	95,377	--	--	--	--
NB	$264,299	314	--	--	$10,799	7,686	--	--
NS	$250,486	396	--	--	$13,158	7,547	--	--
PEI	$235,767	66	$36,439[62]	428	--	--	--	--
NL	$260,166	223	--	--	$13,610	4,262	--	--

[55] Average physician salary compiled by MacLean's Magazine from CIHI data. "Average doctor salaries by province," *Macleans,* August 22, 2013.
[56] Data for hip surgery from CIHI. Patient Cost Estimator. https://www.cihi.ca/en/patient-cost-estimator (accessed February 10, 2017)
[57] Data for hip and knee surgery from CIHI. Patient Cost Estimator. https://www.cihi.ca/en/patient-cost-estimator (accessed February 10, 2017)
[58] Mehra, Natalie "Private Clinics and the Threat to Public Medicare in Canada: Results of Surveys with Private Clinics and Patients" *Ontario Health Coalition* June 10, 2017.
[59] Hip replacement with trauma
[60] Mehra, Natalie "Private Clinics and the Threat to Public Medicare in Canada: Results of Surveys with Private Clinics and Patients" *Ontario Health Coalition* June 10, 2017.
[61] Hip replacement (unilateral)
[62] Hip replacement with trauma