A Needs-Based Canada Health Transfer: Drawing Lessons from Australia

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Introduction

The federal and provincial governments of Canada jointly fund Medicare. The federal government provides financial assistance to reduce the fiscal imbalance between the federal and provincial governments (Bird and Smart 2002), and the Canadian Constitution requires that governments ensure reasonable access to public services for all Canadians (Constitution Act 1982; Boadway 2004). Using the Canada Health Transfer (CHT), the federal government transfers money for provincial Medicare. Provinces are eligible to receive the transfer if they abide by the five principles of the Canada Health Act (CHA): public administration, comprehensiveness, universality, portability, and accessibility. Upholding these five principles maintains a minimum national Medicare standard and builds a sense of nationhood, but the amendment to the CHT formula in 2014 may compromise these objectives (MacNevin 2004).

Since 2014, the CHT distributes on an equal-per-capita basis funding to the provinces. The Harper government claimed this treated provinces more equally, but this policy change is incongruent with national healthcare policy objectives from a number of perspectives (Vodrey 2012). First, an equal-per-capita distribution assumes Canadians have the same health needs and the same abilities to access healthcare services; this stands in contradiction to empirical evidence, illustrating health needs and access to services vary across the population (Rosella et al. 2014; Hay 1988). In addition, this policy assumes the costs of providing healthcare are the same per person and fails to recognize the additional costs of providing healthcare, resulting in an inefficient and inequitable CHT, which may undermine values of the CHA (Stillborn 1997).

Compared with an equal-per-capita allocation, an NBF is a more equitable distribution of CHT, but the formula has issues. An NBF demands choices by using needs indicators. These indicators require empirical evidence and justification for use in a formula. The process is difficult for policymakers because the more nebulous a formula grows, the more complex and less transparent it becomes. In addition, some needs variables reflect an inefficient distribution of resources. Policymakers must choose among a variety of needs indicators and simultaneously balance equity and efficiency concerns (Peterson 2002).

Policymakers interested in changing CHT can make informed decisions by examining the development of other NBFs. The current literature on NBFs focuses on differences in the observed formula composition (Rice and Smith 1999). However, few studies describe the reasoning and contextual factors behind formula development (Penno 2013). Attempting to fill this literature gap, this study researches the desirability and feasibility of an NBF for CHT. The study takes a two-pronged approach: it defines the desirability of an NBF, thereby satisfying both the equity and efficiency criteria. This conceptual framework is useful because it provides a template for policymakers to design an NBF based on empirical evidence. Providing a theoretical framework that summarizes the reasoning behind needs-based allocation formula development,

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1 Vertical imbalances arise when two levels of government have a fiscal arrangement, and the revenue of one government, usually the federal government, exceeds its expenditures (Bird and Smart 2002). In Canada, vertical fiscal imbalance exists because the tax revenue collected by the federal government is more than its expenditure liability, and the opposite is true for provincial and territorial governments.
the study draws useful policy lessons on the feasibility of an NBF through the contextual analysis of Australia’s and Canada’s transfer development histories.

Chapter 1 Setting a Theoretical Framework

1.1 Defining need

In the literature, the two common definitions of need are medical necessity and capacity to benefit (CTB; HSIP 2006; Birch and Eyles 1991). The CHA uses the term “medically necessary” to identify publicly fundable Medicare (i.e. services provided by doctors and in hospitals), but the CHA fails to define medical necessity and leaves the definition of need to healthcare practitioners (CHSR 2002). The “medical necessity” definition separates healthcare needs from healthcare wants (i.e. the experts determine who needs services). This definition of need is fair because professionals with medical knowledge make educated decisions and treat those with necessary medical concerns and those without a need for services remain untreated. Nonetheless, this definition has the potential to create inefficiencies because practitioners have a financial incentive to induce their patients to receive treatment even though the patient lacks need for service.

Aside from medical necessity, the CTB from treatment definition of need assumes a need exists if the value of treating the patient exceeds the costs of treatment (Birch and Eyles 1991). This definition indicates governments should prioritize interventions based on services and provide the largest financial benefit to Canadians. A government may choose to prioritize acute care over chronic care because the marginal benefit to Canadians is greater when treating acute issues. In this way, resource allocation maximizes benefit.

Medical necessity and CTB seek to promote different goals; medical necessity promotes equity and fairness whereas CTB promotes collective social welfare and efficiency. With CHT, the more appropriate definition of need is medical necessity because it conforms to the values of Canadians and the principles of the CHA. The CHA has defined the services deemed medically necessary in the comprehensive principle of Medicare, but CHT allocation formula is incompatible with this same principle and the definition of need. Thus, an NBF for CHT should use needs indicators consistent with the principles in CHA.

1.2 Needs, non-needs, and the total cost of Medicare

The federal government is obligated to ensure provinces have sufficient revenues to provide comparable public services to Canadians (Constitution Act 1982). The constitutional requirement implies provinces be given revenues to meet their expenditure costs and further implies the allocation formula should reflect the population cost for Medicare services. Nevertheless, not all costs reflect actual needs; some healthcare costs lack empirical evidence to suggest medical necessity (Stevens 1998; Kephart and Asada 2009). Classifying needs with need and non-need factors is important in creating a capitation formula because not all needs incur costs, and some costs may not reflect needs.

Describing the conceptual framework required in developing an NBF, Figure 1 illustrates the total cost of Medicare is the sum of realized needs, overutilization, and expenditure costs.
The total cost disregards unmet needs because the needs go unaddressed in the Medicare system. An ideal formula would include variables accounting for legitimate needs, which are Medicare costs directly related to a person’s need for services. Examples of legitimate needs are realized needs, for those who receive treatment require care, and unmet needs, which are not reflected in the cost because the needs go unmet. Overutilization is not a legitimate need despite being part of the total cost. Finally, expenditure costs lacking empirical basis, expenditure costs are linked to medical necessity but can affect access to services for those who have needs.

Figure 1 details how the total cost of the Canadian Medicare system can be broken down. Areas 1 and 2 are needs factors and, together, determine the total volume of healthcare needed by the population; non-needs factors are areas 3 and 4, which, when combined, determine the actual volume of healthcare consumed. Needs realized or met are illustrated in Area 2 and are reflected in the overall cost of Medicare, but among medically necessary needs, some needs are unmet and revealed by Area 1. An unmet need is unaddressed by the current medical system. Populations generally have unmet needs because access to services is limited, either by the unavailability of physical resources or a person’s inability to receive Medicare services. Access to services is dependent on location whereby needs can go unmet if distance to treatment becomes a factor.

In contrast, Area 3 represents overutilization of Medicare, usually because of a moral hazard of patients or supplier-induced demand. A moral hazard in healthcare is an overuse of the healthcare system because patients have no costs upfront and may use services in excess of need. Supplier-induced demand is an excessive use of services at the behest of the healthcare supplier. Leaving the assessment of needs to subjective judgements of medical practitioners creates supplier-induced demand. Supplier-induced demand and moral hazard of patients lead to overutilization of healthcare services unrepresentative of medical need, taking away resources from those who need them. Furthermore, Area 4 represents the factors not reflected in the other three areas; usually, the expenditure cost factors influence the average input cost of providing Medicare given a volume of needs. Expenditure cost factors include, for example, technology, physician salaries, and the cost associated with service location. Areas 3 and 4 represent cost factors not included in need measurement but contribute to the overall cost of healthcare.

**Figure 1: The Decomposition of Costs of Medicare**

1.3 Criteria for selecting need factors for a needs-based capitation formula
1.3.1 Equity

Medicare is often considered to be the pinnacle of Canadian nationhood because Canadians are proud of their healthcare system and demand fair and equitable treatment for all. Equity in healthcare means Canadians have fair access to services when they need them. This definition coincides with the CHA because the purpose of Medicare is to provide services to all Canadians (CHA 1984). Among measures of equity, “equity of access” is ideal because it supports all five principles of the CHA. In addition, equity of access is an appropriate definition because it coincides with the federal government’s responsibility, recorded in section 36.2 of the Constitution Act (1982), to “ensure that provincial governments have sufficient revenues to provide reasonably comparable levels of public services” (CHA 1984).

Equity of access means Canadians have equal ability to access a service if needed (Mooney 1983). Using the egalitarian theory, Mooney (2000) argued equity has two main criteria: vertical and horizontal equity. Vertical equity means those with unequal needs warrant unequal treatment. Horizontal equity means those of equal need should be treated equally (Le Grand 1987). CHT formula treats Canadians horizontally equal; however, the health needs of Canadians vary. This imbalance implies CHT should reflect horizontal equity and focus on the vertical inequity inherent in the country (Le Grand 1987; Mooney 2000). The resulting formula designed on the principle of equity supports the sense of nationhood because it recognizes inherent disparities throughout the country and seeks to mitigate these differences (Kirigia 2009).

1.3.2 Efficiency

Unlike equity, efficiency is not an explicit value or principle examined in the CHA or the Constitution, but an NBF must minimize perverse incentives to maximize social benefit (Smith 2012). Consistent with the objectives of the CHA, efficiency requires that resources go to those who have the largest healthcare needs. An efficient allocation formula means the marginal cost of CHT (money transferred to the provinces) equals the marginal benefit (improvement in health status). To meet efficiency criteria, a formula should include variables measuring legitimate needs or legitimate non-needs and should minimize perverse incentives. For example, if “poor housing condition,” a proxy for SES, became a factor in a CHT allocation formula, the recipient government may not create policies affecting poor housing conditions because the government receives CHT based on the number of poor houses it has. The use of “poor housing condition” as a variable in an NBF could create a perverse incentive.

Policymakers must confront the trade-offs between equity and efficiency in making an NBF. The objective of the formula is to reflect the equity objective of the Canadian Constitution and CHA by ensuring reasonable access to Medicare services for those with legitimate needs. The criteria of equity and efficiency are helpful in choosing need indicators reflecting the health needs of Canadians and, simultaneously, maximizing the possible benefit in allocating financial resources.

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2 A perverse incentive is the negative result of an otherwise good intention. For example if the government provided the provinces with funds based on socio-economic status, provinces may be dissuaded from addressing socio-economic concerns.
Chapter 2 Creating a Formula

2.1 Needs Indicators
The preceding chapter set the framework for developing an NBF by identifying the core components of a capitation formula, creating a link between needs and costs and establishing the equity and efficiency criteria for selecting need factors. The next step in designing an NBF is to find appropriate indicators of need. Three common categories are utilization, demographics, and SES. Utilization data is a direct measurement of some needs because those with health needs use the health system, but the measurement only captures those who use the system and disregards those who have unmet needs. Unmet and realized needs can be captured indirectly using demographics and SES. Empirical studies have linked these two indicators to health need, and policymakers use demographics and SES in designing NBFs.

2.1.1 Utilization of Healthcare
The utilization of healthcare is a commonly used indicator of direct need (Hurley 2004; Hutchinson 1999). Utilization data measure the number of services used whether or not services are deemed medically necessary. Gravelle et al. (2003) argued using utilization data was the best indicator of need if adjusted for distance to hospitals, wait times, and minority ethnic group data. Vallejo-Torres et al. (2009) used the Gravelle et al. (2003) model and compared it to the use of an epidemiological model—allocation based on disease prevalence—and concluded the utilization model better reflected need. Gravelle et al. (2003) and Vallejo-Torres et al. (2009) clearly stated a utilization model is a useful method to indicate needs, but utilization data failed to capture overutilization (Area 3 in Figure 1) and unmet need (Area 1 in Figure 1). For this reason, Gravelle et al. (2003) suggested against direct use of utilization data. Instead, he argued utilization data adjusted for distance to hospitals, wait times, and ethnicity better reflected actual need.

2.1.2 Population Demographics
A common indirect indicator of needs is demographic data. Mustard and Derksen (1997) conducted a study measuring the health status of the population of Manitoba. They concluded regions with larger senior populations required more funding because of the increased health costs associated with age. Furthermore, a study by The Canadian Community Health Survey attempted to link healthcare use to health behaviours and socio-demographics. From a sample of 91,223 adults over the age of eighteen, the survey concluded healthcare usage correlated with age (Rosella et al. 2014). Nevertheless, some research suggests the entire elderly population is not in need of more healthcare funding. Roos and Shapiro (1981) studied ambulatory, hospital stay, and patient interview results in the province of Manitoba, and they concluded the average elderly population aged 65 to 86 did not require more in health funding than the younger population (i.e. 1-65). Comparatively, those who were in high age brackets (i.e. over 85) needed substantially more healthcare than the younger population. These studies suggest distribution of age has an impact on healthcare need.

2.1.3 Socioeconomic Status
The advantage of using demographic indicators is they reflect some legitimate needs, but, referring to the framework, they may reflect overutilization of the system and fail to reflect unmet needs. Socioeconomic indicators, however, reflect the unmet needs not captured by demographic indicators. Wilkins and Adams (1983) studied Montreal’s population and found
those in the lowest quintile of education and income had the lowest life expectancy and the highest disease prevalence. In another study, Wilkins et al. (1990) studied mortality rate of urban populations in Canada from 1971 to 1986 and found those in lower income groups had lower life expectancy and greater disease prevalence. In his study of two thousand males from the 1978 Canadian Health Survey, Hay (1988) found a male’s SES and health status positively correlated. Recently, a CIHI study looked at SES and health status in Canada’s Census Metropolitan Areas and found those with lower education and income have greater healthcare needs than the highly educated and wealthy (CIHI 2008).

Utilization, demographics, and SES are useful indicators to capture population needs, but the indicators have issues. Realized needs, whether necessary or not, are captured by utilization, but unmet needs are neglected. Demographics indirectly capture some realized and unmet needs but may neglect some unmet needs. Socioeconomic variables capture both the increased use of the healthcare system and unmet needs, but choosing SES variables requires caution because variable choice could lead to perverse incentives. Policymakers must consider these facts when balancing the trade-offs between equity and efficiency in designing an NBF (Magnussen 2010).

2.2 Needs-based allocation formulas in developed countries

Policymakers can learn from others who developed their own NBFs and confronted similar trade-offs. In particular, Canadian policymakers can study the experiences of other nations and draw important lessons on how to design an NBF for CHT. Table 1 is a comprehensive summary of the NBFs used in developed countries.

Table 1: NBFs in Other Developed Nations
<table>
<thead>
<tr>
<th>Country</th>
<th>Formula Variables</th>
<th>Program Name</th>
</tr>
</thead>
<tbody>
<tr>
<td>Australia</td>
<td>Age, Sex, Aboriginal, Location, Socio-economic status</td>
<td>Equalization</td>
</tr>
<tr>
<td>Canada</td>
<td>Population Size</td>
<td>CHT</td>
</tr>
<tr>
<td>Finland</td>
<td>Age, Disability</td>
<td>State Subsidy System</td>
</tr>
<tr>
<td>England</td>
<td>Age, Mortality, Morbidity, Socio-economic status, Ethnicity</td>
<td>Resource Allocation Formula</td>
</tr>
<tr>
<td>France</td>
<td>Age</td>
<td>Regional Resource Allocation</td>
</tr>
<tr>
<td>Germany</td>
<td>Age, Sex</td>
<td>Federal Insurance Office Risk Adjustment Scheme</td>
</tr>
<tr>
<td>Israel</td>
<td>Age</td>
<td>National Risk Adjustment Scheme</td>
</tr>
<tr>
<td>Italy</td>
<td>Age, Sex, Mortality</td>
<td>Regional Resource Allocation System</td>
</tr>
<tr>
<td>Netherlands</td>
<td>Age, Sex, Socio-economic status, Urbanization</td>
<td>Central Sickness Fund Board Risk Adjustment Scheme</td>
</tr>
<tr>
<td>New Zealand</td>
<td>Age, Sex, Socio-economic status, Ethnicity, Rurality</td>
<td>Health Funding Authority</td>
</tr>
<tr>
<td>Northern Ireland</td>
<td>Age, Sex, Mortality, Socio-economic status</td>
<td>Health Board Allocation Formula</td>
</tr>
<tr>
<td>Norway</td>
<td>Age, Sex, Mortality</td>
<td>Local Government Financial System</td>
</tr>
<tr>
<td>Scotland</td>
<td>Age, Sex, Mortality</td>
<td>Health Authority Revenue Allocation Scheme</td>
</tr>
<tr>
<td>Sweden</td>
<td>Age, Socio-economic status</td>
<td>Stockholm County Hospital Resource Allocation Formula</td>
</tr>
<tr>
<td>Switzerland</td>
<td>Age, Sex, Region</td>
<td>Federal Association of Sickness Funds Risk Adjustment Scheme</td>
</tr>
<tr>
<td>USA</td>
<td>Age, Sex, Socio-economic status</td>
<td>Medicare</td>
</tr>
<tr>
<td>Wales</td>
<td>Age, Sex</td>
<td>Health Authority Allocation Formula</td>
</tr>
</tbody>
</table>

Source: Rice and Smith 1999
Countries use NBFs to allocate healthcare resources. Each country grapples with finding a set of need indicators and achieving an acceptable balance between equity and efficiency concerns. The table reveals that Canada is the only country that does not use age as a need indicator and ages suggests importance given its prevalence around the world. Some countries go further to capture unmet needs or other unavoidable barriers to ensure access to healthcare services; for example, some countries use a type of socioeconomic metric, and some use a location metric to allocate resources. Although Table 1 is useful for policymakers interested in designing an NBF, policymakers need to know why an NBF exists in the first place. The answer to this question requires a detailed analysis of the countries and their contextual background of the adoption of the specific NBF.

Chapter 3 Methodology: Drawing Lessons

The theoretical framework and technical composition of formulas around the world are helpful to policymakers designing an NBF but neglect the contextual reality of a given country. Policymakers need to know if a technical formula is acceptable given the present context. For this reason, a comparative study is helpful because policymakers can draw lessons from other countries, discovering how to balance equity and efficiency concerns, justify formula composition, and gauge the political climate necessary to foster policy change. Therefore, to assess the suitability of an NBF, Canadian policymakers can methodically compare Canada to a similar country using a needs-based approach.

This study compares Canada and Australia by observing the contextual history of developing a transfer allocation formula. Australia is ideal to compare with Canada because both countries are federations, members of the British Commonwealth, and constitutional monarchies with similar political structures. The two countries share large geographic landmasses and have Aboriginal populations spreading throughout the country (Watts 2008). However, the two countries have adopted different allocation formulas to address the vertical and horizontal imbalances present in the federation. Australia is a highly centralized federation where the Commonwealth holds substantial revenue raising and expenditure power and, in turn, uses the power to influence state policy decision-making through transfers. In contrast, Canada is highly decentralized as the federal government has retreated from healthcare policymaking (Boothe 1996). The comparative study is important in understanding the contextual differences, determining the federal transfer system in each respective country, and allowing policymakers to evaluate if Australia’s approach to federal transfers is desirable and feasible in Canada.

To narrow the focus of the study, this comparative analysis examines the equalization institution of Australia and CHT of Canada. Equalization and CHT are comparable because both attempt to address vertical imbalances and help subnational governments meet healthcare needs. The Australian equalization transfer is the natural counterpart to CHT. The policy objective of CHT is to support the provinces in providing reasonable access to Medicare services by providing provinces with funds to spend on their Medicare programs, and the policy objective of equalization in Australia is to ensure Australians have comparable access to public services. Overall, the two programs have the same overall objective to provide a national standard of services for the respective population.
Although equalization in Australia lacks specificity to healthcare, the alternative transfer Australia uses to fund Medicare is incompatible to the funding scheme of CHT. Medicare in Canada is a jointly funded provincial jurisdiction with the provincial governments providing the majority of funding and the federal government providing supplementary funds through CHT. Australian Medicare is a joint federal and state jurisdiction funded by each government. The Commonwealth has its own health jurisdiction whereas states have their own health jurisdictions. The difference between the two countries is that Canada’s federal government transfers money to the provinces where provinces use the money to fund their own Medicare schemes, while Australia’s Commonwealth government transfers money through the states to pay for Commonwealth Medicare responsibilities (Parliament of Canada 2005).

Using equalization and CHT, the study adopts a historical institution perspective to examine Canada and Australia. Historical institutionalism attempts to explain how institutions formed. Arguing that institutions form incrementally over time historical institutionalists also contend institutions sometimes drastically change through radical revolution called punctuated equilibrium (Cambell 2004). Historical institutionalism is helpful for policymakers because the theory helps uncover specific reasons why and how policies change in a given context. Policymakers can draw lessons from the historical analysis, translate knowledge into the given Canadian context, and form an understanding of how and why Australia made the trade-off between equity and efficiency in designing an NBF. Thus, historical institutionalism provides a foundation for contextualizing the Canadian and Australian transfer systems.³

Learning from the Australian experience through comparison is the purpose of the comparative study. By drawing lessons from Australia and applying them to the Canadian context, policymakers can potentially develop a working NBF for CHT. Advantageously, scholars have identified a number of methods in transferring policies from one country to another (Dolowitz 2009; Bennett and Howlett 1992; Rose 2005). Bennett and Howlett (1992) identify three types of policy transfer learning: government learning, social learning, and lesson drawing. Each type is concerned with separate purposes: government learning changes governmental structure, social learning examines shifting paradigms, and lesson drawing concerns changing programs. Because CHT is a government program, lesson drawing is an appropriate method.

This study follows the comparative study procedure outlined in Learning from Comparative Public Policy (Rose 2005). Rose’s (2005) book provides a guide in conducting a comparative analysis for drawing lessons and enacting policy change. Using three steps, the study compares the transfer systems of Canada and Australia in a contextual manner, draws lessons from the Australian experience, and finds applicable lessons for Canada. Step 1 is to explore Canada’s federal transfer system and its technical and contextual development over time. Step 2 is to examine Australia’s federal transfers in both a technical and contextual way. Finally, step 3, a comparison between step 1 and 2, is to draw relevant lessons from the Australian experience that policymakers can apply in creating an NBF for the Canada Health Transfer

³ To establish the context, varieties of sources are needed, ranging from government documents, peer-reviewed journal articles, commissions, and news articles. Government statistics and historical information on transfer development comes from the relevant government websites and data came from databases of the Australian Bureau of Statistics and Statistics Canada.
Chapter 4 A Comparative Study of CHT and Australian Equalization

4.1 Step 1: The Canadian story

In a federation, transfers are a tool to secure nationhood by keeping the country together and providing a minimum standard of public services. The Canadian federal transfer system is the product of institutional evolution and political decision-making. Transfers for Canadian Medicare underwent three major changes: program inception in 1957, the creation of Established Program Financing (EPF) in 1977, and the equal-per-capita formula change in 2014.

In 1946, Prime Minister King called the premiers together to formulate a national Medicare scheme on the condition the federal government retained full control over income taxes and other tax areas it had appropriated during the war. The Western provinces obliged and were prepared to yield tax autonomy to gain a national healthcare scheme. However, Ontario and Quebec opposed the proposal, and King’s plan failed. Consequently, the nationalization of healthcare failed because of conservative ideology in Quebec, Ontario, and within the federal cabinet. The result of the federal and provincial negotiations was a gradual reduction of federal power over income taxation in favour of the provinces, giving them more autonomy in spending their own source revenue on provincial jurisdictions, including healthcare.

Observing the growing public support for national health care and undergoing intense negotiations with the province of Ontario, the federal government eventually adopted a national Medicare program in 1957. One by one, the provinces joined in the cost-sharing mechanism with Quebec being the last to join in 1961. The federal government provided up to 50% of funding for provincial Medicare schemes, and the arrangement lasted until 1977. Quebec’s resistance to federal interference in provincial autonomy was quieted with the Liberals gaining power in Quebec and the beginning of the Quiet Revolution. Quebec opted out of the national scheme but retained cost-sharing funding from the federal government because the province met minimum federal standards on providing Quebecers access to medically necessary services. This option was available to the other provinces, but Quebec used this course of action to demonstrate provincial autonomy (Lecours and Beland 2009).

By 1977, Canada had a national Medicare scheme jointly funded by the federal government and the provinces, but increasing healthcare costs were troublesome for both levels of government. The Trudeau Government argued the ideal method of decreasing their costs for healthcare was to abandon cost-sharing transfers in favour of block cash grants. The provinces unanimously opposed the federal government’s recommendations. Ontario, Quebec, and Alberta argued for tax room, claiming the federal government had fulfilled its role of establishing a national program and provinces were capable of dealing with their own constitutional jurisdiction. British Columbia opposed the change for fear of budget caps whereas Saskatchewan saw a threat to national standards. The compromising solution was half tax points and half cash distributed on an equal-per-capita total transfer basis under a new program called EPF (Telford 2003).

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4 King later wrote that the government avoided commitment to a national Medicare program because of interest in staving off another depression and keeping unemployment down (Finkel 2006).
Through EPF in the 1970s, the federal government found a way to contain its ballooning cost of Medicare, which resulted in provinces instituting medical user fees. Medical professionals, labour unions, and Canadians opposed what they perceived to be the deterioration of universal Medicare. The 1980 Hall Report criticized the use of user fees as contradictory to the principles of Medicare, which gave the federal government political ammunition to blame the provinces for eroding Canada’s national Medicare (Gray 1991). The report claimed Canadians wanted a universal health system free at the point of use. In turn, the federal government passed the Canada Health Act in 1984, enshrining the five principles of Medicare, which were federal conditions provinces had to meet to receive EPF. Shortly after its passage, the provinces slowly removed user fees. The introduction of EPF and the CHA demonstrated two major shifts in the federal transfer system. First, the federal government desired to remove itself from a costly Medicare scheme, leaving the provinces to manage costs. In addition, the federal government, with the support of the Canadians, assumed the role of protectorate of national Medicare by using financial incentives.

In 1995, the federal government scaled back its transfer spending and changed EPF into the Canada Health and Social Transfer (CHST; Rangarajan and Srivastava 2004). The change in 1995 was different from the change in 1977. In 1977, the federal government changed from cost sharing to bloc funding without decreasing the total cash transfer. In 1995, bloc funding remained, and cash transfers were substantially cut. The provinces claimed the federal government balanced its books by exploiting the provinces by cutting transfers (Madore 1997). Tensions were high between the two levels of government whereby the provinces claimed a substantial vertical imbalance existed, but the federal government denied any imbalance.

A decade later, the federal government managed to regain provincial support through the health accord in 2004 whereby the federal government split the CHST and created independent CHT and Canada Social Transfer (CST). The government injected more money into CHT, making it the largest federal transfer, and promised a 6% annual increase in CHT funding. This new money provided stability for the provinces and guaranteed funding until the expiration of the health accord in 2014. Despite efforts, the federal government could not fix the divide between provincial and federal governments, which was largely caused by cuts to federal transfers. The result of federal cuts was the creation of the Council of the Federation (COF), a body composed of all premiers without the federal government. The body’s initial goal was to find methods to fix healthcare issues (Collins 2011).

In 2006, the COF commissioned a study to examine the fiscal imbalance in Canada. The committee based its findings on the principles of transparency, accountability, adequacy, predictability, equity, and fairness. By recommending CHT and CST be distributed on an equal-per-capita basis, the advisory panel made the allocation process highly transparent and predictable. Furthermore, the panel recommended dropping tax point transfers to avoid the confusing process of deciding tax point transfers determined by the federal government.

Shortly after the COF commissioned the report, the Conservative Party gained power and pledged to end the vertical imbalance by working with the provinces to rebalance the federation. In 2007, the Harper Government promised to fulfill the recommendation of the COF report on
allocating CHT, starting in 2014. The final change in 2014, combined with the Harper government’s desire to increase provincial autonomy, reveals a long process of a diminished relationship between the federal government and provinces, resulting in the COF demanding the federal government all but remove itself from Canadian Medicare.

The history of Canada’s Medicare transfer system is lengthy, and Table 3 provides a summary of the formula change over time. Starting in 1957, the table illustrates how the federal and provincial governments shared the burden of Medicare and collaborated towards a national system while respecting provincial autonomy. The table reveals the federal and provincial governments eventually drifted apart with the federal funding mechanism changing from cost sharing to both cash and tax transfers, ending at a cash only contribution.

Table 3: History of Allocation Formula for Federal Transfers for Medicare in Canada

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<thead>
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<tbody>
<tr>
<td>Program Name</td>
<td>Hospital Insurance and Medicare</td>
<td>EPF</td>
<td>CHST</td>
<td>CHT</td>
<td>CHT</td>
</tr>
<tr>
<td>Formula</td>
<td>Cost Shared 50/50</td>
<td>Equal Per Capita Cash and Tax Points</td>
<td>Equal Per Capita Cash and Tax Points</td>
<td>Equal Per Capita Cash and Tax Points</td>
<td>Equal Per Capita Cash</td>
</tr>
</tbody>
</table>

4.2 Step 2: The Australian story

Whereas Canada developed into a highly decentralized federation, Australia advanced into a highly centralized federation. Fiscal federalism, punctuated by major events, evolved gradually in Australia, setting the country on a path towards centralization and strong cooperation between the Commonwealth and state governments. The major events signalling Australia’s drive towards centralization and cooperative federalism are the establishment of the Commonwealth Grants Commission, the Uniform Tax Act, “new federalism,” and the introduction of the goods and services tax (GST). Each event is an example of punctuated equilibrium shifting the trajectory of Australian federalism.

The years following federation demonstrated the fiscal disparities between states. The Commonwealth Government controlled major revenue sources but removed itself from political decision-making at the state level by allocating three-quarters of its raised revenue on an equal-per-capita basis. The states of Western Australia, South Australia, and Tasmania complained an equal-per-capita transfer was insufficient to meet their financial needs and that federation created more economic problems for them than independence. To keep the country together, the

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5 The government delayed changes to CHT until 2014 because the health accord signed by the federal government and the provinces in 2004 did not expire until 2014.
6 Australia has 6 states: New South Wales, Queensland, Western Australia, South Australia, Tasmania, and Victoria.
Commonwealth arranged for unconditional special payments to poor states that demonstrated fiscal need (Collins 2011).

The process was ad hoc, and need was assessed by special state committees in consultation with Commonwealth appointed committees. The ad hoc process ended when Western Australia threatened secession, and the Commonwealth agreed to an independent commission responsible for special grant allocations. The union was preserved, and the Commonwealth Grants Commission (CGC) was created in 1933 (CGC 2008). CGC became the independent arbiter responsible for unconditional transfers between the Commonwealth and state governments. CGC methods were intended to “ensure that a claimant State had the financial capacity to provide the same range and quality of services as the standard States, as long as it imposed the same range of taxes and charges at the same rates as the standard States” (CGC 1995, xiv). Adhering to this principle ensured a fair approach to financial management and the preservation of the federation.

The Uniform Tax Act, passed in 1942 and lasting until 1976, marks a watershed moment when the Commonwealth assumed major financial power over all income taxes. During the Second World War, the Commonwealth accrued income taxation rights, allowing the Commonwealth to collect all income taxes both during and after the war. The Commonwealth gained legal standing through the High Court when the court ruled on the Uniform Tax Act, granting the Commonwealth power to collect income taxes and transfer revenue to the states using conditional grants. The High Court cited section 96 of the Constitution whereby the Commonwealth is privileged in making any grant it wishes to the states, provided the states accept the grant (Twomey 2014).

By 1946, the Commonwealth collected over 80% of all tax revenue but was responsible for half of expenditure needs (Dollery 2001). The Commonwealth expanded its expenditure role by assuming more responsibility for social programs, including hospital insurance, pharmaceuticals, and pensions. The trend towards a more centralized and nationalized system was allowed because successive labour governments at national and state levels promoted both national unity and the role of the Commonwealth in providing equitable public services to Australians. At the time, the Commonwealth was the ideal government to achieve these goals, and states, for the most part, supported the centralization of power in the Commonwealth. The Commonwealth obtained major taxation power at the end of the Second World War. The government utilized its financial power by using two types of transfers to the states: unconditional equalization and conditional special purpose payments (SPP) transfers. Equalization allocation, determined by the CGC, supports all public services in the states, and SPP, determined by the Commonwealth, supports specific services funded directly by the Commonwealth. The war allowed the Commonwealth to retain tax power and shifted the country towards centralization but over time, subsequent liberal governments challenged the balance.

The defeat of the Whitlam Government by the liberal Fraser Government in 1975 marked an important change in Australian federalism in which the Commonwealth adopted the “new

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7 SPP are highly specific and complex and program specific. The role of SPP expanded during the years after the Second World War under the Whitlam Labor Government where the Commonwealth government sought to establish a national welfare state. Until the Rudd government in the 1990s, there were 90 SPP categories, and each determined by negotiations between the state and Commonwealth governments.
federalism” approach (Saunders and Wiltshire 1980). New federalism was a different view of the role of government itself, arguing the role was becoming large and had been increasing since the 1960s’ Whitlam Government (Dollery 2001). The Fraser ideology was to cut government spending through privatization of sectors of healthcare and other social services. Introducing the States (Personal Income Tax Sharing) Agreement Act 1978, the Commonwealth transferred a fixed 39.87% of the personal income tax to the states based on per capita “relativities” in exchange for reducing SPP (Wallack and Srinivasan 2006, 122-123).8

The CGC reviewed all relativities and recommended how to distribute the new tax revenue to the states. After the Commonwealth transferred a fixed amount based on CGC recommendations and simultaneously reduced SPP to the states, state governments were not impressed with the new arrangement and argued the Commonwealth should vacate income taxes and devolve all income tax revenue to the states. Some states, however, argued against this proposal on the grounds of unnecessary administrative cost for the states.

The Labor Party returned to power in 1983 and shifted Australian fiscal federal policy again. In exchange for reducing SPP, both the Hawke Government and subsequent Keating Government increased equalization payments. By changing the total allocation budget for equalization from a percentage of personal income tax revenue to a percentage of total general revenue, the Commonwealth regained all personal income tax revenue. States preferred to meet fiscal needs by using unconditional grants rather than depend on SPP or raise their own source revenue (Boothe 1996). To achieve a more efficient use of government sources, the CGC adopted the principle of full fiscal equalization.9

The NBF is politically feasible in Australia because the country is committed to achieving full horizontal equity and because the CGC is an independent arbiter for the states, thus diffusing political tension between the Commonwealth and state governments. Furthermore, through the CGC, the Australian governments agree to the principles of full fiscal equalization and balance equity and efficiency concerns. Each formula variable has undergone intense scrutiny by the Commonwealth and state governments to create a fair formula, satisfying both levels of government. For example, a contentious variable in the formula is rural location. The Commonwealth asked the CGC to review the effectiveness of using rural location in the formula. States demanded the rural location variable remain, and the CGC found no empirical evidence existed to suggest rural location effected need or efficiency distortion (CGC 1995). The example demonstrates that through negotiations and research, Australia has been able to find a balance between equity and efficiency in its own context to create a feasible NBF.

In 2000, the last major change to the Australian fiscal federal system occurred when the Commonwealth gave 100% of GST revenue to the states (Hollander 2008). By giving the

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8 A “relativity” is a number reflecting the general strength of a state economy. If a state’s relativity is below one, which is the national average, the state receives less; a state with a greater number than one receives more in equalization (CGC, 2015).

9 Full fiscal equalization assesses the fiscal capacity and expenditure need of each state instead of the fiscal need of each state. Fiscal need is the required funding needed to meet government priorities given revenue deficiencies (Clemens and Velduis 2013). For example, because a state cannot raise sufficient money to meet its budgetary needs, the Commonwealth allocates sufficient funds to the state to cover its budget deficit. Fiscal capacity and expenditure need are determined by factors outside government control.
revenue to the states, the Commonwealth renounced a large amount of autonomy. Following this change, the CGC immediately became responsible in determining how to allocate the GST, which is the source of equalization funding to the present day, and continued the use of full fiscal equalization. The allocation formula has been unchanged since GST inception in 2000, but the Commonwealth has attempted to change the fiscal arrangement through its negotiations with the states.

Table 4 summarizes the history of federal transfers in Australia. Initially, transfers met a claimant (relatively poor) state’s budgetary deficiencies. Funding these deficiencies came from the Commonwealth instead of non-claimant (relatively rich) states. Transfers changed under the Fraser Government where personal income tax became the source of transfer funding, and states became eligible to receive funding. The year 2000 brought change to the major source of transfer funding and the principles of the transfer system. Australia’s transfer system adopted the principle of full fiscal equalization whereby states received funds for revenue and expenditure deficiencies outside state control. The change to full fiscal equalization meant Australia adopted a more efficient outlook on federal transfers and retained the equity principle of meeting state expenditure and revenue needs.

Table 4: History of Federal Transfers in Australia

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<tbody>
<tr>
<td>Source Funding</td>
<td>Commonwealth General Revenue</td>
<td>Personal Income Tax Revenue</td>
<td>GST</td>
</tr>
<tr>
<td>Transfer Type</td>
<td>SPP</td>
<td>Equalization</td>
<td>Equalization</td>
</tr>
<tr>
<td>Purpose</td>
<td>Eliminate Budget Deficiencies of Claimant States</td>
<td>Meet Fiscal Need of All States</td>
<td>Full Fiscal Equalization</td>
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4.3 Step 3: Comparing Canada and Australia and drawing lessons

Analyzing the Canadian and Australian federal transfer systems reveals more differences than similarities. The major divide between the two federations occurred at the end of the Second World War when the two countries chose separate paths in dealing with fiscal federalism. Canada addressed the vertical imbalance through transfers and tax allocations, and Australia used transfers. The horizontal imbalance in Canada equalizes provincial fiscal capacity, and Australia equalizes based on both fiscal capacity and expenditure need. Because Australian states recognized poorer states had poor fiscal capacity to meet their expenditure needs, the states and Commonwealth agreed to mitigate these differences through an NBF.

Because of the vertical and horizontal fiscal gap, Australia developed and maintained a needs-based allocation for equalization. The Commonwealth and other states agreed financial

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10 Autonomy is increased because equalization is unconditional while SPP are conditional, and GST is substantially larger than SPP grants. In addition, GST is transparent because states know where funding comes from as opposed to general revenue, which is not transparent.
assistance should help less affluent states meet budgetary deficits. In addition, the High Court allowed the Commonwealth to retain fiscal power over the states, making the states dependent on Commonwealth grants. Although states preferred tax room to conditional grants, states were confident the CGC would represent their interests to meet their needs and, thereby, went along with using the NBF developed by the CGC. Therefore, Australia adopted and maintained an NBF because of a strong degree of political cooperation between the Commonwealth and the states.

The final point is evident in the presence of COAG, a formal institution dedicated to ensuring all governments work together (Warhurst 2007). Evidently, the historical development of Australia illustrates the states and Commonwealth were willing to work together to mitigate the inherent imbalances throughout the federation. The adoption of the needs-based approach at the time of the Great Depression illustrates the states recognized inherent differences in fiscal capacity and that expenditure need would not dissipate over time. By introducing the CGC, an independent body was allowed to meet the requirement of mitigating financial differences between the states. Appropriately, the Uniform Tax Act and the High Court ruling made the Commonwealth financially responsible for mitigating the horizontal differences through the CGC. The formal institution of COAG solidified an existing relationship whereby the Commonwealth and states could work together to face future challenges and maintain the strong relationship developing over the country’s history. These points form a context where Australia could adopt and maintain the needs-based approach for its fiscal transfer system.

Australia adopted the needs-based approach in the 1930s, but the Canadian federal government was less concerned with reshaping fiscal federalism and more concerned with staving off another Great Depression after the Second World War. The provincial governments of Ontario and Quebec did not agree with the social progressives in the West who wanted the federal government to establish a strong national social welfare system. Therefore, Ontario, Quebec, and the federal government had little desire to centralize taxation and develop national major social policy, at least in the years after the war. The federal government chose decentralization, giving the provincial governments the fiscal power to meet their needs instead of taking a centralist approach. Health policy development began at the provincial level with the federal government playing catch-up to create a national Medicare scheme under political pressures.

The 1970s marked a change in federal transfers in both countries. The federal and state or provincial governments agreed to new arrangements in taxation powers. The federal government in Canada stopped cost-sharing transfers in favour of cash and tax point transfers. Australia did not remove cost-sharing arrangements but reduced the amount of funding transferred in favour of unconditional grants. Regardless, in the 1970s, both the Canadian and Australian federal governments wanted to reduce the burden of spending. The Canadian federal government feared increasing healthcare costs, and the Fraser government in Australia preferred a limited role of government in areas of social policy. Canada’s Trudeau government removed cost-sharing arrangements for Medicare and established bloc funding, which included both income tax points and cash grants; simultaneously, the Fraser government cut SPP for all states equal to the value of income tax received by the state. At the federal level, the governments attempted to reduce financial responsibility and maintain a national standard of Medicare. Canada accomplished this goal through the CHA and the Canadians’ desire to preserve their Medicare system free of user
fees, and the Commonwealth in Australia retained fiscal power by ensuring states were still dependent on federal grants.

Federal grants underwent drastic changes in the 1990s when Canada’s federal government unilaterally slashed federal transfers to the provinces. Australia’s federal government made federal transfers efficient by instituting full fiscal equalization and substantially reducing the number of SPP. The changes in Canada created a highly distant relationship between the provinces and the federal government: the provinces formed the Council of the Federation for solving provincial issues without the federal government. Australia moved in the opposite direction and established COAG, a national body with members of the states and Commonwealth.

Policymakers can draw lessons from the Australian story to determine if adopting an NBF is practical for Canada. Although changes in Australia’s federal history are the result of institutional decisions, including the High Court’s interpretation of the constitution favouring the Commonwealth or the Uniform Tax Act solidifying the Commonwealth’s dominance over tax revenue, the Australian federation became a cooperative federation because the states and Commonwealth were willing to work together to meet national objectives. Initially, the country focussed on equity in providing public services, regardless of location. The required cooperation and trust for achieving this goal came through the CGC whereby it made non-partisan decisions based on evidence. Over time, efficiency became important to both levels of government, reflected in the CGC’s adoption of full fiscal equalization. Throughout its history, both levels of government in Australia have been able to work together to secure national unity and standards for public services.

Canada’s story of federal transfers demonstrates a divide in respecting autonomous provincial jurisdiction. Initially, the two levels of government worked together through cost-sharing agreements towards a national standard in healthcare and social services, but after the transferring of tax points to provinces in 1977, the federal government slowly retreated from the field of provincial social policy. The provinces achieved their goal of autonomy gradually, and the federal government withdrew from Medicare policymaking, culminating in the equal-per-capita cash transfer of 2014. A change to a needs-based approach would require a fundamental shift of the federal and provincial relationship away from clear divisions of jurisdictional power towards a cooperative federation to meet national Medicare needs.

One-lesson Canadian policymakers can learn from Australia to increase the likelihood of a needs-based CHT is its governance structure. The presence of the CGC and COAG reduces political tensions between both levels of government, reduces political tension between the Commonwealth and state governments in the contentious zero-sum game in allocation transfers, and allows formal cooperation (Lecours and Beland 2013). The CGC is an independent organization, using evidence and transparent criteria to recommend how to allocate equalization in Australia (McLean 2002). The Commonwealth respects the CGC and its judgements, and the CGC listens to the concerns of the states. The CGC revisits its methodologies on a quinquennial basis and consults with states and stakeholders on potential changes to the formula. The Commonwealth occasionally asks the CGC to review its allocation methodologies given certain criteria.11 The CGC listens to the arguments put forward by states and stakeholders and weighs

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11 For example, in the 1980s the CGC was asked to review the efficiency of its rurality variable.
their arguments against the principles of full fiscal equalization. States can dispute CGC decisions, but the allocation is a zero-sum game.

The strongest lesson policymakers can draw from Australia is the presence of COAG, a formal body where state and Commonwealth governments collaborate on fixing issues. Australia has an equivalent body to the COF in Canada, called Council of the Australian Federation. The purpose of the Council of Australian Federation is to meet prior to COAG meetings where states can find common ground with united ideas and potential solutions to policy problems before approaching the Commonwealth (Twomey and Withers 2007). Canada does not have an equivalent federal nor provincial body to COAG. Although premiers casually meet, there is no formal institution designed to facilitate provincial and federal cooperation. As demonstrated by Australia’s COAG, an independent body allows the federal and state or provincial governments to unite ideas and combat national issues.