ANALYSIS

Assessing Canada's Health Accords 2000–2023: Buying Time or Buying Change?

INTRODUCTION

As the COVID-19 pandemic progressed, leaders across Canada became increasingly concerned about its impact on health system sustainability. Premiers called on the federal government to increase its share of provincial and territorial health spending from 22% to 35%, an increase of $28 billion a year.

On March 28, Ottawa tabled a new budget, with health funding including: $196.1 billion over 10 years through increases to the Canada Health Transfer (CHT) and bilateral funding agreements focused on four key priorities — family health services, health human resources and reducing backlogs, mental health and substance use services, and standardized health data and digital tools. An additional $2.5 billion over 10 years to support Indigenous priorities and complementary federal support brings the total to $198.6 billion over 10 years.

Is it a good deal? Premiers expressed initial disappointment when the federal government put forward a new health funding proposal on Feb. 7. But following a meeting of the Council of the Federation on Feb. 13, they decided to accept it. Details of bilateral agreements will be made public as they are completed.

The CMA commissioned this paper to compare this new funding package with previous health accords, focusing primarily on the amount of funding committed by the federal government and accountability measures.

FUNDING

Health accords — a feature of health care federalism since 2000 — have varied in terms of the magnitude of the funding provided.

Looking only at the nominal value of the investment, the 2023 health funding agreement appears to be the largest, followed by the 2004, 2003 and 2000 accords and, in last place, the 2017 Common Statement of Principles on Shared Health Priorities.

However, there are confounding variables such as different durations (five versus 10 years), how increments in the value of health transfers are counted, and the impact of inflation over time. And while the 2000 and 2003 accords included the total cumulative value of increases in health transfers over the base year, the 2004 accord and the 2017 deal did not.

Table 1 compares the value of the accords with adjustments for duration and inflation, and to factor in the cumulative value of health transfer increases during the period in question. Nominal spending figures have been deflated using an appropriate price inflation index and an average annual increase has been derived to enable comparisons. For the 2004 accord and the 2017 and 2023 agreements, the full value of transfer increases has been noted to allow for a proper comparison with the 2000 and 2003 accords.

Table 1: Comparison of health accords

	Total nominal value	Average annual increase	Total inflation — adjusted value[1] (2022=100)	Average annual increase
2000 Health Accord	$23.4B/5 yrs	$4.7B/yr	$33.1B/5 yrs	$6.6B/yr
2003 Health Accord	$34.8B/5 yrs	$7B/yr	$48.5B/5 yrs	$9.7B/yr
2004 HEALTH ACCORD				
Incremental $ only	41.3B/10 years	$4.1B/yr	51.6B/10 yrs	$5.2B/yr
Total w/full CHT increase[2]	$98B/10 yrs	$9.8B/yr	$122.6/10 yrs	$12.3B/yr
2017 COMMON STATEMENT OF PRINCIPLES				
Targeted $ only	$11.5B/10 yrs	$1.15/yr	$10.6B/10 yrs	$1.1B/yr
Total with CHT increase[2]	$108B/10 yrs	$10.8/yr	$94.6B/10 yrs	$9.4B/yr
2023 HEALTH AGREEMENT				
Targeted $ + CHT top-up	$56.5B/10 yrs	$5.7/yr	$48.1B/10 yrs	$4.8B/yr
Total w/ full CHT increase[2]	$198.6B/10 yrs	$19.9/yr	$159.9B/10 yrs	$16B/yr

[1] Note: spending was deflated using Statistics Canada's GDP deflator for general government services from 2000 to 2022. Forecasts of GDP inflation from the 2022 Fall Economic Update were used to deflate spending in 2022 and onward.

[2] Includes targeted funding from the line above.

These results, too, show that the 2023 health funding agreement is the largest, at an average of $16 billion per year in increases over 10 years. The 2004 Health Accord is second with an average increase of $12.3 billion per year, followed by the 2003 Health Accord and the 2017 Common Statement of Principles at an average of $9.7B and $9.4 billion per year, respectively. The 2000 Health Accord comes in last at $5.2 billion annually.

Another important aspect of the accords has been the balance between targeted funding and general transfer increases.

As shown in **Table 2**, except in the 2003 accord, general transfer increases through the Canada Health and Social Transfer (CHST) or CHT have accounted for upwards of 80% of the value of the accords. Earmarked transfers (i.e., transfers under the CHST/CHT with a designated purpose) were used in the 2000, 2003 and 2004 accords but not where bilateral funding agreements were deployed in 2017 and 2023. These other forms of targeted funding, including bilateral funding agreements, trusts and federal grants and contributions, varied between 0.5% and 19.5% of the total value of accords.

Table 2: Share of targeted funding in health accord

	General transfer increase as % of total	Earmarked transfer as % of total	Other targeted funding as % of total
2000 Health Accord	81.4	9.4	9.2
2003 Health Accord	34.5	46	19.5
2004 Health Accord	93.9	5.6	0.5
2017 Common Statement of Principles	89.4	-	10.6
2023 health agreement	81.2	-	18.8

ACCOUNTABILITY

Accountability around federal health accord investments has been a common theme across all accords. Anticipating this, PTs negotiated the inclusion of new accountability rules for social programs in the 1999 Social Union Framework Agreement (SUFA) that placed the emphasis on jurisdictions reporting results to their residents rather than to the federal government. Under SUFA, the federal government also committed to work collaboratively with all PT governments to identify Canada-wide priorities and objectives, and to allow each to determine the program design and mix best suited to their needs.

The most common feature of the accountability regime in all of the accords has been a shared commitment by all governments to measure and report to their residents using a mutual set of metrics. Some of the accords have been quite precise, whereas others have provided more general direction on areas to be addressed and have mandated third parties to consult experts and stakeholders to establish the indicators.

The 2003 accord, for example, included a commitment to accessible primary care 24/7 but did not have a precise goal. This opened the door to different interpretations of success, including referencing 24/7 telehealth services, which was not the original intent.

The 2004 accord did include the establishment of evidence-based wait time benchmarks for select procedures, as well as targets to improve performance. The Canadian Institute for Health Information (CIHI) began reporting on them the following year and showed that funding of $5.5 billion through the Wait Times Reduction Fund delivered on access to procedures within designated time frames for over eight in 10 Canadians.

In the case of the 2017 Common Statement of Principles, CIHI consulted with stakeholders and experts to develop 12 common indicators for home care and mental health. After health ministers endorsed them in 2018, CIHI rolled out the chosen indicators in stages and, in December 2022, included the results in its annual progress report on shared health priorities.

The 2017 agreement also added accountability features to ensure that PTs used targeted federal funding as intended. As part of the bilateral health agreements, PTs were required to provide action plans describing how they would invest federal dollars in accordance with the priorities identified in the Common Statement of Principles and to attest annually to Health Canada that federal funding had been spent in accordance with those action plans, with any variances accounted for.

The 2023 health funding agreement improves the prospects of enhanced accountability, based on the work of the Expert Advisory Group on a Pan-Canadian Health Data Strategy. To receive their CHT allocation during the first five years of the agreement, PTs must align to national data standards and policies, including shared governance and ensuring interoperability of electronic health records.

The agreement also includes $25 billion over 10 years that will support bilateral agreements with PTs. PTs will be required to develop action plans for how funds will be spent and how progress will be measured. The investments are to be focused on four priority areas: expanding access to family health services, supporting health workers and reducing backlogs, improving access to mental health and substance use services and modernizing the health system with standardized health data and digital tools.

The bilateral agreements will be underpinned by key principles, including upholding the *Canada Health Act*, support for the principles of the 2017 Common Statement of Principles, reconciliation with Indigenous Peoples and equal access for equity-seeking groups and individuals.

DELIVERING RESULTS

What the health accords have delivered in concrete terms is difficult to determine, and the issues that have compelled governments to pursue intergovernmental agreements with promises of new federal investments remain. Wait times, accessibility concerns and gaps in the health workforce not only persist but have been aggravated by the pandemic. Canadian health systems still do not provide deep and consistent coverage of prescription drugs, home care and mental health services; Canada continues to underperform in the Commonwealth Fund's international comparisons of health systems.

However, the accords have served to mobilize collaboration among governments and stakeholders on common challenges, increasing capacity to take action, measure results and share best practices. Investments in traditionally underfunded areas such as home and community care, long-term care and mental health and substance use are also accelerating.

And so, once again, the 2023 health funding agreement sets the table for health reforms with significant federal investments, clearly defined priorities targeting shared challenges and a more robust accountability framework.

CONCLUSION

Although federal/provincial/territorial health accords vary by scope and funding, they embody an evolving health care reform agenda centred around reducing wait times and improving access to primary care, home care, mental health services and prescription drugs.

Compared to other accords, the 2023 health funding agreement represents the most significant federal investment in health care in more than two decades.

In addition, new provisions in the agreement requiring jurisdictions to participate in a pan-Canadian health data strategy provide some hope of further progress in strengthening accountability.

The 2023 health funding agreement is an opportunity for governments to demonstrate to Canadians that they can work together to make meaningful and transformative changes to the way health care is delivered across the country.

Will they take that opportunity? There is nothing standing in the way of developing high-performing health systems in Canada other than political will. The need for change has never been greater.

This report was prepared by health policy consultant Marcel Saulnier.

	New funding	Key areas of focus	Key initiatives	Accountability approach	Goals & targets
2000 Health Accord	$23.2B over five years, of which $18.9B for health care through the CHST, $2.2B targeted for early childhood development through the CHST and $2.1B in targeted funding	• Access to care • Health promotion and wellness • Primary health care • Health human resources • Home and community care • Pharmaceuticals management • Health information and communications technology • Health equipment and infrastructure	Primary Health Care Transition Fund Medical equipment fund Early childhood development Information technology (initial investment leading to creation of Canada Health Infoway)	Each jurisdiction reporting to residents based on common metrics of health status, health outcomes and quality of care	No specific goals or targets included
2003 Health Accord	$34.8B over five years, of which $12B through general transfers, $16B through the Health Reform Fund and $6.8B in targeted funding	• Primary care • Home care • Catastrophic drug coverage • Access to diagnostic and medical equipment • IT and electronic health records • Patient safety • Health human resources • Technology assessment	Creation of the Health Reform Fund to support primary care, home care and catastrophic drug coverage Creation of the CHT starting in 2004 Diagnostic/medical equipment fund	Each jurisdiction reporting to residents based on common metrics of quality, access, system efficiency and effectiveness Creation of Health Council to monitor and make annual public reports on the implementation of the accord	At least 50% of residents have access to an appropriate health care provider 24/7 by 2011 First-dollar coverage of a minimum basket of home care services by 2006 First ministers to take measures, by the end of 2005–06, to ensure that all Canadians have reasonable

	New funding	Key areas of focus	Key initiatives	Accountability approach	Goals & targets
		• Health innovation • Aboriginal health • Health promotion			access to catastrophic drug coverage
2004 Health Accord	$41.3B over 10 years, of which $35.3B through transfers, $5.5B as an earmarked transfer and $0.5B in targeted funding	• Wait times for priority procedures • Health human resources • Home care • Primary care • Pharmaceuticals • Access to care in the North • Prevention, promotion and public health • Health innovation	$5.5 billion Wait Times Reduction Fund National Pharmaceuticals Strategy New legislated 6% escalator starting in 2005–06 $500M for medical equipment	Same as for 2003 Health Accord	Achieve meaningful reductions in wait times in priority areas such as cancer, heart, diagnostic imaging, joint replacements and sight restoration by Mar. 31, 2007 Reiteration of primary care and home care commitments from 2003 Health Accord
Harper health initiatives	$1.04B to implement wait times guarantees	• Wait times • Electronic health records • Mental health • Cancer prevention and control	$612M for Patient Wait Times Guarantees (PWTG) in 2006 budget Creation of the Mental Health Commission of Canada Creation of the Canadian Partnership Against Cancer Announcement to move from 6% CHT escalator to moving average of GDP with 3% floor starting in 2017–18	PWTG implemented through series of MoUs with PTs No additional accountability measures beyond those included in the 2004 Health Accord Health Council of Canada was disbanded in 2013	No specific goals or targets

	New funding	Key areas of focus	Key initiatives	Accountability approach	Goals & targets
2017 Common Statement of Principles & bilateral agreements	$11B over 10 years for mental health and home care $500M for Patented Medicine Prices Review Board, Canadian Agency for Drugs and Technologies in Health, Canadian Institute for Health Information, Canadian Foundation for Healthcare Improvement and territorial health funding	• Mental health and addictions • Pharmaceuticals management • Health innovation • Long-term care	Home care and mental health funding provided directly to PTs Budget 2017 provided additional investments to support pharmaceuticals management Emergency Treatment Fund to support PT response to opioids crisis (supported by separate bilateral agreements) Long-term care funding commitments made in the 2020 Economic and Fiscal Update and 2021 budget	Common Statement of Principles on Shared Health Priorities sets out principles and menu of priority actions Bilateral agreements provide detailed action plans for each jurisdiction Annual reporting of progress to Canadians by CIHI based on common metrics Annual attestation by PTs that funding was used as intended	No specific goals or targets

	New funding	Key areas of focus	Key initiatives	Accountability approach	Goals & targets
2023 health investment & bilaterals	$56.5B over 10 years, of which $19.3B through transfers, $32.8B through bilateral agreements and $4.4B in other targeted investments	• Expanding access to family health services, including in rural and remote areas • Supporting health workers and reducing backlogs • Improving access to mental health and substance use services • Standardized health data and digital tools • Supporting access to home care and safe long-term care • Indigenous health	Guaranteed 5% CHT top-up Pan-Canadian data strategy to improve collection, sharing and use of health data; foster adoption of common data standards and policies; support interoperable digital health records; and create centre of excellence for health worker data Renewed funding for the Territorial Health Investment Fund Support for equitable access to quality and culturally safe health care services for Indigenous populations to be distributed through an Indigenous Health Equity Fund Pan-Canadian licensure of health professionals Wage support for personal support workers	Similar to 2017 approach, bilateral agreements provide detailed action plans for each jurisdiction Bilateral agreements to be underpinned by principles from the 2017 Common Statement of Principles, the *Canada Health Act*, Indigenous reconciliation, and equal access for equity-seeking groups Annual reporting progress to Canadians by CIHI based on an expanded set of common metrics PTs must commit to develop and use pan-Canadian health indicators and agree to pan-Canadian data standards and policies in order to access their share of CHT funding during the initial five years	No specific goals or targets

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