Re: Your request for access to information under Part II of the Access to Information and Protection of Privacy Act [HCS/043/2017]

On March 27, 2017, the Department of Health and Community Services received your request for access to the following records:

"I would like access to all briefing notes provided to the minister or deputy minister relating to the health funding agreement with the federal government reached at the end of 2016.

Furthermore, your request was clarified from October 2015 to present, and briefing notes defined as "internal" briefing notes which includes decision notes, information notes and meeting notes provided to the Minister or Deputy Minister.

As discussed, the Department has briefing binders/materials created for Federal and/or Provincial Territorial meetings (F/P/T) which would include the topic of the Health Accord. Should you require these materials please submit a separate ATIPP request for these materials.

Please note the Department of Intergovernmental Affairs, and the Premier's Office may also have records responsive to your request. Please contact the ATIPP Coordinator for these departments for further assistance.

I am pleased to inform you that a decision has been made by Mr. John G. Abbott, Deputy Minister for the Department of Health and Community Services, to provide access to some of the requested information.

Access to the remaining information contained within the records, has been refused in accordance with the following exceptions to disclosure, as specified in the Access to Information and Protection of Privacy Act (the Act):

Section 29 - Policy Advice or Recommendations
Section 34 - Disclosure Harmful to Intergovernmental Relations or Negotiations
Section 35 - Disclosure Harmful to the Financial or Economic Interests of a Public Body

As required by 8(2) of the Act, we have severed information that is unable to be disclosed and have provided you with as much information as possible.

In accordance with your request for a copy of the records, the appropriate copies have been enclosed.

Please be advised that you may appeal this decision and ask the Information and Privacy
Commissioner to review the decision to provide partial access to the requested information, as set out in section 42 of the Act (a copy of this section of the Act has been enclosed for your reference). A request to the Commissioner must be made in writing within 15 business days of the date of this letter or within a longer period that may be allowed by the Commissioner. Your appeal should identify your concerns with the request and why you are submitting the appeal.

The appeal may be addressed to the Information and Privacy Commissioner is as follows:

Office of the Information and Privacy Commissioner
2 Canada Drive
P. O. Box 13004, Stn. A
St. John’s, NL A1B 3V8
Telephone: (709) 729-6309
Toll-Free: 1-877-729-6309
Facsimile: (709) 729-6500

You may also appeal directly to the Supreme Court Trial Division within 15 business days after you receive the decision of the public body, pursuant to section 52 of the Act (a copy of this section of the Act has been enclosed for your reference).

Please be advised that responsive records will be published following a 72 hour period after the response is sent electronically to you or five business days in the case where records are mailed to you. It is the goal to have the responsive records posted to the Completed Access to Information Requests website within one business day following the applicable period of time. Please note that requests for personal information will not be posted online.

If you have any further questions, please contact me by telephone at (709) 729-7010 or by email at vanessamacey@gov.nl.ca.

Sincerely,

Vanessa Macey
ATIPP Coordinator

Enclosures
Policy advice or recommendations

29. (1) The head of a public body may refuse to disclose to an applicant information that would reveal

(a) advice, proposals, recommendations, analyses or policy options developed by or for a public body or minister;

(b) the contents of a formal research report or audit report that in the opinion of the head of the public body is incomplete and in respect of which a request or order for completion has been made by the head within 65 business days of delivery of the report; or

(c) draft legislation or regulations.

(2) The head of a public body shall not refuse to disclose under subsection (1)

(a) factual material;

(b) a public opinion poll;

(c) a statistical survey;

(d) an appraisal;

(e) an environmental impact statement or similar information;

(f) a final report or final audit on the performance or efficiency of a public body or on any of its programs or policies;

(g) a consumer test report or a report of a test carried out on a product to test equipment of the public body;

(h) a feasibility or technical study, including a cost estimate, relating to a policy or project of the public body;

(i) a report on the results of field research undertaken before a policy proposal is formulated;

(j) a report of an external task force, committee, council or similar body that has been established to consider a matter and make a report or recommendations to a public body;

(k) a plan or proposal to establish a new program or to change a program, if the plan or proposal has been approved or rejected by the head of the public body;

(l) information that the head of the public body has cited publicly as the basis for making a decision or formulating a policy; or
(m) a decision, including reasons, that is made in the exercise of a discretionary power or an adjudicative function and that affects the rights of the applicant.

(3) Subsection (1) does not apply to information in a record that has been in existence for 15 years or more.

Disclosure harmful to intergovernmental relations or negotiations

34. (1) The head of a public body may refuse to disclose information to an applicant if the disclosure could reasonably be expected to

(a) harm the conduct by the government of the province of relations between that government and the following or their agencies:

(i) the government of Canada or a province,

(ii) the council of a local government body,

(iii) the government of a foreign state,

(iv) an international organization of states, or

(v) the Nunatsiavut Government; or

(b) reveal information received in confidence from a government, council or organization listed in paragraph (a) or their agencies.

(2) The head of a public body shall not disclose information referred to in subsection (1) without the consent of

(a) the Attorney General, for law enforcement information; or

(b) the Lieutenant-Governor in Council, for any other type of information.

(3) Subsection (1) does not apply to information that is in a record that has been in existence for 15 years or more unless the information is law enforcement information.

Disclosure harmful to the financial or economic interests of a public body

35. (1) The head of a public body may refuse to disclose to an applicant information which could reasonably be expected to disclose

(a) trade secrets of a public body or the government of the province;

(b) financial, commercial, scientific or technical information that belongs to a public body or to the government of the province and that has, or is reasonably likely to have, monetary value;
(c) plans that relate to the management of personnel of or the administration of a public body and that have not yet been implemented or made public;

(d) information, the disclosure of which could reasonably be expected to result in the premature disclosure of a proposal or project or in significant loss or gain to a third party;

(e) scientific or technical information obtained through research by an employee of a public body, the disclosure of which could reasonably be expected to deprive the employee of priority of publication;

(f) positions, plans, procedures, criteria or instructions developed for the purpose of contractual or other negotiations by or on behalf of the government of the province or a public body, or considerations which relate to those negotiations;

(g) information, the disclosure of which could reasonably be expected to prejudice the financial or economic interest of the government of the province or a public body; or

(h) information, the disclosure of which could reasonably be expected to be injurious to the ability of the government of the province to manage the economy of the province.

(2) The head of a public body shall not refuse to disclose under subsection (1) the results of product or environmental testing carried out by or for that public body, unless the testing was done

(a) for a fee as a service to a person or a group of persons other than the public body; or

(b) for the purpose of developing methods of testing.

Access or correction complaint

42.(1) A person who makes a request under this Act for access to a record or for correction of personal information may file a complaint with the commissioner respecting a decision, act or failure to act of the head of the public body that relates to the request.

(2) A complaint under subsection (1) shall be filed in writing not later than 15 business days

(a) after the applicant is notified of the decision of the head of the public body, or the date of the act or failure to act; or

(b) after the date the head of the public body is considered to have refused the request under subsection 16(2).

(3) A third party informed under section 19 of a decision of the head of a public body to grant access to a record or part of a record in response to a request may file a complaint with the commissioner respecting that decision.

(4) A complaint under subsection (3) shall be filed in writing not later than 15 business days after the third party is informed of the decision of the head of the public body.
(5) The commissioner may allow a longer time period for the filing of a complaint under this section.

(6) A person or third party who has appealed directly to the Trial Division under subsection 52(1) or 53(1) shall not file a complaint with the commissioner.

(7) The commissioner shall refuse to investigate a complaint where an appeal has been commenced in the Trial Division.

(8) A complaint shall not be filed under this section with respect to

(a) a request that is disregarded under section 21;

(b) a decision respecting an extension of time under section 23;

(c) a variation of a procedure under section 24; or

(d) an estimate of costs or a decision not to waive a cost under section 26.

(9) The commissioner shall provide a copy of the complaint to the head of the public body concerned.

Direct appeal to Trial Division by an applicant

52. (1) Where an applicant has made a request to a public body for access to a record or correction of personal information and has not filed a complaint with the commissioner under section 42, the applicant may appeal the decision, act or failure to act of the head of the public body that relates to the request directly to the Trial Division.

(2) An appeal shall be commenced under subsection (1) not later than 15 business days

(a) after the applicant is notified of the decision of the head of the public body, or the date of the act or failure to act; or

(b) after the date the head of the public body is considered to have refused the request under subsection 16(2).

(3) Where an applicant has filed a complaint with the commissioner under section 42 and the commissioner has refused to investigate the complaint, the applicant may commence an appeal in the Trial Division of the decision, act or failure to act of the head of the public body that relates to the request for access to a record or for correction of personal information.

(4) An appeal shall be commenced under subsection (3) not later than 15 business days after the applicant is notified of the commissioner’s refusal under subsection 45(2).
Decision Note

Department of Health and Community Services

Title: Negotiating Mandate for Health Ministers Meetings

Direction Required: To provide the Minister of Health with a mandate to commence negotiations toward a Federal/Provincial/Territorial (FPT) agreement on health at the upcoming FPT Health Ministers Meeting in Vancouver, January 20-21, 2016.

Background & Current Status:

- The new federal government has signaled its intent to re-engage with PTs on matters related to health care. Multilateral discussions are anticipated to commence at the upcoming FPT Health Ministers Meeting in Vancouver, January 20-21, 2016. PT Ministers will meet on January 19-20 and Atlantic Ministers are meeting to consider a collective position in NB on January 13.

- The federal Health Minister’s mandate letter directs Minister Philpott to negotiate a Health Accord which should include the following elements:
  - A long term funding agreement.
  - Support for the delivery of more and better home care services. This includes more access to in-home caregivers, financial supports for family care, and, when necessary, palliative care – related to the Liberal commitment to a $3B investment (over 4 years) to deliver more and better home care services for Canadians.
  - Pan-Canadian collaboration on health innovation to encourage the adoption of new digital health technology to improve access, efficiency and outcomes for patients.
  - Improved access to necessary prescription medications. This will include joining with PT governments to buy drugs in bulk, reducing the cost governments pay for these drugs, making them more affordable, and exploring the need for a national formulary.
  - Making high quality mental health services more available to Canadians who need them.

- Minister Philpott has indicated that this is a high priority for the federal government and she plans to act quickly. Health Canada officials have indicated that they wish to commence negotiations towards an agreement on these subjects at the upcoming January Health Ministers Meeting (HMM).

- The reference to “Health Accord” in the federal Liberal platform and the federal Health Ministers Mandate recalls the 2004 Health Accord. The bulk of the funding ($35.3 billion) for this 10 year agreement included growth to the unconditional CHT block transfer at 6% per year. The Accord also included conditional funding: $5.5 billion over 10 years to reduce wait times, $500 million for investments in medical equipment, and $850 million for Aboriginal health and funding for Territories. While the conditional funding received considerable media attention at the time, the most significant element was the CHT. PT acceptance of the conditionality associated with the relatively small targeted funding was tied to federal government acceptance that the bulk of new federal money should be unconditional.

- The Conservative government declined to renegotiate the 2004 Health Accord upon its expiry in 2014, instead unilaterally extending the 6 percent growth rate of the CHT for three additional years before scheduling it to decrease to the higher of 3 percent or a three-year moving average of nominal GDP growth from 2017-2018 to 2023-24, at which time it will be reviewed. A 2012 report from the federal Parliamentary Budget Office projected the overall federal share of CHT
health spending will decrease from 20.4 percent in 2010-11 to an average 18.6 percent between 2012 and 2036.

- The Conservative government also changed the allocation formula for the CHT, commencing in 2014-15, from one that took differences in provincial-territorial tax capacity into account to “equal per capita cash” based on population alone. In 2014-2015 the formula change resulted in a CHT payment to NL that would have been $35M less than the 2013-2014 payment were it not for the scheduled overall 6 percent growth in the CHT and a one-time floor provision which kept the CHT payment to NL roughly equal to the 2013-2014 level. On the other hand, AB’s payment increased by $1.2B in that year due to the formula change. In 2014 the Atlantic Provinces Economic Council reported that the combined impact of these changes would be a $2.5B loss to the Atlantic provinces to 2024.

- PT Premiers expressed their collective views on the federal government’s role in health care and health financing a July letter from then-Chair of the Council of the Federation (COF), Paul Davis, to federal party leaders in which Premiers sought federal support for:
  o the needs and opportunities presented by an aging population, including investments to address the impact of population aging on the fiscal balance between the federal government and provincial-territorial governments;
  o increasing funding through the Canada Health Transfer (CHT) so that the federal share of Canada’s health care costs is at least 25 percent of all health care spending by provinces and territories. This additional investment would help address innovation and transformation in health care systems; and
  o providing supports to families such as affordable quality childcare and supports for affordable and social housing.
Premiers also directed Finance Ministers to identify the impact of extending the 6 percent escalator beyond 2016-2017 compared to the current scheduled decrease.

- In June 2015 the Council of Atlantic Premiers (CAP) noted the unique health care needs of Atlantic Canadians, including the challenges of delivering health services in rural areas and meeting the needs of an aging population.

- Some PT Finance Ministers referenced funding for health care, and the Canada Health Transfer in particular, in the media at the December 21, 2015 Finance Ministers Meeting. In particular, the QC Minister of Finance called for reform of the allocation formula for the CHT to address the proportion of those over 65 years of age, and indicated that this proposal is also supported by ON, though FIN indicates that this overstates the level of agreement on this position at the FPT table. The federal Minister of Finance, Bill Morneau, indicated that the “Health Accord” was not on the agenda for the Finance Ministers Meeting and that discussions would be led by the federal Minister of Health.

Analysis:

- \[s.34(1)(a)\]
• The CHT, along with the Canada Social Transfer and Equalization among other programs, is part of the package of major transfers that comprise Canadian fiscal federalism. These transfers have been considered as a package, not as separate issues, and to address the CHT at one sectoral table would be inconsistent with the long-standing FPT fiscal relationship.

• The position expressed by federal officials that “unconditional funding for health is not helpful” appears to be based on the premise that the injection of unconditional funding inflated costs (particularly labour and pharmaceutical costs) in the Canadian health system without substantial improvement in health outcomes. The Canada Health Council, created to monitor the success of the 2004 Accord, found that “access to care has not substantially improved and patients are not reporting that their care is better integrated or more patient-centred.” On the other hand, the conditional funding for wait times did achieve some measurable progress on the specific surgical wait times that were targeted. It should be noted, however, that the core unconditional funding allowed PTs to maintain their core health delivery systems after a period of protracted stress from spending restraint. From an NL perspective, unconditional funding offers maximum flexibility to address provincial spending priorities. In particular, the increase in the CHT after 2004 was critical to address core cost pressures in PT health delivery systems. On the other hand, conditional funding carries the risk of warping provincial policy priorities and creating accountability problems.

• PTs are likely to find significant common ground in upcoming discussions, however the negotiations are sure to expose varying positions. This will be especially acute in area of seniors and aging where jurisdictions with older populations (Atlantic Canada, QC, BC) may advocate for new federal health spending to be allocated along demographic lines, rather than a simple per capita formula (supported by ON, MB, SK, AB).

• Aging is not the only factor that drives costs in the health care sector. CIHI has also found that the number of health care services seniors will use is largely driven by the number of chronic conditions that they have rather than their age. NL has a high rate of chronic disease: 62.9 per cent of the population has at least one chronic disease compared to the Canadian average of 53.4
per cent. The population with at least two chronic diseases compared to the Canadian average is 37.5 percent compared to 28.8 percent. As chronic diseases also have a high rate of prevalence in the Maritimes, a common position could be found on a needs-based formula using both aging and chronic disease indicators.

Alternatives:
- Provide the Minister of Health with a mandate to commence negotiations towards a multilateral agreement, including the authority to agree to a multilateral communique, while indicating, during the meeting and potentially through a unilateral or Atlantic Ministers news release, that final approval of any agreement is contingent upon agreement on a total funding package, which may include both enhancements to the CHT and conditional funding, by First Ministers. (Recommended)

- Direct the Minister of Health and Community Services not to discuss a conditional multilateral agreement in the absence of a federal commitment to enhance the CHT. (Not recommended)
Prepared by: M. Harvey in consultation with IGA and FIN/B, Clarke
Ministerial Approval: Received from the Honourable Dr. John Haggie

January 7, 2016
Information Note
Department of Health & Community Services

Title: Provincial/Territorial (PT) and Federal/Provincial/Territorial (FPT) Health Ministers’ meetings held on January 19-21, 2016.

Issue: To provide information on key outcomes and issues to the Premier as Minister for Intergovernmental Affairs, following a meeting of PT and FPT Health Ministers in Vancouver, British Columbia on January 19 – 21, 2016.

Background and Current Status:
- PT and FPT Health Ministers held their annual meeting in Vancouver, BC on January 19-21, 2016. PT Ministers met in advance of the FPT meeting.

- Prior to the scheduled Ministers’ meetings, a roundtable breakfast was hosted by the Canadian Federation of Nurses Union (CFNU) and the Canadian Nurses Association (CNA). Minister Haggie, NL Health Minister, attended this meeting. The CFNU and CNA presented their perspectives on a new health accord, how to improve access to health services in the home and community settings, a national strategy for healthy aging, a Canadian Prescription Drug Program and ways to improve access to mental health services.

- Key items on the PT Ministers’ agenda included a discussion on their approach to collaborating with the federal government on a shared health agenda (health accord) and how a long term funding agreement would help support investments in innovation and transforming the health care systems.

- At the FPT Ministers meeting, Ministers agreed to do further work on the following shared priority areas:
  - enhancing the affordability, accessibility and appropriate use of prescription drugs;
  - improving care in the community, home care and mental health; and
  - fostering innovation in health care services.

- The federal Minister confirmed the federal government’s commitment to work with provinces and territories on a long-term funding arrangement, which could include bilateral agreements.

- PT Health Ministers also discussed physician assisted dying and Indigenous health in advance of their FPT meeting.

- With respect to physician assisted dying, PT Health Ministers discussed the outcomes of the PT Advisory Panel’s report and discussed jurisdictional approaches to prepare for the provision of physician assisted dying. This discussion continued at the FPT meeting where information was shared about the Federal Panel’s report and the proposed work of the Special Joint (Parliamentary) Committee. Ministers recognized the value of a consistent approach in Canada.
• PT Health Ministers also discussed how best to work with Indigenous peoples to address their health concerns and the role of governments to work together. FPT Ministers discussed Indigenous health and wellness and agreed to work together and within their respective jurisdictions to determine areas of shared priorities.

• FPT Health Ministers, including Minister Haggie, attended an engagement session with First Nations, Inuit and Metis Health organizations on the afternoon of January 20th. The session provided an opportunity for these organizations to share their perspectives. There were no specific outcomes from this meeting.

• PT Health Ministers received an update on work on Expensive Drugs for Rare Diseases, Mental Health and Substance Use as well as efforts to achieve national consistency on newborn screening. Ministers directed work to continue in these areas.

• Other issues discussed at the meetings included access to primary care, interprovincial health coverage and prescription drug abuse.

• PT Health Ministers will meet again in the fall 2016, while FPT Health Ministers have agreed to meet again in mid-2016 to take stock of progress and discuss next steps.

• Ontario is the incoming chair of the PT Health Ministers Forum and co-chair of the FPT Ministers Forum. The next annual meeting will be hosted by Ontario.

• A copy of the PT and FPT press releases are attached.

Prepared/Approved by: K. Rodway/V. Reddick/M. Harvey
Deputy Minister Approval: 
Ministerial Approval: 
February 4, 2016
Potential copyright material

If you wish to obtain a copy please contact the ATIPP Office at (709) 729-7072 or atippoffice@gov.nl.ca.
Meeting Note
Department of Health and Community Services
Telephone Call with Atlantic Health Ministers
Wednesday, May 11, 2016 5:00 PM (NL time)
Minister’s Boardroom, Department of Health and Community Services

Attendees:
Honourable Dr. John Haggie, Minister of Health and Community Services
Bev Clarke, Deputy Minister, Health and Community Services
Michael Harvey, ADM, Policy Planning and Performance Monitoring

Purpose of Meeting:
• There is no formal agenda for this telephone call.

• the Council of Atlantic Premiers (CAP) meeting being held on Monday, May 16, 2016.

• Atlantic Ministers may also have a brief discussion regarding the other Health items on the CAP agenda, including and the Shared Health Agenda (new Health Accord).

Background:
• At the May 15-16, 2016 CAP meeting Premiers will discuss progress made on health care in the Atlantic region. Discussion will focus on:
  o 
  o an Atlantic approach to creating a Shared Health Agenda (new Health Accord) with the federal government.

• IGA has prepared a note on the Shared Health Agenda with input from HCS.

• At the Atlantic DMs meeting on March 31 – April 1, 2016,

Shared Health Agenda (new Health Accord)
• Premiers are expected to discuss Atlantic positioning and interests relating to future federal health funding, including reiterating the importance of demographics and chronic disease prevalence. Premiers have previously noted the unique health care needs of Atlantic Canadians, including the challenges of delivering health services in rural areas and meeting the needs of an aging population.
• For Newfoundland and Labrador, our pressing needs including the challenges of delivering health services in rural and remote areas, meeting the needs of an aging population and addressing patients with multiple chronic conditions. Expenditure need should be a factor in allocation decisions.

• NL has a high rate of chronic disease: 62.9% of the population has at least one chronic disease compared to the Canadian average of 53.4%. Moreover, the population with at least two chronic diseases compared to the Canadian average is 37.5% compared to 28.8%.

• Minister Philpott indicated she “would like to see the discussions wrapped up toward the end of this year and hopefully have a big announcement in 2017.”

• In the context of discussions on federal medical assisted dying legislation, federal officials indicate that supports for improvements for a “full range of end-of-life options” will be addressed through the “multi-year health accord, including improvements to home care, palliative care.” While previously the $3B commitment was linked to home care, federal officials now are linking “a significant amount” of this funding to palliative care.
Decision Note
Department of Health and Community Services
Title: Negotiating Mandate for October 2016 Health Ministers Meetings

Direction Required: To provide the Minister of Health with a mandate to commence negotiations toward a Federal/Provincial/Territorial (FPT) agreement on health at the upcoming FPT Health Ministers Meeting in Toronto, October 17-18, 2016.

Background & Current Status:
- The primary focus of HMM preparations has been on the ongoing discussions regarding an FPT Health Accord.
- The federal Health Minister's mandate letter directed Minister Philpott to negotiate a Health Accord which should include the following elements: A long term funding agreement; Support for the delivery of more and better home care services; related to the Liberal commitment to a $3B investment (over 4 years) to deliver more and better home care services for Canadians; pan-Canadian collaboration on health innovation to encourage the adoption of new digital health technology to improve access, efficiency and outcomes for patients; Improved access to necessary prescription medications; making high quality mental health services more available to Canadians who need them. Minister Philpott and federal officials have indicated that they wish to conclude an agreement by the end of this calendar year so that new money can be included in the federal Budget 2017.
- The reference to "Health Accord" in the federal Liberal platform and the federal Health Ministers Mandate recalls the 2004 Health Accord. The bulk of the funding ($35.3 billion) for this 10 year agreement included growth to the unconditional CHT block transfer at 6% per year. The Accord also included conditional funding: $5.5 billion over 10 years to reduce wait times, $500 million for investments in medical equipment, and $850 million for Aboriginal health and funding for Territories. While the conditional funding received considerable media attention at the time, the most significant element was the CHT. PT acceptance of the conditionality associated with the relatively small targeted funding was tied to federal government acceptance that the bulk of new federal money should be unconditional.
- In 2014, the Conservative government unilaterally extended the 6 percent growth rate of the CHT for three additional years before scheduling it to decrease to the higher of 3 percent or a three-year moving average of nominal GDP growth from 2017-2018 to 2023-24, at which time it will be reviewed. A 2012 report from the federal Parliamentary Budget Office projected the overall federal share of CHT health spending will decrease from 20.4 percent in 2010-11 to an average 18.6 percent between 2012 and 2036.
- The Conservative government also changed the allocation formula for the CHT, commencing in 2014-15, from one that took differences in provincial-territorial tax capacity into account to "equal per capita cash" based on population alone. In 2014-2015 the formula change resulted in a CHT payment to NL that would have been $35M less than the 2013-2014 payment were it not for the scheduled overall 6 percent growth in the CHT and a one-time floor provision which kept the CHT payment to NL roughly equal to the 2013-2014 level. AB's payment increased by $1.2B in that year due to the formula change. In 2014 the
Atlantic Provinces Economic Council reported that the combined impact of these changes would be a $2.58B loss to the Atlantic provinces to 2024.

- PT Premiers expressed their collective views on the federal government's role in health care and health financing in a July letter to federal party leaders seeking federal support for: the needs and opportunities presented by an aging population, including investments to address the impact of population aging on the fiscal balance between the federal government and provincial-territorial governments; increasing funding through the Canada Health Transfer (CHT) so that the federal share of Canada's health care costs is at least 25 percent of all health care spending by provinces and territories.

- In July 2016, PT FIN Ministers reported to COF on the implications of the CHT escalator reduction. Premiers subsequently sent a letter to the Prime Minister seeking a First Ministers Meeting (FMM) on the subject. COF sent a further letter to the Prime Minister in September, again seeking an FMM or, if not, at least the temporary restoration of the 6% escalator. The Prime Minister responded with two letters, on September 28 and 30, in which he referred to his interest in hearing the outcomes of discussions at the October HMM.

- In numerous public speaking engagements in advance of the HMM, Minister Philpott has indicated that, while the CHT is not within her mandate, she is not interested in changing the currently legislated scheduled decrease in the CHT escalator. The federal Finance Minister, Bill Morneau, has also said that the government believes that the 3% escalator "is the place where we should be." Health Canada officials have argued that there is no desire for enhancing unconditional funding, believing that the increases in the CHT since 2014 have not driven health system transformation or sustainability but instead have inflated costs, particularly through physician salaries and pharmaceuticals. Reports from such entities as the Health Council of Canada and the C.D. Howe Institute have made similar arguments.

- Minister Philpott instead has reiterated the federal government's commitment to spend $3B over 4 years on home care.
The 2016/2017 CHT contribution to NL of $527.9M as a proportion of our approximately $38 billion health budget is approximately 18%. NL’s current Fiscal Forecast holds NL’s health budget at 0% nominal growth over the next five years. If the CHT escalator is 3% over five years, the CHT as a proportion of NL’s health budget will increase to approximately 19% over the period. If the escalator is restored to 6% it will increase to approximately 23%. An additional $49M would be required to reach the 25% target at a provincial level. The positive effect of the 6% escalator rather than the 3% escalator in 2017-2018 would be $15.5M.

If the federal government does propose a deal at, or shortly before, the HMM that restores the CHT escalator to 6% and also meets its commitment to funding for home and community care of $3B / 4 years (extended to five years)

Canada’s Premiers have noted the importance for Canada’s health care systems to remain sustainable and to ensure quality health services for all Canadians in the face of challenges such as chronic diseases, pharmaceutical costs, a growing and aging population and the disparities in health outcomes for Aboriginal peoples.
Based on historical positions taken by the federal government, it is unlikely that it will entertain changes to the CHT formula. However, it is possible that it may characterize its targeted funding for home and community support as itself a response to the aging issue. Moreover, it may be possible to negotiate a needs-based formula for the targeted funding.

- IGAS advises that the agenda for the December 9 First Ministers’ Meeting on Climate Change remains under development and...

Alternatives:
- Provide the Minister of Health with a mandate to negotiate an agreement-in-principle, subject to ratification by the Premier and Minister of Finance, a Health Accord that includes a restoration of the CHT escalator to 6% and targeted funding for home and community care, mental health and addictions and, via the C-Orgs, innovation. (Recommended)
- Do not provide the Minister with a mandate to conclude an agreement in principle in the absence of a meeting involving either or both of First and Finance Ministers. (Not Recommended)
Meeting Note
Department of Health and Community Services
Meeting with Minister Philpott
January 19, 2017 (PM)

Attendees:
Honourable John Haggie, Minister of Health and Community Services
John Abbott, Deputy Minister Health and Community Services
Honourable Jane Philpott, federal Minister of Health

Purpose of Meeting:
- The purpose of the meeting is to discuss the next steps and timing in finalizing the Canada-NL Health Agreement that was announced by the respective governments on December 23, 2016.

- In the federal release announcing the agreement, it stated that both governments will be developing a detailed plan on how the specific funds for home care and mental health will be spent along with performance indicators and mechanisms for annual reporting to citizens. NL is interested in commencing discussions on these agreement elements as soon as possible in order to finalize them over the next several weeks so as to inform the 2017-18 budgetary process.

- It is also anticipated that the federal Minister will want to discuss the issue of how Canadians pay substantially more for pharmaceuticals made by Canadian companies. The federal government has indicated that they plan to change Canadian regulations to force drug companies to lower their prices. The federal Minister has been in the media recently on this issue (see attached news article).


Background:
- On December 23, 2016, the federal government and the provincial governments of NL (see news release) and NS agreed to new targeted federal funding over 10 years for investments in home care and mental health care. An agreement was also reached with NB (December 22, 2016) in an accord to support transformative change in these same priority areas.

- Minister Philpott has been consulting with key stakeholders to determine how to get the best value for health care dollars. She recently held roundtable discussions with key stakeholders in home care and mental health, in Toronto on January 10, 2017 and is interested in engaging local stakeholders in these areas.

- In recent tweets by Minister Philpott, she has stated that federal investment is for new programs, including publicly funded psychotherapy for >500,000 youth currently on wait lists, who now wait up to 18 months. From NL’s perspective, having flexibility to use federal funding to expand or scale up existing programming is critical.
The December 23, 2016 news release states that over the next 10 years, the federal government will support home care and mental health initiatives in NL through combined funding of $160.7M ($87.7M for home care, including addressing critical home care infrastructure requirements and $73M for mental health initiatives). The funding will start flowing to the province as of April 1, 2017. These targeted investments are in addition to the existing legislated commitments through the CHT, which would increase by at least 3 per cent annually and perhaps more, depending on the growth in the national GDP.

The federal Health Minister's mandate letter directed Minister Philpott to negotiate a Health Accord which should include the following elements: A long term funding agreement; Support for the delivery of more and better home care services; related to the Liberal commitment to a $3B investment (over 4 years) to deliver more and better home care services for Canadians; pan-Canadian collaboration on health innovation to encourage the adoption of new digital health technology to improve access, efficiency and outcomes for patients; Improved access to necessary prescription medications; making high quality mental health services more available to Canadians who need them.

The federal Health Minister’s mandate letter directs Minister Philpott to negotiate a Health Accord which should include the following elements:

- A long term funding agreement.
- Support for the delivery of more and better home care services. This includes more access to in-home caregivers, financial supports for family care, and, when necessary, palliative care – related to the Liberal commitment to a $3B investment (over 4 years) to deliver more and better home care services for Canadians.
- Pan-Canadian collaboration on health innovation to encourage the adoption of new digital health technology to improve access, efficiency and outcomes for patients.
- Improved access to necessary prescription medications. This will include joining with PT governments to buy drugs in bulk, reducing the cost governments pay for these drugs, making them more affordable, and exploring the need for a national formulary.
- Making high quality mental health services more available to Canadians who need them.

Potential General Speaking Points

- We are very pleased to discuss the next steps and timing in finalizing the Canada-NL Health Agreement that was announced by the respective governments on December 23, 2016. Now that we have secured these federal investments, we can move forward in improving some of our priority health care services. Funds will be targeted towards mental health, home care and palliative care services.

- The needs of rural communities, our aging population, chronic disease, new technologies and higher drug costs are the pressures that continually challenge our province’s ability to ensure the long-term sustainability of the health care system.

- We are looking forward to continued discussions with on accountability and reporting.
Item 1: Home Care

Potential Speaking Points
• It

Item 2: Mental Health

Potential Speaking Points
• It

Item 3: Rising Cost of Drugs

Potential Speaking Points:
• Pharmaceuticals is an area where NL is very supportive of collaborative national work. While much has been done to control the rising cost of drugs, there is always more that can be done to reform Canada’s pharmaceutical system to better meet the needs of Canadians.

• While we appreciate that the federal government can do much from a regulatory and policy perspective to lower pharmaceutical costs and improve timely and appropriate access, there are also gaps that federal support and investments would help address. For example, funding for catastrophic drug coverage and drugs for rare diseases.

Analysis:
• NL’s generic costs are comparable to other jurisdictions, given the national tiered pricing agreement with CPGA and the fact that we had implemented generic pricing strategy in 2012, eventually reducing generic cost target to 25% of brand price. This is similar to most other provinces. NL’s cost per unit on new drugs (since 2012) has been comparable to other provinces due to PCPA.
• NL is an active participant in pCPA for both generics and brand name drugs. We have led 4 drug negotiations to date on behalf of PCPA. NL has concluded over 80 Product Listing Agreements with drug manufacturers to increase the cost effectiveness of drug therapies, with 20+ currently under negotiation. For 2016-17 those agreements are projected to generate $7.0M in revenues for the program. Participation in the PCPA generics initiative is projected to save $14M over the four years of the agreement with CPGA.
• With regards to the issue to regulatory changes, if changes were made to the PMPRB to force a lower price during its review process it would reduce the level of effort the jurisdictions have to make through pCPA to increase cost effectiveness. Many times, companies go in
high knowing they will be focused down somewhat by pCPA (and that they will still be able to charge the higher price to the private drugs plans and cash paying residents). Lower prices set initially through the PMPRB would also mean that the prices would be available to all Canadians, not just those who are beneficiaries of the private plans.

- A key issue with addressing access to medications will be who will fund increased access. If NL is mandated to fund a drug under a national program that we could not afford to normally fund, will the federal government step in financially? Key to this would be an agreement on a common national core formulary of medically necessary and effective drugs that everyone covers, and then a mechanism to keep it updated as drugs enter and leave the market.

**Prepared/Approved by:** D. Barrett/P. Baikie/A. Tucker  
**Ministerial Approval:** Received from Hon. [Minister’s Name]

*July 22, 2016*
Meeting Note
Department of Health and Community Services
Meeting with Federal Deputy Minister of Health
January 25, 2017
Via telephone (12:30 – 1:00 p.m NL time)

Attendees:
John Abbott, Deputy Minister Health and Community Services
Simon Kennedy, Deputy Minister of Health Canada

Purpose of Meeting:
• The purpose of the meeting is to discuss the next steps and timing in finalizing the Canada-NL Health Agreement for targeted funding towards mental health, home care and palliative services as well as alternatives for a future Ministers’ discussion.

Background:
• On December 23, 2016, the federal government and the NL provincial government (see news release) agreed to new targeted federal funding over 10 years for investments in home care and palliative care, and mental health care.

• The December 23, 2016 news release states that over the next 10 years, the federal government will support home care and mental health initiatives in NL through combined funding of $160.7M ($87.7M for home care, including addressing critical home care infrastructure requirements and $73M for mental health initiatives). The funding will start flowing to the province as of April 1, 2017. These targeted investments are in addition to the existing legislated commitments through the CHT, which would increase by at least 3 per cent annually and perhaps more, depending on the growth in the national GDP.

• An agreement has also been reached with NB (Dec. 22, 2016), NS (Dec. 23, 2016), NWT, YK and NU (Jan. 16, 2017) and SK (Jan. 17, 2017) in an accord to support transformative change in these same priority areas.

• Minister Philpott has been consulting with key stakeholders to determine how to get the best value for health care dollars. She has held roundtable discussions with key stakeholders in home care and mental health, in Toronto on January 10, 2017 and has expressed interest in engaging local stakeholders in these areas.

• The federal Health Minister's mandate letter directed Minister Philpott to negotiate a Health Accord which should include the following elements: A long term funding agreement; Support for the delivery of more and better home care services; related to the Liberal commitment to a $3B investment (over 4 years) to deliver more and better home care services for Canadians; pan-Canadian collaboration on health innovation to encourage the adoption of new digital health technology to improve access, efficiency and outcomes for patients; Improved access to necessary prescription medications; making high quality mental health services more available to Canadians who need them.
**Item 1: Opportunities for Ministerial Discussion**
- Minister Philpott was originally scheduled to meet with Minister Haggie on January 19, 2017, but that meeting was postponed until a later date. Alternative options for a Ministerial meeting should be explored with the federal DM.

- Minister Philpott is visiting NB and NS on January 19th and 20th to meet with provincial ministers of Health, stakeholders and local service providers to discuss mental health and home care investments. Stakeholder roundtable sessions will be held during the visits, which have been left to officials in NB and NS to organize (e.g., there is no pre-defined structure, questions etc). It is likely that a similar request will be asked of NL if the federal Minister visits this province.

**Potential Speaking Points**
- Minister Haggie is still very interested in arranging a meeting with Minister Philpott to discuss mental health and home care investments and any potential partnerships along with federal funding, which might be available to help us proceed with our health system transformation.

**Item 2: Health Accord Funding**
- The purpose is to communicate NL’s interest to commence discussions on the Canada-NL Health Agreement in order to inform the 2017-18 provincial budgetary process.

- In recent tweets by Minister Philpott, she has stated that federal investment is for **new** programs, including publicly funded psychotherapy for >500,000 youth currently on wait lists, who now wait up to 18 months. From NL’s perspective, having flexibility to use federal funding to expand or scale up **existing** programming is critical.

**Potential Speaking Points**
- We appreciate the commitment that you have made to the Canada-NL Health Agreement and we are very interested in continuing work on next steps and timing in finalizing the details of the Agreement.

- Now that we have secured these federal investments, we can move forward in improving some of our provincial priority health care services.

- We are eager to commence discussions on the agreement elements of mental health and home care investments, in order to finalize them over the next several weeks so as to inform our 2017-18 budgetary process.

**Item 3: Mental Health**
- The purpose is to communicate NL’s priorities in the area of mental health, including those described in the letter sent to the federal Health Minister on December 15, 2016.

- Minister Haggie wrote to the federal Health Minister on December 15, 2016 to provide an update on the government’s plans to transform mental health and addictions system in the
Potential Speaking Points

- Throughout our All Party Committee (APC) public consultations and expert presentations, access to services as close to home as possible with an emphasis on providing services in the least intensive and intrusive setting as possible are key consideration for future system transformation.

- We are operating with a significant budget deficit that has forced us to innovate in order to address budget concerns and keep our health system sustainable and able to meet the future mental health needs of our population.

- The Health Agreement may present one funding source to address our needs, but perhaps others, like a new round of Social Infrastructure Funding, could also contribute. We are interested in discussing our ideas further and any potential partnerships along with federal funding which might be able to help us proceed with system transformation.

Item 4: Home Care and Palliative Care

- The purpose is to communicate NL’s priorities in the area of home and palliative care, including those described in the letter sent recently to the federal Health Minister.

- The letter specifically notes the need for a community-based palliative approach to expand services and reduce barriers that prevent individuals with palliative conditions from managing their care needs in the community.

- System enhancement would include system-wide education on a palliative approach, earlier assessment and identification of support needs, coordinated case management, reduced barriers to accessing required home care, enhanced professional services available in the community and timely access to required equipment. Where appropriate these services will facilitate timely discharge from acute care. Any program enhancements will be multi-year and have an evaluation framework including measurable objectives and reportable outcomes.
Potential Speaking Points

- Palliative care is particularly relevant in this province given our aging demographic. We also face a high prevalence of chronic disease and palliative care is required at all stages of the life cycle.

- The new targeted funding will help integrate a community-based palliative care approach in our health system and respond to individuals with multiple medical and/or home support needs due to a palliative condition. We propose to address this need within the context of our broader efforts on home and community care, which we look forward to discussing further when our Ministers have an opportunity to meet in the near future.

- Through the recent Provincial Home Support Program Review, we have identified opportunities in the community sector that would enable us to provide greater support at an earlier stage in the trajectory of the illness or condition. We are interested in talking to you further regarding any federal funding available to assist in meeting these needs.

- We look forward to further discussions with your government on developing a plan to use the targeted funding. We would like to discuss other creative ways in which other federal support can be leveraged to assist in our common health system transformation goals: to improve the quality of care and cost efficiency through care provision in the home and community.

Prepared/Approved by: V. Reddick
Ministerial Approval:

July 22, 2016