IN BRIEF

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The Romanow Commission: Proposals for Federal Funding of Health Care

The Commission on the Future of Health Care in Canada (the Romanow Commission) acknowledges that the primary focus of the health care debate has been money. Much attention has been directed to questions about the increasing costs of health care, who should pay for what aspects of it, and whether the system is "affordable." The Commission addresses these fiscal questions directly, proposing measures for financing renewal and reform and recommending a substantial injection of cash for health care.

The Romanow Commission points out a number of weaknesses in the federal government's present method of funding health care through the Canada Health and Social Transfer (CHST). The report argues, first, that the combined use of cash and tax point transfers makes the CHST contribution to medicare extremely difficult to estimate. Second, the inclusion of financing for health care, post-secondary education and social assistance in one block transfer makes for a lack of clarity in federal-provincial fiscal relations. And third, the absence of a funding escalator, which leaves the amount the provinces receive to the discretion of the federal government, reduces predictability.

A New Canada Health Transfer

Recommendations number 6 and 7 in the Commission's report would lead to the creation of a new cash-only transfer exclusively for health care, and help establish stable and predictable federal funding by 2005-2006. Essentially, the current CHST cash contribution would be divided into two transfers: one specifically for health care, and the other for post-secondary education and social assistance. In the two years prior to the establishment of the proposed "Canada Health Transfer," five health transfers targeted specifically at diagnostic services, rural and remote access, primary health care, home care, and catastrophic drug coverage would be created, totalling $8.5 billion over the two years. These five transfers would provide short-term funding in needed areas while the Canada Health Transfer was being passed into law. Chart A illustrates the proposed evolution of health and social transfers between 2002-2003 and 2005-2006.

The Romanow Commission recommends that once the Canada Health Transfer is fully implemented in 2005-2006, the federal government should not be allowed to let the amount of the Transfer fall below 25% of provincial-territorial expenditures on *Canada Health Act* services (that is, services provided by physicians and hospitals). This cash base, along with an escalator that remains to be determined, is intended to provide stable and predictable health care funding. The Commission estimates that currently, the portion of the CHST cash transfer notionally allocated to health care covers 18.7% of provincial-territorial expenditures on *Canada Health Act* services. However, the Commission proposes expanding the range of services to eventually include targeted home care services and some coverage of prescription drugs. This expansion will mean that *Canada Health Act* services will account for a larger percentage of total provincial and territorial spending on health care.

No New Taxes or Increases

The Commission proposes that additional funds for health care come out of the federal government's general revenues. Unlike the Standing Senate Committee on Social Affairs, Science and Technology, which estimated that a new National Variable Health Care Insurance Premium would be needed to finance a greater federal investment in health care, the Romanow Commission proposes neither an increase in taxes nor the introduction of new taxes. Although the federal government is projected to run budget surpluses for the next six years, many wonder if the increased

CHART A

2002-2003	2003-2004	2004-2005	2005-2006
	One-time Bridge Funding $8.5 billion over two years		
	Diagnostic Services **Rural and Remote** **Primary Health Care (50/50)** **Home Care** **Catastrophic Drug (50/50)**		**Canada Health Transfer** Health: $15.32 billion
Canada Health & Social Transfer (CHST) Cash	**CHST Cash**	**CHST Cash**	**Social Transfer**
Health: $8.16 billion Social: $10.94 billion	Health: $8.41 billion Social: $11.39 billion	Health: $8.67 billion Social: $11.73 billion	 Social: $12.18 billion

Notes: Notional health portion of CHST cash estimated by the Commission on the Future of Health Care in Canada and calculated as approximately 43% of CHST cash total.

(50/50) denotes cost-sharing or matching transfer – provincial-territorial governments must match federal contribution.

Source: Commission on the Future of Health Care in Canada, *Building on Values: The Future of Health Care in Canada*, Ottawa, November 2002, Chapter 2 and Appendix E.

federal funding recommended by the Romanow Commission's final report will "crowd out" other program spending, reduce debt repayments, or possibly even lead to federal deficits if an unexpected economic downturn were to occur. In fact, Finance Minister John Manley has said that it might not be possible to come up with the sums called for by the Commission (*Globe and Mail*, 3 December 2002).

Table 1 compares the additional revenues required to implement the new health transfers with projected federal budget surpluses. The surpluses shown have been adjusted to take into account the federal reserves for contingencies and economic prudence.

TABLE 1
PROPOSED HEALTH CASH TRANSFERS
($ billions cash)

Fiscal year	Projected CHST Cash for Health	One-time Bridge Funding	Canada Health Transfer	Additional Revenues Required	Projected Federal Budget Surpluses
2002-2003	8.2	-	-	-	1.0
2003-2004	8.4	3.5	-	3.5	3.1
2004-2005	8.7	5.0	-	5.0	3.5
2005-2006	8.8	-	15.3	6.5	6.8

Source: Commission on the Future of Health Care in Canada, *Building on Values: The Future of Health Care in Canada*, Ottawa, November 2002; Department of Finance, *The Economic and Fiscal Update*, Ottawa, 2002.

Notes: According to the Romanow Commission's proposal, the CHST will not exist after 2004-2005.

"One-time Bridge Funding" column assumes that the $3.0 billion for the Diagnostic Services Transfer and the Rural and Remote Access Transfer will be spent equally in 2003-2004 and 2004-2005.

The federal government has subtracted reserves for contingencies and economic prudence from projected budget surpluses to arrive at the surpluses listed.

Figures may differ slightly from totals in Chart A due to rounding.