

## **The Romanow Report's Funding Plans**

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Roy Romanow's task included ascertaining how much additional money was needed to correct the fundamental problems in Canadian health care, ensure that future expenditures would keep pace with needs, and establish mechanisms for accountability of spending. He was clearly anxious to keep all his recommendations within what might be politically feasible in Canada today.

My conclusion regarding Romanow's funding proposals is that his recommendations represent an unequivocal step forward. Romanow, however, underestimates short-term health care costs, and backs away from desirable full funding of home care and pharmacare. Furthermore, his proposals fail to adequately address issues of provincial accountability. Finally, he does not specify from where the money should come, and indeed has implied that it should may be drawn from anticipated federal surpluses. Romanow might well be aware of these limitations, and regret them, but argue that he has gone as far as current political exigencies permit. The remainder of this article provides specifics of Romanow's proposal, and expands on the criticisms.

### **Historical Background**

Understanding Romanow's proposals requires some context. In 1968, the federal government enticed the provinces into national Medicare by offering cash transfers that would pay half the costs of provincial programs that met federal requirements. All ten Canadian provinces bought in, and established publicly funded and administered programs that provided universal coverage of all medically necessary physician and hospital services.

Over the years, rules changed. Encouraged by provinces who wanted more flexibility in use of federal dollars, the federal government provided some of the money in the form of "tax points" rather than cash transfers. This broke the link between money transferred for social programs, like health care, and what provinces do with that money. In 1996 the federal government drastically reduced their contribution, rolling together funding for health care, post secondary education and social assistance in the

Canada Health and Social Transfer (CHST).

These changes make it difficult to sort out the federal contribution to health care funding. The provinces ignore the tax points and focus only on the cash transfers, which currently cover 16 per cent of the provinces health care costs. Even the federal government's calculations of its contribution shows a drop from 45 per cent in the mid 1970s to under 30 per cent today. The changes in funding structure have compromised accountability. The money goes in to a big pot, and the provinces can allocate the funds in whatever way they wish.

### **Federal transfers have facilitated provincial tax cuts**

Health economist Armine Yalnizyan has calculated that these cuts cost provincial governments \$20 billion in lost revenues for 2001-02 alone. While complaining they don't have the money for adequate health care funding, the provinces have tossed away the dollars they could have used to prevent growing waiting lists, nursing shortages, and emergency room delays. The federal government has played the same game as the provinces, pleading inadequate funding for health care while instituting tax cuts that cost the federal government \$20 billion per year. Furthermore, the federal government's budgetary surpluses have allowed them to pay down more than \$47 billion on the national debt. Some of the money allocated to tax cuts and debt reduction could have helped the provinces maintain public health care. To put these dollar values in context, the entire government expenditure on health in Ontario is in the range of \$28 billion.

### **Romanow's proposal for federal base funding**

Romanow now suggests that the government divide the CHST, and establish separate health and social services cash transfers. He suggests the current health portion of the CHST as \$8.14 billion - a disputable calculation. He recommends that the federal government should ultimately contribute 25 per cent of the money for provincial physician and hospital services, which by his calculations would constitute \$15.3 billion by the 2005/2006 fiscal year. This would represent an increase of \$6.5 billion to the cash base.

Romanow then suggests an escalator to ensure continued stable and adequate funding. The initial escalator would be tied to growth in the

GDP, multiplied by 1.25. The 1.25 figure comes from the average greater growth in health expenditures over the GDP from 1960 to 2000. Ultimately, these funding proposals would provide dollars to the provinces without constraints as to how they spend the money, other than that it be spent on "health care". Over the next two years, however, Romanow suggests that the federal government use new money to buy change.

### **Short-term targeted expenditures**

While the legislation for the long-term transfer of funds is being prepared, the federal government would make some immediate targeted expenditures. These include, over a two-year period, \$1.5 billion to a rural and remote-access fund, \$1.5 billion for a diagnostic services fund, \$2.5 billion to promote primary health care reform, a \$2 billion transfer for a limited home care program and a \$1 billion catastrophic drug transfer. The total, 6.5 billion, would end up rolled in to the base for the cash transfer.

Provincial responsibility would include matching the primary health care transfer. The \$1.0 billion transfer for drugs would cover 50 per cent of provincial and territorial costs above a pre-set threshold.

### **Strengths and Limitations of the Romanow funding proposals: Total dollar amount**

Clearly, a substantial boost in federal spending on health is a wise move. Targeting of funds for national home care and pharmacare programs is an unequivocal step forward, as are the other targeted programs. The dollar amounts should be seen in context. It could be easily argued that they are insufficient. Armine Yalnizyan has pointed out that even current contractual commitments to increases in salaries for nurses and doctors (at minimum \$2.5 billion over the next 2 to 3 years) will require substantial new expenditures in the next several years.

Romanow acknowledges the coverage of chronic home care, and full coverage of needed drugs are desirable. In particular, he notes that a full national pharmacare program will reduce total costs that Canadians pay for pharmaceutical products. He has, nevertheless, provided only very limited home care and particularly pharmacare for pragmatic reasons.

The increased bill for the government - notwithstanding the total decreased bill for the taxpayer - would be, he believes, a political non-starter. Hospitals have noted that they have been left out of the Romanow report. The repeated crisis funding of hospitals over the last few years suggests their point is well-taken.

On the other hand, critics such as Noralou Roos, who holds the Canada Research Chair in population health, points out that despite decades of research documenting that some areas of the country have twice as many physicians per capita as other areas, (or MRIs or middle ear surgery), there is no evidence showing that "having twice as much care" shows up in the health of the population. Furthermore, she highlights the social choices involved in the health care expenditure (alternative use of the funds might include, for instance, rent-geared-to-income housing units, subsidized day care spaces, or transitional shelter beds). Unfortunately, the most likely alternative use of the funds is to reduce taxes.

Counter-arguments to suggestions that Romanow did not suggest sufficient federal funds for health also include those of health policy analysts such as Michael Rachlis who suggest that we can achieve efficiencies in health care that would obviate the need for appreciable increase in funding.

### **Where are the Dollars?**

The Kirby Senate report suggested a dedicated health care tax. Romanow has implied the federal government can find the dollars in their surplus. If the money does come from the surplus, will there be anything left for other social programs? That depends on the magnitude of the surplus. Economists such as Jim Stanford suggest the federal government is consistently, and substantially, underestimating the surplus.

Irrespective of arguments about the surplus, tax reductions in the last few years add up to \$20 billion yearly in foregone federal income, and another \$20 billion in provincial tax cuts. Social expenditures, as a proportion of GDP, have dropped by over one-third since the mid-1990s. Social expenditure as a proportion of GDP is at its lowest level since 1947. As Mr. Romanow has pointed out, there is plenty of money for health care, and other social expenditures, if they constitute a high

priority for Canadians, and politicians listen to the citizens. Unfortunately, the media have failed to highlight the magnitude of the tax cuts, who benefits from those tax cuts, and the massive reduction in the proportion of our national resources we are devoting to social programs. If they had, the political pressures might be different.

## **Accountability**

The Romanow proposals still leave the option for provincial governments to effectively use federal health transfers to cut taxes. Let us assume that a province needs, at minimum, to spend an additional half billion dollars on a health in a given year. This amount happens to correspond to the increase in revenue that province can expect as a result of economic growth. Without increases in federal transfers, the dollars for health care would have to come from the provincial budget.

If increases in federal transfers cover the added health expenditures, the increased potential provincial income can be allocated elsewhere. This has, to an extent, been happening in provinces such as Ontario in response to recent federal increases in funding for health. Romanow makes his recommendation for funds to contribute to provincial home care and drug benefit programs in anticipation that provinces won't reduce their contribution by commensurate amounts. However, the current funding structure provides no guarantees that they will not.

## **Conclusion**

Romanow's funding proposals represent an unequivocal step forward. I suspect that they are limited by Mr. Romanow's sense of what is politically feasible. Indeed, pressures for new tax cuts, and provincial resistance to targeted federal program demanding provincial responsibility, may mean that even the relatively modest Romanow recommendations will receive only partial implementation. Forward movement is contingent on the federal government allocating the full \$3.5 billion Romanow recommends in the first year, and the provinces accepting (or the federal government insisting) on Romanow's limited accountability provisions.

My sense is that, even if fully implemented, the limitations in Romanow's proposals will mean continued severe pressures on health, excessive waits for surgical procedures, heart catheterizations, and cancer care,

and continued emergency room chaos.

Furthermore, they will fail to deal effectively with accountability issues, and in particular provinces that place a higher priority on tax cuts than programs (both health care and social) that are likely to improve public health.

Romanow clearly has the right idea. Can the world unfold so that his report constitutes only a first step forward? If the change in momentum that Romanow represents continues, perhaps that is possible.