Commission on the
Future of Health Care
in Canada

Commission sur
l'avenir des soins de santé
au Canada

BACKGROUNDER

COMMISSION RECOMMENDATIONS ON FUNDING

Description

- The Commission is recommending a **new cash-only, dedicated Canada Health Transfer (CHT)**. The CHT would replace the health component of the current Canada Health and Social Transfer (CHST). In addition, the Commission believes that the federal government should commit itself to providing stable and predictable funding by agreeing to an **annual "escalator"** for its funding, **to be negotiated every five years. The Commission believes the new transfer should be in place by 2005/06.**

- In conjunction with the new transfer, the Commission is also recommending a permanent federal funding floor amounting to 25% of provincial *Canada Health Act*-related spending on health services by 2005/06. Based on current economic forecasts and spending patterns, this would translate **into an additional $6.5 billion federal contribution to health spending in 2005/06.**

- Recognizing that it will take time to introduce a negotiate a new transfer, and consistent with the Commission's over-arching conclusion that any additional money invested in the health care system be used to address pressing needs and begin longer-term changes, the Commission is proposing provisional funding for the next two years as follows:

    - $1.5 billion over two years for a Diagnostic Services Fund;
    - $1.5 billion over two years for a Rural and Remote Access Fund;
    - $2.5 billion over two years ($1 billion in Year One, $1.5 billion in Year Two for Primary Health Care);
    - $2 billion over two years ($1 billion annually) for homecare;
    - $1 billion (in Year Two) for a catastrophic drug transfer.

These provisional funding arrangements would require the federal government to increase health spending by an **additional $3.5 billion in 2003/04 and $5.0 billion in 2004/05** and would be additional to existing funding arrangements, including that provided in conjunction with the 2000 First Ministers Accord on Health.

- Current economic forecasts and spending patterns suggest **that without any additional changes**, the federal share CHA-related health spending under the existing CHST would amount to an estimated **$8.82 billion by 2005/06**. **If the 25% federal funding floor proposed by the Commission is implemented by 2005/2006, this will mean a total federal funding contribution of $15.32 billion (the forecast $8.82 billion plus the additional $6.5 billion).**

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Background

- The original medicare bargain struck in the 1960s only committed the federal government to covering 50% of *hospital and physician services* and NOT to 50% of *all provincial health costs.*
- In the 1970s, the federal government converted a portion of its cash transfer into "tax points'" that were permanently transferred to the provinces (i.e. the federal government gave a portion of its tax room to the provinces). As a consequence, the historic bargain changed to the federal government covering *roughly 25% of the cash costs of hospital and physician services.*
- In addition to the transfer of tax points, the structure of the federal transfer has changed significantly over time, sometimes through intergovernmental agreement, sometimes unilaterally by the federal government.
- It is clear that the federal government's cash contribution to health care under the current Canada Health and Social Transfer shrunk substantially in the late 1990s.
- Similarly, under the CHST any increase or decrease to the transfer is at the discretion of the federal government, thus compromising long-term planning.
- The unpredictable nature of this multi-purpose transfer has led to annual calls for increases from the provinces, and a lack of transparency about how much the federal government contributes to any particular area of social spending.
- This is further complicated by the ongoing dispute over whether the federal government's contribution should be calculated based on a combination of cash and the value of the tax points transferred in the 1970s, or solely on the value of the cash component.
- While it is beyond its mandate, the Commission believes that reform of the equalization program is critical to the sustainability of health care programming in smaller, less wealthy provinces. The Commission notes the commitment to review equalization set out in the September 2000 First Ministers' Meeting, and supports efforts to review and update the program to make it more effective.
- In the Commission's view this leads to two conclusions:

  - The value of the tax points should be considered as provincial revenue and not as part of the annual federal transfer; and

  - The federal government's cash contribution should be approximately 25% of provincial spending on CHA health services.

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The Commission on the Future of Health Care in Canada
Backgrounder
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