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The Changing Political and Economic Environment of Health Care in Canada

by

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The views expressed herein are solely those of the author and do not necessarily reflect those of the Commission on the Future of Health Care in Canada.

Contents

Highlights

How does a political environment oriented towards balanced budgets, debt reduction and/or reduced taxes affect the sustainability of the health care system?

- The linkage between health care and fiscal issues has been politically constructed and the sustainability of public health care in Canada is, fundamentally, a political – rather than simply a fiscal – issue.
- The existence of a fiscal crisis of health care in Canada is not evident in current expenditure trends:
    - provincial health expenditures relative to GDP are the same currently as they were in the early 1990s;
    - recent patterns of expenditure increase are likely a response to pent-up demand created by expenditure restraint in the mid-1990s.
  - Long-term projections of fiscal unsustainability must be based on one of the following assumptions:
    - cost acceleration *above and beyond cost increases driven by aging and moderate cost increases in services now offered*;
    - current levels of tax effort are unsustainable, for which there is currently no empirical evidence.
- Federal-provincial fiscal relations undermine the political underpinnings of the existing system of health care by:
  - creating the illusion of the rapid growth in the overall fiscal burden represented by health expenditures relative to the economy;
  - allowing for the manipulation of the fiscal system so that the burden of government debts and deficits is borne primarily at the provincial level (whose primary program responsibility is health care), strongly reinforcing the linkage in public debates between health care spending and the issues of deficits and debt;
  - providing provinces with strong incentives to emphasize declining quality and fiscal unsustainability in an attempt to maximize leverage for their demands on the federal government to enrich transfers.
- These dynamics have contributed to the following public perceptions
    - the quality of the health care system is low and declining;
    - the system is experiencing a major funding crisis, governments are not spending enough on health care, and increased funding is required to improve the health care system;
    - both levels of government are mishandling health care issues and are falling further behind in addressing health care problems.
- Reforms to the Canadian health care system that address the issue of fiscal sustainability and future cost containment without addressing the issue of political sustainability are likely to founder. *Ensuring the political sustainability of health care in Canada requires altering the incentives faced by federal and provincial governments under the current institutional arrangements for the funding and provision of health care in Canada.*

Executive Summary

In the post-deficit political context, the political sustainability of public health care seems precarious. While the tension between health care as a large public expenditure program and a broader political context oriented towards balanced budgets, debt retirement and tax reduction seems relatively obvious, the political fragility of public health care in Canada is neither the automatic nor necessary result of this broader context. Rather, the linkage between health care and fiscal issues has been politically and institutionally constructed. As a result, the sustainability of public health care in Canada at the current time is, fundamentally, a political – rather than simply a fiscal – issue. The existence of a fiscal crisis of health care in Canada is not evident in current expenditure patterns; however, public beliefs that there is a funding crisis in health care are, nonetheless, real. The crucial question is how and why this linkage between health care spending and fiscal issues such as deficits, debt and taxes, so clearly captured in current understandings of sustainability, has become so firmly embedded in Canadian policy debates over the past half decade. While the contemporary political orientation towards balanced budgets, deficit/debt reduction and lower taxes does not necessarily undermine the sustainability of the current health care system, more robust political support is required to sustain the current system of public health care in this context and the potential for current institutional arrangements to undermine support of the health care system is magnified.

The fiscal crisis of health care is not merely an ideological construct; rather, it has firm and enduring institutional underpinnings. It is rooted in the paradoxical situation by which the public health care system's institutional framework – especially the nature and dynamics of federal-provincial fiscal relations – are structured such that they fundamentally undermine rather than bolster public support for the system. The current political fragility of the system is the result of political dynamics generated out of nearly a decade of federal-provincial wrangling over funding in a context of fiscal restraint. The incentives created by federal-provincial fiscal arrangements and the resulting patterns of interaction have led to widespread perceptions both among the elite and the broader Canadian public that the public health care system in Canada is of rapidly declining quality, is wracked by a funding crisis, is unable to control costs, and is, ultimately, fiscally unsustainable.

Current expenditure patterns provide slim grounds for arguments that the system is fiscally unsustainable. Provincial health expenditures relative to GDP are the same now as they were a decade ago and recent patterns of expenditure increases are, in part, a response to pent-up demand created by expenditure restraint in the mid-1990s. Arguments that the system is fiscally unsustainable are only plausible if based on assumptions of cost acceleration above and beyond cost increases driven by aging, population growth and moderate cost increases in services now offered or, alternatively, on the claim that current levels of tax effort are unsustainable. The former issue can be plausibly debated; however, arguing that the *potential* for *future* cost increases poses a threat to sustainability is fundamentally different than arguing that existing expenditure patterns demonstrate that the current system is unsustainable. The sustainability of current provincial tax efforts in the face of increasing global and continental economic integration is also an open question in the longer term; however, to this point, there is no evidence of downward harmonization in provincial fiscal efforts.

Despite this, there is now a widespread perception of an existing fiscal crisis in public health care. The roots of this perception lie, to some significant degree, in the institutional underpinnings of health care – especially federal-provincial fiscal arrangements. In the context of more generalized restraint, these arrangements began to generate dynamics with serious potential to undermine public support for the system of public health care. First, the illusion of the rapid growth in the overall fiscal burden of health expenditures (relative to the economy) is primarily an artifact of federal-provincial financing arrangements. Secondly, the manipulation of the fiscal system so that the burden of government debts and deficits is borne primarily at the provincial level, whose primary program responsibility is health care, has strongly reinforced the linkage in public debates between health care spending and the issue of debt and deficits. Finally, current fiscal arrangements provide provinces with strong incentives to emphasize the failings of their own health care systems and the broader fiscal unsustainability of public health care in an attempt to maximize leverage for their demands on the federal government to enrich transfers.

These dynamics have had important impacts on public perceptions of health care including the striking decline in public perceptions of the quality of health care that exists despite the prevalence of positive personal health care experiences. In addition, there also are widespread public perceptions that the public health system is experiencing a major funding crisis (despite the fact that the fiscal burden of public health care relative to the economy is no heavier than at the outset of the 1990s) and that increased funding must be a central component of improving the health care system. Finally, public confidence in the handling of health care issues by both levels of government is decreasing and the belief that governments are falling further and further behind in terms of addressing the problems facing health care is becoming more prevalent.

Current expenditure patterns do not suggest that the fiscal sustainability of the public health care system in Canada is in jeopardy in the immediate term. This does not mean that future cost acceleration poses no threat to the sustainability of health care or that there is no need for a concern with fiscal restraint in health management. Nor does it mean that the issue of sustainability should be dismissed as a transitory phenomenon that will fade as the politics of fiscal restraint ease. The conditions resulting in broad perceptions of an existing fiscal crisis of health care have very real and enduring institutional underpinnings that can be expected to continue into the foreseeable future regardless of whether there are objective grounds for it, and regardless of whether solutions to containing future cost pressures are implemented. Under current arrangements, a continuing and not easily reversible decline in public perceptions both of the quality and sustainabilility of the existing system public health care in Canada seems likely. It is here that the real potential for crisis lies.

Introduction

Public health care in Canada is portrayed with increasing frequency and urgency as unsustainable. The desire to eliminate deficits, reduce the debt load and lower taxes appears to have come in conflict with the desire to sustain a comprehensive, universal and publicly administered health care system in Canada. Both the federal and provincial governments have had to struggle with what appear to be the conflicting demands of the public (and some organized interests) for lower taxes and balanced budgets while, at the same time, maintaining a high quality, publicly administered and publicly funded health care system. This conflict has raised questions regarding the sustainability of the current system of health care in Canada, which, in turn, has raised a number of related questions: To what extent is the crisis in health care a fiscal reality driven by the changing economic context? To what extent is it driven by the changing political context? To what extent is this a temporary phenomenon linked to the transition to a post-deficit era and to what extent does the "new" political economy of Canada mean permanent changes to what Canadians can expect from their health systems?

The existence of a fiscal crisis of health care in Canada is not evident in current expenditure patterns. While the tension between health care as a large public expenditure program and pressures for balanced budgets, debt retirement and tax reduction seems relatively obvious, this relationship is not so straightforward. Rather, the linkage between the two issues has been both politically and institutionally constructed with the political fragility of the health care system being neither the automatic nor necessary result of a political environment increasingly oriented towards balanced budgets, debt reduction and lower taxes. At the same time, public beliefs that a fiscal crisis exists are, nonetheless, real. In the immediate term, the sustainability of public health care as it currently exists in Canada is, fundamentally, a political rather than simply a fiscal question. The crucial question is how and why this linkage between health care spending and fiscal issues such as deficits, debt and taxes, which is so clearly captured in contemporary understandings of "sustainability," has become so firmly embedded in Canadian policy debates over the past half decade. Understanding this linkage becomes all the more pressing as a political context oriented towards balanced budgets, deficit/debt reduction and reduced taxes appears likely to magnify the impacts of this linkage.

The fiscal crisis of health care is not merely an ideological construct. The real crisis of the Canadian health care system lies in the paradoxical situation by which its institutional underpinnings – especially the nature and dynamics of federal-provincial relations – are structured to fundamentally undermine rather than bolster public support for the system. The political weakness of the health care system is the result of crucial political dynamics that were generated out of nearly a decade of federal-provincial wrangling over funding in a context of fiscal restraint. These incentives and resulting patterns of interaction have led to widespread perceptions both among the elite and the broader Canadian public that the public health care system in Canada is of rapidly declining quality, is wracked by a funding crisis, is unable to control costs, and is, ultimately, fiscally unsustainable.

Because the current perception of fiscal crisis in the public health care system is rooted in its institutional framework, pressures on the health care system have not eased and should not be expected to ease as fiscal pressures abate or as mechanisms to control future cost pressures are implemented. Reorienting the health care system to a more politically sustainable basis requires

seriously rethinking the relative roles and responsibilities of the federal and provincial governments in the funding and delivery of public health care, and the incentives and public perceptions generated out of these arrangements.

Overview

The first section of the paper examines provincial health care expenditures over the course of the 1990s. It argues that current expenditure patterns provide slim grounds on which to base arguments that the system is fiscally unsustainable. Such claims must be based on forecasts of cost escalation above and beyond cost increases driven by population growth, aging, and moderate cost increases in services now offered or, alternatively, claims that current levels of tax effort are unsustainable. The latter issue of the sustainability of current provincial tax efforts in the face of increasing global and continental economic integration is considered in the conclusion of this section.

Despite the fact that provincial health expenditures relative to GDP are the same as they were at the beginning of the 1990s, there is now a widespread perception of an existing fiscal crisis in public health care. The second section of the paper argues that roots of this perception lie, to some significant degree, in institutional underpinnings of health care – especially federal-provincial fiscal arrangements. While they appeared to work well enough in a period of expansion, federal-provincial fiscal arrangements, in a context of more generalized restraint, began to create dynamics with serious potential to undermine public support for the current system of public health care. First, the illusion of a rapid growth in the overall fiscal burden represented by health expenditures (relative to the economy) is an artifact of federal-provincial financing arrangements. Second, the manipulation of the fiscal system so that the burden of government debts and deficits is borne primarily at the provincial level has strongly reinforced the linkage in public debates between health care spending and the issue of deficits and debt. Finally, in a context of federal transfer restraint, current fiscal arrangements provide provinces with strong incentives to emphasize the failings of their health care system and the broader fiscal unsustainability of the current system.

The third section examines the effects of government responses to the incentives outlined above on public perceptions of health care. There is a striking decline in public perceptions regarding the quality of health care that exists despite the prevalence of positive personal experiences with the health care system. There also are widespread public perceptions that the public health system is experiencing a major funding crisis and that increased funding must be a central component of improving the health care system. Finally, public confidence in the handling of health care issues by both levels of government is decreasing and the belief that governments are falling further and further behind in terms of addressing the problems facing health care are becoming more prevalent.

In conclusion, the paper argues in favour of a definition of sustainability that incorporates the political – rather than just fiscal – sustainability of the health care system. In the absence of reform, the incentives built into the federal-provincial institutional structure are likely to continue to undermine the political sustainability of the public health care system in Canada.

Fiscal Sustainability of Health Care Expenditures

Sustainability, in current debates, has been understood primarily in fiscal terms. The following section examines the issue of fiscal sustainability and argues that current patterns of expenditure, on their own, are not sufficient to demonstrate the argument of unsustainability.

Assessing Current Patterns of Provincial Public Health Expenditures

There are two approaches that generally underpin arguments regarding the fiscal unsustainability of health care. The first is to extrapolate future health care costs from current spending patterns (primarily since 1996) and the second is to extrapolate the current trends in these expenditures expressed as a proportion of total provincial program expenditure. However, there are serious problems with both approaches. The first lies in identifying the appropriate time frame on which to base expenditure extrapolations. Extrapolations of health care costs based on the late 1990s ignore the fact that expenditure restraint in the middle of the decade likely contributed to the creation of pent-up demand that was reflected in higher annual spending levels later in the decade. Secondly, expressing health care expenditures as a proportion of total provincial program spending is an inappropriate measure of the fiscal sustainability of health care expenditures.

The Context of Current Expenditure Increases – Expenditure Restraint and Pent-Up Demand

One of the difficulties encountered in extrapolating from current health care expenditure trends is judging the drivers underlying recent expenditure increases. The Provincial and Territorial Ministers of Health report on health care costs notes the "severe restraint directed toward health care in the early-to-mid 1990s [which] produced a very low annual average growth rate." (2000, 3.17) The report goes on to note that "[s]ince 1996, provinces and territories have been reinvesting, partly to make up for the restraint applied in the early years of the decade." (3.17)

Annual provincial health expenditures (see Figure 1) did increase significantly over the period after 1996.[1] However, from 1993 to 1996, actual provincial expenditures were lower than they would have been if public health expenditures per capita had been simply maintained at 1992 levels. By 1997, actual provincial expenditures were cumulatively over $13 billion (constant 1992 dollars) less than they would have been if provinces had simply maintained their per capita expenditures at 1992 levels. As provinces began to reinvest in health care after 1996, actual cumulative provincial expenditures by 2001 *almost* reached the amount that provinces would have spent in the 1992-2001 period if they had simply maintained per capita expenditures at 1992 levels. (See Figure 2.)

Thus the crucial issue is delineating between expenditure increases which resulted from discretionary choices of provincial governments to enhance or expand health services, those which were in response to pent-up demand created by expenditure restraint in the early and mid-1990s, and, finally, expenditure increases necessitated by other cost pressures. Each of these

Figure 1
Annual Provincial Health Expenditures, Canada, 1992-2001

Actual Expenditures vs. 1992 Expenditure (Adjusted for Population Growth)

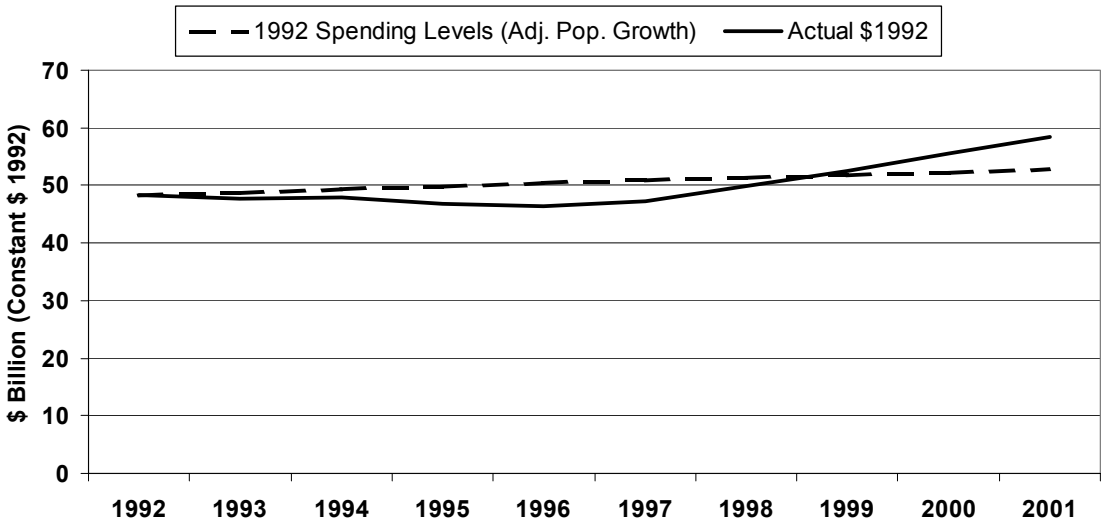
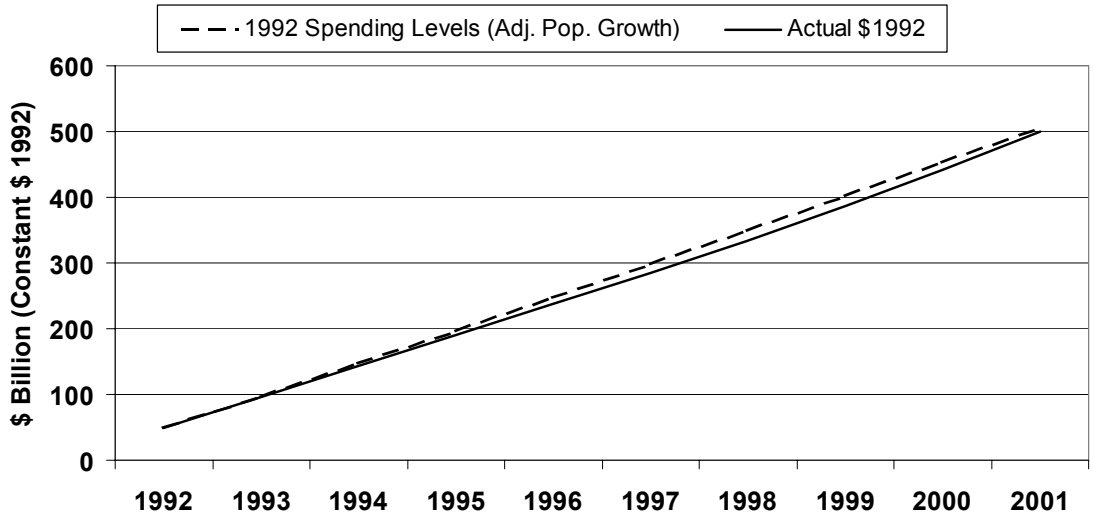


Figure 2
Cumulative Provincial Health Expenditures, Canada, 1992-2001

Actual Expenditures vs. 1992 Expenditure (Adjusted for Population Growth)



elements has different implications for future expenditure patterns. Discretionary service enhancement or expansion is more amenable to restraint than other non-discretionary cost pressures. Cost expansion driven by pent-up demand is likely to abate. Neither is suggestive of the inevitability of future cost increases. It is only cost expansion due to the third set of cost pressures which is germane to the issue of inevitable fiscal unsustainability. As such, extrapolating from current expenditure patterns without clearly demarcating the various underlying drivers of cost escalation and identifying their different implications for future expenditure patterns is not an appropriate methodology for forecasting future expenditure patterns.

Health Expenditures as a Relative Measure

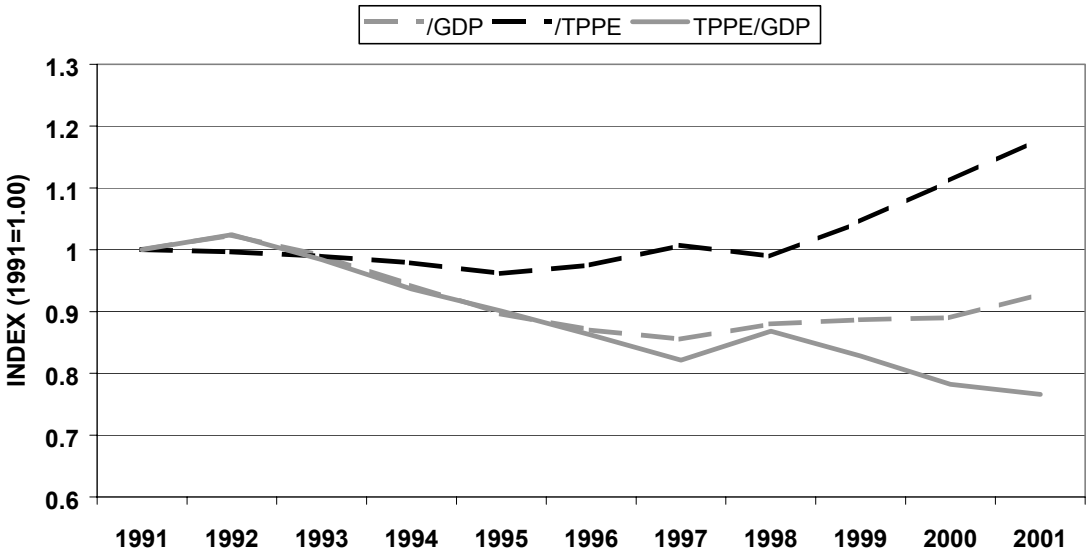
The barometer of provincial health spending in recent public debates is health expenditure as a proportion of total provincial program expenditures. This measure is important in itself; however, it is seriously deficient as a measure of the fiscal burden of health care spending and is not a good indicator of the overall fiscal sustainability of current patterns of health care expenditure.

Provincial public health expenditures fell relative to provincial gross domestic product from 1993 to 1997. (See Figure 3.) While expenditures have increased since 1997, provincial health expenditure as a proportion of GDP is still lower than it was over a decade ago. At the same time, provincial health expenditures have increased relative to total provincial program expenditure. The explanation for this apparent discrepancy is that total provincial program expenditures remained static from 1991 to 2000 in real dollar terms and have dropped to 78 percent of their 1991 levels relative to GDP. Thus provincial health expenditures rose as a proportion of total provincial program expenditures while remaining static relative to GDP.

A more appropriate measure of fiscal burden and fiscal sustainability is provincial public health expenditure relative to total provincial revenues. In 2001, provincial health expenditures (measured relative to total provincial revenues) were the same as they were in 1991 and slightly lower than they were throughout the early 1990s. (See Figure 4.) Relative to fiscal resources, there has been no increase in the fiscal burden represented by provincial health care expenditures. Changes in the fiscal burden posed by health expenditures have neither been masked nor exaggerated by changes in overall provincial fiscal effort: overall fiscal effort across provinces (measured as own source revenues as a percentage of GDP) has remained constant over the course of the 1990s. (See Figure 5.) At the same time, the overall contribution that the federal government makes to provincial total revenues has declined.[2]

Thus the overall picture that emerges is that restraint in federal transfers has meant that an increasing proportion of *the growth* in provincial own source revenues is going to health care rather than to other provincial programs or provincial deficit reduction/debt retirement. To this extent, health care is crowding out the provision of other public goods. Clearly, this is a serious problem from the provincial perspective. In this sense, the fiscal sustainability of health care expenditures is a very real problem *from the provincial perspective*. It is *not*, however, indicative of the unsustainability of the overall fiscal burden of health care relative to the overall ability of Canadian governments to bear this burden.

Figure 3
Provincial Health Expenditures, 1991-2001
Various Measures, Indexed (1991=1.00)



TPPE = total provincial program expenditures.

Figure 4
Provincial Health Expenditures, 1991-2001
Percent of Total Revenue and Provincial Own Source Revenue

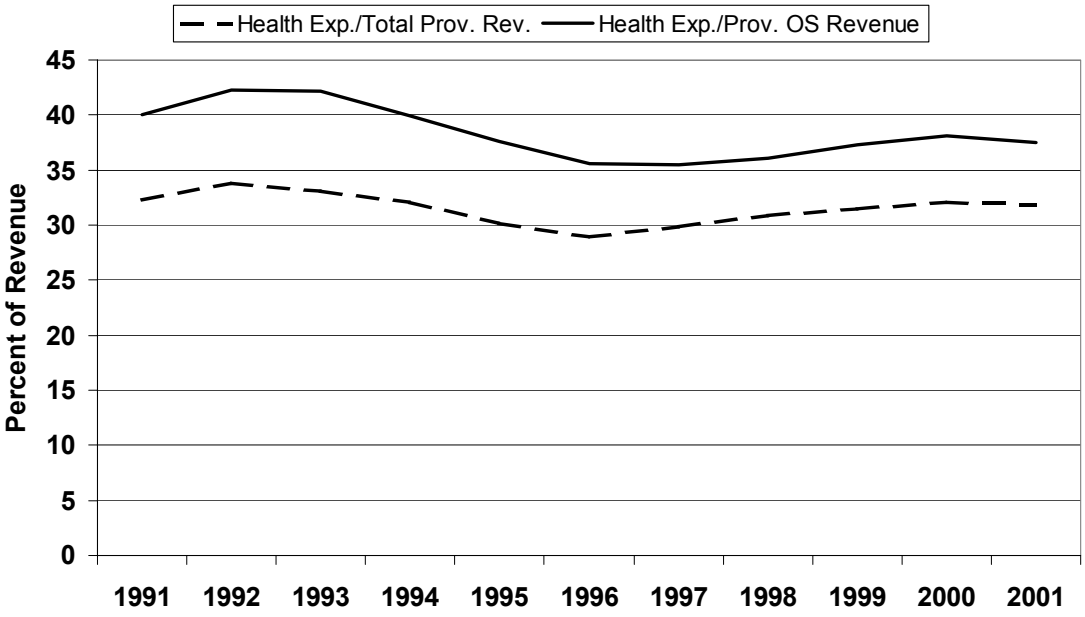
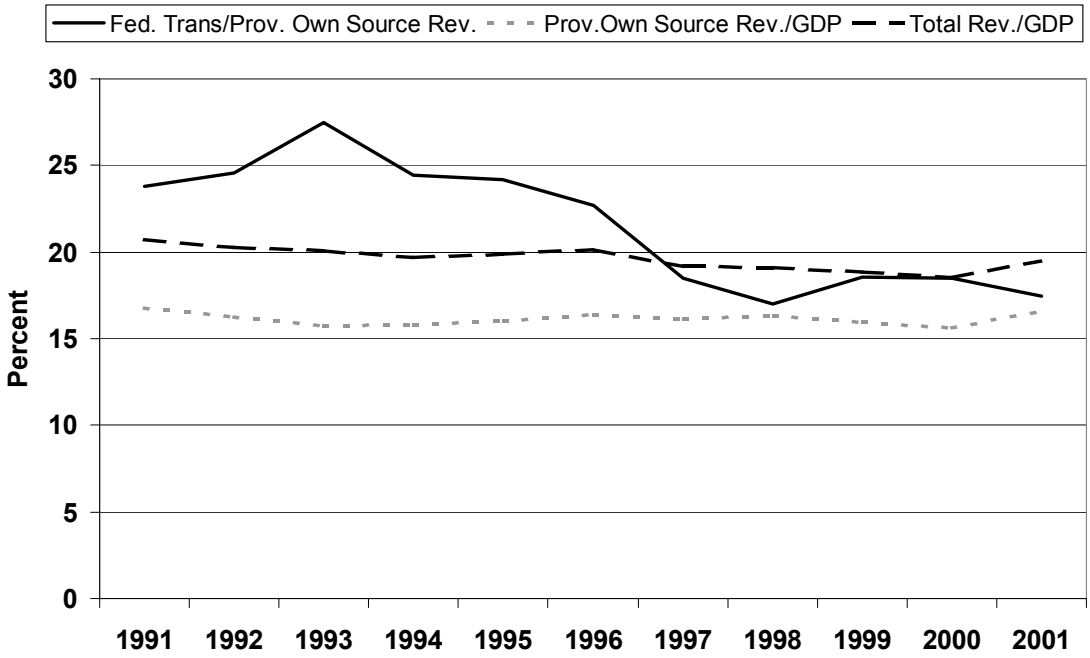


Figure 5
Federal Transfers and Provincial Own Source Revenues, 1991-2001



Assessing the Future Fiscal Sustainability of Public Health Care Expenditures

In the current circumstances, the sustainability of the overall fiscal burden of health care relative to the ability of government (as opposed to individual governments) to bear that burden is not in question. However, in the longer term, the fiscal sustainability of public health care in Canada becomes a serious issue under two scenarios: rapidly accelerating health care costs or the erosion of current provincial fiscal efforts or ability of provincial governments to maintain this level of fiscal effort.

Long-term Forecasts for Growth in Health Care Spending

In the absence of cost acceleration, other cost drivers such as aging will not increase the burden of the health system relative to the economy in the foreseeable future. The Provincial and Territorial Ministers of Health report, *Understanding Health Care Costs*, presents a detailed forecast of health care costs to 2026-27. Including the effects of population growth, aging, inflation and a 1 percent per year increase to reflect "other" health care service needs, the report concludes that "[t]he base scenario gives rise to health operating expenditures that remain fairly consistent as a share of GDP over the period." (31) The report does not outline the source of the GDP forecasts though it notes that "nominal GDP growth rates will moderate from 6.5 percent for 2000 to 4.8 percent for 2002, and more slowly thereafter to 4.0 per cent in 2026." (31) [The average annual growth rate in GDP (expenditure-based at market prices) for the 1990s was

4.4 percent.] Using conservative economic growth rates based on expectations of a long-term secular decline in GDP growth and adding in a 1 percent per year increase for expenditure growth on top of aging, inflation, and population growth, health care costs will not pose a greater burden over the next quarter century on the Canadian economy than is currently the case or was the case a decade ago.

However, questions of fiscal sustainability clearly emerge under a scenario of accelerating costs above and beyond those due to aging, population growth, and modest cost increases in the services currently provided. There are compelling reasons to expect considerable future cost pressures – a discussion of which lies beyond the scope of this paper. The fact that current patterns of expenditure are not unsustainable does not mean that questions of affordability pose no threat to the future sustainability of health care or that there is no need for fiscal restraint in health management. However, it raises fundamentally different questions than the claim that current expenditure patterns demonstrate the fiscal unsustainability of the existing system. The main issue is whether the acceleration of costs to an unsustainable level is inevitable. This question involves important issues regarding the willingness of provincial governments to attempt to control health care costs in the face of powerful political pressures for expansion. Secondly, it raises questions regarding the ability of governments to control costs even if determined to do so. If provincial governments are unable to control health care spending in the long term, the system will ultimately become fiscally unsustainable – a serious concern in addressing the issue of sustainability.

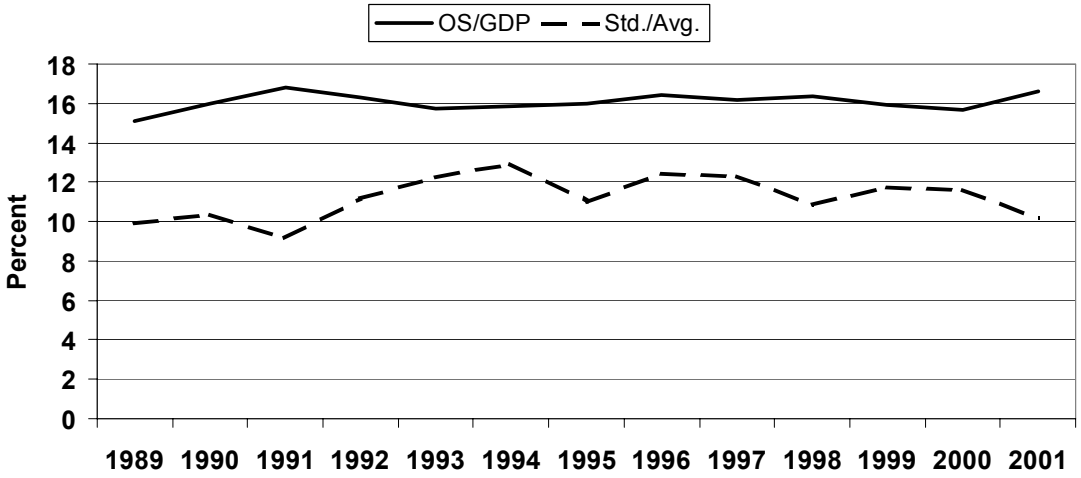
The Sustainability of Provincial Fiscal Efforts

Health care costs may also become fiscally unsustainable if current provincial fiscal efforts and taxation rates are unsustainable. Provincial fiscal efforts have remained constant over the course of the 1990s in terms of own source revenues as a percentage of GDP. (See Figure 6.) Evidence of an erosion of provincial capacity to maintain current levels of fiscal effort have not yet emerged. There has not been any convergence among provinces in terms of their fiscal effort and, as such, there is no evidence of a downward harmonization of fiscal efforts.

At the same time, it can be argued that downward pressure on provincial taxation rates and ability to maintain fiscal efforts will build as a result of increasing global and continental economic integration.[3] There are reasons to expect that such pressures will be felt earlier and more acutely at the provincial rather than the federal level. Provincial governments are arguably more sensitive to the competitive pressures generated by cross-border economic integration and competition. According to Courchene, provinces will increasingly tailor their public policies – including taxation policies – to the patterns prevailing in the U.S. states with which they are increasingly integrating and competing. (Courchene and Telmer 1998: 289-91)

There is now a substantial body of literature that is sceptical of the general proposition that globalization is generating convergence in social policy or taxation regimes across OECD countries. Few countries can escape the need to adjust their social policy regimes to the new economic order, but differences in national politics still condition the way in which countries react, mediating the impact of economic pressures on the social contract. As a result, there is no reason to presume that social policy or taxation regimes will converge on a single approach to

Figure 6
Provincial Own Source Revenues, 1989-2001
Percent of GDP and Standard Deviation (as Percent of Average)



the social needs of citizens. Banting (forthcoming) has pointed out that social spending as a proportion of GDP in OECD countries continues to inch upwards and that there is no overall pattern of convergence in the proportion of their national resources that different countries devote to social programs. Olewiler's detailed analysis of taxation trends and Garrett's analysis of both taxation and public expenditures similarly find no evidence of significant convergence across OECD countries (Olewiler 1999, Garrett 1998). These themes recur in a variety of other studies (Krugman 1996; Martin 1996; Esping-Andersen 1996; Swank 2001, 1998; Iversen 2001). The conclusions that emerge from considerations of policy in Canada and the United States echo the findings elsewhere. There is also increasing scepticism regarding arguments (predominant early in the free trade period) that Canada will ultimately be unable to maintain higher tax rates relative to the United States. (Brown 2000; Kesselman 2001; Skogstad 2000)

These conclusions are, nevertheless, open to challenge. The "lagged effect" argument contends that the full logic of economic integration is still unfolding and that a pervasive pattern of convergence between the Canada and U.S. policy systems is sure to emerge over time. There are two forms of this argument. An economic version holds that there is a natural sequencing in adjustments to integration, with the first wave of adjustments emerging in industrial structures, and that pressures to narrow tax and expenditure differentials will build over time. A cultural version of the argument holds that economic integration will inevitably produce greater cultural integration between the two countries, as media and other linkages steadily pull Canadian attitudes more firmly towards American norms. In this scenario, Canadians will start to bring more American values to their own politics, including an increasingly limited tolerance for differential taxation rates. This objection is impossible to counter fully, since evidence of continuing policy divergence can always be dismissed on the grounds that the anticipated lag is

simply longer and that convergence remains just around the corner. However, to this point, downward pressures on overall provincial revenue-generation ability is not yet evident.

The Dynamics of Federal-Provincial Relations in Health Care

Despite the fact that provincial health expenditures relative to GDP are the same as they were at the beginning of the 1990s, there is now a widespread perception of an existing fiscal crisis in public health care. The roots of this perception lie, to some significant degree, in the institutional underpinnings of health care – especially federal-provincial fiscal arrangements. While they appeared to work well enough in a period of expansion, federal-provincial fiscal arrangements, in a context of more generalized restraint, began to create dynamics with serious potential to undermine public support for the current system of public health care.

Both levels of government play a role in health care although the preponderance of jurisdictional responsibility for the provision of health services lies with provincial governments. (For a general overview, see Maioni 2002.) The federal government shares part of the cost of provincial medicare, runs health protection (e.g., regulates drugs), funds health care to Aboriginals on reserves, and shares health promotion and education with the provinces. The federal role in sharing the costs of provincially provided health services falls under the rubric of the Canada Health and Social Transfer (CHST) under terms governed by the *Canada Health Act* (CHA).

The *Canada Health Act* (CHA) governs federal transfers to provinces for the provision of public insurance for hospital care and physician services. There are five federally defined principles comprising the core of the *Canada Health Act* (CHA), which is the legislative basis for the Canadian health care system: public administration (each provincial plan must be run by a nonprofit, public authority accountable to the provincial government); comprehensiveness (provinces must provide coverage for all necessary physician and hospital services); universality (insured services must be universally available to all residents of the province under uniform terms and conditions with waiting periods for new entrants being limited to a maximum of three months); portability (each provincial plan must be portable so that eligible residents are covered while they are temporarily out of the province); and accessibility (reasonable access to insured services is not to be impaired by financial or other barriers and reasonable compensation must be made to physicians for providing insured services).[4] The CHA mandates dollar-for-dollar federal transfer reductions for funds collected in a province through user fees and extra billing. In contrast, application of penalties for violation of the five federally defined principles is discretionary and, to date, no province has ever been penalized for violation of any of the principles outlined in the CHA even though a number of provinces have been and continue to be in clear violation of various principles.[5]

Given this division of responsibility, the dynamics of federal-provincial relations in regard to health are relatively straightforward. The federal government strives to minimize its fiscal commitment to the degree possible while ensuring its visibility in health and ability to claim credit for enforcing the CHA. For their part, provincial governments strive to maximize federal fiscal commitment while also preserving their room to manoeuvre vis-à-vis constraints imposed directly or indirectly through public pressure as a result of the CHA.

The significance of federal-provincial fiscal arrangements for the politics of health care did not become fully evident so long as federal transfers were expanding. Pressures began to build as growth in Established Programs Financing (EPF) transfers were restricted (indexed to GNP

growth minus 2 percent in 1986, which was changed to GNP growth minus 3 percent in 1989) and frozen in the early 1990s. However, it was the shift from EPF to the CHST that signaled the full extent to which the federal government would retract its financial commitment to public health care. The shift to the CHST marked a reduction of transfers of $2.5 billion in 1996-97 and $4.5 billion in 1997-98. The federal government pushed the restraint envelope to the point that it appeared that the principles enshrined in the CHA would be imperiled, and many observers wondered how the principles of the CHA could be enforced against a recalcitrant provincial government as the cash component of the CHST was programmed to phase out of existence. The federal implementation of a floor on the cash component of the CHST transfers was an attempt to optimize between minimizing fiscal contributions and maintaining a federal ability to claim credit for the politically popular aspects of Canadian Medicare.

There are three crucial effects generated out of this situation. The first is the illusion of health care as a rapidly growing fiscal burden relative to the ability of government to bear this burden, which contributes to concerns regarding the sustainability of public health care in Canada. Public health care expenditures do not constitute a higher proportion of GDP than they did a decade ago. Yet, as a result of federal transfer restraints, provincial governments now make a compelling case that public health care as it currently exists is no longer affordable. This argument appears compelling and, from the provincial perspective, is real regardless of whether or not it is the result of federal-provincial fiscal arrangements for funding health.

Second, in part as a result of federal transfer retrenchment, the federal government's fiscal position is disproportionately brighter relative to the provinces. The situation in which surpluses are held at the federal level (which has limited direct involvement in the delivery of health care services) and deficits or near deficits are held at the provincial level of government (whose most important single program responsibility is health care) contributes to the political construction of a strong linkage between health care and the issues of balanced budgets and debt/deficit reduction. The goals of providing public health care and debt/deficit reduction are cast into sharp political competition as a result of the fiscal imbalance between levels of government that has been exacerbated by federal-provincial fiscal arrangements for funding health care.

Finally, these fiscal arrangements have generated perverse incentives for provincial governments. The provincial strategy in reaction to federal transfer restraint was to generate public pressure on the federal government to increase the cash component of transfers. As a result, provinces face limited incentives to forcefully combat public perceptions regarding the declining quality of health care and the sensationalist media coverage, which strongly reinforces such perceptions. There are incentives for provincial governments to leverage their demands for greater federal funding by allowing such perceptions to flourish – if not actually encouraging them – so long as some measure of the blame can be successfully shifted to the federal government. Second, provinces also have a similar incentive to focus disproportionately on the funding aspect of the health care issue emphasizing the perception that a central explanation of problems with the health care system is a lack of financial resources. Finally, as part of the blame-shifting strategy, provinces have an incentive to claim that the CHA is a straitjacket that does not allow for serious innovation to the health care system and limits their ability to respond to the problems of health care themselves. Not surprisingly, a national newspaper recently called for the CHA "… to be scrapped, given the intolerable 'constraints' it imposes provinces' freedom to innovate." (Coyne 2002)

The line of argument that provincial governments have developed in response to incentives inherent in the fiscal arrangements has culminated – predictably – in provincial claims that the current public health care system is unsustainable. In concluding the recent meeting of premiers in Victoria, Gordon Campbell, the Premier of British Columbia, noted: "We all agree as premiers that health care under the current situation is not sustainable." (*The Globe and Mail*, 25 January 2002) The *National Post* reported the following comments by Don Mazankowski: "Public health care in Canada will soon collapse unless bold reforms are introduced…" (Kennedy 2002) A final illustration is the Ontario government advertisements, which, in a banner headline, claim: "Unless Ottawa pays its fair share for health care, the prognosis isn't good." These responses simply represent the provincial calculation of a rational response to the incentives structured into current fiscal arrangements.

These various effects combine to form a vicious circle. Federal shifting of part of its debt burden to the provinces through transfer restraint has created incentives for provinces to emphasize the failings of the existing public health care system in Canada. At the same time, the shift has contributed to linking debt and deficits to health care thereby exacerbating the image of the fiscal unsustainability of the existing public system. To the degree that the federal fiscal situation is now relatively brighter than that of the provinces, provinces face increased incentives to attempt to extract higher transfers from the federal government through the kinds of strategies outlined above. To the extent the federal government now responds by enriching transfers, the more successful the strategy appears from the provincial perspective.

The Effects on Public Opinion

Public perceptions regarding health care that otherwise might seem puzzling become more clearly explicable in light of the political dynamics emerging out of federal-provincial fiscal arrangements operating in a context of fiscal restraint. While there are very good reasons to be highly skeptical regarding the reliability and interpretation of public opinion polling on public policy issues, the following section examines three relatively stable and relatively well-documented trends in public opinion that appear likely to be related to the dynamics of federal-provincial jockeying over health care funding.

1. *A belief that the system is in crisis and that the quality of health care is declining despite personal experiences to the contrary.*

The increase in the perception among Canadians that health care is the highest priority facing the country is nothing short of astounding. Over the course of the 1990s, health care has shifted from being a non-issue to being far and away the highest priority among Canadians. (For an overview, see Vail 2001, 1-2.) While concern for other, more perennial issues such as the economy has waxed and waned, health care emerged out of nowhere to become the top issue of concern in less than five years. In part, health care has become such an important issue because of growing perceptions that the system is in crisis – a belief now held by nearly four out of five survey respondents. (Vail 2001, 1)

This increase in the salience of health care is related to public perceptions of declining quality of health care provision in Canada. The erosion of public confidence in the quality of the health care system did not take place gradually over time; rather, it first emerged in the early 1990s and accelerated significantly in the mid-1990s. (Vail 2001, 8) The predominance of the popular perception that the quality of health care is in decline has remained stable since 1997 despite the fact that provinces have begun to reinvest in health care. When asked if Canadians generally are receiving quality care, the percent of respondents agreeing dropped from 67 percent in 1999 to 49 percent in 2001. (Health Care in Canada 2001, 6) This is a staggering decline in positive perceptions regarding the quality of health care in Canada in such a short period.

These stark trends clearly require explanation. The most obvious explanation for such a pattern would be that the system *is* in crisis. To the degree that what Canadians know about the health care system stems primarily from their contact with it, which has been overwhelmingly positive, the image of crisis must lie elsewhere. There is little evidence of decline in the positive nature of personal experiences with the health care system and individual perceptions regarding the quality of care in Canada are strikingly high. For example, satisfaction among those who themselves or a family member experience a hospital stay reported an 80 percent satisfaction rate and a 70 percent satisfaction rate among those visiting an emergency room. (Vail 2001, 17) Similarly, Canadians are much more sanguine about the system's ability to meet their own personal health needs and those of their families than to meet the needs of the population as a whole. Vail speculates that the consistent discrepancy between levels of confidence in health care at the system level versus those at the individual level may be a problem of communication. (Vail 2001, 17) However, this discrepancy is more plausibly explained by media reporting of many stories depicting the stresses and strains in the health care system. While these problems are certainly not imaginary, they are not representative of the norm in health care provision and

are exaggerated by virtue of being generalized. As outlined above, key in this process is the apparent willingness of provincial governments to allow and sometimes even encourage such perceptions. This behaviour on the part of provincial governments is best explained as a reaction to incentives built into federal-provincial fiscal arrangements rather than simply a failure to effectively communicate.

2. *A belief that we are now in a major funding crisis and that the system needs more resources.*

There is a widespread belief that the system is either currently facing a funding crisis or that a funding crisis is imminent. These public perceptions are not surprising given ongoing provincial government efforts to publicly demonstrate the existence of a health care funding crisis. In this context, it is also not surprising that four out of five Canadians believe that too little is being spent on health care. Certainly, while most citizens do not believe that funding alone is the answer (it is surprising, in fact, that any respondents give this answer), most Canadians are skeptical that the system can be improved without increased funding: the "conviction that the system needs more resources is an increasingly held view." (Compas 2001, 13) While Canadians may not be convinced that simply adding more money to the system is the complete answer, they remain unconvinced that the system can be "fixed" without the addition of resources and "… Canadians are more and more resistant to the idea that the system can be improved without more money. They no longer believe that there remain more efficiencies to be extracted from the system." (Compas 2001, 13.) Nor is it surprising that a majority of Canadians prefer to deal with increasing costs by increasing spending rather than allowing private services or limiting services. Thus "… increasing public funding was Canadians' preferred option for relieving pressure on the health care system." (Vail 2001, 21)

3. *A striking decline in public approval ratings for how both federal and provincial governments are handling the issue of health care and a belief that governments are losing ground in solving the issues facing health care.*

Public satisfaction with both the federal and provincial governments' handling of health care reached a peak in the early 1990s. After 1992, public approval ratings for both governments began a precipitous and long-term decline that has not recovered much beyond the lowest points it reached in the late 1990s. Again, as with many of the trends described here, the picture is not one of slow and steady erosion of support but rather precipitous decline. This trend is not surprising considering general perceptions of a system crisis and declining quality of health care. It seems likely that this trend has been exacerbated by intergovernmental strategies in which both levels of government, in an effort to avoid accepting public blame for problems with the health care system, attempt to shift responsibility to the other level of government.

Conclusion: The Political Sustainability of Health Care in Canada

Despite the fact that the sustainability of the health care system in the current context has been increasingly portrayed primarily as a fiscal issue arising from the inherent tension between public demands for lower taxes, debt reduction and balanced budgets, which conflict with public demands for accessible, high quality, and primarily publicly funded health care, sustainability needs also to be considered from a political vantage point. As outlined above, there is no *immediate* threat to the fiscal sustainability of the public health care system – the threat to which lies in potential patterns of future cost acceleration. However, the conflation in public debates of the notions of existing and potential fiscal crisis points to serious problems in the political sustainability of health care. Political sustainability requires ensuring the ongoing ability of the health care system to maintain sufficient popular and elite support to guarantee that there are incentives for governments to adequately fund and effectively provide public health care services. Fiscal sustainability is a moot issue if the health care system is politically unsustainable and *vice versa*. Health care reforms that address only one of these components of sustainability without consideration for the other are likely to founder.

Addressing the issue of political sustainability will be no easier than addressing the issue of fiscal sustainability. The most simplistic solution to the problems of political sustainability outlined above is to suggest that the federal government and provinces simply "get their act together and fix health care." Certainly, the public is unlikely to disagree with this motherhood prescription. While the failure of both orders of government to collaborate effectively has significantly contributed to fuelling public cynicism regarding governments' ability to deal with the problems faced by health care, to naively suggest that the two orders simply work together without fundamentally rethinking the incentives faced by each order of government under the current set of institutional arrangements will merely raise public expectations for such cooperation without significantly increasing the likelihood that governments will deliver. It is a prescription that entails greater risk than promise.

In the absence of institutional change that addresses the incentives generated by existing federal-provincial arrangements and the public perceptions that result from governments' responses to them, a continuing and not easily reversible decline in public perceptions both of the quality and sustainability of the public health care system in Canada seems likely. It is here that the real potential for crisis lies.

Notes

1 All provincial health expenditure data are taken from the Canadian Institute for Health Information, *National Health Expenditure Trends, 1975-2001* (Ottawa: CIHI, 2001*b*). All other data (provincial revenues, total federal transfers, etc.) are taken from CANSIM II.

2 All major federal transfers to the provinces (equalization, CHST) go directly into consolidated revenue so to identify particular transfers for health (as is often attempted) is simply not relevant to the question of the overall fiscal sustainability of provincial health care expenditures. At the same time, the issue of federal contributions to health is an extremely important issue in discussing the legitimacy of the conditional nature of specific transfers.

3 The following four paragraphs draw from Gerard W. Boychuk and Keith G. Banting, "The Paradox of Convergence: National Versus Sub-National Patterns of Convergence in Canadian and American Income Maintenance Policy" in Richard G. Harris, ed., *North American Linkages* (Calgary: University of Calgary Press, forthcoming 2002.)

4 Drawn from Robert Chernomas and Ardeshir Sepheri, eds., *How to Choose? A Comparison of the US and Canadian Health Care Systems* (Amityville: Baywood, 1998).

5 Colleen Flood, presentation to Ontario Health Coalition public forum *Does Medicare Work?*, Toronto, April 3, 2002.

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