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Paying to Play? Government Financing and Health Care Agenda Setting

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

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Highlights

- We may be entering into a new health policy "window of opportunity": the federal government has become more enthusiastic about its role as protector of the Canadian Health Act (CHA), but is unwilling to pay the dollars required to play this role effectively. If Ottawa does not wish to commit the funds it needs to enforce the CHA to its satisfaction, it must use its legislative powers as its political capital.

- The heart of the dilemma is that a clear assignment of health policy roles between levels of government results in strongly accountable systems, but can also exacerbate the instability of the system insofar as autonomous governments may choose to pursue independent goals disadvantageous to other governments. A system-shared jurisdiction can facilitate communication, but exacerbate problems of accountability.

- One possible approach is for the federal government to enter into a set of binding procedural rules with the provinces/territories regarding the long-term administration and funding of health care. Ottawa gives up some flexibility but wins greater recognition for its spending power and, importantly, is able to maintain some control over national standards in health with less expenditure. The provinces, for their part, accept some (formal) federal presence in the field of health care, but achieve stability and predictability in health care funding, recourse to dispute resolution, and clear limits on federal actions.

- Such a quid pro quo would involve clear provisions for consultation and due process between governments -- like those articulated in section 5 of the Social Union Framework Accord (SUFA) --, a formal opting-out formula regarding both transfer and direct funding programs, an explicit recognition of the federal expenditure power, the establishment of a "health council" to coordinate intergovernmental activity in health on an ongoing basis, an agreement on the part of both levels of government to report formally to their constituents and to each other regarding both outcomes and activities using a set of standardized processes and indicators.

Executive Summary

Discussions of "greater federal influence" or "more provincial autonomy" simply stated are in health policy inappropriate and obsolete: given the political, legal, and economic context of the contemporary health care system in Canada, it is more useful to consider instances where the federal government should have more influence, where the provinces should have more presence, where more cooperation is vital (and viable), and where independent actions on the part of the respective governments is appropriate.

Changes in the federal role over the past thirty years have not been consistent with changes in cost-sharing and other fiscal arrangements. Federal funding to the provinces has dropped considerably from the 50% funding it provided to the major health programs when the system of national health care was established. Yet over the past two decades the federal government has become more, not less, concerned with its role in maintaining the principles of the CHA. This imbalance has obliged Ottawa to hone its influence more precisely, and increasingly to trade off its legislative powers rather than simply using its economic influence.

The heart of the dilemma is that a clear assignment of health policy roles between levels of government results in strongly accountable systems, but can also exacerbate the instability of the system insofar as autonomous governments may choose to pursue independent goals disadvantageous to other governments. A system of shared jurisdiction can facilitate communication, but exacerbate problems with accountability. Any shift in the relationship between governments should thus attempt to achieve some balance between *predictability and stability,* on the one hand, and *accountability and transparency*, on the other. Any change from the status quo will also require political compromise from both levels of government.

We may be entering into a health policy "window of opportunity" in which the federal government has become more enthusiastic about its role as protector of the CHA, but is unwilling to pay the dollars required to play this role effectively. If Ottawa does not wish to commit the funds it needs to enforce the CHA to its satisfaction, it must use its legislative powers as its political capital. One possible arrangement is for Ottawa to agree to specific limitations on the scope and nature of its spending power. It gives up some flexibility but wins greater recognition of its spending power and, importantly, is able to maintain greater control over national standards in health care while spending less on it than provincial governments (and far less, proportionately, than it used to). The provinces, for their part, accept some lasting federal presence in the field of health care, but achieve stability and predictability in funding, recourse to dispute resolution, and clearer limits on federal actions.

Such a system could be modeled on the existing SUFA. The starting point is to maintain the provisions for consultation and due process between governments articulated in section 5 of the SUFA. The next steps would be explicitly to establish an acceptable opting-out formula regarding both transfer and direct funding programs, and to formalize federal spending power. An opting-out formula has important implications for wider Canada – Quebec relations, and is consonant with recent discussions on constitutional change. Such an option would not be unconditional, but it would allow more room for specific provincial policy objectives than at present. Despite objections to the idea of a formalized federal spending power, the principle has nonetheless already become embedded into the fabric of intergovernmental relations in Canada. Explicitly recognizing the federal spending power may be a relatively cheap way for provinces to achieve other objectives (including the opting-out clause and a binding dispute resolution mechanism). The federal spending power is also important from a policy point of view insofar as it is still the federal government's most potent instrument for corralling disparate points of view into a workable national health system, and it would be essential in balancing out some of the provisions allowing for greater provincial influence in national health policy.

There is room for much greater federal activity in its research and evaluation role, especially in its support for innovative pilot programs and in publicly-funded health research. More collaborative activity between governments is useful both in the technological and informational health care infrastructure, and in the long-term planning of health human resources. Both levels of government should report formally to their constituents and to each other regarding the outcomes and activities in health programs, using a set of standardized processes and indicators. The health system itself would be well served by having a better system of accountability in place. Too much reliance on "the general public" as a health care watchdog is not appropriate. A "Canada Health Council" would be one means of achieving this level of accountability.

Finally, despite some political demands for greater legislative and taxation capacity by local or regional bodies, there is insufficient empirical evidence at this point to support an institutionalized movement in this direction. Structures of local and regional governance in health care are simply too disparate to arrive at any clear analytical conclusions about the felicity of greater decentralization. There is enough anecdotal evidence, however, to support a substantive comparative study investigating the qualitative and quantitative dynamics of health care regionalization.

If health care itself is not – yet – in deep trouble, its governance is. The mechanism of government partnership and collaboration – that of federal-provincial – has become totally dysfunctional.

The Hon. Monique Bégin, in a lecture to the Institute for Research on Public Policy, 20 February 2002.

Introduction

Two overarching issues inform the relationship between governments regarding health care: first, what kind of change is desirable? And second, how is it possible politically to achieve such change? The objective of Canadian public health care is of course the health of the Canadian public: yet patients are also taxpayers and citizens, and as such often have contradictory expectations. Thus to say simply that the roles of government must be structured to be responsive to the voice of the people is not particularly useful insofar as democracy is a cacophony: the question of *whose* voices register is the very heart of democratic politics, and does not necessarily provide a clear basis for public policy. Moreover, any change in the relationship between governments must be considered within a fairly restrictive context: first, any change must obviously conform to the Canadian constitution. Second, in true Canadian spirit, political convention as well as constitutional requirement must be acknowledged. Third, any discussion of health care management must take into account financial constraints and issues of economic efficiency: given the contemporary emphasis that governments place upon cost containment and "sound fiscal management", any potential solutions must be perceived as affordable, however subjective the term may be. And, finally, any answer to the issue of the proper distribution of roles also depends upon the willingness of governments to embrace change. In the area of health care, particularly, autonomous political jurisdictions do exist (both *de facto* and *de jure*); and the motivation for change must ultimately come from within each unit.

This paper holds that change in federal-provincial relations regarding health care is necessary; that it is timely; and that each level of government can be persuaded to make these changes. It also argues that we must aim for a balance between federal involvement and provincial autonomy. Change is necessary because of the current cost of health care, because of the complexity involved in maintaining a modern health care "system", and because of the awareness and expectations of the very people to which it is directed. This discussion paper argues that there currently exists a "window of opportunity" that may improve the institutional context of intergovernmental relations within the area of health. The challenge is to take advantage of the flexibility and innovation that a federal system can provide without succumbing to the beggar-thy-neighbour dynamics that can also inform federal systems. Making a case for either "greater federal involvement" or "more provincial autonomy" in health care *per se* is not a helpful answer to the issue of rethinking the respective roles of each level of government. Rather, this paper

argues that Ottawa ought explicitly to accept the provinces as equal partners in health care and enter into binding regulation regarding long-term administration and the funding of health care. The provinces, for their part, ought explicitly to accept some formal and consistent federal presence in the field of public health care. In this way, the provinces can achieve stability and predictability in funding, dispute resolution, and federal accountability; while the federal government can better achieve adherence to the principles of the Canada Health Act as well as provincial accountability.

The first section of the paper discusses the constitutional division of powers constraining intergovernmental relations in health care, and explains how federal spending in health care has evolved since the establishment of a Canadian health care "system". The next section discusses in more detail how predictability and accountability can realistically be achieved within a highly politicized intergovernmental context, while the final section considers briefly what role, if any, regional or municipal governments ought to play.

The Institutional Context

Three distinct types of constitutional powers in Canada together form the fiscal relationship, which determines and circumscribes public policy: these are regulatory, expenditure, and taxation powers. In the area of health care, the *Constitution Act 1867* clearly gives the regulatory power over hospitals (section 92.7) and "local and private matters" (92.16) to the provinces. This, however, has been balanced by the evolution of the federal expenditure power (the "spending power") which refers specifically to "the power of Parliament to make payments to people, institutions, or provincial governments for purposes on which Parliament does not necessarily have the power to legislate, for example, in areas of exclusive provincial legislative jurisdiction" (Watts 1999, 1). While this spending power is not explicitly articulated in the *Constitution Act 1867*, the courts have interpreted other sections of the constitution to mean that the federal government may spend in any area as long as it does not amount to a "regulatory scheme" within an area of normal provincial jurisdiction. That the spending power is not explicitly recognized in the constitution may seem rather irrelevant, given the judicial support for its application, but, as we shall see below, it is nonetheless an important factor in the negotiation between governments regarding the delegation of roles in health care.

The third type of constitutional power is, of course, the power of taxation enjoyed by both senior levels of government. As Watts (1999) and Brown (2002) have pointed out, Canada is quite distinct among federal states in the wide-ranging ability provinces have to garner money for expenditure within their own jurisdictions. This gives provinces much greater independence from the federal government than other comparable jurisdictions have in other federal states; although, somewhat paradoxically, it also forces both levels of government to work more closely together in order to harmonize their respective systems of taxation. The net result of the present composition of the constitution, then, is that it allows both for greater decentralization (the increased capacity for provinces to raise taxes) *and* for greater centralization (the *de facto* recognition, and sustained exercise, of the federal spending power, as well as the articulation of a commitment to minimize regional disparity). Ottawa also enjoys indirect and/or obscure pieces of legislation (such as the Peace, Order, and Good Government provision) that can in principle be invoked, but are not relevant enough bases upon which to establish new and overarching health care provisions (as opposed to very specific legislation in very specific areas).

How important is the federal spending power? And how much influence does it potentially have as a tool in restructuring health care? The evaluations vary, although the answer seems to be largely dependent upon the economic and political context of the day. Some, such as Muszynski, argue that the spending power has become "significantly eroded as a result of economic conditions, the deficit and debt, and the emergence of more conservative attitudes toward social policy" (1995, 289). Paradoxically, however, the same conditions have been seen by others as conducive toward federal control when the wider federal fiscal powers are considered: as Campbell, for example, writes, "[i]f a neo-conservative orientation to economic policy persists – with market goals, inflation control, and deficit spending in the forefront – then the federal

government will remain in the economic management driver's seat" (1995, 209). It is nonetheless clear that Ottawa's ability directly to influence the structure of national health care depends primarily upon two factors: the amount of money the federal government has at its disposal to spend, and any specific limitations to this power negotiated by provincial and federal governments (such as those contained in the ill-fated Meech Lake Accord and Charlottetown Agreements, and the current Social Union Accord). This will be discussed in greater detail below.

The evolution of federal spending in health care can be roughly divided into five periods, each of which was defined by the introduction of major federal legislation: the *Hospital Insurance and Diagnostic Services Act, 1957* (HIDSA); *Established Programs Financing, 1977* (EPF); the *Canada Health Act, 1984* (CHA); the *Canada Health and Social Transfer, 1996* (CHST); and the *Social Union Framework Accord, 1999* (SUFA). Viewed historically, what is notable is that with each piece of legislation the federal intent oscillates from the desire to influence the nature of health care itself (HIDSA, CHA, SUFA) to the simple quest for cost containment (EPF, CHST).

The initial period of conditional, shared-cost grants gave way in 1977 to a model of block grants distributed on an equal per capita basis. Funding increases according to this formula were no longer based upon provincial expenditure, but upon the growth rate of the GNP. This measure not only decreased federal costs but also allowed Ottawa to remove itself from a situation where its own spending was determined by the provinces' policy decisions. But the EPF ultimately created even more friction between governments (Maslove 1992, 59). Moreover, the lack any mechanism obliging provinces to spend in specific areas was exacerbated by the social and economic environment of the day; and, largely at the instigation of the NDP, Ottawa was increasingly pushed from 1979 to address the "erosion of Medicare" (Bégin 2002, 2). In 1984 Bill C-3 (later the *Canada Health Act*) was tabled to eliminate (or at least discourage) extra-billing and user fees by penalizing provinces dollar-for-dollar for the levying of such fees. Provincial adherence to this legislation was voluntary, but full federal funding was conditional upon observing these principles. By 1987, the practice of extra-billing and the imposition of user fees had largely ceased.

Yet EPF was still highly problematic. Provinces objected that the federal government was not pulling its share of the load, while Ottawa keenly recognized that its tax point transfer meant increased provincial revenues and a decreased residual federal cash transfer: no longer paying the piper, it was unable to call the tune. Moreover, the federal government was dissatisfied with the lack of visibility it received for the monies it expended, while the provinces resented that Ottawa's spending power undermined the long-term stability and predictability of funding for two of the most expensive provincial programs (ibid., 61).

EPF was replaced unilaterally, and without intergovernmental consultation, by the CHST in April 1995. With its genesis directly within the Department of Finance, the CHST was largely acknowledged as a strategy to achieve federal expenditure and deficit reduction. But while the CHST was successful in its primary objective – alleviating fiscal pressure on Ottawa – it failed to

address the substantive problem evident in the EPF: it did not give the federal government enough financial clout to compel compliance to the principles of the CHA. The final period of evolution in federal-provincial relations over health care spending began in February 1999, with the partial ratification of the Social Union Framework Agreement.

Specifically, the SUFA required Ottawa to consult with the provinces regarding any changes to conditional block grants or shared-cost programs and to build "due notice" provisions into any new social transfers; to permit a form of "opting out" of national jointly-funded initiatives with the support of a majority of provinces; and to give at least three months' notice to (and to offer to consult with) the provinces regarding *direct* transfers. It also calls for broad public-access and public-consultation mechanisms; establishes support for the existing principles of Medicare; addresses the need for joint fact-finding; and articulates the need for dispute-avoidance and resolution mechanisms. The evaluation of the SUFA is mixed. Maioni, for example, argues that the SUFA "has done little to encourage a focus on the real political debate over two unresolved but crucial issues on the health agenda: Who should make the rules in health care? And what should the rules look like?"(2000, 39). Lazar, however, is more cautiously optimistic: if the political will exists to work within the agreement, he writes, "the Framework Agreement could turn out to be a major innovation in the workings of the federation, heralding a new era of collaboration, mutual respect among the orders of government and a more coherent and systematic approach to policy-making" (2000a,100).

While the trajectory of federal-provincial funding can be plotted with relative ease, the roles that the governments themselves have played (or have been expected to play) have not been characterized by the same clarity. This is largely because the meaning of "clarity" here is itself ambivalent: if clarity is determined by Occam's razor, then the period represented by the 1957 HIDSA and the 1966 *Medicare Care Insurance Act* is overwhelmingly clear in its simplicity. This arrangement, of course, was that the federal government would cover half the costs of provincial medical insurance plans, as long as the provinces adhered to the conditions of comprehensibility, universality, portability, and public administration (the condition of accessibility was added in 1984). The problem, however, was that the political nature of health care became emphasized over time: not only did the actual costs of providing health care increase, but the provision of public health care became seen – especially by Ottawa – as a form of political capital, in which public support for Medicare was a form of political leverage over provincial governments. This confronted the fiscal trend experienced by the provinces, who were by 2000 devoting at least one-third of their *total* expenditures to health care (Ontario, for example, spent almost 40% of its total expenditure in health in 1999: see CIHI 1999, Table B.4.4). As the political stakes rose, both levels of government wanted more out of their respective roles (viz., maximizing their influence and minimizing their costs). Thus, increasingly detailed documents (CHA and SUFA) have attempted to explicate the roles of each government: if, then, clarity refers to the amount of detail rather than to the level of simplicity, the current regime best exemplifies the rights and obligations of each government.

Have, then, changes in the federal role over the past thirty years been consistent with changes in cost-sharing and other fiscal arrangements? On the surface, no: the current federal funding levels of 14-16% contrasts quite dramatically with the 50% it gave to the provinces for the major health care services (doctors and hospitals) when the system of national health care was established. And yet over the past two decades the federal government has become more, not less, concerned with its role in maintaining the principles of the CHA. The EPF was largely responsible for this imbalance, for it not only cut federal funding levels to the provinces, but also transferred tax points to the provinces. In retrospect, writes Monique Bégin, the EPF was in a sense " a mistake, maybe an unavoidable one in that decade of provincial autonomy." But, she adds, "[t]ax points transfers are a taxation capacity lost forever and they carry no enforcement power whatsoever. So let us stop talking of them" (Bégin 2002, 5). It is unsurprising that the EPF was enacted well before Ottawa realized the (long forgotten) political capital to be found as protector of a national Medicare system. But what is interesting is that this imbalance has forced the federal government to hone its influence more precisely and surgically, rather than depending upon its broad economic clout. And there is certainly more room for this approach (see below).

What we see now is a recognition by Ottawa that, first, there is a great deal of public support for its position as protector of Medicare (notably, none of the political parties in the last federal election argued for eliminating the CHA) and, second, that enforcing adherence to the CHA cannot rest purely upon an economic approach. The current strategy, then, is one of legislative horse-trading, in which Ottawa has shown some willingness to blunt the force of its federal spending power in exchange for achieving specific policy objectives (such as agreement on the CHA). While changes in the federal role over the past three decades have not been at all consistent with changes in cost-sharing, then, we have seen evidence of more sophisticated and nuanced approaches depending less on economic influence and more on a strategic political give-and-take. This will be discussed more fully below.

Setting Health Care Policy: Current Roles

One of the best accounts of the various roles played by the federal government in setting health care policy can be found in the interim report of the fourth volume of the Standing Senate Committee on Social Affairs, Science, and Technology (also known as the Kirby Report). The report lists five distinct federal roles in health and health care:

i. the *financing* role, which covers the transfer of funds for the provision of health services administered by the provinces and territories;

ii. the *research and evaluation* role, which includes funding innovative health research and evaluation of innovative pilot projects;

iii. the *infrastructure* role, which addresses support for the health care infrastructure and the health infostructure, including human resources;

iv. the *population health* role, which focuses upon health protection, health and wellness promotion, illness prevention, and population health; and

v. the *service delivery* role, which targets the direct provision of health services to specific population groups (Canada Senate 2001, chapter 3).

Although not addressed by the report, the *provincial* roles in health and health care can also be divided into the same groupings, although the scope and nature of provincial activity within each section will of course be quite distinct in many cases from that of the federal role (and indeed, the distinctions between provinces in many cases will be pronounced as well). The breakdown in roles presented by the interim report of the Kirby commission is especially useful in reminding us that direct funding to the provinces (and territories) is not the only role that the federal government can play due to its constitutional restrictions. To a large extent Ottawa's influence is indeed limited by the amount of funding it chooses to direct to health care *per se*; there is, however, some room regarding the precise allocation of these funds.

Suggestions for Change: The Status Quo, Only Different

To ask what health system objectives might be served by changes in the roles the senior governments play, one must first ask *which* health system objectives ought to be promoted. The dominant opinion in Canada is perhaps best reflected in the mandate of the Commission of the Future of Health Care in Canada, which is to "ensure over the long term the sustainability of a universally accessible, publicly funded health system, that offers quality services to Canadians and strikes an appropriate balance between investments in prevention and health maintenance and those directed to care and treatment." There are two ways of achieving this from an intergovernmental perspective: first, it is essential to achieve a context of greater stability and predictability for this system of national standards noted above. A number of the problems experienced by the Canadian health care system are caused not by the specific organization of health policies *per se* as much as by the federal political context within which they are found. If a greater sense of common purpose and trust could be established between governments, it is likely that the first set of objectives could be more readily achieved. But mutual understanding and confidence will not simply arise through sustained exhortation: there must be a clear set of institutional changes to facilitate such behavioral and attitudinal shifts. The second way of promoting and protecting such a system is through the development of substantial and evident accountability between governments (as well as within the system itself). Not only are accountability and transparency manifestly democratic qualities that are now seen as desirable in and of themselves, but they are invaluable in achieving the sense of common purpose noted above (insofar as it is simply easier to trust other parties when their actions are transparent and predictable).

How, then, are such objectives to be achieved? It is essential to remember that, unlike discussions of "health care reform" simply stated, the issue of intergovernmental roles is characterized by institutional divisions of power (noted above) that must be recognized and respected before any discussion of reform can be undertaken. Solutions cannot be obtained by simple governmental fiat: that, in fact, has been the very *cause* of much recent intergovernmental dispute. Thus the only real method of approach must involve compromise and trade-off; and any attempt to move forward must risk being viewed with some dissatisfaction by all parties. "If what 'works' in policy terms creates untenable intergovernmental tensions that spill over into other relationships or clearly violates the constitutional division of power or marginalizes the oversight roles of legislators and citizens, then the very ability of social policy to weave and strengthen the ties that bind Canadians to each other is compromised" (Adams 2001a, 6).

Towards Predictability and Stability

The most important component of a stable and predictable working relationship between governments, either nationally or internationally, is a set of clear procedural rules for the political actors (as well as the clear articulation of consequence for failure to comply with these rules). The SUFA is a major step forward in this direction because of its emphasis upon procedure as

much as upon more substantive content. The existence of trust is absolutely essential in achieving any progress in a cooperative system of administration: as Lazar comments, "[w]ith trust, SUFA will survive the periodic hurricanes that come from changing government, prickly personalities and external shocks. Without trust, SUFA will be a footnote in Canadian history" (2000b, 12). To achieve this trust, then, change in the governance of the health care system must be achieved cautiously and consensually. This is a difficult strategy to accept if one holds that the most effective strategies are those that are imposed comprehensively, and that political give-and-take simply results in a watered-down compromise that is second-best in terms of policy-making. There is probably no little evidence for this claim. However, as Adams (2001b) reminds us, in the realm of intergovernmental relations some form of compromise is essential, and, as Kennett (1998) and others have argued, autonomous policy-making in the sphere of health policy is inefficient and possibly obsolete.

Thus, regardless of the temptations for wholesale change in our health care system, the best-considered strategy here is one of evolutionary change rather than world-historical shift; of surgical technique rather than the wielding of blunt instruments. If we accept that improvements in health care require consensus and stability over the long term, we must return to the arena of political horse-trading rather than the flexing of political muscle. It is understandable why this approach is especially unpalatable for the federal government (which has been generally quite unwilling to commit itself in this way), insofar as such commitments limit governmental flexibility in policy-making writ large. But governments do engage in such agreements *internationally,* on the grounds that greater gains are to be made despite constraints on flexibility (recent agreements limiting state sovereignty in the European Union are particularly relevant here); and the same can be said for intergovernmental agreements. Given its desire to maintain some say over a set of national standards in health care, and given its unwillingness simply to use its pocketbook extensively for this purpose, it must accept some constraints on its flexibility as the cost of achieving these ends.

In general terms, the suggested *quid pro quo* is this: Ottawa explicitly accepts provincial governments as equal partners rather than junior ones by agreeing to enter into a set of binding procedural rules with them regarding the long-term administration and funding of health care in Canada. It gives up some flexibility but wins greater recognition for its spending power and, importantly, it is able to maintain some control over national standards in health care while spending less on it than provincial governments do (and far less, proportionately, than it once did). The provinces, for their part, accept some (lasting) federal presence in the field of health care, but achieve stability and predictability in health care funding, recourse to dispute resolution, and, not least, clearer limits on federal actions. Let us unpack this in more detail.

The SUFA is an appropriate blueprint for the kind of agreement considered here. The nature of SUFA is that "it contemplates both orders of government agreeing on Canada-wide objectives, the federal government transferring some funds to the provinces to assist them in pursuing the objectives, provinces then designing and delivering their own programs to achieve the objectives

and public accountability for the results" (Lazar 2000a, 122). One of the key achievements of SUFA was the securement by provinces of federal agreement to consult on "significant changes in existing social transfers" and to "build due notice provisions into any new social transfers"; to offer provinces a *de facto* opting-out provision; and due notice and consultation regarding new direct federal spending on health care. These measures were in large part due to Ottawa's unilateral drive to get its own financial house in order throughout the 1990s, which led in turn to a sour resentment by the provincial and territorial governments who bore the brunt of this federal housekeeping. As Maslove points out, the level of federal-provincial fiscal harmonization that actually exists is quite impressive: nonetheless, "the consequence of one government's being forced to react to major revenue (or expenditure) shocks resulting from the unilateral decisions of another causes strains to the fiscal system" (1996, 296).

The primary component of stability is the predictability built into federal CHST funding under section 5 of SUFA which, again, calls for federal-provincial consultation on "significant changes in existing social transfers" and "due provision " regarding any new social transfers. And, while this stipulation does not in itself remove the possibility of drastic federal spending changes (such as the CHST), securing the ability of provinces to plan for the consequences of such programs well in advance is important both in terms of policy coherence and intergovernmental relations. To the extent that health care writ large is experiencing a significant transformation from an emphasis on acute care to a focus upon health promotion and disease prevention, and from isolated "smokestack" programs to greater consolidation between programs, provinces are working hard to reconfigure health care systems within their jurisdictions to better respond to the needs of a modern population. Predictability of funding is essential to this strategy of reconfiguration. The essential starting-point, then, is simply to maintain the provisions for consultation and due process between governments articulated in section 5 of the SUFA.

The next steps are more provocative, and must be considered together. These are first**,** to establish an acceptable "opting-out" formula regarding both transfer and direct funding programmes and, second, to formalize federal spending power. It is important to remember that SUFA came into being in the first place through concerted provincial negotiations in response to the implementation of the CHST. These negotiations, supported by Quebec, included a formal opting-out provision that was later dropped when Ottawa agreed to adjust its position on issues including public accountability and dispute settlement in return for the provinces modifying their position on the federal spending power. This, in turn, led to Quebec's refusal to sign the accord (Lazar 2000a, 110).

The discussion of an opting-out option is not new. Such a measure was established in 1964 for the administration of a separate pension plan for Quebec; and has been raised with reference to constitutional change since then. The Meech Lake Accord, for example, would have allowed the federal government "to provide reasonable compensation to the government of a province that chooses not to participate in a national shared-cost program that is established by the Government of Canada after the coming into force of this section in an area of exclusive

provincial jurisdiction*, if the province carries on a program or initiative that is compatible with the national objectives.*" The SUFA is similar, insofar as it permits Ottawa to establish new initiatives with the support of any six provinces, and stipulates that any dissenting province could then receive federal compensation for its own program as long as it meets the agreed objectives of the national program. However, as Lazar points out, SUFA goes further in accommodating provinces: first, by permitting provinces which do "not require the total transfer to fulfill the agreed objectives" to "reinvest any funds not required for those objectives in the same or a related priority area"; and, second, by applying this formula not only to shared-cost programs but also to jointly-financed programs that are not based on cost-sharing (Lazar 2000a, 111). In Lazar's view, SUFA is at least as flexible for the provinces as the provisions contained in either the Charlottetown or Meech Lake accord, although the SUFA stipulations are implicit rather than explicit (Lazar 2000b, 10).

The reason this point is of such import is because it speaks to the wider problem of Quebec's position within the Canadian federation. As such, then, it has grave importance not only for health policy objectives but also for those of Canadian federalism at a broader level. But even if the opting-out provision were accepted with an eye to the political stance of Quebec, it is arguable that there is no reason to fear that this would pose a threat to the national standards of Canadian health care noted above: as Vaillancourt argues, for example, Quebec has shown that its more idiosyncratic policy directions in health care have actually been more innovative and within the spirit of contemporary health care reform – including, for example, community health care centres, early childhood centres, and eschewing the private provision of long-term care for province-led policy – than those occurring in much of Canada (Vaillancourt 2002). (There is speculation that the rising strength of the ADQ may be a reflection of growing support for neoliberal policies in Quebec, but it is simply too soon to verify this.)

Most commentators agree that any federal-provincial arrangement on health policy cannot function well without the participation of Quebec. Some critics hold that the SUFA's failure to secure Quebec's signature "confirmed and further deepened the Canada-Quebec impasse," and also demonstrates the "significant bias" against Quebec "and its particular concerns" (Dufour 2002, 8, 9). During the 1998 Premiers' Conference in Saskatoon, observes Alain Noël, the Quebec government compromised on three conditions: "it left aside unsolved constitutional difficulties to join a bargaining process that did not make the opting-out formula unconditional; it accepted much of the inter-provincial – and pan-Canadian – discourse on the social union; and it recognized implicitly a legitimate role for the federal government in social policy" (2000, 8). The provinces, for their part, agreed to include a formal opting-out formula as a bargaining position; a stance which resulted in a limited and informal opting-out condition.

Others, however, object that Quebec refuses to participate in such a collaborative measure – and would potentially refuse to collaborate on any but the most lucrative agreements – because its position of non-participation is advantageous from a game-theoretical perspective, wherein "Quebec will either get transfer money without having had to agree to broad rules of engagement vis-à-vis Canadians in other provinces, or the federal government will deny Quebec money that the other provinces are receiving" (Robson and Schwanen 1999, 5), thereby playing into the separatist agenda of the Parti Quebecois government (see also Gibbins 1999).

Two points can be taken from this: first, for larger political reasons as well as for more specific policy reasons, Quebec cannot be left outside of any social policy agreement on health care. Second, as Dufour maintains, "Quebec cannot remain on the sidelines of Canadian intergovernmental relations in the field of social policy" for its *own* benefit (2002, 7). The best compromise has been presented by Harvey Lazar, who argues that a formal opting-out provision "would explicitly acknowledge that opting out is possible without making it a right. In effect it would leave room for considering opting out on a case-by-case basis, which is consistent with practice during the years of building the post World War Two welfare state" (Lazar 2000b, 10). Lazar stipulates four characteristics of such a possible compromise: first, the opting-out provision would be explicit, rather than implicit; second, any province opting out would publicly acknowledge Ottawa's financial contribution; third, the province would use the funds either in a way that was "broadly compatible with the purposes of the new program" or, if the province already had a program that met Canada-wide objectives, it could use the monies in the same or in a related priority area. Finally, to ensure the possibility of Quebec agreeing with "Canada-wide priorities", national consensus would be measured by agreement by seven provinces with at least half the population, rather than simply by any six provinces (Lazar 2000a, 117-8).

Except for those who take issue with the idea of asymmetrical federalism on principle, however, the issue here for most is not what Quebec will do with any opting-out provision: Quebec's commitment to a public health care system is clearly on the record (Vaillancourt 2002). The real concern regarding such an opting-out clause is Alberta, with its stated intention to utilize private health care resources more fully. Notwithstanding this, however, it must be remembered that this opting-out formula could only be applied in cases where a province's existing programs were "broadly compatible with the purposes of the new program" or, where existing programs already were achieving such objectives, funds could be used in a related priority area. The more political concern might be that federal objectives would be tailored to be more consonant with Quebec's in order to avoid any major political disputes (Lazar 2000a, 116, 118), thereby skewing health policy in general toward Quebec's. This may be a valid concern it and of itself; however, to the extent that Quebec's health policy is much more in line with CHA principles than is Alberta's potential health policy blueprint, any such informal tailoring of health policy should not cause great concern for those who wish to preserve the CHA standards. The concerns that may be raised by implementing an explicit opting-out clause would also be mitigated by the

concurrent formalization of the federal spending power. Would Ottawa agree to this? It is important to remember that the provinces were persuaded to sign the initial SUFA largely because of the extra federal dollars that Ottawa was prepared to distribute as a *quid pro quo*: thus, unless the federal government is willing to pay, either in cash or in tax points, for an enhanced agreement on health care, it will have to compromise in terms of sharing its political power.

Like the principle of opting out, the federal spending power is more implicit than explicit, although the SUFA "institutionalizes" the recognition of this power. Objections to the federal spending power in principle are best articulated by Hamish Telford, who argues that "[t]he federal spending power, at best, can only be *inferred* from the constitution; the JCPC ruled that the spending power was *ultra vires*; the gift-giving argument is tenuous; and justifying the spending power as in the national interest is highly problematic in a multinational federation" (by which he means that the federal spending power limits Quebec's "freedom to determine their own social and cultural policies") (Telford n.d., 11).

However, one can respond by arguing, first, that decades of practice (as well as the recent Supreme Court decision regarding the cap on CAP) have embedded the principle of federal spending into the fabric of Canadian intergovernmental relations. Given that it will not go away simply by refusing to acknowledge it, recognizing the federal spending power explicitly may be a relatively cheap way for provinces to achieve other objectives (including a formal opting-out clause or a binding dispute-resolution mechanism). Second, the federal spending power is important from a *policy* point of view insofar as it is still the federal government's most potent instrument for corralling disparate points of view into a workable national health plan; and it will be essential in balancing out some of the provisions allowing for greater provincial influence in national health policy. Third, the explicit recognition of the federal spending power may be important from a *political* point of view in persuading Ottawa to accept *some* formal restrictions upon this power: legitimizing this policy tool may be, in its estimation, worth accepting some clear limitations on it. An explicit recognition of the federal spending power is partially symbolic, but it nonetheless holds a great deal of political potential. Again, its force is counterfactual and thus difficult to evaluate: in essence, provinces simply could not challenge federal spending in broad constitutional grounds. This is of little import *if* Ottawa has little inclination (or money) to become more involved in the provision of health services; but it would give the federal government a great deal of political and moral clout *were* it desirous of doing so.

It is also imperative that both levels of government articulate a consonance of direction, which would be useful in provinces' attempts to develop overarching shifts in the way in which they need to focus health service delivery in the medium- to long-term future, and in the federal government's attempts to refocus how it can best consider its health care roles outside of its financing role. One essential issue that is being addressed constructively by both levels of government collaboratively is that of health information. This includes a national infostructure

system, the development of common data standards, and health reports to debrief Canadians. The federal government, which has contributed to the Canadian Health Infostructure program since 1997, committed $500 million in September 2000 "to accelerate the adoption of modern information technologies to provide better health care" (Canada Senate 2001, chapter 10). A second collaborative strategy should be established to address the issue of health human resources (generally but not exclusively doctors and nurses). Although the training and provision of health personnel are under clear provincial jurisdiction, issues of professional mobility (including the practice of better-funded provinces "poaching" health care personnel from poorer provinces) are best addressed from a national rather than regional perspective.

As Adams (2001b, 278) observes, there is evidence to support "the use of a more collaborative intergovernmental regime in certain circumstances," including health program development issues with a country wide impact, new program initiatives, and common political problems (such as reinvigorating the blood collection service). Given a clear assignment of major roles to the senior levels of government, especially and crucially pertaining to simple issues of funding levels, funding formulae, and dispute resolution, the more specific programmatic issues can usefully be addressed collaboratively. As Lazar notes, within the federal and provincial line ministries there is much more likely to be commonality of purpose and viewpoint (2000b, 8-9); and thus, once overarching issues of long-term funding patterns are sorted out (usually by the respective departments of finance), intergovernmental cooperation can be better facilitated on specific policy questions. Thus the specific type of body within which such collaboration ought to be pursued would be a Canada Health Council (discussed at length by Adams 2001b, 282-287).

Perhaps the role in which the federal government has the most independence is in its research and evaluation role. The research and evaluation role is quite crucial at this point, with health reform, in general, and evidence-based medicine, in particular, the focus of much governmental activity. The Health Transition Fund (1997-2001) and the Canada Health Infostructure Partnerships Program (2000-2002) are two such examples of national health evaluation programs involving federal funds. Given the important role of health research, federal funding must be increased in this area. The pharmaceutical industry has for almost a decade been the leading source of funding for Canadian health research (Canada Senate 2001, chapter 9), a source of some anxiety to those concerned with the nature of independent research. Federal funding for health research should again rise to at least 25% of total expenditure on health research funding (from its low of 16% in 1998 – see Canada Senate 2001, section 9.1.1) to balance the strength of the drug industry in Canada. Another aspect of Ottawa's research and evaluation role, albeit one that would require coordination with the provinces, is the need to support innovative pilot projects in the delivery of health services. This emphasis upon federal funding of innovative programs also supports the "experimental laboratory" model of federalism espoused by those defending provincial jurisdiction over health care.

Towards Accountability and Transparency

Section 3 of the SUFA articulates a commitment to the Canadian people to increase the scope and nature of democratic government by keeping them informed on the progress of social programs, by engaging in an ongoing process of dialogic participation, and by providing a procedure for appeals on administrative decisions. The overarching objective of citizen engagement is not directly relevant to this paper, the focus of which is the appropriate roles for senior governments. The issue of accountability more broadly stated is, however, relevant insofar as intergovernmental relations can be facilitated by greater accountability in both health care funding and health care expenditure; moreover, insofar as accountability to the public is an oblique means governments use to hold each other accountable, it can be discussed within the context of intergovernmental relations.

We live in an era where the values of democratic governance, including transparency and accountability, are held to be self-evidently important. But we also live at a time where efficiency and the ability to get things done in a complex and contradictory environment are also highly valued. And the paradox for health care governance, succinctly stated by Lazar, is that "the more successful the social union turns out to be from an executive federalism perspective, the greater the risks that it will increase the size of the democratic deficit" (2000a, 110). From the perspective of health system objectives, accountability is a good thing simply because it ensures that the funds get to where they are supposed to be going. The most publicized example of this has been the utilization of the $1 billion medical equipment fund established by the federal government during the September 2000 first ministers' conference. The monies, which were to be designated for high-technology equipment such as dialysis machines, MRIs, or computer tomography scanners, were found to have paid for lawn tractors, dishwashers, floor scrubbers, paper shredders, and fax machines (Priest 2002, A1). Although there was an understanding that the provinces were to provide a public accounting of how the funds were spent, because federal funds (including CHST funds) go directly into provinces' general revenues, it is impossible to determine whether, for example, federal funds were used for MRIs and provincial funds for paper shredders, or *vice versa*. The issue is not the lack of accountability *per se*: under the current system, the provinces (subject to the CHA) have the responsibility to account to their constituents regarding their utilization of health care funds. But when one or both levels of government engage in cost containment, each level of government can blame the other for the cutbacks that result, with both refusing to take primary responsibility (Fierlbeck 2001).

One must also understand the political motivation of the respective governments in advocating any form of accountability mechanism. As Susan Phillips recounts in some detail, during SUFA negotiations the provinces supported a form of accountability based upon individual provinces' stipulation of indicators (thus preserving provincial autonomy) in order systematically to show the effects of future potential federal cutbacks on their respective health

care systems. Ottawa, for its part, wanted to be able indirectly to press "underperforming provinces to direct spending towards social programs and to design more effective programs" (Phillips 2001, 18). Even though its transfers are formally unconditional beyond CHA restrictions, the federal government can use public pressure (or more specifically, public censure) to goad provinces into certain types or levels of health care spending.

Despite protestations based upon autonomy and jurisdiction, the stipulations of accountability and transparency noted in section 3 of the SUFA should be augmented and strengthened. Both levels of government should be expected to report formally to their constituents and to each other regarding both outcomes and activities, using a set of standardized processes and indicators**.** There has been some progress made on reporting stemming from recent Premiers' meetings; but there is still much resistance to provinces losing the autonomy to determine the standards of measurement, and also to measuring the *outcomes* of health programs (although this, again, is improving). Governments have in the past two decades shown instances of a willingness to put political ends before health care objectives; if, as the rhetoric would imply, both levels desire a sincere undertaking to protect these objectives, then there is no reason not to regularize this commitment. The stipulation that governments formally become more accountable to each other rather than simply using "the public" as a watchdog is important because, as Phillips notes, "[o]utcome measurement of social policies has proven to be much more complex in practice than in concept, and citizens and voluntary organizations are extremely limited in their ability to be effective watchdogs" (2001, 23).

Provincial governments may argue that they have the constitutional jurisdiction and thus the ultimate responsibility for health spending, and that they should thus be able to account for these funds as they see fit. But, to the extent that federal transfers involve monies from federal taxpayers, Ottawa too has a responsibility to its constituents to inform them of how its funds are utilized. The principle of "ultimate provincial jurisdiction" also evokes little sympathy from the broader public, which has articulated the collective viewpoint in public opinion surveys that both levels of government are appropriate watchdogs for each other's respective activity (Centre for Research and Information on Canada 1997). Moreover, as Phillips argues, now that federal transfers have been restored to earlier levels, "the idea of public reporting and rendering of accounts for the modification of existing programs and their funding, coupled with commitments to clearly state the roles and responsibilities of each order of government," becomes less attractive to the provinces (2001, 22). Notwithstanding the possibility that provinces may well object to more stringent accountability provisions given the restoration of federal funding, it would nonetheless be shortsighted of them given the provinces' frequently articulated anxieties and lack of trust concerning the long-term stability of federal funding.

The measurement and comparison of outcomes is admittedly one which will require sustained and vigorous development, and one where we would be naive to expect clear results in the short term. This is, however, no reason to dismiss the effort. A corollary of this suggestion, and one

which can be more easily operationalized, is the establishment of a health commissioner whose function it would be to report on dubious or inefficient practices regarding the allocation of health funds. The existence of a third-party auditor (based on the model of the current auditor-general) is of course no panacea (see, e.g., Kroeger 2000, Sutherland 2001). But it could at the same time be a mechanism to oblige governments to account for their activities simply by opening existing practices to public scrutiny which, both levels of government seem to hold, is an effective way of keeping the *other* party in check. Finally, it is useful to reiterate the utility of a jointly-appointed ministerial council responsible for developing a national framework for public accountability, facilitate coordination between governments at the sectoral level, serve as a neutral fact-finding body when intergovernmental disputes arise, and to report back to participating governments and the Canadian public on the performance of the health care system at a national level (see Adams 2001b, 283).

Other Levels of Government

Intertwined with the discussion regarding the respective roles of federal, provincial, and territorial governments is the debate regarding the role of municipal government and regional health authorities in the provision of health care services. Roger Gibbins, for example, argues that because so much of the creative policy-making in health care reform occurs at the local level, we can expect in the years to come "an intensified campaign for greater legislative scope, financial powers, and constitutional recognition" (Gibbins 1999, 210). This is indeed the crux of the problem: while local and regional health authorities design and implement the detailed substance of health care services (and take first responsibility for the policy choices they make), they have little to no tax base or constitutional authority in which to work. There has been some speculation that this imbalance of responsibility and power has allowed provincial governments to offload some of the less politically-popular policy decisions to local decision-making bodies, echoing the strategy of federal cost containment throughout the 1990s (see, eg, Fierlbeck 1997).

There is in fact an increasingly emphatic political drive by large municipalities to increase both their legislative power and their financial capacity. In a brief to the Prime Minister's Caucus Task Force on Urban Issues, the Federation of Canadian Municipalities argued that

> Canadian politics is defined principally by a divisive federal/provincial dynamic driven heavily by partisan issues. Structural realities dictate that the federal/provincial equation will never be easy. But when partisan interest is added, this natural tension can become debilitating conflict and confrontation. In contrast, municipal governments are non-partisan, focused generally on practical outcomes and the delivery of services to citizens (Federation of Canadian Municipalities 2002, 6)

In a similar vein, the "Big City" mayors have argued the case for a charter that would give cities "powers and resources that match their responsibilities" (Canada's Cities 2001, 1); it is interesting though that the political campaign for greater municipal powers has not been articulated within the context of health policy. Andrew Sancton concludes that there is insufficient political support at the municipal level to counter the control of provincial policy-makers and that, as long as this state of affairs continues, "municipalities will remain minor actors in the drama of Canadian federalism" (2002, 275).

Is there a good case for such a shift in power toward the local level in Canada? The answer is, unfortunately: we just do not know. The main reason for this is, as most observers concur, because the organization of local governance in health care varies "considerably in terms of structure and responsibilities;" thus, "it is very difficult to generalize about them" (Rasmussen 2001, 250). It is also very difficult to come to any clear analytical conclusions about them. There are, in the first place, competing ideological visions underlying the *raison d'être* of

decentralization: on the one hand, decentralization and regionalization are seen as a means of securing an inclusive and participatory public policy regime by facilitating individuals' involvement within particular policy jurisdictions. On the other hand, decentralization and regionalization are also viewed approvingly by proponents of a market-oriented delivery system (for more on this debate see Fierlbeck 1997; Tomblin 2002; and Taft and Steward 2000). The second issue is one of accountability: ought health care governance structures ultimately be responsible to a local population, or to the articulation of national standards? In the third place, as Tomblin notes, regionalization was never designed to deal with adjacent components of the health care system (such as the collegial and market spheres) which operated relatively autonomously: "the jury is still out," states Tomblin, "on whether regionalization was ever intended or designed to challenge the old bio-medical model" (2002, 19).

Moreover, the functions of regionalization are varied and potentially contradictory. There is, for example, the *integrative* function of regionalization, which focuses on moving health care delivery away from the traditional "smokestack" design and towards a more comprehensive system of provision (Rasmussen 2001). Then there is the *economic* function of regionalization, which attempts to achieve greater economies of scale in paying for health care services (e.g., the Council of Atlantic Premiers: see Tomblin 2002, 20). In addition, as previously noted, regionalization can contain a *political* agenda (either explicit or implicit) regarding the respective roles of the population, the market, and the state (Rocher and Rouillard, for example, argue that the move towards decentralization in Canadian federalism veils "another approach that seeks less to reform intergovernmental relations than to instill in the institutional framework a desire to see the State (provincial and federal) disengage from economic and social regulatory mechanisms" [1998, 233].)

The bottom line is that there is no clear conception of what regionalization is, what its functions are, how it operates, and what the implications are. And, despite the conservative and perhaps unsatisfactory nature of this conclusion, the best that can be suggested is that more formal information-gathering be conducted on the nature and potential of local and regional forms of government. The number of phenomena that "ought to be studied" regarding the Canadian health care system is admittedly exasperatingly high: the advantage of this, however, is that the information-gathering mechanisms which can administer such studies are essentially already in place. A substantial comparative study investigating the qualitative and quantitative dynamics of health care regionalization is essential before any clear policy proposals can with confidence be articulated. Pilot projects under provincial jurisdiction could then be established in order to test the viability of any perceived policy options based upon evidence collected in the larger survey.

Conclusion

The discussion of what roles senior governments should play in formulating health policy is bound most directly by constitutional jurisdiction; it must, however, be tempered by a recognition of what policy objectives are served, what governments are willing to do, and the motivations they have to do so. The advantage of a clear assignment of roles for federal and provincial governments in terms of health objectives is that accountability is more easily achieved: the ultimate responsibility for actions taken is clear. There is less buck-passing, finger-pointing, or gainsaying for policy failures, funding cuts, or simple mismanagement. Given the particular political and constitutional context of the Canadian health system, however, a clear autonomy of roles could also result in highly disparate provincial health care systems (if provinces were given increased capacity to tax) or acrimonious and unpredictable funding patterns (if Ottawa exercised more responsibility for funding provinces on its own terms). The advantage of mutual cooperation, on the other hand, is that it facilitates greater communication between parties over policy objectives and policy strategy. This approach, however, can lead to rancorous beggar-thy-neighbour practices or blame-shifting tendencies if mechanisms do not exist to mitigate differences of opinion or conflicting policy directions when they arise.

We may be entering into what Tuohy (1999) calls a "window of opportunity" in health policy formulation where the actors are either willing to change the rules of the game, or simply have no recourse to any more preferable alternatives. Changes in the federal role in setting health care policy have clearly not been consistent with changes in cost-sharing; relative levels of federal funding have dropped at the same time as Ottawa has, for various reasons, become more enthusiastic about its role as protector of national standards for a uniquely Canadian health care system. It is unwilling to pay the dollars required to play this role, but it seems equally unwilling to relinquish the role.

This paper has argued that one way forward may be to establish a compromise balancing the advantages of a clear assignment of responsibility with those of mutual cooperation, securing both accountability and stability. If Ottawa does not wish to commit the funds it needs to enforce the CHA to its satisfaction, it must use its legislative powers as its capital. It can agree to limits upon its autonomous spending power both in terms of scope and application in exchange for a formal and ongoing presence in health policy-making. It gains not only greater political control for less economic outlay, but also wins formal recognition for a power the constitutional status of which has never been completely accepted. Provinces may be willing to enter into such an agreement despite the formalization of a federal presence because of explicit and predictable limits upon federal activity combined with the capacity to receive funding for similar-but-distinct programs under a justiciable opting-out option.

This solution does, however, depend upon certain assumptions (that, e.g., provincial governments' objectives are largely consonant) which may rightfully be queried. It is also

contingent upon the particular manifestation of political dynamics (such as the relationship between departments of health and finance within discrete jurisdictions) which are technically not within the sphere of intergovernmental relations proper. It depends, most profoundly, upon the judgment of those who have the power to grasp such a window of opportunity and who have the acuity to recognize that while such a distribution of roles might not permit the best of all possible worlds it may, at the very least, avoid the worst.

One might also argue that the fact that such a trade-off builds upon the existing logic of the SUFA makes its possible implementation slightly more optimistic, as the basic form of the compromise is already set out. One might, however, argue that this recommendation is also too dependent upon the health of SUFA. The accord is coming to the end of its three-year agreement, and is currently being evaluated by the respective governments. Some governments are skeptical about its usefulness, and about the willingness of other governments to observe the spirit of the accord: if it is all about trust and collaboration, some might ask, then why did it take a year and a half to get a dispute resolution mechanism in place? Part of the problem in the evaluation process is that SUFA is in some important respects a counterfactual safeguard: for example, the provinces *would* be informed *were* Ottawa to introduce radical new changes to programs. Ottawa has not done so; and thus the utility of SUFA in its safeguard function is largely undetermined. Moreover, SUFA is relatively silent on the federal use of one-off, targeted funding initiatives: for instance, the September 2000 Primary Healthcare Fund has in some instances not been received by provincial governments due to federal-provincial disputes over the conditions attached to it. Thus provinces dislike targeted funding because it is too conditional and too short term (again undermining the predictability of long term health funding), while the federal government prefers such targeted programs because of their high public profile, limited financial liability, and detailed conditionality.

These are serious reservations, but they are not conclusive evidence that a compromise as sketched out in this paper could not work. The proposal suggested here is merely a possibility, not a foregone conclusion (nor even an easy sell). The demise of SUFA would surely make such a tradeoff less likely, as it would lessen even further the trust or goodwill between parties, and increase the perception that nothing but hard-nosed political realism can work in intergovernmental relations. But the idea of an explicitly-recognized federal spending power could nonetheless be broached again, whether SUFA survives or not; the desire for predictable funding patterns will always exist (especially in difficult economic times); and the public will most likely continue to press for intergovernmental accountability and transparency. Thus the elements to such a compromise will be with us for some time, even if SUFA is not.

Some might observe that the suggestions noted here are largely institutional, and give short shrift to a more sustained social and political analysis. Does this mean that the right institutional solution could end the intergovernmental disputes that characterize past and present political relations? Absolutely not. However, there are better and worse institutional contexts; and a

context in which confrontation is minimized goes a long way in improving, though not solving, intergovernmental political conflict. As the focus of this paper must of necessity be a very narrow institutional one, such measured social and political analysis must be found elsewhere (e.g., Maioni 1998 , O'Reilly 2001, Tuohy 1999).

Finally, one must (paradoxically) be wary also of successful intergovernmental collaboration insofar as this is frequently manifest as "executive federalism", a form of decision-making which is characterized by in-camera negotiation and decision-making between government officials. The issue here, as Smiley (1979) argued, is that transparency and accountability to the wider public is sacrificed in order to facilitate collaboration between governments. At this point, however, an overly-cozy intergovernmental relationship is not one of the most pressing issues to confront the Canadian health care system.

In sum, then, the institutional and policy changes suggested here are premised both on the need to achieve the long-term sustainability of a universally-accessible, publicly-funded health system *and* on the acknowledgment that governments make decisions with an eye to whether measures strengthen or disadvantage them vis-à-vis other political actors. Trade-offs may have to be made however unpalatable they may be either to the participants or to those preferring a model unsullied by political concessions. Compromise is a hallmark of politics writ large, not only of federalism; and if the only way forward is with a few sidesteps, it is nonetheless preferable to an unproductive status quo.

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