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Federalism and Health Care: The Impact of Political-Institutional Dynamics on the Canadian Health Care System

by

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Highlights

This paper surveys the relationship between the federal government and the provinces in health care policymaking over time. It examines the way in which the division of powers in the health care system has been shared between the two levels of government, as well as the conflicts that have arisen over direction in Medicare spending and policies. The paper surveys the comparative literature on the impact of institutional differences on policymaking, as well as the historical evolution of federalism and the health care system. The paper also explores comparable federal systems such as Australia, Germany and the United States, as well as describes possible impacts of globalization and recently established trade agreements on the evolution of Canadian health care.

The paper argues that greater cooperation between the federal government and the provinces could be achieved by eliminating the Canada Health and Social Transfer and the counting of tax points in funding the system. Instead, the principles of partnership, transparency, accountability and citizen involvement should be entrenched and agreed to by all the parties. We advocate a return to 50-50 block funding by the federal government and a reinforcement of the principles of the *Canada Health Act*, but with the establishment of an intergovernmental mechanism that would also permit participation by stakeholders in the system.

Executive Summary

This paper surveys the relationship between the federal government and the provinces in health care policymaking over time. It examines the way in which the division of powers in the health care system has been shared between the two levels of government, as well as the conflicts that have arisen over direction in Medicare spending and policies. The paper surveys the comparative literature on the impact of institutional differences on policymaking, as well as the historical evolution of federalism and the health care system. The paper also explores comparable federal systems such as Australia, Germany and the United States, as well as describes possible impacts of globalization and recently established trade agreements on the evolution of Canadian health care.

In this study, we were asked to explore four central questions: Are there sectors in which federal-provincial relations are more harmonious and which could lead to great innovation in the system? How do federal-provincial relations in Canada compare to other countries? How do other countries deal with their tensions? What changes should be brought to the mechanisms of cooperation between the two levels of government in order to improve relations between them over the long term?

Our survey of the political institutional literature suggests that governments, both federal and provincial, will naturally defend their own turf. Most conflicts between the two levels of government naturally concern financial and fiscal issues. The Canadian case is somewhat different from other cases in that the government of Quebec is a particularly strong defender of the original division of powers as outlined in the *Constitution Act, 1867*. While other Canadian provinces have proven flexible in terms of their interpretation of the jurisdictional division (although all provinces have raised the issue of vertical fiscal imbalance), Quebec has not been willing to sacrifice its powers, as we can see from the fact that the government of Quebec did not sign on to the Social Union Framework Agreement (SUFA).

SUFA is often viewed as providing a model for a more harmonious relationship. However, we do not believe that this model is workable and we would reiterate the points made by the government of Quebec. The model of federal provincial diplomacy or intergovernmental negotiation has been successful across a broad range of federal-provincial relations, especially when these negotiations are based on the principles of mutual respect, partnership and equality of status of the participating governments. These principles could be more successfully applied in the health care sector than they have been in the past, as we will discuss in the paper.

Our comparative analysis demonstrates that tensions between federal and subnational governments are found in all federal systems except in cases such as Australia's, in which one level of government dominates the health care area. We do not believe that the Australian or American models are helpful; in the Australian case, the dominance of the federal government would never be accepted by provincial governments (particularly but not exclusively Quebec) and would upset the historical institutional relationships between the two levels of government in this area. The American case is not particularly relevant because it is based on a patchwork of programs (Medicare and Medicaid) and is still an overwhelmingly private system. However, we believe that the institutionalization of stakeholders in the system in the German model, as well as

the stable and long-term commitment to funding in that system are two ideas that should be taken up in Canada.

The general principles that should guide cooperation between the two levels of government are: equal partnership between the federal and provincial governments in managing the health care system; stability, transparency and accountability in funding the system over time; and citizen and stakeholder involvement and input into the management of the system. In addition, we assume that we will maintain a public health care system, without opening the door to significant privatization, and that we will maintain the principle of a public, universal, accessible and portable system according to the 1984 *Canada Health Act*. Specifically, we believe that the Canada Health and Social Transfer (CHST) and the counting of tax points transferred from one level of government to another are not consistent with these principles. They have introduced instability and uncertainty into the funding system, caused systematic underfunding and fiscal disequilibrium in the system, and have opened the door to political forces both in Canada and continentally, who favour privatization in whole or in part of the system. In our view, it is absolutely essential that the federal government dispense with both the CHST and with debates over the transferred tax points. We believe that the best system would be one in which there was a single block grant for health care from the federal government, governed by the general principles of the *Canada Health Act*, but with the flexibility of a limited opting out mechanism. We believe that the government should make a long-term commitment to a gradual return to a 50-50 funding of health care, and that the federal transfer to the provinces for health care should be mandated as health care spending for the provinces. Further, we believe that intergovernmental mechanisms to manage the federal provincial relationship in health care should institutionalize relationships between health ministers and, as in the German model, include other stakeholders. Along the same lines, in accordance with these principles and new mechanisms, the federal government should not undertake unilateral initiatives in using its spending power in provincial jurisdiction but should propose new health care initiatives through this new intergovernmental institution.

Effect of Political Institutions on Public Policy: Canadian and Comparative Evidence

The object of this study is to explore the effects of federal political institutions on the viability, efficiency and adaptability of the Canadian health care system. As such, the main question of the study taps into one of the major questions of political science itself, namely, the impact of political institutions such as federalism on policymaking and politics, and the ways in which policies may be designed for greater or lesser efficiency or adaptability. In particular, institutionalist perspectives in political science have focused theoretically and empirically on these questions with respect to the overall shape of welfare state development (Liebfried and Pierson 1995; Pierson 2001) as well as the specific case of Canadian health care (Maoini 1998). In this section, we will briefly review the Canadian and comparative literature on the impact of federal political institutions on policies and policymaking.

One of the main questions of the Canadian and comparative literature is the impact of federalism on public provision in social policy. Does federalism inhibit public provision and retard the development of the welfare state in the first instance? How does federalism shape the policy design of social policies, once such policies have been adopted? Does federalism create obstacles to restructuring and retrenchment, just as it might have originally inhibited social policy construction? Or, are the dynamics governing retrenchment quite different from those that govern program creation and expansion (Pierson 1994)? Does federalism create a social policy system of what Alan C. Cairns has called “constitutional conservatism” (1971), which makes the system less adaptable, flexible and open to change than it might otherwise be? Once social programs have been established, does federalism create obstacles to the retrenchment and restructuring of such programs and, as such, render the system impervious to certain types of policy change?

Federalism may inhibit policy change and adaptability for a number of reasons. Where jurisdiction over social policy is shared between federal and provincial governments such as in the area of contributory pensions, the consent of both levels of government is necessary for social policy establishment and change. In cases in which provincial governments have jurisdiction, the federal government plays an important role by funding the social policies through the use of the spending power. The use of the federal spending power in areas of provincial jurisdiction has aroused major political and constitutional controversy as provinces have claimed that it is a violation of the federal principle for the federal government to shape or make policy by using its spending powers in policy areas that have been constitutionally assigned to provincial governments. Federalism complicates the policymaking process by multiplying the number of actors who have constitutional or political status in shaping policy (Weaver and Rockman 1992; Pierson, 1994; and Banting 1987). By multiplying the number of actors, federal political institutions multiply the number of veto points in the decision-making system, permitting each province and the federal government to veto the establishment of new policies or changes to existing social policies. In this regard, it is very important to note that the design and impact of federalism will vary across policy areas. The constitutional and political rules that govern contributory pensions are quite different from the constitutional and political rules that govern Medicare because the jurisdictions of governments in the Canadian federal

system are different in the two policy areas. In the area of contributory pensions, both levels of government have a clear constitutional authority (with provincial paramountcy), spelled out by the 1951 constitutional amendment. This has evolved over time into a set of clearly understood rules that govern the decision-making process (a seven and fifty decision rule plus the consent of Quebec) and a flexible policy design that allows provinces to opt out of the Canada Pension Plan, thus permitting a *de facto* special status for Quebec (Banting 1985). In Medicare, the situation is more fluid. With a few exceptions (e.g., health care for Aboriginal peoples), health care is squarely in provincial jurisdiction and the federal government's intervention is on more controversial political and constitutional ground in using its spending power to shape policy.

Does the multiplication of veto points in the federal system retard social policy development and change? The evidence on this point is mixed. Banting's comparative analysis of Canada's income security programs found that federalism had a moderately restraining impact on the development of income security (Banting 1987). However, analyses of the health care field specifically have found that federalism has been neutral in the development of Medicare. In a comparative analysis of the development of health policy in Canada and Australia, Gwendolyn Gray, for example, argues that the partisanship of government and the determination of politicians to enact (or not enact) Medicare was more important than the impact of federalism itself (1991). Others who have examined the development of the Canadian system have argued that, while federalism certainly affected the development of health policy, it did not prevent it or slow it down significantly (Tuohy 1993). Similarly, surveying a broad comparative examination of federalism and social policy in Europe and North America, Pierson concluded that there was no clear correlation between federalism and expansionist social policy (Pierson 1995).

The flip side of federal political institutions is that multiple veto points may also provide multiple points of access for policy change. This argument has two parts. First, as Antonia Maioni argued in her comparative study of the origins of the modern health care systems of Canada and the United States, the relatively decentralized shape of Canadian federalism permitted local experimentation in social policy, which led to the establishment of the contemporary Medicare model in Saskatchewan in hospital insurance in 1947 and medical insurance in 1961 (Maioni 1998; Trudeau 1968). From Saskatchewan, the Medicare model diffused to other provinces, in part because of the support of the federal government, which, as Maioni puts it, "acted as the agent for the diffusion of reform" (Maioni 1999, 99). Similarly, in the current period, policy change in one province could lead to diffusion throughout Canada, including the possibility that the delisting of medical services and opening the door for private insurance companies in one province could be diffused through other jurisdictions by a comparative race to the bottom. Just as the federal government diffused the expansion of Medicare throughout the country through the use of its spending power, so too the federal government may diffuse the retrenchment of Medicare by weakening its own funding and enforcement role. To date this dynamic has not really been considered in studies of retrenchment in social policy. The multiple veto point dimension of federalism has been used to argue that federalism complicates the process of making cuts to social programs (Pierson 1994; Pierson and Smith 1993), but it has not been developed systematically as an argument for the diffusion of incremental and invisible retrenchment over time. This applies particularly to a situation in which policy change may be occurring "by stealth" (Gray 1990) as the public role in health care is incrementally eroded by the rise of the private sector competition (Armstrong 1996). Noël has

recently presented a powerful argument against the view that decentralization creates a "race to the bottom" in welfare state provision and points out that a decentralized federal system may offer important opportunities to make social programs accountable, transparent to citizens, sensitive to local needs, and more effective and efficient in delivering solutions to public health problems (Noël 1999).

A second aspect of the multiple veto point argument is that such veto points also constitute political opportunities for organized social forces to influence the shape of policy. In a federal system in which responsibility for certain aspects of policy are shared between federal and provincial governments – as is the case in Medicare – groups may target both levels of government in seeking to influence health policy. If they fail at one level of government, they may attempt to influence the other level of government in what the American political scientist Grozin called "the multiple crack hypothesis," i.e., the idea that federalism provides groups with more than one chance at bat, to use a baseball analogy. Groups may even try to shift responsibility from one level of government to another if they perceive that the other level of government may be more favourable to their views. On the other hand, the involvement of multiple governments in the federal policymaking system also means that many intergovernmental mechanisms are used to coordinate policy. Executive federalism creates a dynamic in which bureaucrats often carry on negotiating policy issues beyond the reach of interest groups. Government to government bargaining can actually diminish the scope for interest group interaction in policymaking (Simeon 1972; Weir 1973).

In order to get beyond these conventional accounts of group interaction with political institutions in the health care sector, the concept of the policy community is a useful one (Pal 2001). This refers to the governmental and non-governmental organizations (NGOs) that are active in a particular policy sector (such as health care) and the patterns of their institutionalized interaction. The concept of the policy community can also be useful in specifying the role of citizen engagement and stakeholders from civil society in the process of policy change and reform. Recent work on interest organizations and governments suggests that governments and NGOs may be allies in the policymaking process and that, contrary to the traditional view of groups as shut out of intergovernmental relations, there have been recent initiative to bring NGOs into the process of policymaking (Fafard 1997).

Furthermore, in complex policy areas such as Medicare, in which there are a large number of highly specialized professional and expert interests such as hospital associations, and organizations of medical professionals such as doctors, rational choice theory has some obvious applicability. This theory suggests that specialized and narrow interests will find it easier to organize and that public policy will often reflect the interests of these narrowly organized interests (such as doctors or medical associations) at the expense of the public interest (Olson 1971). This is a major problem in the debate over Medicare. There are competing claims at work over how the problems of the system are to be defined. In particular, certain actors within the system, such as doctors, make claims to specialized knowledge and expertise that may be difficult for the public to assess and may even operate to the detriment of the public's definition of its interests. Private sector for-profit insurance companies may carve out specialized benefits for themselves from friendly governments at the expense of the public's clearly stated preference for and interest in an accessible, universal and portable system.

These diverse views of federalism and health care, however, agree that the arena of fiscal federalism and understanding the roles of the federal and provincial governments is complex and, as such, runs the risk of reinforcing a democratic deficit in Canada's political institutional system (Lazar 2000, 23-25). For the sake of the credibility, legitimacy and efficacy of a health care system about which Canadians care passionately, it is important to find ways in which, as in the Social Union Framework Agreement (SUFA), citizen engagement can be woven into Canada's institutions of federalism on health care issues.

To date, we do not have many systematic empirical studies of the way in which organized groups influence policymaking in the health care system at the federal and provincial levels that tests out these ideas (Tuohy 1988). Despite the lack of empirical evidence, it is important to emphasize that these perspectives have tested out in analyses of other policy areas in the Canadian context as well as in other countries with federal systems (for example, Gray 1991). Therefore, there is reason to think that these ideas might have some applicability in the Medicare area. If taken seriously, they suggest that federalism plays a very important policy-shaping role in the Medicare system and that suggestions for reform must take into account the possibility that federalism may facilitate policy change in some areas while creating obstacles to policy change in other areas. Well-designed reforms, whatever their specific content, must take these dynamics into account.

Historical Evolution of Policymaking in the Canadian Health Care System

Division of Powers, *Constitution Act, 1867*

In the 19th century, health care was considered to be a local and private matter rather than a matter of governmental responsibility and the Fathers of Confederation no more considered which government should have jurisdiction over Medicare than they considered which level of government should have jurisdiction over off-shore oil. As the Rowell-Sirois report (1940) pointed out, "[i]n 1867 the administration of public health was still in a very primitive state, the assumption being that health was a private matter and state assistance to protect or improve the health of the citizen was highly exceptional and tolerable only in emergencies"(Canada 1940, 33-34). Much public health activity was carried out by local and municipal authorities, which were under provincial jurisdiction.

Under the *Constitution Act, 1867,* all matters of "a merely local or private nature" were assigned exclusively to the provinces and the Act explicitly gave the provinces the exclusive authority to legislate for the establishment, maintenance and management of hospitals, asylums and charities (other than marine hospitals) in subsection 92(7). Federal responsibilities in this area occurred in relation to other areas of federal jurisdiction such as navigation, immigration, shipping, trade and commerce, Aboriginal peoples (or Indians in the words of the Act), public works and defence. By the interwar period, the Dominion Department of Health had been established to administer federal statutes on public health relating to narcotics, food and drug safety, leprosy, medical patents and public works. In addition, a Dominion Council of Health brought together the provincial and federal ministers of health to coordinate federal and provincial activities (Canada 1940, 32-33). This early intergovernmentalism foreshadowed the contemporary thicket of intergovernmental meetings and negotiations between the two levels of government in this area.

The federal spending power was the main means by which the federal government exerted authority in the health care area, however. The *Constitution Act, 1867* assigns a virtually unlimited authority to tax and spend to the federal government. Through the use of this power, the federal government has intervened in areas of provincial jurisdiction such as health care and has attempted to force the provinces to adhere to uniform national standards, and may shape the substance of policies that fall under provincial jurisdiction. National standards in Medicare, therefore, are enforced through the use of the federal spending power. The federal government has the option of financially supporting Medicare while the provinces have the responsibility for service design and delivery.

Historical Evolution of Canadian Federalism

While the division of powers between federal and provincial jurisdiction is set out in the *Constitution Act, 1867*, federal political institutions in Canada, like other federal systems, have changed and developed over time. As the federal system developed, the provincial governments

took on a greater role than had been originally anticipated by the Fathers of Confederation. During different historical periods, nearly every region of Canada experienced a movement of provincial assertiveness, ranging from the provincial rights movements in Ontario and Quebec immediately after Confederation, through the Progressive Party's Western challenge to Central Canada and the Maritime Rights Movement during the 1920s. The regional, national and linguistic diversity of Canada tended to reinforce provincial power. Furthermore, the transition from the laissez-faire state of the 19th century to the interventionist state of the 20th century as well as the processes of urbanization and industrialization demanded new types of policies from the federal government. Keynesian economic interventionism and the rise of the welfare state posed fundamental problems for the Canadian federal system. These problems reached a head during the Depression era, a veritable 20 years' crisis of Canadian federalism (Mallory 1954; Simeon and Robinson 1990). The provinces had responsibility for many areas of social policy according to the interpretation of jurisdictions in *The British North America Act* that had been provided by Canada's highest court of appeal prior to 1949, the Judicial Committee of the Privy Council (JCPC). However, the federal government had more solid sources of stable revenue and, hence, was in a better position to fund social programs.

The solution to this conundrum emerged in the postwar period as the federal government used its spending power in areas of provincial jurisdiction to build social programs. Further, during and after the war, the political will was found to amend the Constitution to provide for federal jurisdiction over unemployment insurance (1940) and contributory pensions (1951). From the 1940s to the 1960s, new forms of intergovernmental negotiation emerged as both orders of government had responsibilities for the newly emerging welfare state. Against this backdrop, hospital insurance and medical insurance emerged, first as the project of one province, and then as a project backed by the federal government as it spread throughout all of the provinces.

Throughout the postwar period, as the relationship between federal and provincial governments over social policy was recast, Quebec consistently asserted a distinctive position. During the pre-Quiet Revolution period, the Duplessis government was not interested in expanding the role of the Quebec government in the social policy area. After the Quiet Revolution, the Liberal and Union Nationale governments of the 1960s asserted Quebec's control over social policy. This became a major constitutional issue and resulted in a series of intergovernmental negotiations over issues such as pensions and Medicare. Following the Quiet Revolution of the 1960s, social policy was seen as an important lever of control and development for the Québec state (Vaillancourt 1988). Quebec governments sought a greater role for the provincial level of government in the development of social policy in constitutional negotiations. In Victoria in 1971, for example, it pushed the federal government to develop more flexible arrangements permitting an independent Quebec role in some social policy areas (such as pension policy in which Quebec established its own Quebec Pension Plan in tandem with the establishment of the Canada Pension Plan), and aimed to limit the reach of the federal spending power in areas of provincial jurisdiction in the 1980-81 Meech Lake and Charlottetown rounds of constitutional negotiation (Rocher 1992*a*, 87-98; 1992*b*, 23-36).

Historical Evolution of Medicare

Federalism provided particular institutional opportunities for governments at both provincial and federal levels who were committed to the establishment of Medicare. At both levels of government, the establishment of Medicare required the election of political parties committed to Medicare. At the provincial level, it was the election of the CCF government in Saskatchewan that provided the political will for the pursuit of hospital insurance in 1947, and health insurance in 1961. Provincial jurisdiction over health care allowed the pioneering CCF government of Tommy Douglas to establish hospital insurance in Saskatchewan in 1947. The federal government's spending power permitted a federal role in financing the plan and in creating incentives for other provinces to follow the Saskatchewan lead. After a long political battle, the federal government established a cost-sharing plan for hospital insurance in 1957 and, by 1961, all provinces had entered the plan (Taylor 1987). Again, in the field of health insurance, Saskatchewan was a pioneer, bringing in health insurance after a doctors' strike in 1961. Following the advent to the Liberal leadership of Lester Pearson, the Liberal government became an advocate of Medicare and put into place a cost-shared program in 1966.

Established Program Financing

By the mid-1970s, problems had emerged in the system. In the federal government's view, it had no means of controlling health care costs as the relevant spending decisions were made by provincial governments. The incentive for cost containment was reduced as the provinces were spending "fifty cent dollars" on health care. In turn, the provinces complained that federal funding of hospital and medical care insurance distorted provincial health care priorities by funding only two types of health care programs – hospital and medical care insurance (Taylor 1989, 89).

These concerns led to the negotiation of a new formula, Established Program Financing (EPF), governing health care and postsecondary education transfers to the provinces in 1977. The EPF established a per capita block grant from the federal government to the provinces. The grant was linked to a three-year rolling average of increases in per capita GNP. In addition, the federal government offered tax points equivalent to one-half of the existing federal contribution. Tax points are a percentage of personal and corporate income tax levied by the federal government. In transferring a percentage of income tax to the provinces, the federal government in effect transferred to the provinces the capacity to levy and to benefit from that percentage of taxation in the future. The original transfer of tax points equaled one-half of the 1976 federal transfer for health care and postsecondary education. Of course, the actual value of tax points in a given year under EPF fluctuated, depending on factors such as the state of the economy. In addition, EPF also contained equalization payments for poorer provinces to increase their tax point yield to the national average.

Thus transfers to the provinces after 1977 were comprised of two components: cash transfers and tax points. It is important to note that eligibility for tax point transfers was unconditional whereas conditions under the original Medicare legislation still applied to the per capita grant (Charles and Badgley 1987). The new formula loosened the link between federal funding and the

actual cost of Medicare. Under the pre-EPF system, the federal government had paid 50% of the actual costs of Medicare: in contrast, under EPF, the cash grant portion of the federal transfer was linked to growth in GNP, rather than to growth in actual health care costs. In addition, although the transfer was supposed to be divided between postsecondary education and health care with one-third of the total transfer (cash grant plus tax points) allocated to postsecondary education and two-thirds to health care, in fact, the transfer was not "tied." The federal government allowed the provinces to treat the transfer as general revenue and left the spending decisions in the hands of the provinces (Maslove 1992, 59).

The federal government had intended the new financing formula to restrain costs and to decrease the federal contribution. The transfer portion of the payments escalated by the three-year average rate of increase in GNP, in effect, a decremental cut because inflation rates in the health care sector were higher than the general rate of increase in the Consumer Price Index. However, because the rate of inflation in the late 1970s rose faster than actual health and education spending, the federal share of provincial spending on health care actually increased after EPF. Total EPF spending (including postsecondary education) resulted in an estimated $1.5 to $1.8 billion more in transfers to the provinces than they would have received under the pre-EPF formula (Canada. Parliamentary Task Force on Federal Provincial Relations 1981; Brown 1986, 111-132).

The complexity of the intergovernmental financing arrangements in the policy field contributed to the "invisibility" of information and can be seen in the fact that, post-EPF, each level of government blamed the other for mounting health care costs. The provincial governments claimed that the federal government was underfunding the system while the federal government claimed that the provincial governments were diverting the transfers to other uses, a charge later found to be without foundation (Charles and Badgley 1987, 51-52). In addition, when EPF (and the accompanying taxation agreements) was renewed for 1982-87, the federal government eliminated the revenue guarantee at a loss of an estimated $5 billion to the provinces for the 1982-87 period (Taylor 1989, 84). As Medicare costs increased, financial pressures on provincial governments opened the door to what was viewed as creeping privatization (increased extra billing by doctors and user fees in some provinces).

Canada Health Act, 1984

It was feared that extra billing and user fees would undermine the basic principles of Medicare. Both opened the door to a two-tiered health care system in which those who could afford to pay would have better access to certain types of services (depending on the extent and type of user fees and depending on the medical specialties that were most prone to extra billing). Ultimately, both practices could lead potentially to a situation in which some regions of the country might not have universal access to certain medical services.

While such measures did not affect large numbers of health care consumers, pressure mounted on the federal government to enforce its own conditions for federal financing. The federal government was seen as the guarantor of universal and accessible health care. The question was: How was the federal government to withhold funding from governments that

violated the principles of Medicare in this manner? In principle, the federal government, the enforcer of national standards in Medicare, should have been able to withhold federal funding if provinces violated the principles of Medicare. However, as federal bureaucrats discovered, neither the original Medicare legislation nor the EPF provided a formula for the federal government to enforce conditionality by means of the withholding of funds. Under EPF, tax points in any case could not be withheld from the provinces; the tax point portion of federal funding had already been transferred to the provinces and could not be easily "taken back" by the federal government from provinces that permitted user fees or extra billing. In principle, however, the cash grant portion of the grant could be withheld. However, neither the Medicare legislation nor EPF contained a formula for the dollar for dollar withholding of federal funding. The only way to bring recalcitrant provinces to heel was to withhold the entire cash grant portion of the transfer, a measure that would not only be a disproportionate penalty but that would also throw provincial health care financing into chaos.

To solve this problem, the Liberal government passed the *Canada Health Act* (1984), which strengthened and clarified the federal conditions for health care financing. The Act established clear criteria governing conditionality and provided for financial sanctions proportionate to the actual extent of user fees and extra billing permitted by the provinces. These conditions only applied to the cash portion of the federal transfer. The Act also required that the provinces clearly state the federal financing role in Medicare in public documents, thus increasing the federal government's visibility in this field. Finally, the Act provided that if provinces adopted binding arbitration (not required in the Act), they must permit the award to be debated in the legislature. This last change was made to accommodate the doctors who felt that public debate in the legislature would aid their cause (Taylor 1987).

The *Canada Health Act* outraged both doctors and provincial governments. The provinces argued that they had not been consulted, that the Act infringed on provincial jurisdiction for health care and that the Act did not solve the underfunding problem. Doctors also objected to the Act as an infringement of their entrepreneurial freedom (Canada. House of Commons 1983-84). As Caroline Tuohy has pointed out, the passage of the *Canada Health Act* is a striking example of the defeat of a powerful and concentrated interest group – doctors – in favour of a diffuse consumer interest (1988, 267-96).

This intervention must be seen in the light of party politics of the period. While the *Canada Health Act* was supported by all three federal parties (including the Mulroney Tories in opposition), the Act embodied several principles that had been critical to the Liberal government's vision of national unity. The Act confirmed the Liberals' willingness to intervene in areas of provincial jurisdiction and to use the federal government as an instrument to build national identities. The Liberals' centralizing version of Canadian federalism had reached its zenith in the 1980-82 period with the debate over the patriation of the Constitution, the entrenching of a charter of rights and the National Energy Program. By 1984, the government was close to the end of its mandate and had retreated from its centralizing and nationalizing bent in the areas of economic and energy policy. The *Canada Health Act* allowed the government to reassert the nationalizing role of the federal government in social policy at no financial cost. While there were powerful actors arrayed against the bill – doctors and provincial governments – these interests were not in a position to threaten the passage of the Act. Unlike the CPP, the

federal government was not obliged to consult the provinces about changes to the rules governing Medicare (Courchene 1985, 3-5). While the doctors testified at the public hearings held on the bill, they had no avenues of protest against a determined executive. Their only recourse was to pressure provincial governments; indeed, the outcome of the *Canada Health Act* in Ontario, for example, was a six-day doctors' strike over the extra billing issue. Thus the consequences of the doctors' dissatisfaction with the bill fell not on the federal government but on the provincial governments who were responsible for negotiating fee schedules with the doctors. Finally, the *Canada Health Act* was overwhelmingly popular with Canadians although, unfortunately for the Liberals, they lost the partisan advantage on the issue when the federal Tories supported the Act (Canadian Institute of Public Opinion, May 10, 14, 1984; Tuohy 1988, 295-296; and Watson 1985). In Brian Mulroney's words, "[a]s far as the Conservative party is concerned, Medicare is a sacred trust which we will preserve" (cited in Taylor 1987, 443).

Retrenchment under the Mulroney Governments

While Liberal attempts to curtail federal responsibility for health care costs were only partly successful, the Conservatives quickly showed that the federal government's unilateral capacity to alter the complicated and obscure EPF formula could be used to the advantage of retrenchment. In 1985, the Minister of Finance restricted federal transfers under EPF to GNP increases less 2 percentage points. The 1989 budget accentuated this trend by changing the indexing formula to GNP increases less 3 percentage points (National Council of Welfare 1991, 32). The 1990 budget went even further by freezing the cash component of EPF expenditure at 1989-90 levels, a freeze that was continued in the 1991-92 budget and extended through 1994-95 (Battle and Torjman 1993, 6).

Despite the obvious implications of these cuts for provincial governments and for consumers of Medicare, there was very little public outcry over the changes. While provincial governments complained that their funding for Medicare was being cut by the federal government, such objections have not mobilized public opposition. In part this is because the funding formula is complicated and obscure, making it difficult for the public to assess the claims and counterclaims of federal and provincial governments in this area.

In addition, interest organizations in the Medicare field that might have opposed such cuts are organized along the lines of provincial jurisdiction because of the provincial responsibility for the delivery of Medicare. Even if such groups choose to bring their views to Ottawa, the budget process itself is one that is fairly well insulated from interest group pressures unless such groups are able to mobilize public opinion against the government, as in the case of seniors' opposition to the de-indexation of the Old Age Security pension in 1985. Nationwide groupings opposed to Medicare cuts, such as the Canada Health Coalition – a broad alliance of labour, antipoverty, church and seniors' groups that support increased health care funding, universality and a strong federal role in funding Medicare – have been unable to mount an effective national opposition to the defending of Medicare. Interest groups are more cohesive at the provincial level, but, even there, powerful groups such as the doctors were defeated in their Ontario strike (Tuohy 1989, 141-160).

Moreover, the effect of the cuts is not only to reduce the funding available to provincial governments for financing Medicare but, more importantly, to erode the federal government's ability to enforce the conditions of the *Canada Health Act*. The (conditional) cash portion of the federal transfer has decreased relative to the (unconditional) tax portion.

Canada Health and Social Transfer and Its Consequences

In the context of an increasing emphasis on deficit reduction, the Liberal government of Jean Chrétien substantially modified the way in which the federal government financed health care, postsecondary education and social assistance in the 1995 budget. The budget called for the replacement of Established Program Financing and the Canada Assistance Plan (CAP) with a single financing mechanism, the Canada Health and Social Transfer (CHST). For 1995-96, the growth of EPF was fixed at GNP minus 3% while the Canada Assistance Plan was frozen at 1994-95 levels for all of the provinces and territories. The CHST was to be $26.9 billion for 1996-97 and $25.1 billion for 1997-98. In 1996-97, the funds were allocated to the provinces and territories based on their entitlement to EPF and CAP for 1995-96.

For the federal government, the introduction of the CHST was justified by the fact that it provided stable financing for health care, postsecondary education and social assistance to the extent that the provinces and territories knew in advance the level of financing they would receive for the upcoming five-year period. However, the net result of this change was a reduction in federal transfer of between $2.5 billion and $7 billion, depending on the method of calculation used. The anti-deficit fight, which had been a priority for the Mulroney government, remained a priority for the new Liberal government at the expense of the funding of social programs (O'Neil 1997, 179).

From its introduction, the CHST was criticized for reducing the capacity of the federal government to maintain the national standards of the *Canada Health Act*. The provinces and territories had to make cuts with regard to social programs in general and health care in particular. They denounced not only the reduction in the transfer but also the federal government's unilateral approach as well as the lack of consultation in the design of the new policy. The design of the policy reinforced the resentment of some of the provinces with regard to CAP, which had been limited for certain provinces such as Ontario. As O'Neil states:

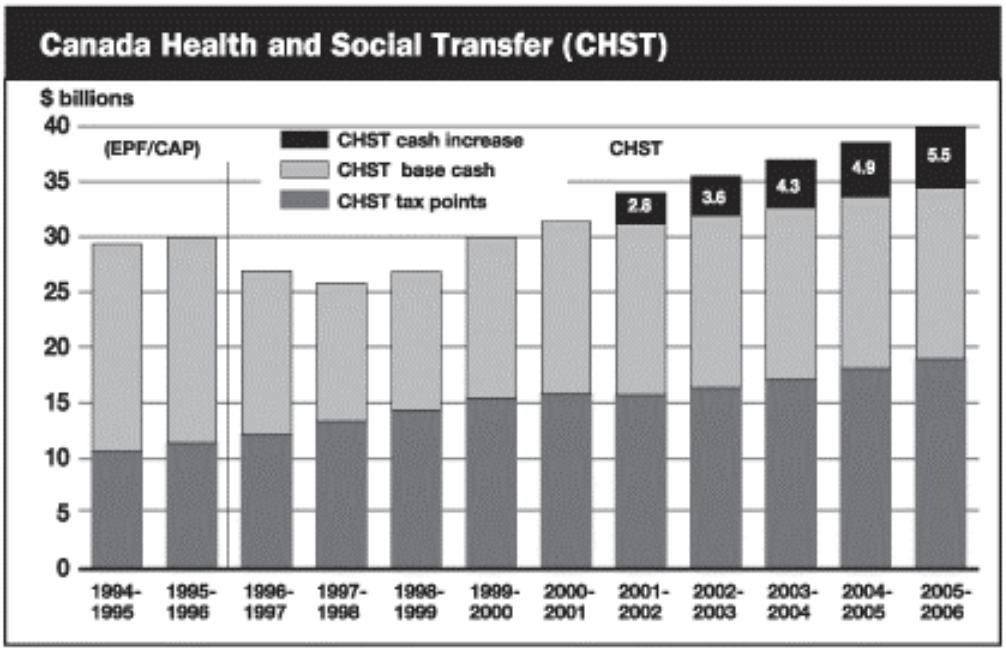
> Beyond simple a change in public policy priorities, the advent of the CHST, also marks a further change in the involvement of the federal government in health policy. Thus, through the CHST the federal government has sufficiently reduced its financial participation in the health sector as to make greatly difficult, or at least not very meaningful, any attempt to withhold federal transfer funds for violations of the *Canada Health Act*. (O'Neil 1997, 182)

Others emphasized that the introduction of the CHST might lead governments to more imaginative and flexible types of policies. However, it is difficult to see how this could have worked when the transfers were substantially reduced: flexibility would be limited to slashing budgets in the face of the new financial constraints created by the federal government. Block

financing maximized the provinces' and territories' incentive to better integrate their social programs. Because the transfer was conditional with respect to the principles of the *Canada Health Act*, provinces and territories had to conform to the condition or risk losing part of the federal transfer. Fears that provinces and territories would substantially reduce their investment in health care were not founded, on the one hand because provincial expenditure continued to grow but also because Canadians were not ready for a reduction in health spending (Courchene 1995, 77; Cohn 1996, 169). Moreover, aside from the fact that public support for the health system acted as a brake on cuts to the system, the fact that there were general pan-Canadian principles contributed to the maintenance and preservation of relatively comparable standards from one province to another. In the same vein, the possibility that the federal government would penalize provinces and territories for imposing user fees or permitting extra billing was another element that reinforced the preservation of a system which, if not uniform, was reasonably similar across the country.

Evidently, the authority of the federal government in the health care area was affected by the introduction of a new financing mechanism, but the retreat of the federal government was not a new phenomenon, as we have already seen. The financing of social programs and health care undoubtedly constitutes a stumbling block between the federal government, which presents itself as the guarantor of principles said to be "national" and which has a significant margin of financial maneuver to influence the provinces and territories, and the provinces and territories themselves, who must administer health services and plan, finance and evaluate spending on hospital care, medical and paramedical services. In this way, "the federal government might have lost its moral authority to set standards for health and welfare, but the provinces have not yet demonstrated the necessary ability to cooperate that would allow them to inherit this authority and exercise it in an effective way" (Cohn 1996, 182). In a more global context, the CHST does not constitute a radical break with the federal government's previously established practices. Certain provinces and territories had already started to discuss the possibility of introducing user fees or even of opening the door to the private sector well before the establishment of the CHST. In this context, it is not surprising that the first demand of the provinces and territories was the re-establishment of the level of financing that had been in place before the introduction of the new financing mechanism.

The 1996 budget put into place a five-year funding mechanism (for 1998-99 and 2002-03) and fixed the floor for cash transfers at $11 billion per year. For 1996-97 and 1997-98, amounts under the CHST were maintained at $26.9 billion and $25.1 billion, respectively. They were subsequently increased at a rate corresponding to GNP minus 2.0%, GNP minus 1.5% and GNP minus 1.0% for the three subsequent years. A new formula was put in place to take into account differences in demographic growth among the provinces and territories, and to cut in half the existing disparities in the calculation of entitlement by 2002-03, a first step in the direction of an equal per capita allocation. In 1998, the law was changed to fix the new floor for cash transfers for the CHST at $12.5 billion for the period 1997-98 to 2002-03. In 1999, the budget provided for an increase in the CHST of $11.5 billion over five years, specifically for health care. The formula was changed so that the entitlement would be calculated based on an equal amount by population by 2001-02. The February 2000 budget added another $2.5 billion under the CHST for postsecondary education and health care. In this way, the cash transfer for the CHST exceeded $15.5 billion per year for the period 2000-01 to 2003-04 (see the chart below).



Notes: Established Programs Financing (EPF) and Canada Assistance Plan (CAP) transfers to the provinces were replaced by the CHST in 1996. CHST base cash includes both the CHST supplements of Budget 1999 ($3.5 billion) and Budget 2000 ($2.5 billion). The CHST cash increase is the funding provided in September 2000 in support of agreements on health renewal and early childhood development.

Source: Canada, Department of Finance 2001.

A number of factors explain the growth in transfers to the provinces and territories. On the one hand, the provinces and territories were particularly active in denouncing the reduction in federal financing. On the other hand, on the eve of the 1997 election, the Chrétien government promised to increase the federal transfer and to fix the floor for transfers at $12.5 billion. At this point, the federal government's budgetary situation had greatly improved and begun to show a considerable surplus.

In September 2000, two months before the federal election, the federal government held a first ministers meeting to discuss health care. The First Ministers agreed on a plan of action for health care and for financing the development of early childhood policies. The federal government committed supplementary funding of $21.1 billion over a period of five years as part of the CHST, including $2.2 billion for early childhood development. This funding came into effect just before the 2000 election was called. The total cash transfer to the provinces and territories through the CHST increased from $15.5 billion in 2000-01 to $18.3 billion in 2001-02 and to $19.1 billion for 2002-03, attaining $21 billion in 2005-06. In view of this greater predictability, the government committed itself to establishing the cash transfer levels for 2006-08 by the end of fiscal year 2003-04. The 2001 budget maintained these commitments, although it did not increase them.

It is important to note that the federal-provincial health care agreement of September 2000 was signed by all the premiers. From the start, the agreement explicitly recognized each level of government's jurisdiction by stating that the principles "shall be interpreted in full respect of

each government's jurisdiction." The accord put forth seven guiding principles, the first of which was to restate the principles of the *Canada Health Act*. The governments agreed to put into place mechanisms for interprovincial partnership, notably concerning the sharing of information on best practices. There was also a commitment to keep citizens informed on health care results and performance of public services as well as on the measures being taken to improve these services. An action place including eight areas of intervention was discussed. One of the most important elements was the commitment to transparency and vertical accountability, and to the establishment of comparable indicators on the state of health care and the quality of service (for example, waiting times, patient satisfaction, home care, and the health protection and prevention) across the country.

The Fiscal Imbalance

The reduction in federal transfers to the provinces and territories to social assistance, postsecondary education and health, along with the fact that the federal government has been running budgetary surpluses over the past few years, has sparked debate on the question of the fiscal imbalance between the federal government and the provinces and territories. It is easy to understand that finances are the main stumbling block between the two levels of government.

It is important to make a distinction between a vertical and horizontal fiscal imbalance (Asselin 2001, 13-14). A horizontal imbalance refers to the significant differences in fiscal strength and capacity of the provinces and territories. The stronger provinces and territories such as Ontario, British Columbia and Alberta find it easier to finance their programs and are less dependent on federal transfers. These three provinces contribute to the equalization program, which permits the less wealthy provinces and territories to offer comparable services at the same cost as the better-off provinces. Although the horizontal imbalance is controversial in debates over equalization, the vertical imbalance is particularly important in the health care field. There is a growing gap between the fiscal capacity of the federal government compared to the provinces and territories and their ability to finance their own programs. The provinces and territories are responsible for programs based on services to citizens such as health, education, social services, etc., which are growing faster than the provincial tax base. For the federal government, the situation is the inverse: the federal government has revenue sources that are likely to increase more rapidly than the programs it finances. Clearly, the powers of taxation of the two levels of government are badly divided in light of the spending for which each is responsible (Wrobel 1994, 5). The revenue and program structure is such that the federal government is accumulating a surplus while the provinces and territories, given their spending commitments, have difficulty in maintaining balanced budgets.

Obviously, the nature and even the existence of a fiscal imbalance has been the subject of controversy. For the provinces and territories, revenue does not permit them to meet their obligations to health, education and social assistance while maintaining their other responsibilities. Cuts to federal transfers since the coming into effect of the CHST have aggravated the fiscal imbalance. Cash transfers were reduced by one-third from 1995 to 1999 and, despite the "re-establishment" of financing in 2000-01, federal financing is still less than $3.2 billion than what it was in 1994-45. At the same time, spending on health care, education

and social assistance was $18.8 billion more than in 1994-95 (Ministres des Finances des provinces et des territoires 2001, 5-8). The structural causes of this imbalance have not been affected by recent changes in the level of federal transfers. It is even possible that surpluses will continue to stack up at the federal level while the fiscal position of the provinces and territories will remain more or less the same. Spending on program areas in provincial jurisdiction is set to increase at an annual rate of at least 5% because of the aging of the population, changes in technology, the increase in the cost of medication, the increase in diseases that are more expensive to treat such as HIV/AIDS, hepatitis C, and traumatic brain injury, under-investment in hospitals and the need to face up to the problem of lack of supply of health care professionals and workers (Provincial and Territorial Ministers of Health 2000: Finance Ministers of Alberta, Saskatchewan, Manitoba, Yukon, Northwest Territories and Nunavut 2001).

In sum, the federal government's budgetary surplus will grow rapidly while the provinces and territories will not be able to maintain a budgetary balance:

> *the federal government has a unbalanced fiscal structure* which is capable of generating revenue growth far in excess of federal spending requirements. By contrast, provincial-territorial revenues are expected to grow only slightly faster than expenditures, a situation that indicates that *the fiscal structure of provincial governments is roughly in balance.* This balance, however, is precarious and can be upset even by relatively small changes in economic conditions or spending pressures (Ruggeri 2001, 5, emphasis in the original).

According to the provincial and territorial governments, the federal government should restore funding with an indexation format that will guarantee a level of financing that takes into account the pressures for increased spending in the health care system. The provinces and territories evaluate the difference between these principles and the CHST transfer at about $13 billion dollars.

Moreover, in reply to the federal government's argument that these calculations do not take into consideration the tax points that were transferred to the provinces and territories, the provincial and territorial governments emphasize that the inclusion of tax points gives the impression that the CHST is much larger than it is. Provinces and territories reject this method of calculating the transfer as illegitimate. The tax points are not controlled by the federal government, do not appear as spending items in the federal budget and do not have to be spent on health care. For provinces and territories then, "the tax 'transfer' is accounted for by provinces/territories as 'own-source' revenue, since it is revenue collected from provincial/territorial tax effort" (Provincial and Territorial Ministers of Health 2000, 11). At the end of the day, increasing the tax base of the provinces and territories should not be considered as a federal transfer to the provinces and territories in perpetuity.

In a recent document (August 2001), the provincial and territorial finance ministers proposed four options. The first three would be undertaken as part of the CHST.

1. Until 2004-05, the CHST would be increased such that it would cover the same portion of social program costs that had been covered by the previous federal transfer in 1994-95.

2. New costs in the health care sector would be shared equally between federal and provincial governments.

3. Immediately increase the CHST to the same absolute level as was paid out in 1994-95.

4. Replace the CHST with a transfer in tax points (Ministres des Finances des provinces et des territoires 2001, 12-13).

The first three options do not eliminate the causes of fiscal imbalance but they permit some catching up, bringing federal financing of social programs to 18% of actual program spending. However, the subnational governments would continue to be vulnerable to unilateral federal decision making. The fourth option would accentuate horizontal fiscal imbalance because the tax base of the provinces and territories varies greatly across the country. It assumes that equalization would also be adjusted. After all, provincial revenue is more affected by the ups and downs of the economy, making it more volatile. The federal government would see its capacity to influence provincial and territorial choices reduced because it would no longer have the means of pressure provided by the *Canada Health Act.*

More recently, the government of Quebec published the report of the Commission on the Fiscal Imbalance, which, unsurprisingly, reasserted the existence of the imbalance, which the Commission attributed not only to the imbalance between spending and access to tax revenue, but also to the weakness of the intergovernmental transfer system and the federal spending power. The report notes that the increase in spending constitutes the main pressure on the provinces because of factors such as the increase in the cost of medication, changes in medical technology and the aging of the population. To deal with this fiscal imbalance, the Commission not only took up several recommendations that had been made to the provinces, such as the abolition of the CHST and its replacement by a new division of fiscal resources, but also proposed that the provinces gradually take over the revenue from the GST. For all practical purposes, with its recommendations, the Commission sought to limit the use of the federal spending power (Québec 2002). Obviously, it is highly unlikely that the recommendations of the Commission on the Fiscal Imbalance would be favorably received by those who believe that "without substantial federal investment in the health system, the federal government cannot sustain its moral and political influence on the system" (Adams 2002, 302).

For the federal government, the rhetoric of "fiscal imbalance" is considered to be verbal overkill that does not correspond to reality. In the federal view, the analysis of fiscal imbalance rests on a methodological approach that only emphasizes budgetary surpluses projected while it would be better to develop a model that took into account the available budgetary margin. From this point of view, there is no vertical fiscal imbalance between the two levels of government (Matier, Wu and Jackson 2001). Several factors should be taken into account: 1) in the context of an economic slowdown, the two levels of government must face budgetary constraints that reduce their margin of maneuver; 2) the two levels of government have access to the same revenue base and can establish their own income tax (tax reductions by the federal level can be recouped by the provinces and territories); 3) total provincial revenue exceeds federal revenue (in this calculation, federal transfers are counted as part of provincial revenue); 4) revenue from income tax will not see rapid growth because globalization creates competitive pressures that

tend to lower income taxes (it is difficult to reconcile this point with 2) above because these same competitive pressures prevent the provincial or territorial governments from recuperating the fiscal space left by the federal government); and 5) the federal government is subject to more serious financial constraints than the provinces and territories because of the weight of the debt (Ministre des Finances. Canada 2002; Dion 2001).

In sum, far from wanting to address the vertical fiscal imbalance, the federal government contests its very existence. The federal government argues that, far from having withdrawn from financing postsecondary education and health care, about 70% of all new federal initiatives are targeted on health care and education. Moreover, the rate of annual growth in the federal transfer over the next five years should be more than 6%, which would be three times higher than the growth foreseen in revenue. Although it is normal to see tensions between the two orders of government in a federal system, on this issue there is a fundamental misunderstanding on the nature and origin of the problem. In this context, it is difficult to identity solutions that would be accepted by both sides.

Social Union Framework Agreement

The signing of SUFA by all of the premiers except Quebec in February 1999 was a response to the growing discomfort of provincial governments with the federal government's unlimited deployment of its spending power. The agreement was the result of an initiative taken by the first ministers at their annual meeting in 1995 to establish the Ministerial Council on Social Policy Reform and Renewal, the mandate of which was to establish mechanisms for limiting the federal spending power, for clarifying the responsibilities of each level of government and for limiting overlap between the two levels of government. This initiative was derailed by the federal government, which, in exchange for an injection of supplementary funds in the health care fields, invited the provinces and territories to sign a framework agreement (Gagnon 2000).

SUFA was based on three main principles: 1) new governmental initiatives would not create obstacles to mobility in the areas of postsecondary education, professional training, health care, social services and social assistance; 2) mechanisms to ensure transparency and accountability would be put into place to measure the performance of social programs, to establish performance indicators and to explain the contributions of the two levels of government; 3) mechanisms would be put into place to facilitate a partnership approach to common problems, notably in the elaboration of objectives and principles. In this way, the federal government accepted to limit its spending power and committed itself to consult the provinces at least one year in advance of renewing or modifying transfers to the provinces. With regard to new federal initiatives in health care, postsecondary education, social assistance and social services financed by the transfer, the government committed itself, on the one hand, to work in collaboration with governments to determine the priorities and pan-Canadian objectives and, on the other hand, to not take new initiatives without obtaining the consent of the majority of the provinces. The agreement also provides that a province or territory that did not need to use all of the transfer to achieve the policy objectives could reinvest the funds in the same area. To have access to these transfers, the provinces and territories would have to respect the accountability framework. At the same time, SUFA did not limit direct spending by the federal government to individuals or groups (as was

the case with the Millennium Scholarships or with the Canadian Foundation for Innovation) although it committed the federal government to consulting and giving three months notice to provinces and territories before establishing such programs.

SUFA can be seen as the fruit of many years of efforts to stabilize intergovernmental relations. For some, the agreement was a return to the situation that had prevailed before the CHST in the sense that it established conditions that permit the introduction of new problems, especially for home care and pharmacare (Tuohy 1999, 106; Mendelson 1999). For others, the accord is a "crucial stage in the historical conflict between the provinces and the federal government by legitimizing the federal government's view on the spending power, in return for only minor concessions" (Noël 2000). At a symbolic level, the refusal of the government of Quebec is important and occurred because of the lack of a meaningful right to opt out, the lack of a means of limiting direct federal intervention in provincial jurisdiction, particularly with regard to direct transfers to people and groups, the lack of recognition of the provinces' primary responsibility for social policy, the absence of a guarantee of the stability and predictability of federal spending, and the fact that major changes can be imposed on all the provinces with the agreement of a majority of the provinces, which could represent as little as 15% of the population. The government of Quebec was the only government that was concerned with the need to see the federal government respect the actual division of powers.

On the whole, SUFA did not really change the politics of health care reform in Canada and did not answer the two most fundamental questions: Who should be establishing the rules in the health care sector and what should these rules be, especially with regard to the boundary between the public and private sectors? In general, the debate over SUFA served to focus the debate once more on the eternal battle between the federal government and the provinces to the detriment of public debate over the public/private divide in the Medicare system.

Some Comparative Considerations: The German and Australian Cases

Given the nature of this study, it is useful to consider how other federal states have managed the development of their health care system and the ways in which the institutional framework facilitates or constrains cooperation between the different levels of government This part of the study does not claim to be an exhaustive survey of the comparative literature but simply seeks to better understand the ways that institutional mechanisms play out in health care systems. We focus particularly on the German and Australian cases, not only because these are federal systems but also because of the important role of the central government in the development of health care policies.

As Table 1 shows, public spending on health care occupied a substantial place in total state spending and the variation among countries cannot be explained by federal political institutions. In other words, we find important differences among federal states in their share of total health care spending, ranging from lows of 44.8 and 54.9% in the United States and Switzerland, respectively, in contrast to highs of 70.1% in Canada and 75.8% in Germany. Certain unitary states in Europe finance health care spending to even higher levels such as 83.8% in Sweden.

It is useful to briefly consider how intergovernmental relations have evolved in certain federal systems, such as Germany and Australia, in order to see if there are any useful lessons that may be drawn from these experiences for the Canadian case.

The first modern national health insurance system was put into place in Germany in 1885. On the whole, the fundamental structure of health insurance coverage and benefits has remained largely unchanged since its inception (Lassey, Lassey and Jinks 1997, 130). We can see the strong financial contribution of patients that use private insurance. With regard to the institutional framework, responsibilities are divided between the federal government, the states and local governments. But in the health care arena, as in many other cases of shared jurisdiction, German federalism is thought to be highly centralized. As Wassener argues, “this dominance of the federal government in the field of concurrent powers is especially true in the field of social policy where the states have very little exclusive legislative competence” (Wassener 2002, 70). Nonetheless, the states are active in the decision-making process because of their representation in the Bundesrat (the upper chamber of the German legislature). Hence, with regard to the institutional structure, federal laws govern practices and policies in health care. In the case of conflict between the Bundestag and the Bundesrat, a mediation committee is responsible for finding a solution. In the German system of what is often called *interlocking federalism*, the establishment of an intergovernmental consensus is required as part of the adoption of legislation. In this way, public policies are stable, although the complexity of the process of negotiation and compromise means that it is more difficult to adopt new initiatives.

The German health care system is organized around several basic principles: the insurance principle, the principle of self-administration, and the principles of organization diversity, to the extent there is no national program of medical insurance (Wassener 2002, 72-73). In this way, if the parameters of health care policy are defined by the central state, “the specific design and

Table 1
Selected National Health Accounts Indicators, Estimates for 1998

	Total expenditure on health as percent of GDP	Public expenditure on health as percent of total expenditure on health	Private expenditure on health as percent of total expenditure on health	Public expenditure on health as percent of general government expenditure	Social security expenditure on health as percent of expenditure on health	Tax funded expenditure on health as percent of public expenditure on health	Private insurance on health as percent of private expenditure on health	Per capita total expenditure on health at official exchange rate (US$)	Per capita public expenditure on health at official exchange rate (US$)
Federations									
Australia	8.6	69.9	30.1	16.8	0	100.0	24.8	1 672	1 172
Austria	8.0	71.8	28.2	11.2	59.6	40.4	25.9	2 097	1 506
Belgium	8.6	71.2	28.8	12.0	88.0	12.0	7.0	2 110	1 502
Canada	9.3	70.1	29.9	14.7	1.7	98.3	37.5	1 867	1 296
Germany	10.3	75.8	24.2	16.4	91.6	8.3	29.5	2 697	2 044
Switzerland	10.6	54.9	45.1	10.4	72.3	27.7	23.8	3 877	2 127
United States	12.9	44.8	55.2	16.9	33.2	66.8	60.7	4 055	1 817
Unitary States									
Denmark	8.3	81.9	18.1	12.5	0	100.0	8.2	2 737	2 241
Finland	6.9	76.3	23.7	10.5	19.8	80.2	10.5	1 735	1 323
France	9.3	76.1	23.9	13.9	96.8	3.2	52.7	2 297	1 747
Sweden	7.9	83.8	16.2	11.4	0	100.0	-	2 144	1 797

Source: *World Health Report 2001: Mental Health. New Understanding, New Hope*. France: World Health Organization, 2001.

delivery of health services is highly decentralized, being the responsibility of close to 600 independent social funds" (Banting and Corbett 2002, 11). Although priorities are defined at the central level of the federal state, the states are responsible for implementing a federal law. That said, self-government is an important feature of the health care system at all levels (Mendoza and Henderson 1995, 243; Lassey, Lassey and Jinks 1997, 134). At the level of the states, there are health authorities and support services equivalent to those in the federal structure. Each state decides on its needs for equipment, hospitals and so forth. All in all, Germany is considered one of the most regulated health care environments in the world (Mendoza and Henderson 1995, 241). It is interesting to note that recommendations to the government are formulated twice per year by a group made up of 90 members referred to as the "Concerted Action for Health Affairs." This is a national group representing sickness-fund members, providers, consumers and a staff of seven medical and economic advisers (Lassey, Lassey and Jinks 1997, 134). In addition to developing guidelines, it prepares an annual report on the state of the health care system and makes recommendations to the federal ministry of labour and social affairs on proposed changes to the system.

The ability of doctors and hospitals to demand fees is limited by budget caps that are negotiated between the principle stakeholders and enforced by the federal government. The state spends about one-fifth of health care expenses from general revenue, a little less than half is paid by employees who contribute to an insurance fund that distributes the revenues (after a 4% administration fee), a little more than a third of the costs are paid by private households by employee contributions to insurance funds, private insurance, and out-of-pocket payments (Mendoza and Henderson 1995, 235). In 1989, a law was adopted to explicitly limit the growth of the costs of the system at the level of salary growth, which makes Germany the first country to formally define a fraction of income to be spent on health care (Lassey, Lassey and Jinks 1997, 141).

The Australian case displays a very different picture. Centralized financial power is far greater in Australia than in the other four OECD countries (United States, West Germany, Canada, Switzerland) in years reported 1975 and 1985. From 1975 to 1985 Australia's trend was toward financial centralization (Gray 1991, 19). In Australia, the focus of early health policy was on the public provision of services. The 1901 Constitution gave states a great authority in education, health and other social matters (Roemer 1991, 170). Originally, health was a responsibility of the states and the federal government's involvement was limited to matters of quarantine. Like many other policy areas, the federal government extended its role with time. In 1921, a Commonwealth department of health was established and, with this, the federal government started to help the states with the provision of public health services. A constitutional amendment in 1946 gave the federal government broad power in all aspects of health policy. Since World War II, policymaking processes have been dominated by the Commonwealth, whereas in Canada "the provinces have remained the senior level of government" (Gray 1991, 22). The 1940s were characterized by what Gray calls "a high level of cooperation between State and Commonwealth policy makers. This experience shows that cooperative federalism can be a reality under certain conditions and that the processes of joint decision making do not necessarily lead to obstruction and delay" (Gray 1991, 79). Nevertheless, it is noticeable that the Labour Party played a major role in on the development of state policies and the formulation of a national health service. Like the CCF-NDP in Canada, the Labour Party

was responsible for putting universal access to health care on the national agenda. However, there are significant differences in the impact of political parties on policy development between Canada and Australia; while both the Liberal Party and Progressive Conservative Party have supported or "acquiesced in" the development of policies put forward by the CCF-NDP, in Australia, non-Labour parties consistently opposed Labour health policies (Gray 1990, 51). Hence every change in government since the 1940s in Australia has been followed by major changes in health policy.

The central government is responsible for the definition of the parameters of the health care system such as medical fees, health insurance rebates, and fees of private patients in public hospitals (Hancock 2002, 111). As Linda Hancock argues,

> The Australian health-care system is built on the following foundations: (i) the Medicare principles: universal coverage, bulk billing, free access to public hospital care, access to the doctor of choice for out-of-hospital care, and the general freedom of doctors – within accepted clinical practices – to identify appropriate treatment for their patients; (ii) an overarching agreement between the Commonwealth and the states and territories on the principles and framework governing federal-state relations in the health and community services fields; and (iii) under the broad leadership of the Commonwealth, the joint setting of priorities, goals, and quality outcomes for both tiers of government, with the states and territories having increased responsibility for the delivery of services to meet agreed outcomes. (Hancock 2002, 108)

At the institutional level, Australia's centralization of power means that reform can only happen at the federal level. The Commonwealth has the capacity to influence or even to impose its will on the details of health policy in contrast to Canada where the federal government can only set broad conditions on its financial grants to the provinces. Federal-states arrangements are essentially financial ones, i.e., states and territorial governments receive grants for the operation of hospitals. For instance, Medicare's introduction in 1984 did not provoke very much conflict even if the federal offer gave no financial benefits to the states. The best explanation for this phenomenon is probably the ready acceptance of the federal scheme by the states as Labor policy is considered to be binding on all members of the party. For Gray, "evidence suggests strongly that the ideologies and orientations of governments and the general pressures within the political systems can be far more important than institutional arrangements" (1990, 103). Since 1984, Medicare funding comes mainly from the federal government, but it is also supplemented by state and territory governments (mainly through publicly owned hospitals), and private sources (mainly out-of-pocket payments by consumers). A Medicare levy was introduced in 1984 to supplement other taxation revenue, to cover state and territory costs of patients choosing to be Medicare patients. The health care providers are registered and controlled by each state (Mendoza and Henderson 1995, 191) and medical practitioners are regulated by each state. According to Gray, "… the centralization of power in Australia, at least in relation to health policy, this gives the Commonwealth a level of policy freedom of a similar order to that found in unitary systems" (1990, 155).

The discussion of intergovernmental fiscal arrangements has historically been held as part of the first ministers' meetings. As in Canada, these meetings are often used by the states to convey their complaints on issues such as fiscal imbalance and the underfinancing of the health care

system. As Hancock points out, “other mechanisms for intergovernmental cooperation include Commonwealth-State Ministerial Councils, the Council of Australian Governments (COAG), the Loans Council, along with ministerial conferences in specific policy areas, officials’ committees, and bilateral communications government agencies” (2002, 120). However, the most important mechanism remains the COAG, put into place in 1992, which “comprises the prime minister, the premiers and chief ministers and the president of the local government association; and it needs to be understood as a reflection of the concurrent nature of Australian federalism and as evidence of ‘cooperative federalism in Australia’” (Hancock 2002, 120). Over the course of the 1990s, the issue of fiscal imbalance became the object of discussion in the committee, which also set out to clarify the roles and responsibilities of each level of government in the health care system. The question of the declining importance of transfers was also the object of debate, as the states complained that such transfers imposed administrative costs on them while, at the same, time, the central government maintained its own substantial bureaucracy.

The Australian experience demonstrates that federal-state relations are not always conflictual and tensions do not always exist between state- and federal-level members of the same party. Nonetheless, as in Canada, conflicts exist on the issues of federal responsibility for health care and on the financing of health care services. On the one hand, party political differences increase intergovernmental tensions and reduce the likelihood that policy agreement can be reached, and on the other hand, institutional mechanisms have been put in place to facilitate the management of the policy design of the health care system.

Recommendations for Change

In this section, we provide answers to the questions that were posed to us in our original instructions for this study.

1. Are the tensions of recent years unusual or are they part of a historical cycle?

   Our survey of the political institutional literature suggests that governments, both federal and provincial, will naturally defend their own turf. Most conflicts between the two levels of government naturally concern financial and fiscal issues. The Canadian case is somewhat different than other cases in that the government of Quebec is a particularly strong defender of the original division of powers as outlined in the *Constitution Act, 1867*. While other Canadian provinces have proven flexible in terms of their interpretation of the jurisdictional division (although all provinces have raised the issue of vertical fiscal imbalance), Quebec has not been willing to sacrifice its powers, as we can see from the fact that the government of Quebec did not sign on to the Social Union Framework Agreement.

2. Are there sectors in which federal-provincial relations are more harmonious and which could lead to great innovation in the system?

   SUFA is often viewed as providing a model for a more harmonious relationship. However, we do not believe that this model is workable and we would reiterate the points made by the government of Quebec. The model of federal provincial diplomacy or intergovernmental negotiation has been successful across a broad range of federal-provincial relations, especially when these negotiations are based on the principles of mutual respect, partnership and equality of status of the participating governments. These principles could be more successfully applied in the health care sector than they have been in the past, as we will discuss below.

3. How do federal-provincial relations in Canada compare to other countries? How do other countries deal with their tensions?

   Our comparative analysis demonstrates that tensions between federal and subnational governments are found in all federal systems, except in cases such as Australia's in which one level of government dominates the health care area. We do believe that the Australian model is instructive because of the formal institutional mechanisms that have been put in place to deal with health issues, especially the COAG; on the other hand, in the Australian case, the dominance of the federal government would never be accepted by provincial governments (particularly but not exclusively Quebec) and would upset the historical institutional relationships between the two levels of government in this area. However, we believe that the institutionalization of stakeholders in the system in the German model, as well as the stable and long-term commitment to funding in that system are two ideas that should be taken up in Canada (see below).

4. What changes should be brought to the mechanisms of cooperation between the two levels of government in order to improve relations between them over the long term?

The general principles that should guide cooperation between the two levels of government are: equal partnership between the federal and provincial governments in managing the health care system; stability, transparency and accountability in funding the system over time; and citizen and stakeholder involvement and input into the management of the system. In addition, we assume that we will maintain a public health care system, without opening the door to significant privatization and that we will maintain the principle of a public, universal, accessible and portable system according to the 1984 *Canada Health Act*. Specifically, we believe that the CHST and the counting of tax points transferred from one level of government to another are not consistent with these principles. They have introduced instability and uncertainty into the funding system, caused systematic underfunding and fiscal disequilibrium in the system, and have opened the door to political forces, both in Canada and continentally, who favour privatization in whole or in part of the system. In our view, it is absolutely essential that the federal government dispense with both the CHST and with debates over the transferred tax points. We believe that the best system would be one in which there was a single block grant for health care from the federal government, governed by the general principles of the *Canada Health Act*, but with the flexibility of a limited opting out mechanism. We believe that the government should make a long-term commitment to a gradual return to a 50-50 funding of health care, and that the federal transfer to the provinces for health care should be mandated as health care spending for the provinces. Further, we believe that intergovernmental mechanisms to manage the federal provincial relationship in health care should institutionalize relationships between health ministers and, as in the German model, include other stakeholders[1]. Along the same lines and in accordance with these principles and new mechanisms, the federal government should not undertake unilateral initiatives in using its spending power in provincial jurisdiction but should propose new health care initiatives through this new intergovernmental institution.

1 The participation of stakeholders in intergovernmental mechanisms is a question that is too complex for a detailed analysis here. We recommend that interested readers consult the following works: Mendelsohn and McLean 2002*a* and 2002*b*; Phillips 2001; and Mendelsohn 2000.

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