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Roles and Responsibilities in Health Care Policy

by

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Highlights

- The period in which federal and provincial *roles* were most clearly defined was the period in which the *responsibility* for health care was not exercised.
- Historically, clarity has not been a characteristic of federal-provincial relations in health care, nor has consensus.
- The federal government's initial role in health policy was that of a catalyst, convener and negotiator in federal-provincial cooperative efforts in health care. The federal government used its spending power as a fiscal incentive to diffuse the public financing model throughout Canada, giving ammunition to those governments who supported the idea, and an inducement to those who did not.
- In the past thirty years, the federal role in setting health care policy has become at once more *unilateral* in process and less *effective* in practice.
- Changes in the federal role are consistent with the general trend toward reorganizing *fiscal arrangements* in a decentralized manner (in terms of the shift away from direct cost-sharing and toward block grants) but, unlike other policy sectors, this has not been accompanied by devolution of *political space* in health care.
- Changes need to be made to minimize the destructive conflict in federal-provincial relations: for federal governments to act as enabler rather than enforcer; and for provincial governments to assume their responsibility for political choices in health care.
- Fiscal arrangements should ensure that provincial governments have sustained capacity to meet their responsibilities in health care, while at the same time allow some complementary role for the federal government.
- Although the roles of levels of government are well-enough defined, what is less clear is the responsibility to be attached to these roles.
- There are two competing “legends” about federalism and health care in Canada that are equally misleading: that there exists a single “national health insurance” or “medicare” system in Canada; and that health care is a purely provincial matter in which the federal government has no role to play.
- In most provinces, regional health authorities exercise considerable authority in the allocative decisions about health care organization and financing, but decentralization and health care are compatible only insofar as a balance can be struck between decision-making and accountability.

Executive Summary

The real world of Canadian politics is a messy place. In fact, there is more clarity around the assignment of roles in health care but less consensus on the apportionment of responsibility. The division of powers in health care, on paper, makes Canada look like the most decentralized of all federations. Yet, the standards that “tie” provincial health care systems together are at once more fragile and more robust than in other countries: more fragile since they rest on a federal statute designed to provide negative incentives; and more robust in the sense that they limit experimentation with private market mechanisms.

Federalism in Canada both had a delaying impact on the development of health policy and served as an innovative dynamic. Eventually, provincial push led to federal pull in convening the provinces together and in intergovernmental cost-sharing arrangements. Provincial experiment, intergovernmental negotiation, and federal incentives provided the diffusion mechanism for public-hospital and medical insurance. Even though the federal government's involvement in health care has been primarily confined to the use of the federal spending power, the allocation of money has an obvious impact on provincial health policy. In fact, health care can be seen as an example of federalism's power to shape effective social reform. Federalism was the agent through which specific ideas about the role of the state, the social rights of citizens, and equity between individuals and regions were operationalized in provincial social programs. The role of the federal government was not to impose uniformity in the playing field, since provincial plans demonstrate varying degrees of diversity which makes innovation possible, but rather to ensure that provinces played by the same “rules of the game” and that Canadian taxpayers' money be used to help finance publicly accountable health insurance systems that achieved some sort of “equality” of social rights among Canadian citizens, regardless of their province of residence.

The *Canada Health Act* of 1984 was an example of the federal role in setting health care policy, but it was enacted at the same time that the federal government was disengaging itself from fiscal responsibility. From 1984 onward, the federal government's fiscal commitment to provincial social programs continually declined. Changes to funding formulae (i.e. EPF in 1977 and the CHST in 1996), allowed the provinces greater flexibility in setting spending priorities, but at the same time meant that provinces were responsible for increases in health care spending and for allocating federal transfers between competing parts of the larger social policy pie.

While intergovernmental conflict has been the norm in areas involving the distribution – and redistribution – of money, provincial government resentment grew throughout the 1990s. During this period, federal and provincial governments seemed to be engaged in parallel tracks on health reform, rather than the cooperative model of the past. The Social Union Framework Agreement of February 1999 acknowledged the need for more transparency and consultation in intergovernmental policy-making, including dispute resolutions, and the 1999 and 2000 federal budgets demonstrated a commitment to providing stable funding for health care in the provinces and introduced measures to eliminate inter-provincial disparities. But the SUFA did not fully reflect the interprovincial processes that led to its development, and the absence of Quebec's support and of agreement about jurisdictional boundaries in health care have yet to be resolved.

Health care policy can, and is, set by provincial governments. Provinces have functioned as laboratories of innovation in the past and continue to do so. But this does not mean that the federal government is, or should be, irrelevant in health policy. It can have an important role to play, in concert with the provinces, in engaging in the long-term vision exercise required to set the markers and determine the resources needed to ensure sustainable health care systems across Canada. In other words, the health system as a whole could benefit from a big picture view of health policy that includes federal input in general and federal involvement where specifically warranted. The federal government's most positive role in health care is as enabler (rather than as enforcer) in ensuring that all Canadians can look forward to affordable, quality health care across provincial borders. This does not necessarily mean that it can "guarantee" exactly the same health benefits to every citizen since its role is not to micromanage the health care system. Nor does it mean that the federal presence in health care is synonymous with "one size fits all" solutions in the provinces. But it means that the federal government has an important role in articulating and affirming health care as a public good. To this end, it must, in symbolic terms, be prepared to articulate and defend a coherent vision of that public good and, in practical terms, be prepared to offer the financial incentives for its affirmation in provincial health care plans.

Conflict is to be expected in the health policy arena, which involves the redistribution of resources and risk. But conflict that paralyzes dialogue and undermines public confidence is ultimately destructive, not only to the federation but to the quality of life of citizens. Curiously, for a decentralized federation, Canada has few mechanisms of intergovernmental cooperation and conflict resolution in health care policy. For all the quibbles over health care resources between the provinces and the federal government, political battles over health care have never been only about money. The contested political space in health policy often has to do with the type of health care system to encourage, indeed more broadly over the role of the state in health care altogether. Attempts to control public spending in health care and the subsequent escalation of conflict in intergovernmental relations have opened a window of opportunity for political and social actors that believe in less state intervention to question the legitimacy of federal standards and to justify attempts to explore other options for financing health care.

If the endgame in health care is to retain its meaning as a public good, then the federal government would be better off putting more emphasis on encouraging consensus rather than enforcing rules. Part of this task involves evaluating alternatives and suggesting the boundaries for what is feasible and desirable in health care reform. Under what conditions can the federal government encourage innovations that are not entirely at odds with the basic premises of the public model? To what extent is more structured exchange of information needed in identifying, evaluating – and possibly diffusing – provincial recommendations from commissions of inquiry, new models of delivery, or experiments such as integrated care in Quebec, or health care systems in Europe and elsewhere? There are relatively large bodies of evidence to suggest that public health care systems do better in providing care and controlling costs, that health care systems focused on preventive and integrated care work better in keeping populations healthy, etc. To retain a relevant role in health policy, the federal government should be willing to evaluate the available evidence in suggesting markers and signposts, and in helping to build the capacity, for real health reform. In order to do so, a measure of "political goodwill" (for lack of a better term), that involves both clear financial incentives and clarity in the exchange of ideas and experience is necessary in reshaping the federal-provincial dialogue in health care.

Question 1

When were the federal and provincial roles most clearly defined? To what extent was this clarity a function of the roles each played in financing the system?

Diagnostic

- The period in which *roles* were most clearly defined was the period in which the *responsibility* for health care was not exercised.
- Clarity has not been a characteristic of federal-provincial relations in health care, even in terms of financing the system.

Discussion

Health Care and the Division of Powers¹

The division of powers enumerated in the *Constitution Acts* of 1867 and of 1982 set the parameters of the federal arrangement in Canada. These statutes reveal a tension between a centralizing tendency implied in the economic and residual powers allocated to the federal government, and the decentralizing effect of the wide-ranging responsibilities accorded to the provinces. This tension has been exacerbated since 1867 for a variety of reasons, including judicial interpretations favouring the provinces and the passage of the 1982 *Canadian Charter of Rights and Freedoms*. Nevertheless, periods of intergovernmental cooperation did lead to important policy initiatives, including the programs that form the core of the welfare state in Canada.

Health care is a prime example of this dynamic. There are few specific references to health care in the *Constitution Act* of 1867 but, since then, conflict between levels of government over health matters has intensified with the growth of provincial power in areas of jurisdiction that became much more important than envisioned in the Constitution. (However, this does not mean, as some have suggested, that had the Constitution been written in 1982 the federal government would have had power over health care; the emphasis on subsidiarity in the European Union, for example, shows this.) Indeed, in 1867, health concerns were considered private rather than public matters, within the bounds of family responsibility and charitable institutions or religious communities, and government intervention was primarily limited to matters of public health (Guest 1997). Nevertheless, as the responsibilities of the modern state expanded over time, the enumeration of provincial responsibilities yielded a wider interpretation in the health sector (Stevenson 1985). Section 92(7) of the *Constitution Act* allows provincial legislatures to enact laws for the “Establishment, Maintenance, and Management of Hospitals, Asylums, Charities and Eleemosynary Institutions”, through Section 92 (13), “Property and Civil Rights in the Province”, and through section 92(16), “Generally all Matters of a merely local or private Nature in the Province.”

Despite the fact that, formally speaking, health policy is considered to be primarily within the bounds of provincial jurisdiction, the federal government also occupies an important political space in the health policy arena. Part of this space is related to the federal government's constitutional responsibilities for public health matters under Section 91(11) and for the general welfare of specific classes of people (referred to as "Indians" and "aliens," as well as federal inmates and members of the armed forces). In addition, although the federal government cannot legislate directly in provincial health systems, it does have a larger scope of financial resources at its disposal, such as the provisions of Section 91(3) for the "raising of Money by any Mode or System of Taxation." Through a series of constitutional amendments, however, jurisdictional space has been created for the federal government in other social policy areas, namely unemployment insurance (1940) and concurrent jurisdiction for old-age pensions (1951 and 1964).

While the federal government's involvement in health care has been primarily confined to the use of the federal spending power, the allocation of money has an obvious impact on provincial health policy (see Tuohy 1989). Two examples of the federal spending power are relevant for health care. The first is the use of transfer payments, whereby federal funds are used to help defray part of the costs of a provincial program. The original shared-cost programs in hospital and medical insurance are examples of this, as are more recent block-funding arrangements, such as the Established Programs Financing (which funded health care and post-secondary education after 1976), and the Canada Health and Social Transfer (which covers health, education and social assistance since 1995). Equalization payments, the second element of the federal spending power, are not targeted directly at program funding but instead flow directly into provincial general revenues. The rationale for equalization payments is to assist provinces with less powerful economies in providing similar levels of health care and other services to their populations. In addition to these two forms of subsidies to the provinces, the federal government also spends "directly" in health care through its responsibility for First Nations and the Inuit, and military personnel in Canada, as well as through its programs in health promotion, protection, and research.

The Definition of Federal and Provincial Roles in Health Care

Ironically, the period in which *roles* were most clearly defined was the period in which the *responsibility* for health care was not exercised. In historical terms, the era in which federal and provincial roles were most clearly defined was at the beginning of the 20th century, a period of so-called "classical" federalism (Mallory 1965; Robinson and Simeon 1990). During the first three decades of the century, two forces were responsible for the endurance of "watertight compartments" between federal and provincial roles: the fact that governments had not taken on a major role in financing health and social services; and the fact that the Judicial Court of the Privy Council in London upheld several provincial complaints against federal intrusion or expansion in provincial jurisdictions.

The absence of appropriate levers for coordinated action became problematic, however, during the Great Depression of the 1930s. The federal government may or may not have had the political will to move forward on social policy, depending on how one interprets the

Conservative government's 1935 *Employment and Social Insurance Act* or the Judicial Committee of the Privy Council's ultra vires ruling against it in 1937 (Smith 1995). What is clear is that provincial governments lacked the fiscal capacity to do so. For example, the British Columbia (Liberal) government passed health insurance legislation in 1936, but it failed to implement it because, without the financial help of the federal government, the province could not afford to do so (Naylor 1986).

A new era of "cooperative federalism" was heralded by the Royal Commission on Dominion-Federal Relations (Rowell-Sirois). Reporting in 1940, the Commission suggested the federal government did have a fiscal role to play in social policy, by virtue of its spending power, but reiterated the provinces' primary responsibility in developing their own health care, education and welfare systems (Smiley 1962). But cooperation in health policy would take considerably more time to develop, and involved substantial political struggles. Although the federal role in health care was actively promoted within the Department of National Pensions throughout the war years, in the 1943 Marsh Report and the 1944 Throne Speech, none of this led to concrete policy development (Maioni 1998). Although the federal government convened the 1945 Dominion-Provincial Conference on Reconstruction as a forum for discussion on concrete proposals for social reform (including health care), some provinces were vocal in their opposition to federal "interference" (in particular Quebec and Ontario), and Prime Minister Mackenzie King had serious reservations about encroaching on provincial jurisdiction and engaging in fiscally expansive social commitments. Paul Martin (Sr.) did convince him to support the 1948 National Health Grants Program, but in the absence of other federal initiatives, provinces began to exercise their jurisdictional purview to innovate in health care. Two examples show how: Saskatchewan's CCF government chose to "go it alone" (Taylor, 1987) in legislating the first public hospital insurance plan in North America in 1946; the Conservative government of Ontario, meanwhile, worked on pushing the federal government into sharing the costs of such a program. The demonstration effect of Saskatchewan, in tandem with some of the political pressure applied by Ontario at the 1955 Federal-Provincial Conference, contributed to the St-Laurent government's passage of the *Hospital Insurance and Diagnostic Services Act* of 1957. In this instance, provincial *push* led to federal *pull* in convening the provinces and in drawing them into an intergovernmental arrangement. This legislation set up an open-ended cost-sharing arrangement, in which the federal government reimbursed about half of the costs of provincial hospital insurance plans that were both *comprehensive* and *universal*. By 1961, all the provinces had hospital insurance plans in place that conformed to this new arrangement. Notably, Quebec was the last province to sign on after the 1960 Lesage victory; prior to this, the Union Nationale government had insisted hospital insurance remain a provincial – and more specifically, a private – matter.

Provincial experiment, intergovernmental negotiation, and federal incentives also provided the diffusion mechanism for public medical insurance. Two forces were at work here as well: first, Saskatchewan's NDP government introduced landmark legislation for public medical insurance in 1961 (although its introduction was delayed by a doctors' strike in 1962); then, the Royal Commission on Health Services (Hall Commission) recommended in 1964 that the federal government, in effect, encourage this model throughout Canada. At the 1965 Federal-Provincial Conference, Prime Minister Lester Pearson convened the provinces to discuss plans for a new arrangement in which the federal government would share the cost of physician services only

(not other health services) under a sliding-scale formula based on a Canada-wide average per capita cost of these services (see Soderstrom 1978, 162-165). To ensure a measure of uniformity across the country, the *Medical Care Insurance Act* of 1966 stipulated that provincial programs would have to be *comprehensive, universal, portable* and *publicly administered*. By 1971, every province had such a plan in operation, although not without several political hurdles. Provincial leaders in Alberta and Ontario objected to the diffusion of universal public health insurance. The Social Credit government in Alberta, for example, preferred its “Manningcare” model for voluntary insurance plus public subsidies for the poor; Conservative premier John Robarts in Ontario referred to the federal policy as “political fraud” (Taylor 1987). Successive Quebec governments attempted unsuccessfully to change the formula to one that allowed opting-out with compensation. Although there was widespread political and popular support for the Castonguay Commission’s recommendations for universal insurance, the sticking point for Quebec was the extent to which the federal government could use taxation to fund programs within provincial jurisdiction (Desruisseux and Fortin 1999).

The hospital and medical insurance programs developed across Canada during the cooperative era were a high-water mark of federalism’s power to shape effective social reform. This was encouraged by the fact that federal governments were able to convene and engage their provincial counterparts in the process of setting social policy. Fiscal responsibilities were relatively well-defined at this point, and care was taken to ensure the perception of provincial autonomy. Provincial governments were beginning to develop their administrative capacities as provincial “states”, most fuelled by the growing public sector responsibility for health, education and social services.

The emergence of a more activist exercise of social policy by *both* the federal government and the provinces also had to do with specific political ideas that were implicit in the post-war world view: Keynesian ideas about the role of the state in the economy; and the legacy of reconstruction that centered on the transition from warfare state to welfare state across the industrialized world. This was bolstered in Canada by the social-democratic influence of the left and centre-left which stressed that health care is a public good, that governments have an obligation to ensure universal coverage and equitable access, and that the federal (central) government belongs in health policy arena as a guardian of the “right” to health care. Federalism was the agent through which these ideas were diffused, although of course the social-democratic impetus was already evident in some cases (the CCF-NDP Saskatchewan) or strengthening (e.g. the Lesage administration in Quebec); but in other cases (e.g. Alberta), the federal purse was able to trump contending ideas and alternatives. An additional idea was implicit in the federal Liberal government: that social benefits, including health benefits, contributed to regional equity in Canada and reflected a “common Canadian citizenship” (Banting 1998).

By insisting on these conditions, and on the portability of benefits for all Canadians, the federal government was attempting to avoid the development of a crazy-quilt of health insurance programs. Thus, the goal was not to impose uniformity in the playing field, since provincial plans demonstrate varying degrees of diversity, but rather to ensure that the provinces played by the same “rules of the game” and that Canadian taxpayers’ money would be used to help finance publicly accountable health insurance systems that ensured some sort of “equality” of social rights among Canadian citizens, regardless of their province of residence.

Question 2

How has the federal role in setting health care policy evolved over the past thirty years? Have changes in its role been consistent with changes in cost-sharing and other fiscal arrangements?

Diagnostic

- The federal role in setting health care policy has become at once more *unilateral* in process and less *effective* in practice.
- Changes in the federal role are consistent with the general trend toward reorganizing *fiscal arrangements* in a decentralized manner (in terms of the shift away from direct cost-sharing and toward block grants) but, unlike other policy sectors, this has not been accompanied by devolution of *political space* in health care.

Discussion

Fiscal Arrangements in the 1970s

The short history described above points to the federal government's initial role in health policy: that of a catalyst, convener and negotiator in federal-provincial cooperative efforts in health care. The federal government used its spending power as a fiscal incentive to diffuse the publicly financed health care model throughout Canada, giving ammunition to those governments who supported the idea, and an inducement to those who did not. It did so despite the opposition of powerful interests (including the insurance sector, business and the medical profession), of several provincial leaders, and from within the Cabinet. In other words, the federal government deployed a substantial amount of political will to promote a progressive (social-democratic or centre-left) model of public-hospital and medical insurance.

Why would the federal government engage itself in this way? It is true that the popularity of public insurance was relatively high, but polls in the 1950s and 1960s showed that Canadians were still divided on private versus public insurance. The "consensus" would come later, in part due to the initial success of the public programs in the provinces. In effect, the federal government considered health insurance as an important social benefit and recognized that not all provinces had the fiscal capacity to sustain such programs. In opting for the public model, the federal government paid attention to the Hall Commission's recommendations and the Saskatchewan experiment, in addition to progressive elements with the federal Parliament itself.

In a period of relative fiscal buoyancy, the political benefits for the federal government were substantial: essentially, it could "claim credit" for what became an increasingly popular social benefit. However, as fiscal constraints closed in, and as the inflationary potential of an open-ended funding arrangement was recognized, the federal role became more difficult to sustain. It sought therefore to disengage itself from part of this commitment, while at the same time

“avoiding blame”, a political strategy that is often easier in federal systems as compared to non-federal systems (Weaver 1996). Fiscal tensions between the provinces and the federal government over social programs began almost immediately with the recessionary fiscal climate of the early 1970s. After the 1973-76 Social Security Review (an exercise which included provincial consultation), the federal government inaugurated a change in the fiscal transfer formula. In 1977, cost-sharing was replaced with a new per capita cash and tax point formula under the Established Programs Financing (EPF) arrangement (for health care and post-secondary education). Ostensibly, this arrangement lessened federal oversight (the end of federal audits for determining costs to be shared) and allowed the provinces greater flexibility in setting spending priorities. However, it also meant that the provinces were now responsible alone for increases in health care spending, and for allocating the EPF transfers between health care and post-secondary education. The federal government, in closing the open wicket for health care, left considerable flexibility in the hands of the provinces as to how to spend the money, but no effective way of monitoring how they did so nor any visible recognition for its fiscal contribution to health care. The EPF arrangement did not have specific conditions attached to it; the prevailing “rules” of the hospital and medical insurance legislations were still presumed in effect and applicable to the *cash* portion of the block transfer (Smith 1995). Emmett Hall’s 1979-80 Commission of inquiry concluded that provinces were using federal contributions for health care purposes but that, in allowing extra-billing and user fees, there was a risk to the long-term viability of public health insurance (Hall’s Royal Commission report in 1965 had made similar observations) (Taylor 1991).

The Canada Health Act

The *Canada Health Act* of 1984 was a response to these concerns and a political effort to regain federal visibility in the health policy arena. It was contested by the provinces for both reasons. Essentially, the new legislation amalgamated the existing federal hospital and medical care insurance acts, introduced a mechanism through which the government could unilaterally impose financial penalties on the provinces, and restated the existing conditions into five principles: universality of coverage, comprehensiveness of services, portability of benefits, public administration, and equal access to care on “uniform terms and conditions”. This last provision was new and explicitly designed to ban extra-billing and user fees through the imposition of deductions to cash transfers. While the first four of these broad principles existed in previous legislation, the CHA emphasized that the “primary objective” of federal involvement in health policy was to “facilitate reasonable access to health services without financial or other barriers.” In addition, for the first time, the federal government requested recognition from the provinces in the health care area: Section 13 of the CHA spells this out by requiring that provincial governments “give recognition” of federal contributions in public documents, advertising or promotional information. (Canada 1985).

Even though the legal scope of the CHA is explicitly limited to the cash transfers the federal government is prepared to deploy, the symbolic scope of the CHA goes much farther. The Act increased the federal government’s political space in the health policy arena, by designating its role in a “Canadian” health care system that could be defined as something greater than the sum of its parts. Through the CHA, the federal government institutionalized its presence in

health policy. And, as “policies restructure politics” (Pierson 1993), the CHA shaped the political playing field in health care by setting the boundaries of health reform. The existence of the CHA has led to a situation in which the federal government has become “embedded” in the public mind as a standard-bearer and protector of Canadians’ health care; much like the state is “embedded” in society through its past policy decisions (Cairns 1986).

This went substantially further than the spirit of the 1957 and 1966 legislation. As in 1966, the federal spending power was deployed as a fiscal incentive to bolster public health insurance. But, unlike the situation in 1966, the process by which this came about was widely criticized. There had been no convening of provincial governments on the matter nor did the Act contain a dispute resolution mechanism that allowed for provincial input. In theory, the mechanism governing this process works in a bilateral fashion, but in practice it resembles more a unilateral process in which decisions are made by the federal government. Each province is required to submit an annual report, including a financial statement that details how its health care plan conforms to CHA principles. Under section 14 of the CHA, if the federal Minister of health decides that a provincial health care plan has “ceased to satisfy any one of the criteria”, he or she is empowered to report to the Cabinet and direct the Finance department to make deductions from transfer payments. There is a consultation process through which the minister informs the province and allows time for discussion, but the final enforcement decision is his or hers alone. In some cases, provincial governments have conferred with the federal government before implementing certain practices, thus voluntarily modifying them to avoid financial penalties. Regardless of whether there is a dispute or not, however, the federal Minister of health is seen to act as “judge and jury” of the provinces (Ministerial Council on Social Policy Reform and Renewal 1995).

Fiscal Arrangements and the Social Union

The CHA is an example of the federal role in *setting* health care policy but it was enacted at the same time that the federal government was *disengaging* itself further from fiscal responsibility. In other words, the federal government attempted to “re-establish federal power” while at the same time displace fiscal responsibilities to the provinces (Hawkes and Pollard 1984). From 1984 onward, the federal government’s fiscal commitment to provincial social programs continually declined, from the limits on EPF payments to the transformation, in 1996, of federal contributions into the Canada Health and Social Transfer. Even in the context of the fiscal crisis that gripped, this was a singularly bold attempt to effect social reform. As in the mid-1970s, this decision came in the wake of an economic recession and after an inconclusive review of social security programs; unlike that precedent, however, there had been little provincial input or forewarning of the 1995 budget speech. This was seen as a unilateral action without the engagement of the provinces and widely decried by provincial governments attempting to address their own fiscal shortfalls in the 1990s. Was the federal government setting health policy through the CHST? It may have been sending a signal to the provinces to get their fiscal houses in order and rein in health care costs, but for many provinces, the “shock” of adjustment proved to be destabilizing for their health care systems. Overall, from the mid-1980s to the mid-1990s, the lack of fiscal transparency allowed the federal government to claim credit as the “guardian” of a popular social policy (the famously cited “sacred trust”, in Prime Minister Mulroney’s words)

while at the same time avoid blame for the types of costs associated with readjustment in health care payments and delivery in the provinces.

Technically speaking, the federal government can deploy its spending power as it sees fit. But the crux of the matter, for many, was this: could the federal government continue to reap the benefits of its role in health care while reducing its responsibility to pay for the costs associated with maintaining a public health care system in the provinces? In other words, was it legitimate for the federal government to “set” policy (by providing the start-up through cost-sharing) and then assume the provinces would develop the capacity to pay for these very expensive programs? For others the question was the extent to which budget decisions actually threatened the federal government’s ability to set policy by undermining its enforcement capacity for existing standards in the *Canada Health Act* (Banting 1995).

While intergovernmental conflict has been the norm in areas involving the distribution – and redistribution – of money, provincial government resentment grew throughout the 1990s. The perception of federal intransigence and the unilateral changes imposed through the CHST, the ideological disposition of activist Conservative governments in Ontario and Alberta, and the legacy of “megaconstitutional” politics which had empowered provincial premiers as political leaders, and the “unity crisis” engendered by the Quebec referendum on sovereignty all seemed to build momentum toward change in intergovernmental affairs and, in a sense, legitimized the quest for provincial autonomy. During this period, federal and provincial governments seemed to be engaged in parallel tracks on health reform, rather than the cooperative model of the past. Much of the tension was related to the proprietary role the federal government staked in the moral “high ground” of public debate, while provinces were increasingly beleaguered by the problems “on the ground” in the health care sector.

The refusal of most provinces to participate in the National Forum on Health was evidence of considerable tension between levels of government in health policy. The NFH itself reported that although the federal government must ensure the integrity of the Canadian health system, there should be more institutionalized cooperation between governments, as well as an end to federal imposition of change on the provinces (National Forum on Health 1997). It was, in part, the perception by provincial governments of unilateral gamesmanship in social policy by the federal government that spurred provincial leaders (including Quebec) to discuss forging a new interprovincial “social union”. The 1995 Ministerial Council’s Report to Premiers reflected concerns about the federal government’s unilateral actions, and recommended federal-provincial discussions to define the *Canada Health Act*, federal-provincial consultations to interpret the CHA and resolve disputes over its meaning, and a predictable funding base for health services through a guarantee that cuts in transfers to the provinces should not exceed federal expenditure cuts. At the 1996 Premier’s conference, a Provincial/Territorial Council on Social Policy Renewal was set up specifically to address the ways in which provinces could be more engaged in standard-setting and put an end to “federal unilateralism.” The Council’s 1997 Report stressed the need for provincial input to identify and enforce “shared” principles, establish procedural ground rules for intergovernmental cooperation, and develop new joint mechanisms for dispute resolution. Provincial and territorial ministers of health (with the exception of Quebec) signed on to a “Vision” document in January 1997, observing that an effective partnership between the federal and provincial governments would entail “adequate, predictable and stable cash transfers”

and new, formal mechanisms to ensure more transparency and less ambiguity in dispute resolution. At their August 1998 Saskatoon conference, it seemed the provinces (again including Quebec) had come to an historic *entente* about how to adapt intergovernmental processes to reflect provincial interests and needs (see chronology in Stilborn and Asselin 2001).

Throughout this remarkable process, the provinces were raising the notion that there could be a basis for cooperation without the presence of the federal government acting as a “hegemon” (a concept borrowed from international relations theory) – an idea that has particular resonance in terms of the CHA (Maioni 1999). The federal government eventually entered into this process with the signature (minus Quebec) of the Social Union Framework Agreement in February 1999. Although broad in scope, the provisions of SUFA were relevant to health policy and largely targeted toward defusing some of the intergovernmental tensions in the health sector. The agreement acknowledged the need for more transparency and consultation in intergovernmental policy-making, including dispute resolutions. The 1999 federal budget, unveiled one week later, demonstrated a commitment to providing stable funding for health care in the provinces and introduced measures to eliminate inter-provincial disparities. But the SUFA did not fully reflect the interprovincial processes that led to its development. The 1998 *entente*, with its provisions for opting out of federal social spending programs, was not incorporated into the SUFA – a decision that cost the process both Quebec’s support and any resolution of where the jurisdictional boundaries in health care lie (Noël 2000). Obviously, the SUFA did not resolve matters, as in August 1999, the provincial premiers’ conference focused on the sustainability of health care funding, echoed the following year by their concerns over the “vertical fiscal imbalance” between the provinces and a federal government with a budgetary surplus. The increased funding in the 1999 federal budget and the September 2000 health care funding agreement increased transfers to the provinces through the CHST, but still left provincial leaders concerned about their fiscal capacity to meet increasing responsibilities for managing health care costs.

Question 3

What health system objectives might be served by changes in the roles the senior governments² play in setting health care policy? How should these roles be changed and what fiscal arrangements would have to be changed to make this happen?

Diagnostic

- Changes need to be made to minimize the destructive conflict and toxic politics in federal-provincial relations: for federal governments to act as enabler rather than enforcer; and for provincial governments to assume their responsibility for political choices in health care.
- Fiscal arrangements should ensure that provincial governments have sustained capacity to meet their responsibilities in health care, while at the same time allow some complementary role for the federal government.

Discussion

Roles of Governments

Arguably, in comparative terms, Canada's health care system is among the most decentralized of any industrialized country, or at least any federal polity (Banting and Corbett 2001). In most other industrialized countries, both federal and unitary, central governments are usually responsible for a certain measure of fiscal harmonization and for some kind of oversight to ensure social benefits to their citizens. Yet, by the same token, in most of these countries, a private market for health care, including medically necessary services, exists to varying degrees. The standards that "tie" provincial health care systems together are at once more fragile and more robust than in other industrialized countries: more fragile since they rest on a federal statute designed to provide negative incentives; and more robust in the sense that they do not allow for much experimentation with private market mechanisms. In most federal systems, the standard-setting role of the federal government in health care is better entrenched, both constitutionally and historically.

Nevertheless, it is clear that provinces have the primary responsibility for setting health policy in Canada, both in theory and in practice. The recent releases of several reports by provincial commissions of inquiry confirm that provinces have built up the administrative capacity and expertise needed to effectively manage health care systems. While it is true that the federal government is more involved in health care than it was 40 years ago – that it has carved out a visible role in health policy – so too have provincial governments built up an active role in this policy area. Provincial governments are responsible for this most costly of program areas, and are faced with day-to-day realities on the ground of how to best respond in the short term to pressing problems in the organization and financing of services to their populations. Given the increasing pressures on the health care system – including demographic pressures, cost

escalation in the pharmaceutical sector, and new technologies, it is understandable that provincial governments are concerned about their long-term capacity to pay for health care, particularly when balanced against the other pressing needs in social services and education.

Thus, health care policy can, and is, set by provincial governments. Provincial health care systems – and the insurance they provide to residents – are publicly administered by provincial ministries or regulated by their public agencies. Each province’s health system is bounded by provincial statutes, not federal legislation. Provinces define what is medically necessary, negotiate fee schedules for payment to health care professionals, and set “global budgets” for health care institutions. A cursory reading of provincial health statutes shows that, despite some differences in coverage, 100% percent of the eligible population is covered for all medically necessary procedures – and so far, on equal terms and conditions. And every recent reform – from the closure of hospitals in major cities to Alberta’s Bill 11 – has been the result of a provincial policy decision for which provincial governments are accountable to their voters.

But this does not mean that the federal government is, or should be, irrelevant in health policy. Health care is a “big ticket” item in the relationship between state and society, both in terms of the considerable commitment in financial resources and in terms of the direct personal impact on people’s lives. The federal government can have an important role to play, *in concert with the provinces*, in engaging in the long-term vision exercise that is necessary to set the markers and determine the resources needed to ensure sustainable health care systems across Canada. In other words, the health system as a whole could benefit from a big picture view of health policy that includes an exchange of input and ideas. The federal government’s most positive role in health care is as an *enabler* (rather than as enforcer) in ensuring that all Canadians can look forward to affordable, quality health care across provincial borders. The federal government can also continue to invest in its public health responsibilities through the promotion of population health and the social determinants of health in provincial health reform (see, for example, Glouberman 2001). Many of the recommendations in Quebec’s Clair report, for example, are based on an integrative model of health and social services that is explicitly concerned with health promotion and the continuity of care.

This does not necessarily mean that the federal government can “guarantee” exactly the same health benefits to every citizen because its role is not to micromanage the health care system. Indeed, the federal government cannot be the arbiter of individual patient caseloads. Nor does it mean that the federal presence in health care is synonymous with “one size fits all” solutions in the provinces. But it does mean that the federal government has an important role in articulating and affirming publicly financed health care as an entitlement. To achieve this, the federal government must, in symbolic terms, be prepared to articulate and defend a coherent vision and, in practical terms, be prepared to offer the incentives for its affirmation in provincial health care plans. The symbolic pay-offs are considerable, but in order to reap these rewards, the federal government must be prepared to invest in the product.

Against this backdrop, the call for a health charter by the Canadian Medical Association is both ironic and interesting (*Globe and Mail* April 8, 2002). It echoes by almost 40 years the 1964 Hall Report recommendation for a “Health Charter for Canadians” based on government-sponsored, comprehensive, universal health services, which was roundly criticized by organized

medicine at the time. But the implicit message that health care must become more centralized – that the federal government must in a sense “re-enforce” its role in health policy – may not be the best scenario to effect health care reform. Much of the rhetoric around the charter idea suggests that the federal government must “protect” Canadians from their provincial governments – a perilous argument in democratic dialogue, even if only for symbolic effect. The other obvious point is that if practicable, how could such a charter be enforced? The *Canada Health Act* does not include such a mechanism, nor could a 21st century federal government be expected to apply disallowance in the health policy area. In the European Union, for example, the *Charter of Basic Rights* includes the right of individuals to access health care under the conditions established by national legislatures, and health policy is jealously guarded by member states both in terms of financing and regulation decisions.

Mechanisms for Cooperation and Existing Fiscal Arrangements

The critical questions surrounding debates about cooperation and conflict in health care are: what is the role of each level of government in health care? What is the responsibility of each with respect to the health of individual Canadians? Conflict, in a democratic polity, is not necessarily a negative thing and conflict in health care, which involves the redistribution of resources and risk, is to be expected (Evans 1990). But conflict that paralyses dialogue and undermines public confidence is ultimately destructive, not only to the federation but to the quality of life of its citizens. It is unconscionable to use a vital issue like health care as a political football in intergovernmental gamesmanship, even more so when one stops to reflect that the football being bounced about represents real people’s lives and well-being, not to mention their tax dollars.

Curiously, for a decentralized federation, Canada has few mechanisms for intergovernmental cooperation and conflict resolution in health care policy. Numerous intergovernmental health advisory committees already operate at the ministerial, deputy minister and administrative levels. In addition, provincial health ministers meet formally twice a year together, and with their federal counterpart, following meetings of their deputy ministers, as part of the Federal/Provincial/Territorial health conference “system.” While these exchanges have been important in policies related to targeted programs (such as tobacco control and blood supply issues) and to specific populations (such as women’s and child health), these intergovernmental committees and meetings have not become venues for addressing broad and pressing concerns related to health care financing and restructuring (O’Reilly 2001).

And, in recent years, First Ministers’ Conferences have been dominated by war of words between provinces and the federal government over the cash crunch in health care. The drill, for the past few years, has been to use these instances of “executive federalism” to publicize claims and apportion blame, intensifying the “corrosive and long-distance hollering” (Romanow 2002) into up-close shouting matches and threats.

There has been movement, stemming from the recommendations of the SUFA, to consider a third-party mediation panel that would involve more provincial input in order to resolve disputes over interpretations of the *Canada Health Act* (Mahoney and Laghi 2002). But the ability to

enforce the CHA, a federal statute, remains in the hands of the federal government so the final decisions of the panel would not be binding. Nor does this initiative resolve the fact that Quebec has not signed onto the SUFA. Basically, dispute resolution through the SUFA is really only the tip of the iceberg of federal-provincial conflict in health care.

In effect, the focus of attention on the CHA as a lightning rod in health care debates diverts attention from the real and pressing needs for real reform in the health care sector across all the provinces. Critics describe the CHA as the roadblock to health reform while supporters liken it to the rampart against the deluge of privatization. But the CHA has no such magical powers. It is at the most basic level a set of negative incentives attached to federal fiscal transfers. The impact of these penalties has so far been minimal, meaning that they work more as a disincentive, or that their impact is better gauged through the “political loop” of public backlash (see Stilman 1997). Indeed, the principal architect of the *Canada Health Act*, former Minister of Health Monique Bégin, argues that, while the CHA was instrumental in “rooting” public health insurance in the Canadian “psyche”, the time has come to consider revising the Act to address the problems of modern health care and the roadblocks in governance and implementation of health reform, and to remedy the “adversarial and arbitrary” nature of the CHA enforcement process (Bégin 2002).

The political problem is not so much that the CHA exists, but the way it used to shape the political debate around health care reform. In effect, intergovernmental discussions in health care have become stymied by the relentless spotlight on a statute that regulates fiscal transfer programs, making it difficult if not impossible to coherently address issues of governance and long-term sustainability in health care. Federal politicians have been wont to brandish it as the “Ten Commandments,” using financial muscle to weigh in on provincial jurisdiction; while some provincial politicians have claimed that it stifles the capacity to address real issues and pursue innovative reform avenues. The focus on the CHA and its “punishment” effects – both real and imagined – have created dysfunctional (some would say toxic) politics around health care in Canada.

While it can be argued that the emphasis on “medically necessary” services has tended to siphon resources toward acute care rather than global health, the CHA does not prevent provinces from funding home care or covering pharmaceutical costs, for example. Rather, the CHA’s disincentives – through the emphasis on public administration and equal access – have for the most part been directed at private market alternatives. The entanglement of conflicts over what level of government is responsible for cost control, and the extent to which provincial health policy choices can be constrained by federal government preferences, has opened the political space for these alternatives to gather political momentum.

One of the solutions envisioned in the perceived democratic deficit in intergovernmental relations (Simeon and Cameron 2002) would be to allow for more “citizen engagement,” a process by which governments encourage citizen participation in public policy-making (Abele et al. 1998). The SUFA itself alludes to the involvement of Canadians in “developing social priorities” through citizen engagement. Recent musings on engaging citizens in the health care system through “policing” the *Canada Health Act* are not exactly in the same spirit. Nor should citizen engagement be a smokescreen to devolve further the responsibility for “tough choices” that are ultimately the responsibility of publicly accountable policy makers

(Lomas 1997). The Romanow Commission's use of consultation research to "dialogue with citizens" may introduce a new frontier in citizen engagement by asking participants to envision and work through concrete scenarios for change. But for such practices to be truly effective, they will have to be accompanied by similar dialogues between senior government officials: dialogues that are not restricted to targeted issues (such as the Federal/Provincial/Territorial conference system); and dialogues that do not become monologues about money and power.

The Quebec government's Séguin commission on fiscal imbalance between the federal government surplus and pressing provincial budgetary needs, recommends a more drastic change: abolishing intergovernmental conflict at its source by replacing conditional cash transfers under the Canada Health and Social Transfer by tax room for the provinces. In this scenario, the federal spending power would become a moot issue in health care, allowing the provinces greater fiscal capacity to set their agendas for health policy. The report is a scathing criticism of the federal government's fiscal neglect of the provinces, but its recommendations cut through the roles and responsibilities debate by suggesting provinces should have exclusive leeway in setting health policy. Although less of a concern for Quebec governments, an earlier version of these arguments put forward in the Ontario context also suggested that a social union could be preserved by replacing Ottawa's "enforcer" role with an interprovincial "convention" (Courchene 1996). But there is no certainty that provincial governments, with divergent ideological baggage and political priorities based on distinct social and economic conditions, would share the same norms about health care without some form of incentives.

For all the quibbles over resources in health care between the provinces and the federal government, political battles over health care have never been *only* about money. In the past sixty years, recurring lines of demarcation between the federal government and some provinces have included ideological battles about public, universal as opposed to private, voluntary health insurance (historically, the preference of fiscally "conservative" governments in "richer" provinces such as Ontario, Alberta and British Columbia). The contested political space in health policy often has to do with the *type* of health care system to encourage, indeed more broadly over the role of the *state* in health care altogether. Attempts to control public spending in health care and the subsequent escalation of conflict in intergovernmental relations over this issue have opened a window of opportunity for political and social actors that believe in less state intervention to question the legitimacy of federal standards and to justify attempts to explore other options for financing health care.

Provinces have functioned as laboratories of innovation in the past and continue to do. Today, however, it is not a relatively less well-off province with a social-democratic government, like Saskatchewan, nor a government pushing the state into modernity, as in Quebec, that are at the forefront of change in health care. It is not insignificant to note that the most innovative solutions being promoted in Canada today are those emanating from "richer" provinces under more fiscally conservative governments with health reform agendas based on stretching the flexibility of the public model. In other words, the provincial governments most vocal about necessary changes to the fiscal order and the federal government's role in it are those that are least tied to its fiscal purse-strings. The exception is Quebec, where the current government has less ideological quibbles with the public model (solidarity and equality, not speed and quality, are the leitmotifs of the provincial Clair Commission report) and more

constitutional baggage about policy sovereignty in health care. For Quebec, the jurisdictional issue takes precedence: the extent to which provinces can opt out with compensation from federal cost-sharing arrangements, and the extent to which a “fiscal imbalance” between the provinces and the federal government threatens the provinces’ ability to provide optimal health and social services to their residents.

Question 4

What works better³ – shared jurisdiction and cooperative roles, or a clear assignment of role to one level of government or the other?

Diagnostic

- Although the roles of levels of government are well-enough defined, what is less clear is the responsibility to be attached to these roles.
- There are two competing “legends” about federalism and health care in Canada that are equally misleading: that there exists a single “national health insurance” or “medicare” system in Canada; and that health care is a purely provincial matter in which the federal government has no role to play.

Discussion

Federalism is a political arrangement by which power is constitutionally distributed between governments and in which the social and economic lives of citizens are affected by both these governments (Smiley 1987). In an uncluttered, ideal world one could suggest that federalism is a system of water-tight compartments in which each sphere of government attends to its own jurisdiction. But the real world of Canadian politics is a messy place. In fact, there is more clarity around the assignment of *roles* in health care but less consensus on the apportionment of *responsibility*. With whom does accountability rest? Whose task is it to ensure the viability of the health care system?

There exist at least two misleading “legends” about federalism and health care in Canada. The first is that there exists a “national health insurance” or “medicare” system in Canada. Both of these terms are imports from the United States and refer, respectively, to the historic and on-going U.S. debates about extending universal coverage for health care services through federal legislation, and to the medical insurance for the aged program financed and organized by the federal government. In Canada, obviously, the federal government does not play such a role; there does not exist a “Canadian health care system”; instead, we have provincially regulated health care systems financed by public revenues, with a federal fiscal contribution tied to certain standards of compatibility between the provinces. In this sense, the “Canadian” health care model can be thought of as a mosaic of ten provincial and three territorial health insurance plans, resembling one another by certain “norms”. Norms are standards of behaviour that reflect a certain code of conduct, but in order to be operative, norms have to be imposed in some manner: formally, through a power relationship in which an actor or set of actors can inflict reprisals or informally in ways that are not legally binding but suggest some kind of sanction. It is, at present, difficult to gauge to what extent the principles of the *Canada Health Act* are norms to which provincial governments, health care providers, and even individual citizens, would ascribe to under different conditions than those in place today.

The second “legend” is that health care is a purely provincial matter in which the federal government has no role to play. Health care has become one of the primary symbols of a modern state’s involvement in society, literally “protecting” citizens’ well-being. In essence, involvement in health care represents a way in which the state can help establish the boundaries of social consensus. This, in turn, contributes to the legitimization of the state’s role in the economic and social lives of citizens. Thus, arguments against federal “interference” repose upon assumptions about jurisdictional autonomy – which level of government should be responsible – (such as those emanating from Quebec), or about the limits of state involvement in citizens’ lives – should governments be responsible in the first place – (emanating from conservative and neo-liberal governments).

In the *Federalist Papers*, James Madison suggests that “aggregate” interests are referred to the central government, while “particular” interests remain in the purview of sub-national or local governments. The real question this dichotomy raises is whether or not health care can be considered in the purview of provincial governments or incorporates a larger vision of the public interest. If health care is an aggregate interest, then the federal government has a role – but also a responsibility – in ensuring that these services are available to its citizens. The health policy realm places an enormous responsibility on the modern state, one that many governments are finding difficult to sustain. The development of provincial health care systems along public, universal lines, would not have been possible across Canada without federal involvement. By the same token, the basic existing model is not sustainable – politically or fiscally – without federal involvement, both in its fiscal capacity and the use of fiscal levers to encourage the public model. Obviously, the provinces were not expecting the federal government to cover only the “start-up” costs in this considerable undertaking, but rather expected a sustained commitment to these expensive programs.

If the endgame in health care is to retain its meaning as a public good, then the federal government would be better off putting more emphasis on encouraging consensus rather than enforcing rules. Part of this task involves evaluating alternatives and suggesting the boundaries of what is feasible and desirable in health care reform. Under what conditions can the federal government encourage innovations that are not entirely at odds with the basic premises of the public model? To what extent is more structured exchange of information needed in identifying, evaluating – and possibly diffusing – provincial recommendations from commissions of inquiry, new models of delivery, or experiments such as integrated care in Quebec, or health care systems in Europe and elsewhere? There are relatively large bodies of evidence to suggest that public health care systems do better in providing care and controlling costs, that health care systems focused on preventive and integrated care work better in keeping populations healthy, etc. In order to retain a relevant role in health policy, the federal government should be willing to evaluate the available evidence in suggesting the markers and signposts, and in helping to build the capacity, for real health reform. To this end, a measure of “political goodwill”, for lack of a better term, is necessary in reshaping the federal-provincial dialogue in health care.

Question 5

What roles should be considered for other levels of government (municipalities, regional health authorities)? What would proposed changes be designed to achieve?

Diagnostic

- In most provinces, regional health authorities exercise considerable authority in the allocative decisions about health care organization and financing.
- Decentralization and health care are compatible only insofar as a balance can be struck between decision-making and accountability.

Discussion

Most provinces have decentralized the allocation of resources in health care through the creation of regional health boards (some elected, others appointed, still others a mix of the two). These initiatives were intended to devolve authority from provincial health ministries to regional or local bodies that would have some measure of discretion in allocating health care resources. This process was generally designed to encourage population-based funding and other allocative efficiencies, such as ensuring the optimal level of resource mix for a particular region (Dorland and Davis 1996). Although almost all provinces have instituted such regionalization through the creation or reorganization of existing local and regional health boards, these experiments have not all been successful in establishing efficiency. Part of the problem is that these boards are not always empowered to make important decisions, such as those related to physician fees and drug use. Questions have been raised as to just what kinds of decisions such boards are equipped to make: in terms of representation and accountability in the case of non-elected members, and in terms of expertise for elected members. In practice, for example, professionals often outweigh community representatives in terms of the influence exerted on the board. In addition, provincial governments also saw these initiatives as a form of “community empowerment” designed to harness public support for health care reform and “conflict containment” in the wake of public sector spending cuts and its consequences (Lomas et al. 1997). Indeed, most regional boards were created or became operative in the mid-1990s, just as provincial governments were faced with tough cost-cutting measures in the public health care sector.

In theory, such decentralization has the potential to “democratize” the health care sector if citizens are being engaged in a process of influencing decisions about service delivery – including issues of allocation and rationalization. If important decisions are made affecting the delivery and use of health care for individuals and their families, then citizens ought to be informed and involved in making and supporting these decisions in their communities. But the rationale of the “democratic wish” behind decentralization – that citizens can engage in public decision-making (Morone 1990) – is potentially problematic for at least three reasons: i) specifically, because health care delivery and financing are part of a highly complex system that is difficult for non-experts to decipher; ii) more broadly, because effective engagement

involves opening up a Pandora's box of new actors in the policy process, which can potentially widen the scope for conflict and make it difficult to achieve consensus; and iii) hypothetically, because attempts at inclusiveness can raise the potential for blame avoidance by governments and the off-loading of accountability between governments and citizens.

Decentralization and health care are compatible only insofar as a balance can be struck between decision-making and accountability. Concepts such as citizen engagement and regional boards cannot become smokescreens for authoritative decisions about cost-control and scarce resources. Of broader concern is the risk that with a continual downloading of decision-making and accountability, local concerns may be served at the expense of the larger provincial – or even national – community (Maioni 2001).

Notes

- 1 This section is based on Antonia Maioni, “Federalism and Health Care in Canada”, in Keith G. Banting and Stan Corbett, eds, *Health Policy and Federalism: A Comparative Perspective on Multi-Level Governance* (McGill-Queen’s University Press, 2002). Some of the subsequent sections in this paper draw in part from “Health Care in the New Millennium”, in Herman Bakvis and Grace Skogstad, eds, *Canadian Federalism: Performance, Effectiveness, and Legitimacy*, Toronto: Oxford University Press, 2001.
- 2 In this paper, we interpret “senior governments” to refer to governments with Constitutional status in Canada; i.e. the federal government and provincial governments.
- 3 The definition of “better” is not specified – we assume here it refers to optimal outcomes in the overall access to health care by Canadians.

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Appendix: Key Events in Health Insurance Legislation in Canada

Source: “Key Events,” *Public Health Insurance Through History*, Virtual Exhibit, McGill Institute for the Study of Canada (www.arts.mcgill.ca/programs/misc/).

- 1919 – Dominion Department of Health established (becomes Department of Pensions and National Health, 1928).
- 1928 – House of Commons Select Standing Committee on Industrial and International Relations studies “sickness insurance”.
- 1932 – British Columbia Royal Commission on the State Health Insurance and Maternity Benefits (recommends compulsory health insurance for low-income workers).
- 1933 – Alberta holds a second Commission of Inquiry on the issue of establishing a provincial health insurance scheme. Winnipeg Medical Society launches “doctor’s strike” except for emergency care.
- 1934 – Canadian Medical Association endorses “the principle of health insurance”.
- 1935 – Government of British Columbia presents a preliminary bill to the provincial legislative assembly calling for the creation of provincial health insurance.
- 1935 – Ontario government signs an agreement with the Ontario Medical Association to subsidize the cost of patients on relief; municipal medical relief plans are also implemented in cities in other provinces.
- 1936 – British Columbia *Health Insurance Act* passed (never implemented).
- 1939 – Voluntary medical insurance initiatives (Windsor Medical Services; Associated Medical Services in Toronto); Manitoba Blue Cross established.
- 1940 – The Report of the Royal Commission on Dominion-Provincial Relations (the Rowell-Sirois Report) recommends cost-sharing by federal government of health insurance to ensure fiscal capacity of provinces and to maintain similar standards throughout Canada.
- 1942 – Interdepartmental Advisory Committee on Health Insurance developed by Minister Ian Mackenzie and chaired by J. J. Heagerty, presents a draft bill for health insurance (via conditional grants-in-aid to the provinces).
- 1943 – House of Commons Special Committee on Social Security studies health insurance.
- 1944 – Prime Minister Mackenzie King delivers the Throne Speech, which calls for health insurance and family allowances as central part of post-war reconstruction.
- 1944 – Ontario (Progressive Conservative) Premier George Drew calls for a reconstruction conference with health insurance on the agenda.

- 1944 – Alberta (Social Credit) adopts the Alberta Maternity Hospital Plan.
- 1945 – Dominion-Provincial Conference on Post-War Reconstruction discusses « Green Book » proposals for social programs, including health insurance; some provinces oppose federal intervention in their jurisdiction.
- 1946 – Cooperative Commonwealth Federation (CCF) government led by Tommy Douglas introduces Saskatchewan Hospital Services Plan (implemented in 1947).
- 1948 – Federal Finance Minister Paul Martin, Sr. develops National Health Grants program (federal financial support to provinces).
- 1948 – British Columbia (Liberal Conservative Coalition) government develops hospital coverage.
- 1949 – Alberta (Social Credit) government begins establishment of hospital insurance via a municipal hospital plan (similar to Saskatchewan, but with patient contributions).
- 1951 – Canadian Medical Association (CMA) establishes the Trans-Canada Medical Service (TCMS) that included seven insurance plans on a provincial basis (by 1955, all provinces with 2 million beneficiaries).
- 1955 – Ontario (Progressive Conservative) government establishes Hospital Insurance Plan; at Federal-Provincial Conference, Ontario Premier Leslie Frost calls on Prime Minister Louis St-Laurent to develop federal cost-sharing for hospital insurance.
- 1956 – Canadian Medical Association opposes universal hospital insurance.
- 1957 – In March, House of Commons (Liberal majority) passes Bill 165 on hospital insurance with a unanimous vote; in June, Prime Minister John Diefenbaker's (Progressive Conservative minority) revokes the majority province rule required to implement Bill 165.
- 1958 – On July 1st, the *Hospital and Diagnostics Services Act* of 1957 comes into effect (based on a 50-50 cost-sharing formula).
- 1960 – Prime Minister Diefenbaker appoints Royal Commission on Health Services, chaired by Emmett Hall.
- 1960 – In June, a referendum on medical insurance is held by the CMA as a means to protect the interests of its members, such as the right for physicians to make clinical decisions in patient care, without intervention or interference from a third party (the government).
- 1961 – All provinces have legislated hospital insurance and have entered into cost-sharing agreements with the federal government.
- 1961 – Saskatchewan Premier Woodrow Lloyd (CCF) introduces a medical care insurance bill to the provincial legislature.

- 1962 – July 1st starting date for medical insurance in Saskatchewan leads to province-wide doctor’s strike; July 22, Saskatchewan physicians are ordered back to work by the provincial Superior Court.
- 1963 – Alberta Premier Ernest Manning (Social Credit) government introduces medical insurance plan (known as “Manningcare”) that offers subsidies for low-income earners to allow them to pay for voluntary coverage.
- 1964 – The final report of the Hall Commission recommends comprehensive health coverage for all Canadians.
- 1965 – The Canadian Medical Association expresses concern about these recommendations.
- 1966 – Ontario Medical Services Insurance Plan introduced to provide insurance to the medically indigent and to low-income earners.
- 1966 – Health and Welfare Minister Allan MacEachen introduces Bill C277 to the House of Commons; *Medical Care Insurance Act* passed with a vote tally of 177:2.
- 1967 – Cost-sharing program for medical insurance comes into effect; Saskatchewan and British Columbia become the first two provinces to join the program.
- 1969 – Newfoundland, Nova Scotia, Manitoba, Alberta join the program.
- 1970 – Quebec passes legislation for medical insurance, after strike by specialist physicians; extra-billing is not permitted by law.
- 1971 – New Brunswick and Northwest Territories join the program.
- 1972 – Yukon joins the program.
- 1976 – At Federal-Provincial Conference, Prime Minister Pierre Trudeau proposes tax points and block-grant funding to replace cost-sharing programs for medical care.
- 1977 – The *Established Programs Financing Act* (EPF), based on per capita transfers to the provinces tied to growth in GNP, passed to replace the 1972 *Revenue Guarantee Act*.
- 1979 – Progressive Conservative Prime Minister Joe Clark appoints Emmett Hall to chair the Health Services Review Committee; Committee recommends end to extra-billing.
- 1981 – Extra-billing is banned in British Columbia.
- 1983 – Health Minister Monique Bégin presents White Paper on “Preserving Universal Medicare” focusing on guarantees to access to health care services.
- 1984 – The *Canada Health Act* of 1984 becomes law; financial sanctions for provincial non-compliance with the five principles of the Act become effective immediately.

- 1985 – Saskatchewan doctors agree to end extra-billing.
- 1985 – The Ontario *Health Care Access Act* introduced in the legislature.
- 1986 – Province-wide physicians strike launched in Ontario; Ontario Medical Association disputes the constitutionality of Bill 94 (Ontario *Health Care Services Act*).
- 1986 – Canadian Medical Association opposes *Canada Health Act* as a violation of the *Constitution Act* of 1982; case is redirected to the Supreme Court of Canada.
- 1986 – Alberta bans extra-billing and proposes that the fee schedule be negotiated through binding arbitration.
- 1987 – Extra-billing end date for New Brunswick.
- 1989 – EPF transfers are scaled back to GNP increases minus three percentage points.
- 1990 – EPF transfers are frozen for five years.
- 1991 – The Health Action Lobby (HEAL) formed as a coalition of health and consumer organizations expressing concern over the erosion of the federal government’s role in health care.
- 1994 – National Forum on Health appointed by Prime Minister Jean Chrétien.
- 1995 – Canada Health and Social Transfer replaces EPF and Canada Assistance Plan; substantial reduction in transfers to the provinces for social programs.
- Mid-1990s – Important reductions in several provincial health budgets; hospital and bed closures; reduction of some services; salary caps for specialist services; regional boards implemented in most provinces.
- 1997 – Quebec introduces mandatory pharmacare plan.
- 1999 – Alberta Progressive Conservative government under Ralph Klein introduces Bill 11 (allows for contracting-out with private care facilities for minor elective surgery).
- 1999 – Saskatchewan Commission on Medicare (chaired by Ken Fyke) releases its report: *Caring for Medicare: Sustaining a Quality System*.
- 1999 – Social Union Framework Agreement signed between federal government and provinces (except Quebec).
- 1999 – Federal budget injects \$11.5 billion in health care over five years.
- 2000 – Federal budget earmarks extra \$2.5 billion in cash for provincial health care needs.
- 2000 – Ontario Health Services Restructuring Commission (chaired by Duncan Sinclair) releases its report: *Looking Back, Looking Forward: A Legacy Report*.

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- 2001 – Quebec Health and Social Services Commission (chaired by Michel Clair), releases its report: *Emerging Solutions - Report and Recommendations*.
- 2001 – Royal Commission on the Future of Health Care appointed, chaired by Roy Romanow (former Premier of Saskatchewan).
- 2002 – Alberta Premier's Advisory Council on Health, (chaired by Don Mazankowski), releases its report: *A Framework for Reform*.