

Commission on the
Future of Health Care
in Canada

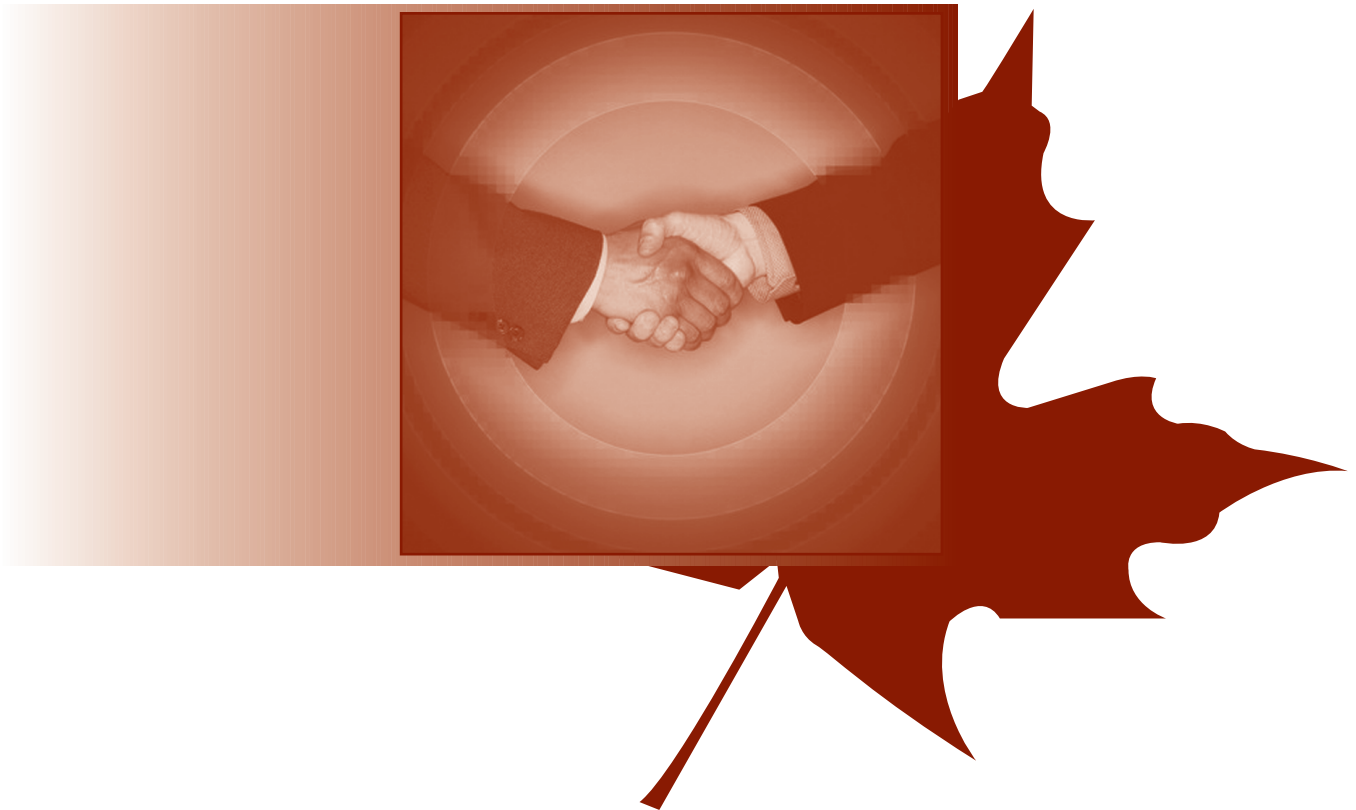


Commission sur
l'avenir des soins de santé
au Canada

SUMMARY REPORT
FISCAL FEDERALISM AND HEALTH

FEDERAL-PROVINCIAL RELATIONS AND HEALTH CARE

Reconstructing the Partnership



by

**The Institute of Intergovernmental Relations
School of Policy Studies
Queen's University
November 2002**

CP32-84/2002E-IN
0-662-32997-X

The findings of this paper are the sole responsibility of the authors and, as such, have not been endorsed by the Commission.

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Introduction

Federal and provincial governments have been jointly involved in the provision of universal publicly insured and administered health care to Canadians for decades. In the early post-war decades, federal and provincial governments agreed on the use of conditional intergovernmental grants as the means to build the Canada-wide set of health care arrangements that exist today. What was done in the 1950s, 60s and 70s was a considerable achievement both in policy and fiscal terms and from the viewpoint of cooperative intergovernmental relations.

Today, however, there are a number of disconnects between the federal government's approach to the financing of health care and to intergovernmental health care relations, on the one hand, and its policy role in promoting a Canada-wide system of health care for Canadians, on the other. These disconnects are contributing to provincial difficulties in reforming their health care systems and they are serious irritants in intergovernmental relations.

The main purpose of this paper is to lay out a range of possible reforms to the federal financial contribution to provincially operated health care systems. The second and related object is to shed light on ways of improving intergovernmental relations, in particular the federal-provincial dispute resolution process for health care policy and its financing. Both are intended as contributions to the wider debate about sustaining and improving health care for Canadians. While both of these issues have a substantial technical side, they also raise broader political questions about the appropriate role for the federal government in Canadian health care.¹

To foreshadow our conclusions, we suggest that there are certain broad principles that should guide the federal government's approach to these issues. We do not consider, however, that there is a single correct approach to future federal financing of health care or to intergovernmental relations more generally. Rather, there are different visions of the federation that embody different values. For any one of these visions, certain approaches to funding and dispute resolution make better sense than do others. Thus, the paper concludes with a set of proposals for using the tools of fiscal federalism for sustaining and improving Canadian health care in ways that are consistent with a number of different visions about the nature of the Canadian federation and with a range of alternative models that could be used to resolve health care disputes.

Constitutional and Political Setting

The Constitution Act, 1867 reflected nineteenth century conceptions about the appropriate role of government. The health and social needs of Canadians were seen then as a matter for the individual, the family, the church and charitable institutions, with the state's role largely confined to rudimentary forms of poverty relief administered through local agencies. When the social role of the state began to expand in the twentieth century, Canada had to resolve the division of responsibility in new domains of state action.

¹ The purposes of this paper reflect the terms of reference provided by the Commission on the Future of Health Care in Canada. There are other important issues in intergovernmental health care relations, including whether the principles of the *Canada Health Act* require revision, that are beyond the scope of this paper.

In the case of health care, Peter Hogg observes that “health is not a single matter assigned by the Constitution exclusively to one level of government” (Hogg and Monahan 2000; Lajoie and Molinari 1978). But Section 92 of the *Constitution Act, 1867* did give the provinces the central role in the field. Section 92(7) specifically grants to the provinces authority over hospitals. In addition, jurisdiction was inferred from other more general provincial powers, especially section 92(13), dealing with property and civil rights, and section 92(16), dealing with matters of a local or private nature. In the early decades of the twentieth century, the courts held that these sections empowered provincial governments to regulate the medical professions and commercial insurance plans. This authority was extended to the new instrument of social insurance during the late 1930s.

The Constitution also provides room for a federal government presence in health matters. Authority over criminal law gives the federal government a role in the protection of public health. Other sections of the Constitution assign to the federal government responsibility for the welfare – including health care – of specific classes of people, including “Indians”, “aliens”, inmates in federal prisons, and members of the armed forces. In addition, the federal tax powers are the basis of extensive federal involvement in the financing of health care expenditures through various tax credits allowed under the personal income tax system and GST exemptions. Ottawa’s spending on research also gives federal agencies a major role in health research and information.

The federal government’s primary role in health services for the population as a whole has developed through financial transfers to provincial governments. The constitutional basis of these transfers is section 36 of the *Constitution Act 1982* and the doctrine of the federal spending power. Section 36(1) commits the federal and provincial governments to “promoting equal opportunities for the well-being of Canadians” and “providing essential public services of reasonable quality to all Canadians.” Section 36(2) then commits both orders of government “to the principle of making equalization payments to ensure that provincial governments have sufficient revenues to provide reasonably comparable levels of public services at reasonably comparable levels of taxation.”

The doctrine of the federal spending power holds that “the federal Parliament may spend or lend its funds to any government or institution or individual it chooses, for any purpose it chooses; and that it may attach to any grant or loan any conditions it chooses, including conditions it could not directly legislate” (Hogg and Monahan 2000). The use of the federal spending power has been controversial, and it was challenged both politically (Tremblay Commission 1956, and Séguin Commission 2002) and in the courts. To date, at least, the courts have accepted that concept although it is probably also true that it has not been tested fully.

Evolution of the Federal Role in Funding Provincial Health Care Services

During the war years, the federal government developed ambitious proposals for a postwar system of social insurance, including public health insurance. Many of these proposals were linked to the court decisions regarding the powers of the two orders of government. But this

package of federal proposals was rejected at the postwar Dominion-Provincial Conference on Reconstruction in 1945, with Ontario and Quebec the principal opposition. However, some other provinces favoured quick action on the hospital insurance component. Thus, in 1947, Saskatchewan introduced public hospital insurance, and to varying degrees British Columbia and Alberta followed in rapid succession. Newfoundland had a measure of public health insurance when it entered Confederation in 1949. With the support of a majority of provinces, which by this time included Ontario, the House of Commons unanimously enacted the *Hospital Insurance and Diagnostic Services Act, 1957*.

To qualify for federal cost sharing under the 1957 legislation, provincial plans had to provide coverage to all residents of the province on uniform terms and conditions, include specified diagnostic services, and limit co-insurance or “deterrent” charges so as to ensure that an excessive financial burden was not placed on patients. All provinces had signed agreements to join the federal plan by 1961.

The introduction of Medicare, which covered physicians’ services, was more controversial. The medical profession and the insurance industry were adamantly opposed to it. Once again, Saskatchewan took the lead by introducing a universal model in the early 1960s and pressing for federal support. But this time, governments in Alberta, British Columbia and Ontario were initially opposed, at least in part because they preferred a system of private health insurance for the majority of the population. In 1965, the federal government opted for the universal model of health care pioneered by Saskatchewan. And it undertook to cover half the costs of provincial expenses for physicians’ services, although at the July 1965 federal-provincial conference the Prime Minister suggested that this not need include a formal cost-sharing arrangement, as was in place for hospital insurance. Following intergovernmental negotiations, the *Medical Care Act, 1966* did, however, include a formal cost-sharing mechanism. Provinces had to meet several conditions to qualify for their share of federal financial support. Provincial medical plans had to provide for: administration and operation on a non-profit basis by a public authority; coverage of “all services rendered by medical practitioners that are medically required”; universal coverage of all provincial residents (at least 95 percent of the eligible population) on equal terms and conditions; and portability of benefits. There are doubts as to whether “access” was viewed then as a co-equal fifth principle or condition, but the federal legislation did explicitly require that insured persons not be charged fees that might impede or preclude “reasonable access” to insured services. This reasonable access provision was apparently intended to exclude provincial charges for physicians’ services to patients, but it may not have applied to extra-billings by physicians that impeded or precluded reasonable access. In any case, to the extent that access may not have been a co-equal fifth principle then (the Prime Minister’s speech to the July 19-20, 1965 federal-provincial conference had not mentioned “reasonable access” as a formal principle), it gradually evolved to gain that status. And, despite the initial resistance of some provinces as noted above, all provinces had joined the plan by 1970.

While the instrument of cost sharing was highly effective in creating a Canada-wide system of public hospital and medical insurance, it also had its downsides. Thus, by the early 1970s, the federal government had become very worried that its open-ended commitment to pay for half of provincial expenditures in a number of programs, including hospital and medical care, was eroding its capacity to control its own expenditures. And by the mid-1970s, provincial

governments were also expressing frustration with the cost-sharing model. They were seeking to escape from the extensive annual negotiations about eligibility issues (e.g. which hospital beds were eligible for cost sharing). They also argued that this form of cost sharing was distorting their resource allocation process.

After extensive federal-provincial negotiations, a compromise emerged in the form of the *Federal-Provincial Fiscal Arrangements and Established Programs Financing Act, 1977*. The transfers for hospital and medical services, as well as for post-secondary education, were combined in one block grant. The initial Established Program Financing (EPF) transfer was intended to be an equal per capita payment to each province. Roughly half was initially paid as an equal per capita cash transfer. The other half was made available to provinces as a tax-point transfer. It included 13.5 percentage points of personal income tax room and one percentage point of corporate income tax room. The tax points were equalized to the national average on the basis of the then prevailing federal equalization formula. In addition, levelling payments were involved. As a result, over a five-year transition period, the tax points (with equalization and levelling payments) were to be worth as much on a per capita basis to equalization receiving provinces as they were to wealthier provinces. The federal government gained greater predictability in its financial commitment. Its cash outlays would escalate according to a formula based on the rate of growth of the economy, not of provincial spending. The provinces gained a reduction in federal administrative controls. Although the conditions attached to Medicare remained in place, federal officials no longer had to rule on whether particular provincial expenditures were eligible for cost sharing.

Today, there is controversy as to whether the end of cost sharing in health care was “a good thing”. Most of the arguments, on both sides of this issue, were understood in 1977 (see, for example, Perry 1977). For some, the shift to block funding was “good” because it removed the federal government from the business of determining the eligibility of provincial expenditures for cost sharing and then from auditing those expenditures. This was thought to be desirable because it was more respectful of provincial constitutional authority over health care. For others, the shift to block funding broke the explicit link between federal cash contributions and provincial health care spending. This was perceived as “bad” because it had the potential to weaken the federal government’s ability to enforce the pan-Canadian principles associated with the hospital and medical insurance legislation (*Toronto Star*, A5). What was not anticipated then was the emergence of a serious federal-provincial dispute over whether the federal tax-point transfer should continue to be “counted” as a federal contribution twenty and twenty-five years after that transfer occurred. It has since emerged, however, as a political football in the federal-provincial quarrel regarding the adequacy of the federal financial contribution to health care. And the ambiguities surrounding this question have served in recent years to confuse and obfuscate public deliberations about the adequacy of federal funding.

The early 1980s were marked by a growth in extra-billing by some doctors and facility fees by hospitals in some provinces. The federal government opposed both as inhibiting equal access to health care, but it lacked the legislative tools to enforce its view. Parliament therefore unanimously passed the *Canada Health Act, 1984* to discourage such practices. The legislation amalgamated the previously separate hospital and medical insurance legislation. To qualify for federal financial support, provincial plans had to satisfy the conditions/principles set out in the

1966 legislation, including that on access. To facilitate enforcement of the “reasonable access” principle, the legislation also determined that such provincial charges would lead to dollar-for-dollar deductions in the federal transfer. Although all provincial governments opposed and were angered by the legislation, they generally moved toward compliance within a few years, recognizing perhaps that the federal government had broad public support for its action.

With the *Canada Health Act* on the statute books, questions arose about how it was to be interpreted and enforced. For the most part, especially after the election of a new federal government in 1984, senior officials did much of this necessary work on a cooperative intergovernmental basis behind closed doors. And by the late 1980s, federal-provincial disagreements about user fees were, at least momentarily, largely on the backburner. During the 1993 federal election, however, the Liberals campaigned on a platform that included the statement that we “will not accept user fees or other attempts to gut the medicare system” (Liberal Party of Canada 1993). With the subsequent change of federal government in 1993, the re-emergence of the user-fee issue and the issues of interpretation and enforcement again became contentious. And since then, the process through which the federal government has interpreted and enforced the *Canada Health Act* has become a serious source of concern for provinces in and of itself. In this view, the federal government is acting as both a prosecutor and judge when disagreements arise (Cameron and McCrea-Logie 2002).

Had federal-provincial-territorial fiscal relations been harmonious during these years, dispute resolution might not have become such a substantive issue in intergovernmental health care relations. However, the federal government unilaterally tightened the EPF and other transfers on several occasions in the 1980s and early 90s, culminating with the 1995 announcement of the Canada Health and Social Transfer (CHST). This combined EPF and the previously separate transfer for social welfare into a single block transfer and reduced the size of the cash transfers to provinces by a very large amount (beginning in 1996) relative to what the previous legislation had anticipated. The impetus for this change was overwhelmingly fiscal. The federal government found itself in an untenable deficit and debt situation, and it engaged in a major expenditure-reducing strategy that included, among other things, these especially large cuts in transfers to the provinces.

We discuss below the tensions associated with the CHST cuts. Suffice it here to note that, today, there is a fundamental disagreement among federal, provincial, and territorial governments regarding the adequacy of the federal financial contribution to the still rapidly-growing provincial health care budgets. Related to this are the differences referred to above concerning the dispute resolution process itself, both for policy matters (including a revival of the user fee controversy in the 1990s) and fiscal issues. As a result, the sense of federal-provincial political partnership that was so fundamental to the early days of public health insurance has eroded badly since the early 1980s. While the Canadian public continues to believe that intergovernmental cooperation is important to the future of universal public health insurance, governments have been in an adversarial mode for at least two decades and have engaged in too little interactive decision-making on the issues that really matter (Adams 2001).

Given this level of intergovernmental conflict and misunderstanding, it is useful to reflect on how we reached the current situation and what might be done to overcome it. And as an initial step in examining these matters, we return to the first principles by posing two questions: i) What are the reasons for a government role in health care? and ii) What is the basis for the federal government role?

Considerations Related to the Public Role in Health Care

Two critical characteristics set many forms of health care apart from other products and services. First, the need for health care is typically uncertain. Second, the risk of ill health is unevenly distributed among the population as a whole. Markets can often be established to pool risk among members of the population at large, especially when outcomes are randomly distributed among the population. But good health is not randomly distributed. Some individuals or groups of individuals have a systematically higher risk of illness than do others. Therefore, private insurance companies can appropriately be expected to offer different insurance terms to persons with different levels of insurability, and those with a high risk of illness will only be insured at relatively high costs. Indeed, some people may be virtually uninsurable because their chances of becoming seriously ill are very high. Moreover, an individual's insurability can also change over time, and especially with aging. Good health and illness are, to a great extent, determined by the luck of the draw, namely, genetic inheritance at birth.

The institution of social insurance entails the idea that the fairest way to insure against the misfortune of having a pre-disposition toward bad health is through all citizens pooling this risk. It reflects the concept that individuals have some responsibility for one another and this can best be implemented through sharing this risk on a society-wide basis. Thus, the case for public health insurance is primarily based on an equity argument.

Efficiency considerations supplement the equity reasons for a public role in health care. Health care providers, especially physicians, have much better information than people who require their services. Physicians also control the supply of health care. As a result, they hold a kind of monopoly power. To avoid inappropriately high prices for these services, a counterweight is required. The public sector is the obvious counterweight. As a single payer, the public sector can effectively negotiate to control costs. A single payer system is also administratively more efficient than a multi-payer system. Thus, the equity case for public health insurance is supported by a powerful efficiency reason. (See Banting and Boadway 2002, for a more detailed discussion.)

At the same time, the logic of social insurance itself does not reject a dual private-public system. As long as a public system is financed out of general revenues and makes health services uniformly available, the co-existence of a private system serving those who wish to opt out is not inconsistent with the principles of social insurance. Arguments to the contrary stem from judgments of political feasibility and the sustainability of a public system in the face of a parallel private system (Flood et al. 2002).

Rationale for a Federal Role in Health Care

Assuming agreement on the principle of social insurance, this still leaves open the question of the precise dimensions of the community within which sharing and redistribution take place. In a *unitary* nation, a common standard of redistributive equity is presumed to apply to all citizens across the country, there being no particular reason to discriminate against citizens of one region as opposed to those of another. Common standards of sharing also apply nation-wide. In a *federation*, matters are complicated by the fact that individuals are members of two political communities – the community of citizens across the country as a whole, and the community of residents within each province. The role of the federal government, in the context of health care, is thus defined by whether one takes the entire country or the province as the primary sharing community. In this context, it is useful to distinguish among three versions of the relevant sharing community along a spectrum of possibilities.

Predominantly Canada-wide Sharing

The *predominantly Canada-wide* version takes the country as a whole as the primary sharing community and defines the extent of redistribution for health care in national terms. This vision of country-wide sharing requires sufficient fiscal redistribution among provinces to enable all provinces to provide services up to the national average without having to resort to tax rates that are above the national average. It also requires strong, detailed country-wide standards with respect to the kinds of services and redistribution policies that should be available in all provinces. It is difficult to envisage this kind of country-wide sharing without a strong leadership role from the federal government.

Predominantly Provincial Sharing

The *predominantly provincial* version of the sharing community reflects the idea that the province is the principal community for redistribution. In this vision, one province may choose to provide a highly redistributive system of public health insurance, while another may decide to rely more on private insurance. Notwithstanding the distinct possibility of significantly different approaches among provinces, as a result of constitutional provisions relating to equalization this vision also preserves the possibility of provinces implementing comparable health care standards across the country if they so wish. In this case, however, the vehicle for such a decision would probably be an inter-provincial pact.

Dual Sharing

An intermediate interpretation of the sharing community might be one in which a country-wide framework defines some basic parameters of major social programs including health care, while leaving room for provincial variation in program design and delivery mechanisms that are consistent with the framework. According to this intermediate position, which is labelled here the *dual sharing community*, citizens across the country are assured of comparable, as opposed to identical, health care services. The potential for differences among regions in the sense of attachment to the community also raises the possibility of asymmetrical relationships between the federal government, on the one hand, and various provincial governments, on the other.

Interestingly, most economically advanced federations in practice give substantial weight to the notion of country-wide sharing in the area of health policy, choosing to engage both the federal government and provincial/state governments in health care (Banting and Corbett 2002). In some of these countries, the central government administers important health care programs itself, dealing directly with citizens and service providers. Moreover, where state/provincial governments manage elements of the system, they typically do so within broad parameters defined for the country as a whole, and normally rely on the federal government for a significant part of their financing. These intergovernmental transfers incorporate a significant element of inter-regional redistribution. Although the balance between orders of government differs significantly from one federation to another, the federal government in most economically advanced federal democracies plays a much larger role than is the case in Canada (Watts 1999).

Surveys of public attitudes and values indicate that Canadians have a sense of attachment or belonging to multiple communities, including both to Canada and to their province. They see no reason to choose one definitively over the others. Surveys also regularly find that Canadians see health care as a country-wide program, and overwhelmingly support the engagement of both orders of government in sustaining it. They are thus uneasy about cuts in federal fiscal transfers to the provinces (Mendelsohn 2001). Public attitudes towards the Equalization program also suggest reasonably strong support for the notion of pan-Canadian sharing. These findings are consistent with the idea of a dual sharing community and a modified conception of social citizenship in health care.

This *dual sharing community* conception also seems to be consistent with the realities of social policy as conducted by the federal government and the provinces up to the present time. In the case of health care, elements of a country-wide framework have existed for several decades. The five principles of the *Canada Health Act* and the inter-regional transfers embedded in our fiscal arrangements do sustain reasonably comparable standards for key health services across the country. At the same time, it has to be recognized that inter-regional variation is greater in Canada than in other federations.

There is some variation in the core hospital and physician services, which fall within the framework of the *Canada Health Act*. However, there are much more substantial regional differences in services that fall beyond the ambit of the *Canada Health Act*, such as drug therapy outside of hospitals and home care. Drug insurance differs sharply across the country. All provincial programs tend to cover low-income senior citizens and social assistance recipients, but the coverage of other citizens varies considerably. In the case of home care, although each province and territory offers some coverage, there are major differences in eligibility, the proportion of those needing care that is covered, the range of services provided, and the level of user fees. When the country-wide framework was established in the postwar decades, hospital and physician services represented the core instruments in health care. In the contemporary period, however, drug therapies and home care are rapidly growing components of that sector. The fact that they also fall outside the scope of the *Canada Health Act* means that the extent of Canada-wide sharing in health care is shrinking with each passing year.

The above discussion of different visions of the sharing community provides a perspective on the equity considerations that are relevant to defining the federal role in health care. With regard

to efficiency, there are arguments for and against centralization and/or decentralization. These arguments are linked to related arguments for and against different forms of intergovernmental relations (for a discussion, see Banting and Boadway 2002). On both these matters (decentralization/centralization and forms of intergovernmental relations), the arguments (avoiding spillovers, exploiting economies of scale and administrative efficiencies, on the one side, and greater ability to reflect local preferences and tastes, and greater opportunity for innovation, on the other) are nicely balanced. If the efficiency arguments pointed powerfully toward centralization and a more federally dominated federalism, or toward decentralization and a more provincially dominated federalism, this might be a major influence in shaping the federal role. But given the balance between the efficiency arguments, the federal role has in fact been determined mainly by the extent to which the country as a whole rather than the province is seen as the appropriate community for insuring against ill health. That is, redistributive equity considerations dominate.

At the same time, the manner in which the federal government fulfills this role can contribute to the efficiency of the federation, rather than detract from it. Provincial governments (or regional authorities) are best placed to understand local needs and preferences. Having several jurisdictions involved in the design and delivery of health care also improves the possibility of useful innovation. The efficiency advantages of decentralization of health care can therefore be best achieved by following the constitutional norms about the provinces' role in providing health care. Predominantly provincial sharing can be achieved by a carefully designed equalization system that attends to both the different revenue-raising abilities and the different needs of the provinces, while leaving them free to design and deliver their own programs. The dual sharing model can be achieved by the setting of pan-Canadian norms in a system of block transfers from the federal government to the provinces in support of health care. Such norms, which can be developed with provincial participation, need not be so intrusive as to interfere unduly with the detailed efficient delivery of health care at the provincial level. Moreover, these norms might address efficiency issues, such as the portability of health benefits across provincial borders. While the efficiency advantages of provincial program delivery may be harder to achieve in a predominantly Canada-wide sharing system, the intergovernmental transfers associated with such a system can be designed to mitigate any distortions in provincial resource allocation. And the conditions attached to such transfers can be established so that they leave much scope for the provinces to innovate in the way they will meet national standards within their jurisdiction.

The Choice of Federal Instruments

Several different types of instruments can be used by the federal government to sustain and improve health care for Canadians. Some instruments are relevant to all versions of the sharing community, whereas others have a special salience for a particular version of that community.

Direct Federal Delivery

The main feature of direct federal provision of health insurance is that the same program would apply in all provinces. One benefit of this approach is that the efficiencies of the single-payer principle would apply Canada-wide rather than only at the provincial level. However, the main

case for direct federal provision is equity related. The country as a whole becomes the sharing community for health care and Canadians are able to enjoy the same health care programs no matter which province they live in.

This approach would represent a major departure in Canada. A federal health program such as pharmacare might survive judicial challenge if it were funded through general revenues rather than through contributions or premiums. But it would also challenge deeply-held political conventions about the division of powers in that sector and, in operational terms, it might fragment what should be an integrated and seamless health care system.

Direct Federal Transfers to Citizens

Canada-wide sharing objectives might also be obtained by a system of direct federal transfers to citizens. Moreover, different degrees of Canada-wide versus provincial sharing could be accomplished through co-provision of transfers by both orders of government. This approach has been used in other areas of social policy, such as the federal program of refundable tax credits. The question is whether it could sensibly be made to fit the case of health insurance.

Direct transfers to citizens could be used to introduce some incentives into the use of health services by citizens, for example by offering only partial reimbursement of expenses incurred. One advantage over the direct imposition of user fees is that by administering these measures as a government program, reimbursement might be easily tied to the ability to pay. This might be a way by which the federal government could actually implement a country-wide income-contingent user fee system, given that health services are provided in provincial programs. An alternative, more direct way might be to include some proportion of health expenses as taxable benefits for income tax purposes. Yet another proposal for integrating individual incentives into health insurance that has attracted some debate would be the use of so-called *Medical Savings Accounts* (Ramsay 1998; Forget et al. 2002).

To a greater or lesser extent, all of these options focus on strengthening incentives to avoid abuse of the system by patients or providers. Perhaps they have not played a major role in Canadian health care to date because there is a lack of convincing evidence that the current social insurance focus is in fact associated with a high level of abuse. In other words, these options undermine the essential purpose of social insurance without sufficient offsetting benefits.

Federal Transfers to Provincial Governments

Whether Canadians wish to maintain some form of dual sharing communities in health care, or to adopt a predominantly Canada-wide sharing system, transfers to provinces are highly likely to remain a central instrument. To be effective, this approach ideally requires a clear definition of relevant standards, sufficient levels and predictability of federal funding to ensure that federal policy parameters are credible and effective, and some suitable procedure for resolving disputes between the federal government and the provinces. However, Canada has never fully met this ideal, and has over time fallen further from some aspects of it.

It is useful to distinguish between the level, form and predictability of the federal transfer. The moral and political authority of the federal government to sustain a meaningful country-wide framework through the *Canada Health Act* is clearly correlated with the level of its

financial commitment. The federal government has to be a serious financial partner to be credible. Moreover, the more exacting the country-wide framework, the greater the level of federal support presumably needed.

As for form, it is doubtful whether a return to cost sharing as it was experienced under the federal hospital insurance and medical care legislation is the best way forward. Given past practice, presumably that traditional form of cost sharing would apply to aggregate provincial expenditures rather than to the expenditures of individual provinces. Even in that case, however, the federal government would have to determine the eligibility of provincial expenditures for cost sharing and this would necessarily reintroduce administrative complexities and costs and add to potential intergovernmental frictions. The advantages of this approach over a simple increase in the block transfer are doubtful, although it is recognized that some form of cost sharing might initially play a role if the coverage of the *Canada Health Act* were to be broadened.

There are those within the federal government and elsewhere who would prefer to make any further increases in the federal CHST contribution conditional on achieving specific health reform objectives, whether related to primary care reform, home care improvements, hospital rationalization or some other worthy goal. There are others in the provinces and elsewhere who would wish to see larger federal block transfers for health care, but only within the framework of the current very broad scope of conditions. The second group considers the block transfer to be the appropriate form of transfer in our federation, as it leaves provinces with the freedom to exercise their constitutional responsibilities consistent with the principles of the *Canada Health Act*. To the extent that this debate is joined, a possible compromise approach worth pursuing is that of the earmarked transfer – incremental federal funding to be spent exclusively by provinces for certain designated health care reform objectives, with the earmarking only for a limited time (say five years) and the increment subsequently folded into the block funding.

The predictability of federal support is also a critical issue. As in the case of interpersonal trust, nurturing intergovernmental trust requires transparency and predictability in relationships. Given the propensity of the federal government to make unilateral changes to the transfer system, the case for an automatic escalator that would base changes in the CHST on a formula rather than on federal discretion is strong. Possible escalators include those linked to the rate of growth of an economic aggregate, like the gross domestic product, or to the rate of growth of all or some federal revenue bases. The escalator that may make the most sense, however, is the rate of growth of health care spending for all provinces and territories, as measured by Statistics Canada. If the different orders of government were able to agree on an appropriate federal contribution at a point in time, and then have it escalated by such an indicator, then the federal share would remain constant (and without the intrusiveness of traditional federal cost sharing). We refer to this idea below as “non-traditional cost sharing”.

Other proposals focus primarily on making the federal contribution more visible by separating the block transfer for health from those for social assistance and post-secondary education. The main argument in favour of this reform is that a separate transfer would enhance the transparency and visibility of the federal role in health care. At the same time, this transfer would remain fully fungible in the hands of the provinces.

At the other end of the spectrum are proposals that would reduce the commitment to a Canada-wide system by converting the CHST into a straight tax-point transfer to the provinces. This approach makes most sense for those who prefer a predominantly provincial conception of the sharing community and would thus entail an end to Canada-wide norms except in the unlikely event of an inter-provincial pact to maintain and enforce them. (Courchene 1996).

Equalization Considerations

To the extent that the federal government continues to make cash payments to the provinces through an equal per capita CHST-like instrument, it will have the effect of equalizing fiscal resources available to the provinces. The CHST is funded from general revenues and wealthier provinces pay more per capita into general revenues than less affluent provinces. The result is a redistribution that favours the less wealthy, thus helping to reinforce the Equalization program.

However, these forms of revenue equalization alone do not satisfy fully the principle of equalization as set out in Section 36(2) of the Constitution. Although revenue equalization goes part way toward enabling provinces to provide reasonably comparable levels of public services at reasonably comparable levels of taxation, provinces may also face different “needs” for public services. In the case of health care, there is a systematic difference in the cost of providing services to persons of different age and other demographic and socio-economic characteristics. It can therefore be argued that some or all of federal equalization payments should be adjusted to reflect needs. It can also be argued that needs ought to be taken into account in the allocation of the CHST. Needs equalization could be based on the cost of a national standard level of care for different demographic groups, where that cost could represent some average of actual provincial costs. As with revenue equalization, the idea would be to base the entitlement to needs equalization on objective measures that are outside the direct control of recipient provinces.

Political Disputes between Federal and Provincial Governments Relating to Health Care

The current federal-provincial dispute regarding the adequacy of federal funding for health care was triggered by the CHST announcement in the 1995 federal budget. That debate is familiar. It is sufficient here to note that, from the outset, the provinces have argued that the cuts in transfers associated with the CHST were grossly unfair. And since the late 1990s, they have also insisted that a vertical fiscal imbalance favouring the federal government has come to characterize federal-provincial fiscal relations. Despite subsequent increases in federal CHST contributions, provinces remain of the view that the amount of the current federal cash payment for health, post-secondary education, and social assistance and services is neither adequate nor fair.

The substance of the provincial position on the vertical fiscal imbalance has been stated in documents prepared by provincial and territorial finance ministers. Their argument is simple. First, the structure of federal finances today is stronger than that of the provinces and territories. The federal government enjoys substantial budgetary surpluses. Provinces and territories do not. Second, federal revenues will grow faster than provincial/territories revenues given the extent to which different governments occupy different tax bases. Third, provincial/territorial expenditures can be expected to increase at a more rapid pace than that of the federal government. This is

partly because of the relative importance the public attaches to health care and education and of the cost drivers associated with them, especially health care (Canada, Standing Senate Committee 2001).

The issue of vertical fiscal imbalance has also received attention recently in Quebec. In 2001, the Quebec Government appointed a Commission on Fiscal Imbalance headed by Yves Séguin. In order to restore fiscal balance and eliminate the use of the federal spending power, the Commission recommended an end to the CHST, with the federal government transferring the GST to the provinces. It also recommended several improvements to the Equalization program (Quebec 2002).

The federal government has all along disputed provincial arguments, pointing to several considerations. First, public debt is much higher at the federal level than at the provincial level. Second, both orders of government have access to all the major tax bases and both can set their own tax rates. Third, the provinces have been simultaneously cutting taxes and claiming revenue shortages. Fourth, federal cash transfers to the provinces are expected to grow at a faster rate (6.1 percent) between 2000-01 and 2005-06 than the growth of federal revenues (1.9 percent over the same period). The federal government's response to provincial arguments was updated during the first half of 2002 in a document entitled *Fiscal Balance and Fiscal Relations between Governments in Canada*. It disputes the merits of a tax-point transfer, as proposed by Séguin, and other assertions in that report, concluding that the notion of a fiscal imbalance is a "myth". (For a much more detailed discussion of the dispute about the vertical fiscal imbalance and the related concept of vertical fiscal gap, see Lazar et al. 2002.)

The dispute regarding the adequacy of federal funding is compounded by disagreements between the federal government and some provinces regarding the appropriateness of various forms of private funding for services covered by the *Canada Health Act*. With the federal government opposed to this source of financing, provinces that favour this approach find themselves doubly frustrated. They not only believe the federal government is contributing insufficiently to health care but also that it is effectively depriving them of other potential funding sources. And on top of this, they have contested the federal government's exclusive power, *de jure*, to interpret and enforce the provisions of the *Canada Health Act*. This has only recently begun to change with the introduction of a new dispute avoidance and resolution process by the federal Minister of Health which reflects ideas advocated by provincial governments.

The Issue of Dispute Resolution

Conflict and cooperation are inevitable in federal systems, and their consequences can be noxious or beneficial depending on the circumstances. An indicator of a mature form of government is its capacity to challenge non-beneficial cooperation, to accommodate useful conflict, and to resolve disputes that impede the effective functioning of the system. The importance of a dispute settlement mechanism in a particular policy field, like health, depends on the tenor of intergovernmental relations more generally. Dispute avoidance is most likely to be an attractive option when the parties involved have shared policy goals and are engaged in a relationship where there is a high level of trust and ongoing dialogue and negotiation.

Parties may need to resort to formal and informal dispute resolution approaches when they have entrenched disagreements and when considerations of turf, status, credit-claiming, and blame avoidance take precedence over substantive policy concerns.

Canada has historically lacked an effective dispute resolution mechanism in the health care field. Instead, it has relied on a system of intergovernmental relations that is weakly institutionalized, with no decision-making rules and no settled processes for tackling the resolution of disputes. The federal government has used its spending power to uphold national standards for health care in areas of provincial jurisdiction that it could not directly regulate given constitutional requirements. The provinces have protested that the federal government does not transfer sufficient resources to them to give it the moral and political authority it needs to encourage them to uphold the *Canada Health Act* principles over the long term. Thus, at least as seen from the provincial perspective, the crux of the conflict has been the hierarchy implicit in the unilateral federal control over health care funding, and over enforcement of the conditions of the *Canada Health Act*.

We do not question the legal right of the federal government to determine the amount of cash it transfers to the provinces or to determine the conditions associated with such transfers. But the federal-provincial relationship in this field is not mainly legal. It is political. And when Ottawa acts unilaterally on such matters it erodes the trust relationship that is essential to a functional political partnership. In this regard, we understand that, over the years, the relationship between Health Canada and the provincial health ministries with respect to the interpretation and enforcement of the *Canada Health Act* has been mainly collegial. There has been a record of collaboration and quiet, effective conflict management that has served Canadians well. However, for issues that cannot be resolved in this way, the establishment of a formal dispute resolution mechanism would be beneficial since it could provide a channel for easing tensions in the health and fiscal systems when intergovernmental disputes break out at the political level.

In a federal state, one's view of the sharing community is likely to shape one's conception about the appropriate site for authoritative decision-making in the health care field, and therefore structures one's understanding about how conflicts and disputes can most appropriately be resolved. If, for example, Canada is understood as composed of predominantly provincial sharing communities, where the federal government withdraws substantially from the health care field, there would be fewer points of conflict between the two orders of government because there would be fewer points of contact. Hence, the absence of an explicit dispute settlement mechanism would not be felt as a significant institutional shortcoming. If Canada is understood as composed of dual federal-provincial sharing communities in which both federal and provincial governments have equal status and equally valid roles and responsibilities, then a dispute settlement process that respects the authority and autonomy of the two orders of government is appropriate. In the predominantly Canada-wide sharing community, where the Government of Canada emerges as the dominant authoritative decision-maker, the situation logically calls for a well-developed dispute settlement mechanism since the relationship between the two orders of government is intense. Nevertheless, the practical reality is that Canada is weakly endowed with such mechanisms in the health care field. This may be in part because the federal government has doubted the benefits of an impartial, equitable dispute settlement mechanism to govern its relationship with the provinces and has had the power to avoid it. It may also be because the

federal government has objected to the idea of another order of government being involved in the interpretation of federal law and deciding on the appropriateness of federal expenditures.

In some respects, this situation is similar to that which applies to Canada's trade relations with the United States. Canada prefers to have a legal basis for resolving trade disputes because if disputes are settled mainly through the exercise of raw power, then it is not likely to fare well very often. For similar reasons, provinces may have a somewhat stronger interest in a formal dispute resolution mechanism for health care than does Ottawa because of disparities in power.

In other respects, however, the analogy with the United States is less appropriate. The U.S. and Canadian governments have obligations toward different groups of citizens, whereas in Canada federal and provincial/territorial governments (collectively) have the same constituents. Therefore, the federal and provincial governments have an incentive to cooperate in establishing a dispute resolution mechanism in order to avoid the many unproductive and destructive traps that can stall and jeopardize intergovernmental agreements designed to serve these constituents.

Ideally, an "effective" dispute resolution mechanism in this field would meet the following criteria (Cameron and McCrea-Logie 2002). It would be authoritative. Hence, the public and the disputing governments would accept its pronouncements as definitive and legitimate. It would be compatible with federalism values since it would recognize that both orders of government have constitutional status and have their own competences and policymaking capacities. Both orders of government would agree to participate in the design of the dispute resolution mechanism, choose representatives to this body, and follow its procedures to bring an end to destructive conflicts that sometimes impede the proper functioning of the health care system. It would be guided by clear rules, be perceived as transparent and impartial, and be accessible to all those who have a legitimate interest in its outcomes. It would also facilitate clear, efficacious, and timely settlement of a broad range of disputes, including those regarding federal fiscal transfers since, as we have seen, this is an area where disagreements have been particularly intense.

The Cameron and McCrea-Logie paper (2002) describes six dispute settlement models, organized from the least to the most highly developed: federal withdrawal, the base case model, the Social Union Framework Agreement, the McLellan dispute settlement process, interlocking legislation, and bringing the public in.

- Model 1, a federal withdrawal, is consistent with the notion of predominantly provincial sharing communities and envisions the federal government transferring tax points to the provinces, abrogating the *Canada Health Act*, and leaving the management of the health care system to the provinces, in accordance with the aspirations of their regional communities. This model would address the problem of destructive intergovernmental disputes by decreasing the extent to which the two orders of government are in relationship with each other.
- Model 2, the base case model, is the *status quo* situation where no explicit conflict resolution regime applies to the fiscal and policy dimensions of the intergovernmental relationship. By most standards of conflict resolution, it would be judged deficient

on several grounds: the relationship between the actors is paternalistic rather than egalitarian; only one party has recourse to the instrument; one of the parties acts both as prosecutor and judge; consequently, the process and the decisions, although they may be effective, are not regarded as legitimate by all government participants.

- Model 3, the Social Union Framework Agreement, seeks to place the conflictual and cooperative behaviour of governments in an orderly frame of reference, and to expose both forms of conduct to the fuller scrutiny of the public. Its provisions for dispute avoidance and resolution, outlined in Section 6 of the Agreement, are clearly intended to apply to the broad range of intergovernmental social policy matters, not just to a particular program. Its scope explicitly includes federal transfers. Although the provisions refer to dispute avoidance, fact-finding, mediation, third-party involvement and public reporting, the details are not developed.
- Model 4, the McLellan dispute settlement process, encourages the two orders of government to avoid disputes and, in cases where they do not, makes provisions for a third party panel that would release a public report with recommendations for resolving a dispute. However, it does not fundamentally alter the play of intergovernmental forces, since the panel report would be non-binding, and the federal government would retain the dominant role in enforcing the *Canada Health Act*. The procedure would be used exclusively to resolve disputes over the interpretation of the *Canada Health Act*; it is not intended to apply to federal fiscal transfers. Citizens and interest groups would be excluded as potential participants in the dispute resolution process.
- Model 5, interlocking legislation, is an approach mooted by Richard Zuker, which effectively ties together the policy and fiscal components of the intergovernmental health care regime, and imposes equivalent obligations on all the actors in the system. It envisions the parties agreeing to a funding formula for a set period of time, with the provincial and territorial governments passing legislation equivalent to the *Canada Health Act*, including a provision stating that the legislation could not be amended without approval from the federal government. This model clearly reflects the underlying philosophy of dual sharing communities in which representatives of the two orders of government find the means to work together on the basis of equality.
- Model 6, bringing the public in, suggested by Richard Simeon, involves the creation of a jointly-appointed advisory body, the Canadian Health Care Commission, which would review the federal government's decisions to withhold funds for violations of the *Canada Health Act* before they could go into effect. Similarly, no provincial health care legislation with significant implications for other provinces or for the national system as a whole could go into effect without the Commission's review. The public would have the opportunity to be involved in its hearings and deliberations and would scrutinize its recommendations. The advantage of this model is that it would elevate the quality and expand the scope of the public debate. Moreover, it would focus attention more on citizens' needs in their health care system, and less on political considerations.

A shift toward a notion of federal-provincial partnership would involve all parties assuming joint responsibility for the functioning of the system and accepting the risks and benefits that go along with it. As we discuss below, it involves working together to ensure that the fiscal strength of the two orders of government is relatively balanced.

The Issue of Fiscal Imbalances

The larger political dispute among governments relates to the magnitude of federal cash transfers for provincial health care programs. In turn, this issue is linked to the broader question of whether or not there is a vertical fiscal imbalance that favours the federal government, and related concerns of less affluent provinces about horizontal imbalances. The concept of vertical fiscal imbalance entails the idea that one order of government has more revenue than it requires relative to its expenditure responsibilities, whereas the other order of government has less. To turn this concept into an operational tool for assessing the appropriateness of the current distribution of revenues between the two orders of government, it is necessary to form a view about the weight to be attached to the expenditure responsibilities of both orders of government. Since such a weighing task is value laden, a large political, as opposed to scientific, element necessarily attaches to the idea of vertical fiscal imbalance. Thus, it is not surprising that there are divided views within the research community over whether and to what extent a vertical fiscal imbalance now exists in Canada.

In this regard, over the last couple of years, three major studies have been published that purport to document or disprove the existence of a vertical fiscal imbalance in the Canadian federation. These studies have been reviewed carefully (Lazar et al. 2002). While space does not enable us to repeat their analysis here, it is important to note that the studies differ in their conclusions, with two arguing that a vertical fiscal imbalance now exists, whereas the third comes to a different assessment. The two studies that argue that such an imbalance exists differ significantly from one another in their calculations. This is because the methodology used to measure the vertical fiscal imbalance is based on various assumptions. Perhaps the most important of these is that the current expenditure and taxation policies of each order of government are taken as given. Thus, revenues and expenditures in the base year are projected to grow from their initial levels at assumed rates over the long term, without any policy changes or adjustments taking place. However, as the last three federal budgets show, governments do adjust to both economic and fiscal circumstances on an ongoing basis. It is therefore important to recognize that the current fiscal position of both orders of government is inevitably the outcome of cumulative fiscal effects and adjustments to changing circumstances over a number of years.

Indeed, a look back on the relative strength of federal/provincial fiscal balances over several decades reveals a pattern of ebb and flow, with important consequences for intergovernmental fiscal relations which have been in a constant state of flux and adjustment. As a result, it is not clear that a state of vertical fiscal balance was ever achieved and which could reasonably be seen as a benchmark or standard to be attained. For instance, coming out of World War II, the financial position of the federal government was stronger than that of the provinces, notwithstanding huge war debts. The federal government chose not to give up the revenue bases it had occupied during the war. Instead, it used its fiscal power through cost-sharing programs,

among other things, to encourage provinces to create or expand provincial programs for health care, post-secondary education, and social assistance and services. However, the growth in federal transfer payments to the provinces did not necessarily improve provincial finances, as provinces were concurrently assuming major new expenditure responsibilities. In retrospect, we can see that the relatively strong fiscal position of the federal government in the early post-war decades (the vertical fiscal imbalance favoured the central government) was used to help provide Canadians with the kind of economic and social security they wanted. During those years, governments created the modern welfare state to ensure that there would be no return to the severe hardships of the Great Depression.

But by the 1970s, the federal government had become increasingly concerned that, as a result of cost sharing, provincial expenditure levels were determining too much of its own spending. As was discussed above, this situation helped to motivate the EPF. And although both orders of government encountered fiscal problems in the early 1980s, the federal position was by far the weaker at that time. If there was a vertical fiscal imbalance then, it favoured the provinces. Thus, the tide had shifted.

Ottawa's deteriorating financial position in turn led to several increases in federal taxes and a growing emphasis on expenditure restraint through the 1980s and early 90s, including important cuts in planned levels of transfer payments to the provinces. With the 1995 federal budget measures, including the CHST, and a return to a more favourable fiscal environment (in terms of economic growth and interest rates), the federal government was able to turn the fiscal corner and, by the end of the century, it was once again in a strong financial position relative to the provinces. All this to say that the current strength of the federal government's fiscal position relative to that of the provinces follows a period during which their respective situations were reversed on two occasions.

Given these circumstances, and whether or not the term "vertical fiscal imbalance" is used to characterize the situation, there are good grounds to debating publicly alternative uses for the substantial federal surplus. Should it be used to pay down federal debt or reduce taxes? Should it be used to enhance spending on children, on the military or on other forms of security? Or should it be used to improve health care in partnership with the provinces?

Calculating the Federal Share of Health Care Today

These questions in turn lead to two related queries. How much is the federal government now transferring annually to the provinces for health? And how much should it be transferring? Although the second question involves normative judgments, the answer to the first question, at least, may appear simple at first blush. As we shall see below, however, the answer to both queries is anything but simple. To understand why this is so, we need to look again at the history of the federal role in funding health care, including the controversy over whether the 1977 federal tax-point transfer to the provinces can and should reasonably be counted as part of the current federal contribution.

For the first year of EPF, the notional value of the federal cash transfer to the provinces, as a share of total provincial health expenditures, has been estimated at 26 percent (Lazar et al. 2002). The reason for citing this estimate is that it sheds light on the magnitude of the federal government's contribution to provincial health care expenditures when cost sharing was discontinued. The federal share, at that time, was not necessarily "fair". But that number reflected 30 years of federal-provincial bargaining that begun with the federal government Green Paper proposals in 1945. For those who believe that the federal government should return to its traditional share of total provincial health spending, a 26 percent cash figure provides one possible benchmark. It must be added, however, that this percentage is far in excess of current federal financial contributions and also well beyond what the provinces are now demanding. In fact, the provinces have argued that Ottawa should now be paying an amount in cash (or the equivalent) equal to its cash share of provincial costs for health care, post-secondary education, and social assistance/services in 1994-95, the year just prior to the announcement of the CHST. According to provincial governments, the federal share in that year was 18 percent. For health care alone, the federal share has been estimated at 16 percent (Lazar et al. 2002). This is another possible benchmark for the federal cash contribution. In short, the figures of 26 percent and 16 percent are possible highs and lows for the appropriate federal cash contribution to provincial health care programs.

As for how much of provincial health care costs Ottawa is currently bearing with the CHST cash contribution, answering this query entails a number of steps. One involves forming a view about the share of the CHST cash component that can reasonably be allocated to health care. On this matter, unfortunately, there are at least five possible perspectives.

From one perspective, the CHST is a block transfer that can be used however the provinces see fit. There is no effective way of tracing federal dollars to any single provincial program. While the federal government may declare the funds to be for health, post-secondary education, social assistance and early childhood development, it is simply perpetuating a myth. From a second and contrary viewpoint, the CHST may be thought of as being used by the provinces for its stated purposes only – health, post-secondary education, social assistance/services and early childhood development. But even with this different starting point, there is still no effective way of determining the shares that are allocated to these different stated purposes. The money remains fungible. From a third perspective, one can notionally divide the CHST among its various purposes using the allocations from the cost-sharing era and carrying them forward. From yet a fourth perspective, account must be taken of the fact that increases in the CHST since 1999 have been intended mainly to supplement provincial health care budgets. In this fourth perspective, therefore, the current share of the CHST cash component that is allocated to health care is greater than the share going to health care in the third perspective. Examining the current allocation of provincial expenditures among the designated spending categories introduces a fifth way of considering this question. In this perspective, we consider the share of provincial spending for health care as a percentage of provincial spending for health care, post-secondary education, social assistance and early childhood development, and we then infer that the resulting percentage is the federal CHST cash share going toward health care. The third,

fourth and fifth perspectives generate estimates of 43 percent, 50 percent and 68 percent², respectively, for the share of the CHST cash component going toward health care.

The next step is simply to apply these varying percentages to the \$18.3 billion spent on the CHST for 2001-02. The results are shown in Table 1. They indicate that the federal cash share was anywhere from 11.6 to 18.2 percent of the \$68 billion spent by the provinces on health care in 2001-02. This range of different, and each partially valid, perspectives should make clear that there is *no single number and no right number that objectively represents the federal CHST cash contribution for health*.

A number halfway between the high and low of these percentages would be just under 15 percent (notionally around \$10 billion); we adopt it here as “no worse than any other estimate.”

A few observations follow from this complex and somewhat bizarre account and analysis of the federal financial contribution. The first is that there is a disconnect or imbalance between the federal government’s cash contribution to provincial health care costs and the amount of policy influence it seeks to exert. The 15 percent federal cash share is low relative to the historic contribution of the federal government, and clearly low also in relation to the influence it would like to exercise.

The second is that it is important to secure intergovernmental agreement on what would constitute a “fair” federal cash contribution to provincial health care costs. Unless the parties agree on what Ottawa’s cash share of provincial health care costs is, and should be, and also on how it is to be measured, within months of a new arrangement on the federal cash contribution, provinces will claim that the new cash amount is too small, while the federal government will argue the opposite. In that event, the best that can be hoped for is a series of brief cease-fires in an ongoing federal-provincial fiscal struggle.

Perspective	Implicit Share of Federal CHST Cash Contribution Targeted for Health Care	Estimate of \$18.3 Billion in CHST Cash for Provincial Health Care in 2001-02	Estimate of Provincial Health Care Costs Paid Via CHST Cash in 2001-02
1	Can’t be determined	Not applicable	Not applicable
2	Can’t be determined	Not applicable	Not applicable
3	43%	\$7.9 billion	11.6
4	50%	\$9.1 billion	13.4
5	68%	\$12.4 billion	18.2

² Note that the 68 percent figure represents provincial health care expenditures as a share of provincial expenditures on health, post-secondary education and social assistance/services, using FMS data for post-secondary education based on “general” provincial and territorial expenditures. If “total” expenditures for post-secondary education had been used, the 68 percent number for health care would have dropped to 62 percent.

Third, there is a disconnect between the expressed public desire for federal-provincial cooperation on public health insurance, on the one hand, and the way in which the federal government has made decisions regarding its financial contribution, on the other. Without being naïve regarding the cost-sharing agreements of the 1950s and 60s, and the 1977 EPF arrangements (hardball was indeed played), it is fair to say that they were the product of a prolonged and genuine intergovernmental dialogue. In contrast, the experience since then has been one where the federal government has largely acted unilaterally.

Fourth, this last point is linked to the issue of an escalator formula for the federal health care cash contribution. Under current law, the size of the CHST is set yearly until 2006 but with no provision as to what is to come afterwards. Nor is there a set of principles that would provide general guidance to the provinces as to what they might expect. This lack of arrangements regarding the longer-term federal cash contribution unnecessarily complicates the task of the provinces (and hospitals) in long-range planning at a time when major reforms are required.

Fifth, the current impasse around health care financing and how to calculate the federal contribution erodes the quality of governance in Canada. The public has no idea how much the federal government contributes to provincial health care costs because of the multiplicity of ways to calculate this contribution. Transparency is absent. Accountability is confused.

Given these observations, the normative question about what amount the federal government *should* be giving to the provinces for health care remains. The analysis to this point has suggested that a “middle of the road” estimate of the federal cash share of provincial health care expenses was just below 15 percent in 2001-02. This is also below the bottom of our 16-26 percent range. We have already suggested that 15 percent is too low to be politically sustainable given the policy influence Ottawa seeks to exercise, and 16 percent is not much better.

On the other hand, a federal cash share in excess of 25 percent of provincial health care costs would in effect require that the federal government pay twice for the same provincial expenses. It was paying for one-half of insurable provincial hospital and medical costs prior to the 1977 EPF arrangements. When Parliament enacted EPF, about half of the 50 percent federal share of insurable provincial health costs (or 25 percent of provincial insurable costs) was to be paid through a tax room transfer. It is thus reasonable to argue that the implicit federal cash share was also 25 percent.

In what follows, a distinction is made between what might be a fair federal cash contribution under the current *Canada Health Act* conditions and what might be fair in the event of more substantial conditions that restrict provincial flexibility and impose costs on them. Under current conditions, a 20 percent figure strikes us as a reasonable and politically sustainable compromise. In making this judgment, we take into account the fact that this percentage is much closer to the 25 percent cash figure notionally associated with the 1977 EPF arrangements, and that the tax room transferred at that time was expected to grow at a faster rate than aggregate federal revenues. It also appears to exceed current provincial demands, although whether it would do so in practice also depends on the growth in the amount of federal cash transfers for post-secondary education and social assistance and services, including early childhood development.

In the event that a new set of arrangements is concluded between the federal and provincial governments relating to health care, the case for increasing the federal contribution beyond the 20 percent figure would arise. In particular, if the conditionality of federal transfers were to become more restrictive for the provinces (even assuming that these new conditions were the outcome of an intergovernmental agreement), then the case for moving toward or even to a 25 percent share would be much stronger. At the same time, other factors might help to influence the choice of a “right” number. For example, direct federal spending on health research and information and on public health should have pay-offs in terms of improved quality and efficiency of Canada’s health care systems. Arguably, these federal expenditures should be taken into account in any negotiation of the benchmark federal cash share of provincial health care costs. Similarly, consideration would need to be given to the relevance of federal expenditures on Aboriginal health.

In summary, a 20-25 percent federal cash contribution strikes us as reasonable given the large tax-point transfer from Ottawa to the provinces in 1977. The financial implications of this contribution range are significant, as shown in Table 2 below.

Assuming a federal cash contribution in this range (and, as will be discussed below, there are financing options than do not entail a continuation of cash contributions), the question of an escalator formula arises. An escalator should have the following characteristics. First, it should provide provinces with a reasonable measure of predictability regarding the growth in transfers. Second, it should be set out in the legislation and based on an indicator that is expected to grow at a rate similar to the anticipated growth rate of Canada-wide health care costs. Third, if the trend in the rate of growth of provincial health care costs changes, then, with appropriate notice (say two or three years), it should be possible to adjust the escalator. Fourth, the legislation should afford Ottawa the necessary degree of flexibility in case of an unexpected financial crisis.

There may be those within the federal government who will be concerned that an escalator formula with the above characteristics would weaken Ottawa’s control of its expenditures. Given the federal government’s long experience with deficits, such a concern is understandable. Yet, if the federal government chooses to continue to participate as a player in Canada-wide health care policy, it seems only reasonable that it assume some of the related financial risks. Provinces would still have a huge self-interest in managing health costs efficiently given that, under all conceivable fiscal arrangements, they would pay for the lion’s share of these costs.

Table 2		
Scenarios for the Federal Contribution to Provincial Health Care Costs, 2001-02		
Federal Share of Health Care Costs	Under Current CHA Conditions: 20%	Under More Demanding CHA Conditions: Up to 25%
Federal required contribution	\$14 billion	\$14.5-17 billion
Federal additional contribution in 2001-02 above notional \$10 billion in CHST health cash	\$3.6 billion	\$4.5-7 billion

It also seems clear that the federal government is worried that further federal cash contributions may do too little to improve either the quality of care or the fiscal sustainability of provincial health care systems. The concern is that additional funds will flow in large measure into the compensation package of current health care providers without contributing to the health care reform that provinces are trying to achieve but that is politically difficult for them to secure. To reduce this risk, further federal funding should be accompanied by other actions that enhance the probability that provinces will be successful in their reform efforts. In particular, the federal government has extensive research, communications and political resources that can be mobilized to help provinces overcome resistance to needed changes. We recognize that it may be easier for the federal government to create such political partnerships with some provincial governments than others.

In recent years, the federal government has made some of its transfers to the provinces conditional upon certain end uses, such as the purchase of particular categories of equipment. It would not be surprising if it were to try to insist that future increases also be tied to specific purposes, such as primary care reform. To the extent that it does, it would be preferable if these funds were designated for their stated purposes only for a limited time period, say five years, and then folded into the general transfer for health care costs. This could be a useful middle ground between conditional and unconditional transfers.

Federal Financing Options

This brings us to the question of how to apply the above normative analysis in the context of what lies ahead for Canadian health care. In this regard, two sets of variables need to be considered. One relates to whether the scope of Canada's country-wide, universal publicly insured and administered health care system is to be expanded to include currently uncovered services. The situation in which there is a broadening of the system to cover items like prescription pharmaceuticals and home care is referred to below as the "transformation scenario". This is distinguished from the "maintenance scenario", where the focus is on improving the quality of care and the fiscal sustainability of the currently insured hospital and medical services. If the scope of coverage is expanded, the political and fiscal dynamics would change markedly relative to a situation in which the scope of the system is not changed.

The second set of variables has to do with one's position on the different visions of the sharing community discussed above. There is no objective basis for asserting that any one of these visions is intrinsically superior to another. While each has advantages and disadvantages relative to the others, deciding among them is much more a matter of societal consensus about values than it is about technical merit. What is relevant here, of course, is that each has significantly different implications for federal funding, with the largest difference being between the predominantly provincial sharing community and the other two sharing models. Taking into account these two sets of variables, key elements of the federal financing options are highlighted below. More details on these options and their underlying considerations are discussed elsewhere. (Lazar et al. 2002).

- While the continuation of an equal per capita block cash transfer for health care would be appropriate in both the dual sharing and predominantly Canada-wide sharing visions, a revenue-sharing arrangement or tax transfer would make more sense in the predominantly provincial sharing model.
- In the predominantly provincial sharing model, the conditions of the *Canada Health Act* should be dropped except for those related to portability and mobility. The current conditions, or an appropriately modernized version of them, are consistent with the other two models. Indeed, in the Canada-wide sharing model, the conditions would need to be buttressed with nation-wide standards to ensure similar levels of services across the country.
- In the maintenance scenario, the federal cash transfer should be equal to at least 20 percent of provincial health care costs. The transfer should be closer to 25 percent in the Canada-wide sharing model, where additional conditions raise provincial costs. This will entail increases in the federal contribution in the order of \$3.6 to 7 billion annually. For the predominantly provincial sharing model, the appropriate shift of resources would be at the bottom end of this range, or slightly lower, as provinces would have fewer costs and constraints associated with a conditional federal transfer.
- In options that entail a continuation of the cash transfer, there are more advantages than disadvantages in having a separate block fund for health care alone – a Canada Health Transfer (CHT). In any case, assuming that the federal cash contribution is re-based at 20-25 percent of provincial health care costs, it would be highly desirable if the federal government abandoned permanently the idea that the 1977 tax room transfer remains a part of current CHST funding for health care.
- In policy options that entail a continuation of the cash transfer, there is a strong case for adjusting the equal per capita payment on the basis of needs. The same argument can also be made, but less strongly, in the event of revenue sharing or of a tax-point transfer.
- The transformation scenario would entail additional public expenditures of several billion dollars. The actual magnitude of the increment would depend on the scope of coverage. Given provincial views about the adequacy of current federal cash contributions for hospital and medical costs, it is likely that the federal government would have to commit to all, or almost all, of the incremental costs to secure provincial agreement to a much-broadened range of covered benefits. While one or more provinces might initially prefer not to participate in the broadened coverage and, instead, seek financial compensation, the prospects of achieving full provincial and territorial participation may be significant given that Ottawa would be absorbing a high proportion of the incremental costs.
- The transformation scenario might be encouraged by the kind of inter-locking federal and provincial legislation referred to above. Federal financial contributions would be buttressed by statutory commitments not to alter the federal financial commitment without the approval of seven provinces representing at least one-half of the Canadian population. All provinces would add country-wide model provisions in provincial health

care statutes committing themselves to meet Canada-wide conditions and undertaking not to amend these commitments without the agreement of the federal government.

- Where a cash transfer to be the preferred option, it should be escalated annually according to a transparent and predictable formula that is expected to grow at a rate similar to the anticipated growth rate in national per capita health care costs. Using a Statistics Canada index of aggregate provincial-territorial health care costs would be the simplest approach to meeting this standard. There should be an “escape clause” for the federal government under a situation of national financial emergency.
- A mechanism is needed to provide a forum to manage intergovernmental disputes regarding the transfer system. Dispute resolution mechanisms must have legitimacy in the eyes of participating governments and must be authoritative. The more stringent the conditionality of any federal transfer to the provinces, the more compelling the case for a dispute resolution mechanism that gives provincial views equal weight with those of the federal government.

Conclusions

Our main conclusions are summarized below.

1. The primary reason for government involvement in health care relates to the uncertainty of the need for health care by any one individual, at any point in time, together with the uneven distribution of the risk of illness and injury. This leads people to want to insure against this risk. For some individuals, however, private health insurance is either prohibitively expensive or simply unavailable. This creates a strong social insurance rationale for a public role in this area.
2. The rationale for the federal role in health care is related to the notion of Canada as a sharing community. There are alternative visions of the Canadian sharing community. Different conceptions of the sharing community affect the relative roles of the federal and provincial governments in social sharing, including in the provision of health care. The federal role is determined mainly by the extent to which the country as a whole, or the individual province, is seen as the appropriate community for insuring against the risk of ill health. Deciding which community is relevant is a matter of societal values, not scientific principles. At present, we have a dual sharing community. However, as the relative importance of services not covered by the *Canada Health Act* grows, country-wide sharing declines and province-based sharing rises in relative terms.
3. A predominantly Canada-wide vision of sharing would entail ensuring that common services, provided at common standards, are available in all provinces and territories. A predominantly provincial sharing community model does not require that any services be insured on a nation-wide basis. It does, however, require that all provinces have adequate fiscal capacity to provide some given basket of health care services on a nation-wide basis, at national average tax rates, if they so choose. A dual sharing community includes elements of Canada-wide sharing and of provincial sharing.

4. While the case for public and federal involvement relates mainly to equity considerations, the manner in which the federal government fulfills its role can contribute to the efficiency of the federation (e.g. removing barriers to mobility). Under the three visions of the sharing community outlined above, there are efficiency advantages in retaining provincial delivery (e.g. reflecting local conditions and preferences and facilitating innovation). These advantages match the constitutional allocation of legislative powers.
5. There is a range of instruments through which the federal government can fulfill its role. While the choice of instruments will be affected by the societal consensus on sharing, under all our models of the sharing community there is a strong case for equalization payments. Other instruments include direct federal delivery (which, on the whole, we consider unwise), transfers to individuals (possibly through the tax system), transfers to provinces, revenue sharing, and a tax-point transfer. Federal transfers to provinces have been a key instrument in the past and are likely to remain so under the dual sharing and Canada-wide sharing visions. If Canadians prefer a predominantly provincial model of sharing, revenue sharing becomes an attractive instrument.
6. The adequacy of federal financial contributions to nation-wide health care is a matter of dispute among governments. In our judgment, the structure of federal public finances is at present stronger than that of almost all provinces and territories. This has been the case since the late-1990s. In the previous couple of decades, the opposite was true. Such shifts are integral to the history of Canadian federalism. They occur with changing economic circumstances and changing revenue and expenditure policies of both orders of government.
7. The prospect of growing fiscal dividends at the federal level and of ever rising health care costs at the provincial level inevitably raises issues of resource allocation. This in turn opens up a much larger debate about appropriate debt levels, tax burdens and other competing claims on the public purse. Improving the federal financial contribution to provincial/territorial health care programs and expanding the coverage of nation-wide health care under the *Canada Health Act* are two options that deserve careful consideration in such a public debate.
8. There is a disconnect between the role the federal government appears to wish to play with respect to the Canada-wide dimensions of health care and the current size of its cash contribution. The federal government's contribution is simply insufficient to sustain the ability and right to play the role it has assumed historically. If we are correct about the federal government's wish to sustain its role, the federal cash contribution needs to be re-based through a process of federal-provincial-territorial negotiations. We consider a fair federal cash contribution to be in the order of 20-25 percent of provincial costs based on the factors discussed above. Looking forward, Ottawa should also share more fully in the fiscal and political risks associated with the future of the health care system.
9. The federal government's largely unilateral approach to fiscal relations with the provinces is also inconsistent with the kind of federal-provincial-territorial partnership arrangement on health care that the federal government appears to want and that the

Canadian public clearly expects. At the same time, to return to a more collaborative approach to fiscal decision-making would also require that provincial finance ministries engage constructively and realistically in negotiations with their federal counterpart.

10. Further considerations that should guide the fiscal relationship between federal and provincial governments include the following:
 - a. If Canada were to move toward a predominantly provincial sharing community vision, a federal-provincial-territorial revenue sharing arrangement would be the preferred option (as already noted), with a transfer of tax room being the second best. In either case, the affected revenues should be equalized. Under this model, the conditions associated with the *Canada Health Act* should be dropped, except those related to portability and mobility.
 - b. Alternatively, under a dual sharing or predominantly Canada-wide sharing vision, a federal cash transfer should be maintained. The cash payment should be visible and understood by all Canadians to be *the* federal contribution. In this case, it would be appropriate to maintain conditions along the lines of those currently found in the *Canada Health Act* or some modernized version of them.
 - c. A continued 20-25 percent federal cash contribution should take the form of a separate equal per capita transfer for health care (CHT) as a single block, in part because of its equalizing properties. It should not be a formal cost-sharing arrangement.
 - d. Any federal cash contribution should be escalated by a measure that reflects the growth in Canada-wide health care costs. It should be predictable and transparent.
 - e. Consideration should also be given to adjusting the equal per capita transfer on the basis of differences in needs among provinces and territories, as determined by measurable demographic and geographic factors. While such a needs-related adjustment can be justified in all scenarios, it is strongest in the case of the predominantly Canada-wide model.

11. Insured hospital and medical services are declining as a share of total health care expenditures. To the extent that there is interest in broadening the insurance coverage and given our conclusions in 6-8 above, it appears that all – or almost all – of the incremental costs of the added coverage would have to be borne by the federal government. Determining these incremental costs would require very detailed information from the provinces about current program costs and a careful assessment of the costs of the proposed programs. Assuming the federal government does absorb these incremental costs, it may wish to take a prudent fiscal approach and finance some of the added costs through a dedicated tax. Additional features of a broadened coverage could include the following:
 - a. As an interim measure, the new Canada-wide health care programs should be part of a health care block or blocks (separate from the CHT).

- b. The separate block(s) should have a separate escalator that reflects anticipated cost increases in areas covered by the new programs (based on Statistics Canada measures of relevant cost increases).
 - c. The new programs should be folded into the CHT when they become mature, with appropriate adjustment, if necessary, to the CHT escalator.
12. The fiscal relationship between the federal, provincial and territorial governments should be re-thought and adjusted to better reflect a partnership. The model of federal-provincial fiscal relations from the era of the 1950s to the 1970s was characterized by tough negotiations, but with a determination to reach agreement. Returning to the earlier model or finding an alternative that provides the provinces and territories with a greater voice in the outcomes is highly desirable.
13. Consideration should also be given to various ways in which the federal government could become the political partner of the provinces and territories with a view to helping them overcome some of the political obstacles they face in moving forward with health care reform.
14. In the context of reconstructing the fiscal and political partnership among orders of government, the arrangements for handling disputes that cannot be avoided must be considered. The need for significant changes in dispute resolution mechanisms is not great in a predominantly provincial sharing model. However, improved dispute settlement arrangements are needed in the dual sharing vision. And to the extent that the Commission proposes policy changes that would broaden the scope of coverage of Canada-wide health care or make the federal conditions found in the *Canada Health Act* broader in scope or more onerous, the need to ensure that dispute resolution mechanisms are seen as authoritative and legitimate by the public and both orders of government will intensify. This will require new institutional tools (Cameron and McCrea-Logie 2002). Under the latter two versions of the Canadian sharing community, the dispute resolution provisions could, for example, incorporate the following features:
 - a. Apply to a broad range of disputes, both fiscal and programmatic.
 - b. Embody the central values guiding health care in Canada.
 - c. Offer to citizens a role in the dispute settlement process.
 - d. Make provision for the use of third parties, as appropriate, for advisory, mediatory and facilitative functions, but in a fashion consistent with the preservation of the democratic accountability of elected officials.
 - e. Encourage the development of shared language and relationships by providing a forum for consultation involving representatives of the two orders of government.
 - f. Include the public release of fact-finding reports to inform citizens and apply moral suasion on the parties.

There is no single “right” solution to the future role of the federal government in funding Canada-wide health care and establishing a dispute avoidance and resolution process because there are competing views about the nature of the Canadian sharing community and the Canadian federation. These require societal debate and consensus. However, independent of the outcome of this debate, there is a series of disconnects between the vocabulary of partnership that marks Ottawa’s policy pronouncements in respect of health care and the way it has used the tools of fiscal federalism and dispute resolution, over the last two decades, to implement these pronouncements.

These disconnects need to be addressed. Accordingly, this paper sets out some principles that can guide a reform process to renew and improve intergovernmental fiscal relations, and health care relations more generally. In this regard, the federal government has taken steps in recent years that are consistent with the proposed principles, in respect of both fiscal federalism and dispute resolution. At the same time, the analysis presented here suggests that further steps will be required of all governments if these improvements are to be sustained and the intergovernmental partnership rebuilt. Reconstructing the partnership is what Canadians want. It is also essential to improving the quality and sustainability of health care for future generations.

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