

**Health Care and Federal-Provincial Relations:
Charting a New Course Into the 21st Century**

Thesis Submitted in Partial Fulfillment of the Requirements of the
Degree of Master of Arts in Political Studies
University of Saskatchewan
Saskatoon

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Abstract

Universal publicly-administered pre-paid health insurance, commonly known as public health care or Medicare, is easily Canada's single most high-profile public policy. Yet very few Canadians understand exactly what the Medicare program is, how it is structured, and how it works. Even fewer are aware that federal provincial intergovernmental relations is the crux upon which the entire Medicare program rests, with all the significant attendant implications of that reality for the day-to-day lives of millions of Canadians.

The purpose of this thesis is to explain how Medicare is structured in Canada, distill the complex and continually raging debate surrounding this topic into comprehensible, clearly articulated worldviews, and expose those worldviews to scholarly analysis. The thesis concludes with recommendations for the future direction of the Medicare program based upon its findings and analysis.

To this end, this thesis examines the developmental trajectory of Medicare in Canada with a particular emphasis on federal-provincial fiscal relations and their impact on the program. The debate over the best way to structure and operate Medicare is distilled into two distinct schools of thought: the 'centralist' and the 'decentralist.' The positions of each school are exposed to a comparative qualitative analysis of their contrasting proposals for federal-provincial relations in the health care field.

The thesis concludes that the 'centralist' school of thought is the superior of the two proposals and should be implemented given that it provides a blueprint for meaningful reform and expansion of the Medicare program while avoiding various pitfalls which are associated with the 'decentralist' approach. Further, it is asserted that federal engagement and leadership has been essential to the inception and maintenance of Medicare up to the present and will be central to the maintenance, reform, and expansion of Medicare moving into the future.

Acknowledgements

I would like to thank my uncle and aunt, Mr. Ike Hammell and Dr. Karen Whalley Hammell PhD, MSc, OT(C), DipCOT (UK), whose scholarly example and ever-thoughtful counsel have guided and inspired me through every step of my academic career, including the writing of this thesis. I want to thank my parents Laurie and Lyndon, my grandmothers Mrs. Phyllis Morrow and Mrs. Evelyn Hammell, my brother Luc, and my partner Josh for their unconditional love and support for me throughout this whole process. In particular I want to thank my mother and my partner Josh, who with saintly patience endured more than a few existential crises with their trademark calmness and resolve, giving me the strength to carry on when dark clouds gathered; and my Grandma Phyllis, who provided me a healthy dose of motivation to see this project through – ‘I’m back!’

I also wish to thank the University of Saskatchewan Department of Political Studies for the very generous financial support extended to me during my time working on this thesis. Without that support, this project would never have gotten off the ground.

Lastly, to my Supervisors, Mr. Roy Romanow and Dr. Hans Michelmann, I owe a debt I can never hope to repay. Thank you both above all for your boundless patience and for your faith in me and in this project. It was both a privilege and an honour to work with you, and truly humbling to be in the presence of such amassed experience and knowledge. I will miss greatly the opportunity of working with you both and hope that we will have occasion to keep in contact far into the future – I will never forget my experience in working with you. All the best features of this project are owed to the guidance and encouragement of these two mentors, in which role they are without peer. Any shortcomings are my own.

Dedication

I dedicate this thesis to the memory of my grandfather William N. ‘Bill’ Morrow, a public servant of thirty-four years, who passed away in September 2010. To him and to his mentorship through my youth, I owe a thirst for knowledge, a passion for politics, and the unshakeable belief that, regardless of where we come from, the boundaries which delimit our path through life are determined only by our own desire to learn and to understand the world around us – a legacy I strive to honour each and every day.

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Chapter 1 – Introduction

1.1 Foreword

In July 2012, universal publicly-administered pre-paid health insurance, commonly known as public health care or Medicare, celebrated its 50th anniversary in Canada, marking the passage of five eventful decades since the province of Saskatchewan under Premier T.C. Douglas introduced the first publicly-funded, not-for-profit, comprehensive health care insurance plan to be found in North America on July 1, 1962. The advent of Medicare in Saskatchewan, and its subsequent adoption on the national scale in the wake of Justice Emmet Hall’s Royal Commission Report of 1964, was far from a painless process. In the early days Saskatchewan found itself embroiled in a tempest of protests and doctor’s strikes, and the implementation of national Medicare was vigorously opposed by some of the provinces, certain ministers of the federal Cabinet, and much of the medical profession.

Underlying the struggles attendant to the birth of Medicare in Canada, however, are the public opinion polls which have consistently indicated that the people of Canada expect that their governments recognise, as a fundamentally Canadian societal value, the idea that access to health care should be based on need and not on the ability to pay. Already in a 1949 Gallup poll, 80 per cent of Canadians indicated that they preferred a model of public insurance to a privately funded health insurance model.¹ In October 2015, Nanos Research reported that, when asked to rank the most important priority if they were Prime Minister, 68 per cent of respondents chose ‘investments in improving public health’ as their number one priority. Of the eight top issues for voters in that survey, five were directly related to health

¹ Malcolm G. Taylor, *Health Insurance and Canadian Public Policy: The Seven Decisions That Created the Health Insurance System and Their Outcomes*, 2nd ed. (Montreal: McGill-Queen’s University Press: 2009), 166. The question was phrased: ‘Would you approve or disapprove of a *National Health Plan* whereby you would pay a flat rate each month and be assured of *complete medical and hospital care by the Dominion government?*’ [emphasis added]. The results of the 1949 Gallup poll were ‘Approve:’ 80 per cent; ‘Disapprove:’ 13 per cent.

care.² And when respondents were asked about two-tier health care, where some people would be allowed to pay for quicker access to care, 64% of Canadians opposed this, while only 34% were open to such a situation.³ This clearly indicates that public health care is one issue around which the majority of Canadians can coalesce with a reasonable degree of coherency and consistency, and they do. While there is widespread public agreement on the basis of the system in the broadest possible sense, however, many Canadians appear unaware there has been a fundamental sea change in the field of health care in recent years.

December 19, 2011 may have seemed just another ordinary Monday to the vast majority of Canadians, but to those concerned with the future of Medicare, a day that began normally enough saw political fireworks erupt in the early afternoon. The place: Victoria, B.C.; the scene: a meeting of the provincial, territorial, and federal finance ministers. As the provincial and territorial ministers wrapped up a morning of meetings and headed into a working lunch with Federal Finance Minister Jim Flaherty, the latter appeared and began passing around copies of a document. The provincial ministers quickly found, to their complete surprise, that the document contained a new, completely revamped funding formula for the federal transfers to the provinces for health services. The provincial ministers had not expected to discuss this issue at this particular conference; their first reaction was one of confusion and disbelief. Then one, Graham Steele of Nova Scotia, expecting that the document represented a proposal and that the issue would be discussed and negotiated at this and future intergovernmental meetings, ventured the question ‘What is the process from here

² EKOS Politics, ‘Canadian Worried Sick About Health Care,’ October 25, 2015. Accessed November 18, 2016. <<http://www.ekospolitics.com/index.php/2015/10/canadians-worried-sick-about-health-care/>>.

³ *ibid.*

on?’⁴ As *The Globe and Mail* related, quoting Mr. Steele ‘...the answer from Mr. Flaherty is that there would be no process. This was Ottawa’s position.’⁵

The Harper government which Mr. Flaherty represented has now gone in the 2015 federal election, but for those who are familiar with the evolution of the national health insurance system in Canada, the significance of this particular event is clear. It represented a manifestation of the often-contentious relationship between the federal and provincial governments in the field of health care, a relationship which has been critical to determining the nature and scope of the system throughout its history. It is this ongoing federal-provincial intergovernmental relationship which is the focus of this thesis. This thesis will examine the trajectory of this complicated political relationship which has been so central to the institution of Medicare. It will examine the pivotal role that the federal order of government has played, both in making Medicare a reality in the early stages, and in the maintenance of the program over the intervening decades. Above all, this thesis will address the question of how the federal and provincial governments ought best to structure their relationship going forward, in order that Canadians may continue to enjoy the very best possible uniquely Canadian health care system, a vibrant, efficient, effective Medicare for the 21st century.

1.2 Research Objectives and Questions

This thesis will explore the fiscal arrangements for health care funding in Canada and the division of responsibility in health care provision between the federal and provincial orders of government from the inception of Medicare to the present. The central objective of this thesis is to provide an account of the contrasting proposals as to what the proper intergovernmental relationship between Ottawa and the provinces ought to be, and to

⁴ Ian Bailey and Bill Curry, ‘Flaherty’s 10-year health-care plan divides provinces.’ *The Globe and Mail*. 19 Dec. 2011. Accessed 1 Jul. 2012 <<http://www.theglobeandmail.com/news/politics/flahertys-10-year-health-care-plan-divides-provinces/article2277221/>>.

⁵ *Ibid.*

determine the implications of these proposals for the future of both Medicare and the Canadian federation. The research questions are:

1. What is the relevant history from program inception to the present in the evolution of Medicare in Canada in terms of the fiscal arrangements between Ottawa and the provinces, and the division of responsibility between the federal and provincial orders of government in the field of health care?
2. What are the conflicting visions for health care funding arrangements in Canada, and the proper roles of the federal and provincial orders of government in relation to the health care enterprise moving into the future? What would the proposals of each of these conflicting visions entail in terms of the structure of health care funding arrangements and intergovernmental relations in Canada?
3. What are the implications of each of these contrasting proposed structures of health care funding arrangements and federal-provincial roles and responsibilities for the structure and functioning of the Canadian federation, as well as for national unity and the pan-Canadian identity?

1.3 Theoretical Perspectives & Methodology

In the broader intellectual and theoretical perspective, this thesis should be understood as a case study in the operation of a federal system, specifically the Canadian federal system, with the Medicare program serving as the focus of inquiry. All federal systems in existence have their own distinctive characteristics, and Canada is no exception. One of the major ways in which federal systems are differentiated is the level to which they are either centralised or decentralised. The more widely that power, authority, financial resources, and political support are spread among the orders of government, the higher the level of decentralisation. Conversely, the more power, authority, financial resources, and political

support are concentrated in the central (generally federal) government, the higher the level of centralisation.⁶

When looking at Canadian federalism in comparative perspective with other federations, Canada ranks as one of the world's most decentralised federations.⁷ Specifically, it can be observed that in international perspective the Canadian provinces have a comparatively high degree of autonomy and authority within their jurisdictions, a relatively high fiscal capacity, a relatively high political capacity in that they have a strong presence in the identities and loyalties of citizens, and a comparatively high level of ability to design and deliver public services (a high bureaucratic capacity).⁸ It is also noteworthy that the Canadian federal model is a rather divided federalism, in that there are two very clearly differentiated orders of government having two differentiated spheres of authority and, while they do cooperate with each other in certain key areas of public policy, at the same time they are in competition for political strength and public support.⁹

This thesis examines Canadian Medicare within this larger context of centralisation vs decentralisation in the operation of federal systems. Medicare in particular is chosen first because of its prominence and central importance in the Canadian context, and second because it provides a model of engagement between the orders of government in a federal system in order to achieve public policy goods, and also highlights the absolutely central importance of federal leadership in achieving over-arching national goals as well as systemic change in established public policy programs. Medicare in Canada casts a light on the tension and acrimony that often exists between the orders of government in a federal system, while calling to mind a key over-arching question when we examine Canada as a

⁶ Richard Simeon, 2013, "Decentralization." *The Canadian Encyclopedia*, 16 December. Accessed 20 July 2018. < <https://www.thecanadianencyclopedia.ca/en/article/decentralization/>>.

⁷ Richard Simeon, 2002. 'Federalism and Decentralization in Canada.' *The Forum of Federations*. < <http://www.forumfed.org/library/federalism-and-decentralization-in-canada/>>.

⁸ *Ibid.*

⁹ *Ibid.*

comparatively decentralised federation and very much a country of geographically diverse regions with divergent social, economic, and political interests – who speaks for Canada?

This thesis is intended to form a part of that larger dialogue. The thesis commences with an exposition of relevant empirical facts, and subsequently will undertake a qualitative analysis of the effects of those facts upon the Medicare system and the functioning of federalism in Canada. It will draw on both primary and secondary literature. This will include government documents and reports of Royal Commissions, parliamentary committees and task forces, and so on. It will also include reports, position papers, policy proposals and briefs, and other publications prepared at the behest of private organisations and think-tanks. Also consulted will be academic publications surrounding the issue of healthcare provision and federal-provincial cost-sharing arrangements and their implications. News in various media such as op-ed publications in newspapers and other reputable publications are also utilised. Lastly, an interview was conducted with one subject matter expert, in particular a proponent of the centralist school of thought, in order to fully flesh out the position of the centralist school and give clear expression to the full breadth of its positions.

1.4 Thesis Structure

The body of this thesis is divided into five chapters.

Chapter 2 is a background chapter and is intended to provide the reader with the necessary foundation to understand the trajectory of federal-provincial intergovernmental relations. This chapter is divided by broad eras, with subsections corresponding to significant landmark events within the history of Medicare from 1945 to the present.

Chapter 3 examines what is labelled the ‘decentralist’ or ‘the Boessenkool school of thought,’ so-called because its decentralist tenets are expressed most coherently and thoroughly by Ken Boessenkool, formerly of the University of Calgary. The concept of

Stephen Harper's 'open federalism,' which informs/is informed by Boessenkool's positions on health care, will also be explored in some detail.

Chapter 4 examines the 'centralist' school of thought surrounding the direction which federal-provincial intergovernmental relations ought to take on the issues surrounding health care moving into the future. The recommendations of the Royal Commission Report *Building on Values* (2002) will be examined in some detail, and the positions of this school of thought on the issues of Canadian values, Canadian unity, and the function of the federation will be laid out.

Chapter 5 is the critical analysis chapter of the thesis. It examines the various implications of the two major schools of thought, and then undertakes a critical analysis of both of them in turn. The end conclusion is that the centralist school of thought is the superior of the two alternatives because it provides a framework for meaningful reform and expansion of the Medicare system while avoiding the potential pitfalls of the decentralist approach.

Chapter 2 – Health Care in Canada: An Historical Overview

2.1 Introduction

This thesis is at its core about the debate surrounding the proper relationship between the federal and provincial orders of government with respect to health care, and about the implications which the conflicting visions in play might have. These issues are not new – they have been at the forefront of an at times acrimonious dialogue which has been ongoing with varying degrees of intensity since public health care was first introduced. To make a cogent contribution to the emerging discourse of the present day, and to understand the complexities of federal-provincial relations regarding Medicare, it is necessary to understand how we got to where we are today. This chapter will explore some of the relevant historical background to the implementation and operation of Medicare, which will provide a foundation for a discussion of the issues in the later chapters of the thesis.

2.2 The Early Days of Medicare in Canada: 1867 – 1950

At the time Canada's Constitution was first ratified as the *British North America Act, 1867*, health care was viewed as a private matter, or as falling within the purview of religious or charitable organisations.¹⁰ By the 1930s up to 1945, however, the expectations of Canadians regarding the involvement of government in the provision of social services began to increase dramatically,¹¹ perhaps a result of the fact that the Great Depression meant that an ever-increasing number of Canadians were simply unable to pay out-of-pocket for even basic hospital or physician services.¹² The Canadian people increasingly began to demand that their access to many basic social services, including health care, would be guaranteed by

¹⁰ André Braën, 'Health and the Distribution of Powers in Canada,' in T. McIntosh, P-G Forest, and Gregory P. Marchildon, eds., *The Romanow Papers, Vol. 3: The Governance of Health Care in Canada* (Toronto: University of Toronto Press, 2004), 25.

¹¹ In a Gallup poll conducted in 1944 and again in 1949, for example, some 80 per cent of Canadians expressed support for a form of national health insurance scheme. See Taylor, 166.

¹² GP Marchildon, *Health Systems in Transition: Canada*. (Copenhagen: WHO Regional Office for Europe on behalf of the European Observatory on Health Systems and Policies, 2005), 21.

entrusting those services to government, and this in turn raised the issue early on as to which order of government ought to be responsible for those services, and further, what the relationship between the two orders of government ought to be in this regard.¹³

In the context of this clear upwelling of popular pressure, the first major push for some form of national public health coverage came from the federal government at the 1945/1946 Dominion-Provincial Reconstruction Conference.¹⁴ At the conference, the federal government put forward a broad package of social security and fiscal changes, including an offer to cost-share 60 per cent of the costs of public hospital and medical care insurance.¹⁵ This offer was rebuffed by the provinces based upon their concerns about the administrative and tax arrangements that would have accompanied the comprehensive social security programme.¹⁶ This early failure to implement a national public health insurance scheme forced a more piecemeal approach to the introduction of public health care in Canada, led by Saskatchewan and British Columbia in particular.¹⁷

2.3 National Hospitalisation Insurance - The HDSA of 1957

With the collapse of the Dominion-Provincial Conference on Reconstruction of 1946 and the attendant rejection by the provinces of the federal government's 60 per cent cost-sharing for health care proposal, 'the federal government's idealistic plans for post-war Canada were in disarray. So, too, was the financial position of most of the provinces.'¹⁸ Against this background of failure, however, there were powerful factors pushing toward the adoption of at least some form of national health insurance scheme. First, there was the clear public pressure. There were other, more powerful factors at work, however, namely: 1)

¹³ Howard Leeson, 'Constitutional Jurisdiction over Health and Health Care Services in Canada,' in T. McIntosh, P-G Forest, and Gregory P. Marchildon, eds., *The Romanow Papers, Vol. 3: The Governance of Health Care in Canada* (Toronto: University of Toronto Press, 2004), 53.

¹⁴ *Ibid.*

¹⁵ *Ibid.*

¹⁶ *Ibid.*

¹⁷ *Ibid.*, 21-2.

¹⁸ Taylor, 162.

Widespread poor health outcomes and lack of medical services for many Canadians;¹⁹ 2) The inequitable distribution of illness in the Canadian population, and more particularly the distribution of the costs of illness in said population, both being clearly correlated to income level;²⁰ 3) Clear disparities in the level of health services available by province, and in the *per capita* burden being imposed on the inhabitants of each of the provinces in order to support health care expenditures; 4) Provincial initiatives which deepened the perception of inequity from province to province.

Points 3 and 4 are of particular concern to the present analysis. British Columbia had one doctor for every 777 persons in 1954; Nova Scotia one for every 1,436; and Newfoundland one for every 2,117 people – a disparity of 100 per cent between B.C. and N.S., and 200 per cent between B.C. and Newfoundland.²¹ In terms of expenditures by provincial and municipal governments on health care *per capita*, these ranged from \$154 in B.C. (54 per cent above the national average), to \$68 in Prince Edward Island (43 per cent less than the national average).²² However, to finance health care expenditures at that level, B.C. spent 2.5 per cent of *per capita* income, while P.E.I. spent 2.3 per cent – a nearly equal burden for far fewer services.²³ In other words, ‘In final terms, the capacity of a province – in the absence of transfer payments from the federal government – to finance governmental goods and services rested on *per capita* income’ – and the average annual personal income *per capita* in British Columbia was \$1,519 from 1952-6, as compared to a mere \$660 in

¹⁹ *Ibid.* The 1946 *Review of Canada's Health Needs and Insurance Proposals* by the National Health Bureau found that, while Sweden and New Zealand (both of which had state Medicare) had an infant mortality rate of 29, Canada's was 54, and the rate was even higher in rural areas: 63 in rural British Columbia, 76 in Manitoba, and 79 in Nova Scotia. The total number of reported days of disability due to illness was 153,500,000, or an average of 11.9 days per person, per year. Furthermore, on average Canadians required an average of 5.6 bed days of care per year, at least some of which were spent in hospital.

²⁰ *Ibid.* In terms of the estimated average number of person days of disability per 1,000 persons by income, the figures were: Low Income: 17,833; Medium Income: 11,042; High Income, Upper: 11, 384. Data from the survey also showed that low-income persons received significantly less physician care than high-income persons: 8.27 units of physician health care received per 100 disability days vs. 21.71 for upper high-income.

²¹ *Ibid.*, 177-8.

²² *Ibid.*, 178.

²³ Taylor, 179, 177. For example, B.C.'s physician ratio was 1 to 777, vs. 1 to 1,280 in P.E.I.

Newfoundland, for example (again, a difference of over 100 per cent).²⁴ Taylor expressed the significance of these facts best when he summarised them thus:

It is the primary function of a national government in a federal system to think nationally. It must constantly address the question, “What in terms of living standards, and particularly in terms of public services, does it mean to be a Canadian citizen?” It was obvious that it meant different – indeed, far different – things province to province. Standards of resources and services that varied as much as two or even three times were clearly indefensible. Equally evident was the fact that disparities could be overcome, or even ameliorated, only one way – by federal participation in the financing of services with large infusion of nationally-collected funds.²⁵

This reality of an urgent need for federal action was exacerbated by the fact that four provinces out of ten had varied health insurance programs in operation by 1950, and one in particular, which had achieved insurance coverage for nearly the entirety of its population²⁶ in a publicly-funded health care scheme, was attracting the notice of citizens across the country. In Saskatchewan, the government of T.C. Douglas had promised upon its election in 1944 to bring in some form of universal health insurance scheme, and in 1947 announced that as an intermediate step toward that goal, there would henceforth be a provincial tax-funded, purely needs-based hospitalisation insurance plan, making Saskatchewan the first jurisdiction in North America to implement such a program.²⁷ The provincial innovation by Saskatchewan in particular, but also by British Columbia, Alberta, and Newfoundland to respond to the pressures of health care needs in their respective jurisdictions, meant that Ottawa was now facing increasing pressure as both citizens and provincial politicians began to demand that the federal Liberal party assume a leadership role in these pressing issues and honour its 1945 promise of health care cost-sharing.²⁸

1955 was to be a critical year for the federal government because it would bring the requirement to begin the process of re-negotiating the federal-provincial tax agreements,

²⁴ *Ibid.*, 179-80.

²⁵ *Ibid.*, 179, 181.

²⁶ *Ibid.*, 170.

²⁷ Alvin Finkel, *Social Policy and Practice in Canada: A History* (Waterloo: Wilfrid Laurier University Press), 2006, 171.

²⁸ Taylor, 181-2.

which were set to expire in 1957.²⁹ That necessitated a federal-provincial conference, which would invariably mean demands from the provinces not only for improved fiscal terms, but also for ‘whatever else might seem of high priority to them.’³⁰ Given the prevailing mood among the populace, the worrying statistics laid out above, and the innovation of the provinces (some of which, such as Saskatchewan, were now financially on the line for costly publicly-funded hospitalisation insurance plans), the issue of federal-provincial cost-sharing in a national health care plan could hardly fail to appear somewhere on the conference’s agenda. Despite all this, the initial response of the federal government was not one of decisive action and definitive leadership, but one of delay.

The federal-provincial conference of October 1955 led to continued strong pressure from the provincial premiers for some decisive federal action. At the close of the first day’s meetings, it was announced that there would be a committee of the provincial and federal ministers of health and finance which would be struck at a later date and which would give detailed consideration to the question of a national health insurance scheme.³¹ The appointment of this committee led to the realisation in the federal cabinet that an offer ‘of some dimension’ would need to be made to the provinces; it simply could not be delayed any longer.³² The eventual federal offer was that the federal government would agree to pay one-half the national cost of diagnostic services and in-patient hospital care (the provinces, except for B.C., had been pushing for 60 per cent).³³ The federal contribution to each province in respect of its shareable costs would be: 1) 25 per cent of the average *per capita* cost for hospital services in Canada as a whole; plus 2) 25 per cent of the average *per capita* costs of

²⁹ *Ibid.*, 206.

³⁰ *Ibid.*

³¹ Taylor, 215.

³² *Ibid.*, 216.

³³ *Ibid.*, 217.

the province itself, less any direct charges to patients for services,³⁴ multiplied by the number of insured persons in the province.³⁵ This federal offer, however, would take effect only if six of the provinces, including at least Ontario or Québec (representing a majority of the Canadian population), announced that they were ready to proceed with such a cost-sharing plan, and the proposed provincial plans were required to provide for universal coverage for all of a province's residents.³⁶

On April 10, 1957, the federal *Hospital Insurance and Diagnostic Services Act* (HIDSA), which formalised these arrangements, was passed in Parliament by a unanimous vote of 165-0. As of July 1, 1958, Newfoundland, Manitoba, Saskatchewan, Alberta, and British Columbia had plans in operation eligible for federal cost-sharing; Ontario came on board on January 1, 1959, as did Nova Scotia and New Brunswick.³⁷ Thus 'six provinces that had not been previously involved in hospital insurance launched programs meeting the federal conditions. With uniform definitions of residency...and uniform benefits, ten provincial plans were melded into the reality of a national program. By 1961 almost the total population of Canada was entitled to the same comprehensive hospital care benefits enjoyed by the people of Saskatchewan and British Columbia for over a decade.'³⁸

It was, however, 'a tough contract the provinces were required to sign.'³⁹ The degree of federal control over the program was extraordinary, for every essential requirement for the operation of a program was prescribed and enforced by the federal government.⁴⁰

Furthermore, the provincial governments were saddled with a good number of administrative

³⁴ Harvey Lazar, France St-Hilaire, and Jean-François Tremblay, 'Federal Health Care Funding: Toward a New Fiscal Pact,' in *Money, Politics, and Health Care: Reconstructing the Federal-Provincial Partnership*, Harvey Lazar and France St-Hilaire, eds. (Montréal: The Institute for Research on Public Policy, 2004), 197.

³⁵ Taylor, 217.

³⁶ Taylor, 217.

³⁷ *Ibid.*, 233-4.

³⁸ *Ibid.*, 234.

³⁹ *Ibid.*, 231.

⁴⁰ *Ibid.*, 230.

burdens.⁴¹ True, the provinces did benefit from having a cost-sharing program in place, but over time the financing formula, which was intended to provide some degree of equalisation, proved to be an imperfect instrument, since provincial *per capita* costs were not perfectly correlated with *per capita* income.⁴² Despite these issues, however, there is no doubt that the HDSA was an historic achievement. The resultant system, while not perfect, was a crucial stepping stone on the road to universal Medicare.

2.4 ‘The Original Deal:’ Pearson and the Original National Health Care System 1965-1977

As the next act in the story of Canadian health care opened on July 19, 1965, Lester B. Pearson had replaced Louis St. Laurent as leader of the Liberal party, and the contrast between their opening statements at the federal-provincial conferences could not have been greater, or a clearer demonstration of the differences between them. ‘The provision of health services...[is] the item on our agenda which is the most important of all,’ Pearson began. He continued ‘Accordingly, *I repeat that it is now the responsibility of the federal government to cooperate with the provinces in making Medicare financially possible for all Canadians. The government accepts that responsibility* [emphasis added].’⁴³ Despite the minority position of the Pearson Liberal government elected in 1963, the decision for universal national health insurance appeared imminent. However, there was to be a significant struggle before national health insurance would be implemented in the country.

The imperatives for federal action were clear. Above all there was the force of public expectation. The Liberals had first promised national Medicare in their 1919 platform, and then again had raised the issue with the (eventually rejected) 1945 Green Book proposals associated with the Dominion-Provincial Reconstruction Conference. Thus, the issue of

⁴¹ Taylor, 230.

⁴² *Ibid.*, 236-7.

⁴³ *Ibid.*, 332.

national health insurance was now firmly associated in the public mind with the Liberal Party, and the fact that this promise had not been delivered on in the intervening forty years was a glaring incongruence. This was reinforced by the fact that national hospitalisation insurance had been a success, creating anticipation amongst the public that the ‘other shoe’ must sooner rather than later be dropped.⁴⁴ It would seem that “Somehow, it had become a natural, normal expectation that awaited only the time when a special concatenation of political forces, public attitudes, and determined leadership would reach the necessary ‘critical mass’ and the dream would be realised.”⁴⁵

Adding fuel to the fire was the newly released report of the Royal Commission on Health Services chaired by Emmett M. Hall, delivered on June 19, 1964. Hall recommended ‘a comprehensive, universal Health Services programme’ to meet the health needs of Canadians, and that ‘the Federal Government enter into agreement with the provinces to provide grants on a fiscal need formula to assist the provinces to introduce and operate comprehensive, universal, provincial programs of personal health services.’⁴⁶ The evidence gathered by Hall’s Royal Commission also highlighted that the unmet health needs of the Canadian populace remained considerable and serious despite hospitalisation insurance.⁴⁷

However, the federal government was also facing several serious constraints in its scope of action on the issue of a national health insurance plan. Although it was generally recognised that the federal government retained its right to dispense its funds when and how it chose, the position of the provinces in the 1960s stood in sharp contrast to that which prevailed in the 1950s during the negotiations surrounding national hospitalisation insurance.

⁴⁴ *Ibid.*

⁴⁵ *Ibid.*

⁴⁶ Taylor, 342-5.

⁴⁷ *Ibid.*, 353. Infant mortality and incidence of illness remained high, there was an inadequate supply of trained personnel, a general lack of adequate health insurance among wide sectors of the population, a highly inequitable pattern of expenditures by the provinces on health services, and a very widely varying fiscal capacity on the part of those same provinces to act to address these problems.

By the 1960s, Québec under Premier Lesage was making unprecedented demands for an ever-increasing degree of autonomy, and the federal government was confronted with a group of determined premiers backed by solid majorities who had no interest in accepting Ottawa's largesse any longer if it meant accepting Ottawa's dictates as well.⁴⁸

The provinces were increasingly unwilling to accept what they saw as the burdens imposed upon them by 'shared-cost programs' in general, of which national health insurance was one. Better termed a 'conditional-grant-in-aid,' the provinces resented the conditions which were imposed upon them under this arrangement, which they claimed eroded provincial autonomy and had the effect of distorting provincial fiscal priorities.⁴⁹ It was clear that federal leadership was needed on the issue of national health insurance, but it was equally clear that the federal government was facing serious constraints in what was acceptable policy to the provinces.

Meanwhile, however, things were proceeding apace in Ottawa. Remarkably, in the initial stages of the policy process, there was a strong leadership bloc which was universally dedicated to the national health insurance project: Prime Minister Pearson, Health Minister Judy LaMarsh, and Finance Minister Walter Gordon were all pro-Medicare.⁵⁰ The Health Department had struck fourteen committees to consider in detail the various recommendations of the Hall Commission report delivered in June 1964.⁵¹ These committees initially envisaged a system much like that which prevailed under national hospitalisation insurance, and the proposal they submitted to the committee struck by Mr. Pearson comprised of senior officials from Health, Finance, and the Privy Council Office (PCO) clearly reflected that line of thinking. The Prime Minister, however, was acutely aware that there was no possibility that such a model would be accepted by the provinces. While federal leadership

⁴⁸ Taylor, 354.

⁴⁹ *Ibid.*, 355.

⁵⁰ Taylor, 360-1.

⁵¹ *Ibid.*

was clearly essential if all Canadians were to be insured, the requirements of the Hospital Insurance Act of a formal agreement and provision for detailed federal auditing of provincial accounts were out of the question. Instead, respecting the federal nature of the Canadian system, the proposal would need to be based upon ‘a general understanding of what a Medicare program was, an agreement only on general principles,’ upon the basis of which ten reasonably similar (but *not* identical) provincial plans were to be put in place.⁵² As Taylor relates:

Accordingly, in the interdepartmental committee, ‘principles’ or ‘criteria’ were examined, rejected, refined and reduced to the absolute minimum, until four remained: comprehensive, universal, publicly administered, and portable. Gone would be the need for written agreements and for federal audit, that irritant and symbol of provincial subordination. It was simplicity itself. Not a federal program, but ten provincial programs that together with federal sharing would aggregate to a national program of uniform minimum standards for all Canadians.⁵³

It was, in other words, a model of federalism in action.

There was one other fundamental detail to be worked out which would accord with the new political reality, and that was a mutually acceptable cost-sharing formula. The federal government preferred a fixed *per capita* amount, which would allow it to limit the growth of the transfers, but that was plainly going to be unacceptable to the provinces.⁵⁴ Similarly, the hospitalisation insurance funding model could not be countenanced. Since the provinces would not tolerate federal auditing, to be consistent the federal government would have to be equally blind to individual program costs in each province; and under hospitalisation insurance, the federal contribution was determined by each province’s *per capita* costs.⁵⁵ The only alternative, therefore, was to establish a single national figure, a national *per capita* cost. Calculations indicated that if the federal government paid one-half of that amount on behalf of every insured person, it would mean the federal Treasury would be covering a little less than half the cost in the wealthier provinces, and up to 80 per cent in

⁵² *Ibid.*, 362.

⁵³ Taylor, 362.

⁵⁴ Taylor, 362.

⁵⁵ *Ibid.*

the poorer provinces – in other words, ‘it would be a serendipitous outcome that all (or almost all) would applaud.’⁵⁶ In the end, the proposal (which was ultimately to be implemented under the terms of the *Medical Care Act*) was as follows: the federal government committed to pay each province half the national *per capita* cost of providing insured hospitalisation and health services, multiplied by the average number of insured persons in that province in the year in question.⁵⁷

Health Minister Allan MacEachen moved in June 1966 to begin piloting the necessary legislation through Parliament. He had hoped to be able to get the *Medical Care Act* through to Second Reading before summer recess, but, in his words,

...I went to the cabinet and said the bill is ready, let’s get it through before the summer adjournment. The medical profession is reconciled to its enactment. Note the word reconciled. I argued that the provinces should not be given a further opportunity to regroup and continue their opposition to Medicare. I argued that we ought to act urgently. Well, I failed in that effort...In August of that year...the cabinet felt that the strong reaction...from many provinces provided an opportunity to re-open the whole question of Medicare...And that gave Mr. Sharp [the federal Minister of Finance] an opportunity to come to cabinet later on in August, arguing for an indefinite postponement of Medicare. That failed, and we had a terrible row in the Cabinet. Everybody was unhappy and we settled that we would defer the beginning of Medicare for one year.⁵⁸

The delay instigated in Cabinet by Finance Minister Sharp resulted in a blowback effect as opponents of Medicare across Canada took advantage of the extra breathing room to mount a final offensive against a national public health insurance plan.⁵⁹ At the regularly-scheduled Provincial Premiers Conference in Toronto on August 1-2, 1966, as Taylor relates, “So strident were the tones, so angry the voices, so vehement the opposition, that one journalist summed up ‘the Federal government’s proposed legislation lies torn, tattered, and politically rejected.’”⁶⁰ To again quote MacEachen’s reflections:

Well it would be unnatural, unexpected...for the provinces to remain silent. They took advantage of the divisions within Cabinet by renewing their opposition to Medicare. At that particular time, Mr. Pearson was also dealing with the Constitution at a big conference. And at that conference, he felt the full brunt from the provincial premiers, the full brunt of

⁵⁶ *Ibid.*

⁵⁷ Lazar, St-Hilaire, and Tremblay, 199.

⁵⁸ Allan J. MacEachen, ‘Legislating Medicare in Canada,’ in *Reflections on Canadian Politics: Vol. II*, compiled by James Bickerton (Antigonish: St. Francis Xavier University Press, 2003), 70-1.

⁵⁹ Taylor, 369.

⁶⁰ *Ibid.*, 370.

their discontent on the subject of Medicare...So it was in this atmosphere of provincial opposition and division within the cabinet, *that Mr. Pearson finally decided that we would go ahead with the Medicare programme...And without his decisive action at that time, because he finally made the decision, we may have lost the whole issue* [emphasis added].⁶¹

The issue, therefore, appeared to be settled, at least for the present moment, by the determined intervention of the Prime Minister. Despite the best efforts of the opponents of Medicare both in and outside of Cabinet, the *Medical Care Act* finally passed Third Reading on December 8, 1966, by a vote of 177 'Yeas' to just two 'Nays.'⁶²

On the inaugural date of July 1, 1968, only Saskatchewan and British Columbia qualified for federal contributions under the new plan.⁶³ Newfoundland, Nova Scotia, and Manitoba quickly followed at the beginning of 1969, with Alberta, Ontario, Quebec, Prince Edward Island, and New Brunswick after that, in that order.⁶⁴ It was a resounding success, for 'whatever the political and economic costs that would impinge upon other provincial priorities, ten provincial programs with portable benefits finally came into being and a national plan was born.'⁶⁵ For as had been the case with hospitalisation insurance, if a province chose not to join in these arrangements, its residents would effectively be subsidising through the federal taxes they paid the residents of the provinces which did choose to participate. In other words, for practical reasons the provinces could not afford to remain outside such an arrangement.⁶⁶ This presented an irresistible incentive for the provinces to come on board.

There were both similarities and some differences to the formulation and implementation of national hospitalisation insurance ten years before. What had definitely changed was the position of the provinces, which had become much more confrontational and

⁶¹ *Ibid.*, 73.

⁶² *Ibid.*

⁶³ *Ibid.*, 375.

⁶⁴ *Ibid.*

⁶⁵ *Ibid.*

⁶⁶ Lazar, St-Hilaire, and Tremblay, 192.

assertive in their relationship with the federal government. The federal government for its part proved out of necessity to be more sensitive to provincial needs, concerns, and priorities, and the system and funding formula it proposed were heavily shaped by the constraints of what would be deemed acceptable to the provinces. Indeed, despite the provincial complaints, there had actually been quite extensive intergovernmental consultations, both at the federal-provincial conferences and more informally.

One thing which was not new in the decision for Medicare was the clearly demonstrated need for strong federal leadership, without which such a comprehensive program would never have been implemented. Prime Minister Pearson's skilled handling of federal-provincial diplomacy in an area of joint constitutional jurisdiction was a key factor in the success of the Medicare proposal. He proved adept at judging how far the provincial governments were prepared to let the federal government push in terms of a national plan, and the committee he struck, which offered a proposal of ten provincial plans centred around a tight constellation of core values, not only greatly increased the chances of provincial acceptance, but proved to be an enduring framework. The progressive cadre of Allan J. MacEachen, Judy LaMarsh, Walter Gordon, Paul Martin Sr., and others pushed Medicare through a Cabinet which was divided and against a Finance Minister who tried every tactic of delay and hindrance he could muster to derail the project. Tremendous credit is also due to the leadership of Mr. Pearson, who, at the eleventh hour, when the opponents of Medicare had all but succeeded in their quest to kill the proposal in Cabinet, showed strength and the courage of his humanitarian convictions when he declared that debate was closed and the programme was going forward.

There was no question that the road to the adoption of Medicare in Canada had been one of the most tumultuous series of events in the history of the country's public life. Yet despite the upheaval, the result was unquestionably a major gain for the people of Canada,

who were now entitled to a reasonably uniform level of comprehensive health and hospitalisation care based upon need, not upon ability to pre-pay for insurance coverage, or in what province they happened to reside. At the same time, Medicare was a uniquely Canadian compromise which respected both the constitutional and political reality of the country: the federal leadership recognised the desire of the provinces for greater autonomy; and presented for provincial acceptance a plan which would both equalise regional disparities, and be based not upon a rigid, monolithic imposition of a national design, but instead a more flexible series of independent provincial plans linked together by a series of core national values. As Allan MacEachen put it,

It is normal...in the Canadian context [that] the achievement of important projects is linked to controversy and bruising. And it certainly happened on this occasion. Bruising of the Prime Minister, the premiers, ministers, and probably the medical profession. However, that is part of politics. That is public service and public life. The result, however, was a major gain for the people of Canada. The fundamental principles adopted in the 1960s have been recently assessed and scrutinised thirty-seven years later by the Royal Commission [on the Future of Health Care in Canada] under Roy Romanow. His conclusions are that these principles are of enduring value and should continue to be a cornerstone of our public health system. So, I conclude by saying, that in truth Mr. Pearson was right when he said that the passing of the *Medical Care Act* on December 21 in 1966 was a major triumph.⁶⁷

2.5 Established Programs Financing and the Canada Health Act – Health Care in Canada 1977-1990

The next major milestone in the history of health care in Canada came in the 1970s. Despite the overall success and strong public support for the hospital and medical care programs,⁶⁸ both the federal and provincial governments had concerns about the funding formula within a few years of implementation of the *Medical Care Act* in 1966. For their part, the provinces found the inflexible administrative details they had been required to agree to under the terms of the *Hospital Insurance Act* objectionable, they resented the federal audit to determine shareable costs, and they claimed that federal funding of just two programs had the effect of distorting their priorities and fiscal resource allocation processes.⁶⁹ The federal

⁶⁷ MacEachen, 73-4.

⁶⁸ Taylor, 422.

⁶⁹ Taylor, 422; Lazar, St-Hilaire, and Tremblay, 200.

government, committed by its own legislation to match provincial fiscal outlays on health, was concerned that it had no control over the rapidly rising provincial budgets for hospital and medical services, as well as for welfare and post-secondary education.⁷⁰ A sense of a ‘health cost spiral’ pervaded the whole system, not least in the upper echelons of the Finance Department in Ottawa.⁷¹ With the federal government increasingly convinced that it must gain immediate control of its health care expenditures, the stage was set for a major restructuring of the financial arrangements underpinning Canadian Medicare.⁷²

At the federal-provincial conference in June 1976, Prime Minister Pierre Trudeau opened by proposing total termination of the open-ended 50-50 cost-sharing arrangements for post-secondary education and for the two health programs (medical insurance and hospitalisation insurance, together comprising the national Medicare program), and proposed instead that the federal government would vacate income tax room which the provinces would be free to occupy.⁷³ In December 1976, the provinces responded with a unanimous counter-proposal demanding an additional four tax points as a continuation of the (in fact unrelated) 1972 ‘revenue guarantee.’⁷⁴ The federal Finance Minister rejected this proposal. After a period of intense intergovernmental negotiations, the matter was again taken up at the

⁷⁰ Lazar, St-Hilaire, and Tremblay, 200. Transfers to the provinces as a percentage of federal expenditures had increased dramatically, from 9.5 per cent of federal spending in 1955 to over 24 per cent of total federal expenditures by 1973.

⁷¹ *Ibid.*

⁷² *Ibid.*

⁷³ Specifically, 12.5 points of personal income and 1.0 points of corporate income ‘tax room.’ This would be equalised to a national average because tax points would yield less revenue in a low *per capita* income province than in a high *per capita* income province. The federal government would also contribute a cash grant equal to the other half of its 1975-76 payments for the three programs, escalated annually in accordance with a three-year moving average of increases in *per capita* GNP. See Lazar, St-Hilaire, and Tremblay, *ibid.*

⁷⁴ *Ibid.* In 1972, the federal government had introduced income tax reforms which further reduced the federal ‘basic tax’ on which all provincial governments (except Québec) calculate their provincial income tax levies. This meant that provincial governments would either have to accept reduced revenues or bear the onus for raising their tax rates. To help out the provinces, the federal government agreed to ensure the provinces would receive no less than they would have if the reforms had not been introduced over a period of three years, during which time the provincial governments could legislate politically painful, but necessary, tax increases. This ‘revenue guarantee’ became entangled with health insurance financing (which in fact was totally unrelated) and caused a great deal of intergovernmental tension and problems. (See Taylor, 423-4.)

First Ministers conference in December 1976. At that meeting, the provinces remained set in their demand that the 1972 ‘revenue guarantee’ be continued, a position the federal government was unwilling to accept.⁷⁵ Finally, to achieve agreement, the federal government compromised, making a two-part offer of a transfer of tax points, and a cash transfer component. The offer was as follows: the two health and one post-secondary education cost-sharing programs previously in existence would be rolled into a single block transfer; the transfer would comprise one additional tax point (for a total of 13.5 personal income tax points), and its 1975-76 equivalent in cash, adjusted as for the basic cash grant – this came to one-half of the amount the provinces had been demanding.⁷⁶ As for the basic cash transfer, it was set to be equal to 50 per cent of the national average *per capita* federal contribution for the three programs (hospitalisation insurance, health insurance, post-secondary education) in the base year (1975/6), plus a small dollar amount, multiplied by provincial population, and adjusted by an escalator linked to the rate of growth in *per capita* GNP.⁷⁷ This arrangement was incorporated into the *Federal-Provincial Fiscal Arrangements and Established Programs Financing Act* (EPF) and became operational for the period April 1, 1977 to March 31, 1982.

The advent of EPF marked a fundamental change in Canadian federalism in respect to health care funding. First, it permanently ended cost-sharing, which gave the provincial governments more incentive to manage their health and education expenditures more efficiently, and left them with the greater flexibility to determine their own fiscal priorities, as well as removing the irritant of forcing them to keep books which the federal government would audit.⁷⁸ From the federal perspective, Ottawa had been successful at placing relatively concrete limits on the amount of provincial health insurance costs which the federal Treasury

⁷⁵ Taylor, 425.

⁷⁶ Taylor, 425.

⁷⁷ Lazar, St-Hilaire, and Tremblay, 201.

⁷⁸ Lazar, St-Hilaire, and Tremblay, 201.

could be held responsible for, thus achieving their most central objective, but this came at a cost: the ability of the federal government to ensure that the principles that had underpinned public medical and hospital insurance were maintained was significantly undermined.⁷⁹ The complicated changes brought in under EPF were also the major factor adding to the confusion which has persisted to this day regarding how much the federal government actually contributes to provincial health care programs.⁸⁰ This has proven not only to be a major irritant in intergovernmental affairs, but has also been used as ammunition in an ongoing war of calculations between the federal and provincial orders of government which reached its zenith through the 1990s, and still persists today.

While Ottawa was increasingly retracting its financial contribution to healthcare in the face of fiscal pressures, however, it was also becoming increasingly concerned about the erosion of the principles enshrined in the *Hospital Insurance and Medical Care Acts*. After EPF was put in place, there were no enforcement measures or penalty provisions available to the federal government in the event that the provincial governments breached the conditions of the Acts, and the amount of extra-billing by physicians and hospital-imposed user fees sharply increased in the wake of the change to EPF.⁸¹

The rapid increase in extra-billing and user-fees brought discussion of the issue to a fever pitch in the election of 1979. Bolstered by the 1980 Health Services Review report chaired by Emmett Hall, which found that user-fees and extra-billing threatened to create a two-tier system, and by the report of an all-party parliamentary task force in August 1981 recommending that the federal government implement legislation to penalise provinces which

⁷⁹ *Ibid.*

⁸⁰ Lazar, St-Hilaire, and Tremblay, 201.

⁸¹ *Ibid.* For example, the proportion of 'opted-out' physicians extra-billing patients in 1983 was at 13.5 per cent in Ontario, 53 per cent in Nova Scotia, and in Alberta at 47 per cent (Edmonton: 55 per cent and Calgary: 62 per cent), adding an estimated \$100 million dollars to physician's income nationally (the figure for 1983 was \$14.5 million extra-billed in Alberta alone). In British Columbia, meanwhile, the government mandated in its July 1983 Budget a daily hospital use fee of \$8.50.

permitted those practices, Health Minister Monique Bégin ordered her department to produce a White Paper policy proposal for just such a piece of legislation, which was presented to the meeting of federal and provincial health ministers on May 26, 1982.⁸² The provincial governments were furious: ‘electioneering,’ ‘blackmail,’ ‘a poor example of federal-provincial cooperation,’ ‘will seriously damage the health care system’ were among their reactions.⁸³ The head of the Canadian Medical Association (CMA), Dr. Marc Baltzan, stated that ‘It is an obvious backdoor intrusion into an area of provincial jurisdiction...Ottawa cannot directly legislate how health care programs are financed and administered, so Madame Bégin plans to use Ottawa’s fiscal leverage, some would call it, financial blackmail, to force provincial governments to operate provincial health care programs according to the dictates of the federal government.’⁸⁴

Despite the opposition of the provinces, however, Bill C-3 passed Third Reading as the *Canada Health Act* (CHA) on April 17, 1984, with an effective date of April 28, 1984.⁸⁵ From a legal standpoint, the CHA consolidated the *Hospital Insurance and Diagnostic Services Act* of 1957 and the *Medical Care Act* of 1966, and defined more precisely the conditions under which federal transfers to the provinces would (or would not) continue to be made.⁸⁶ The five principles of Medicare in Canada were re-affirmed and enshrined in the Act as enforceable by the federal government, and were as follows: public administration, comprehensiveness, universality, portability, and accessibility.⁸⁷ Furthermore, the federal government was given a reasonably ‘fine-toothed’ enforcement instrument in that it was empowered to withhold the federal cash contribution to a province at an amount equivalent to

⁸² *Ibid.*, 438.

⁸³ *Ibid.*, 440.

⁸⁴ *Ibid.*

⁸⁵ *Ibid.*, 440-1.

⁸⁶ *Ibid.*, 441.

⁸⁷ *Ibid.*

the total of any extra-billing or user-fees permitted by that province, as well as discretionary penalties for violations of the other conditions.⁸⁸

The importance of the CHA to the story of Medicare in Canada cannot be underestimated. Determined federal leadership in the person of Monique Bégin, backed by the recommendations of the Health Services Review of 1980 and the all-party parliamentary task force report of 1981, allowed the CHA legislation to move forward and be placed into the statute books as a solid protection for the Medicare system in the face of strongly opposed provincial governments and the vociferous condemnation of the CMA. True, the CHA was a unilateral imposition by the federal government on the provinces, and the legislation did make Ottawa judge, jury, and executioner when it came to the enforcement of the five core values of Canadian health care, particularly accessibility.⁸⁹ More fundamentally, however, these five criteria, which started out merely as technical legal requirements which had to be met to allow federal health transfers to flow to the provinces, have come to be enshrined in the Canadian political culture and public discourse as being foundational to the conception of the vast majority of Canadians as to what a health care system ought to be: publicly-administered and financed, with portable and comprehensive benefits, universally available to every citizen of Canada, and accessible based upon need, not upon ability to pay.⁹⁰ The *Canada Health Act* has thus become both the embodiment of and the protective bulwark for that constellation of values.

2.6 Crisis, Withdrawal, Fiscal Retreat, and Dysfunction – The ‘Dark Decade’ of the 1990s

Since the implementation of the CHA and strong federal action in the field in the 1980s, however, the situation has become rather less clear-cut. The *Canada Health Act*’s

⁸⁸ *Ibid.*

⁸⁹ Indeed, in the first years of the CHA’s being in force Ottawa did act decisively by withholding money from five provinces, forcing them to end extra-billing and user-fees. See Taylor, 444-462.

⁹⁰ *Ibid.*

Sec. 20 power to impose dollar-for-dollar and/or discretionary financial penalties for violations of the five principles has not been effectively enforced, evidenced by Québec's failure to fully adhere to the portability requirements of the CHA, as just one example.⁹¹ This failure on the part of the federal government to vigorously enforce this centrally important piece of legislation has been compounded by the fact that, through the 1990s, federal transfer payments for health were cut drastically and unilaterally as Ottawa attempted to put its fiscal house in order, which obviously had serious repercussions for the provinces as they struggled to maintain the integrity of their health care delivery systems.⁹² These unilateral cuts not only jeopardised Ottawa's legitimacy as the traditional 'guardian and enforcer' of Medicare, but also created lasting intergovernmental tensions.⁹³ This is largely because of the fact that while Ottawa attempted to maintain its central role as the enforcer of the core values of Medicare on the policy front, it was increasingly withdrawing from the fiscal aspects of participation in the system. In other words, the level of policy input it sought was not commensurate to the increasingly limited financial contribution it was willing to make, leading some scholars to suggest that Ottawa needed to start 'paying to play.'⁹⁴

This was further exacerbated by Ottawa's move in 1995 to combine the health funding transfer into the Canada Health and Social Transfer (CHST), which contained funding for post-secondary education and other social programs as well as health care, all rolled into one. This trend began with the introduction of the EPF regime, when transfers for health were combined with those for education, and half of Ottawa's cash contribution was

⁹¹ Greg Marchildon, 'Guest Lecture on Health Care in Canada,' University of Saskatchewan, November 17, 2011.

⁹² Marchildon, *Health Systems*, 45. Ottawa's share of the expenditures declined from 19 per cent in 1989 – already well below the 50-50 mark – to an extreme low of just 10 per cent in 1997-1999. Recall the 'original deal' was for 50-50 cost-sharing between the two orders of government. That deal was badly broken.

⁹³ *Ibid.*, 110.

⁹⁴ Katherine Fierlbeck, 'Paying to Play? Government Financing and Health Care Agenda Setting,' in *The Romanow Papers, Vol. I: The Fiscal Sustainability of Health Care in Canada*, edited by T. McIntosh, P-G Forest, and Gregory P. Marchildon (Toronto: University of Toronto Press, 2004).

converted to a permanent transfer of tax points. Despite this, Ottawa still counts that 1977 transfer as part of its total contribution to health, while the provinces do not.⁹⁵ The CHST further complicated the funding arrangements, providing ammunition for a continuing battle of calculations between the federal and provincial governments regarding the true federal share of Medicare spending. Marchildon summarised it best when he said that, when the CHST was introduced in 1995/6, it

...changed the assumptions on which the original federal-provincial Medicare bargain had been struck and precipitated a major struggle between the federal government and the provinces...The country was subjected to a series of episodic and unpredictable negotiations producing one-off agreements on escalation [of federal revenue transfers for health] that were little more than temporary ceasefires in the continuing war between Ottawa and the provinces.⁹⁶

2.7 From *Building on Values* and a 'Fix for a Generation' to the Present

In short, although health care has been more or less the salient issue in federal-provincial relations from 1990 to the present, the relations between the two orders of government in regard to this issue have not improved, but instead have been somewhat dysfunctional. Largely ignoring the newly delivered recommendations of the Royal Commission on the Future of Health Care in Canada of 2002, in 2003 Prime Minister Paul Martin agreed to very large increases in federal health transfers (a \$2.1 billion 'top-up,' a \$16 billion investment in a five-year 'Health Reform Fund,' this to be enriched by a further \$2 billion, one-time top-up the following year) and a six per cent year-over-year escalator clause while imposing no conditions which the provinces would have to meet in order to gain access to those federal dollars.⁹⁷ In so doing the federal government missed a potential opportunity to reform and strengthen the terms and enforcement of the *Canada Health Act*, and provided

⁹⁵ Marchildon, *Health Systems*, 44.

⁹⁶ *Ibid.*, 110.

⁹⁷ Gregory P. Marchildon, 'Three Choices for the Future of Medicare,' (The Caledon Institute of Social Policy, 2004), 2.

further precedent for a continuing dynamic of blame-casting and provincial demands of more non-conditional federal dollars for healthcare.⁹⁸

Finance Minister Flaherty's springing of a *fait accompli* health care funding proposal upon unsuspecting provincial ministers and officials over a luncheon in Victoria in 2011 is yet another example of what the provinces perceive as federal unilateralism. The tenure of Prime Minister Harper was largely characterised by a refusal by the federal government to engage with the provincial governments in general, and certainly a refusal to engage in the type of intensive and protracted negotiations which characterised the early development of Medicare. The 2011 Victoria meeting will doubtless be seen by some as emblematic of the Harper government's approach to governance and represented the most intensive attention given to the file during Harper's time in power.

We are presently a little over halfway through the first term of Prime Minister Justin Trudeau, who was elected in October 2015 under a campaign of 'sunny ways' in which he promised sweeping political change (e.g. electoral reform) as well as social and economic reforms to benefit the middle class. The Liberal platform committed the federal government to re-engage with the provinces to reach a new health accord and 'provide the collaborative federal leadership that has been missing during the Harper decade,' invest \$3 billion over four years to improve homecare services, and partner with the provinces to control drug costs by buying in bulk.⁹⁹ The federal and provincial governments met in late 2016 to negotiate a new health accord. The federal offer was 3.5 per cent annual increases to the federal health transfer at a value of about \$20 billion, and \$11.5-billion over 10 years to be spent on mental health, home care, and other areas.¹⁰⁰ The provinces took the position that the federal offer was too low, that the federal government was taking a take-it-or-leave-it rather than a

⁹⁸ Marchildon, 'Guest Lecture.'

⁹⁹ 'A New Health Accord,' *liberal.ca*, <<https://www.liberal.ca/realchange/a-new-health-accord/>>.

¹⁰⁰ 'Ottawa, provinces fail to reach a deal on health spending,' *CBC.ca*, <http://www.cbc.ca/news/politics/health-accord-meeting-1.3903508>.

collaborative approach to negotiations, and that putting conditions such as the targeted priorities on the transfers was, in the words of Quebec's Health Minister, 'patronising.'¹⁰¹ *The Hill Times*, quoting anonymous sources in the federal government, reported that the provinces apparently regarded the federal position as a bargaining tactic and did not take it seriously.¹⁰² On December 19, 2016, the provinces collectively rejected the federal government's offer entirely. The 'script,' if so it can be called, was being acted out to the letter, until three days later when the federal government, abandoning the prospect of a pan-Canadian health accord, inked a bilateral health accord deal with New Brunswick, and with Nova Scotia and Newfoundland and Labrador the next day. On January 16, 2017 all three territories followed, and Saskatchewan the next day signed a bilateral health accord deal complete with a one-year amnesty from federal penalties for the provinces parallel private MRI system. As *The Toronto Star* reported on March 10, 2017, Ontario was the latest signatory to a bilateral health accord with the federal government: 'That means all provinces and territories except for Manitoba have now signed off on new funding arrangements, ending months of inter-governmental squabbling and political grandstanding.'¹⁰³ The final holdout inked an agreement with the federal government on August 21, 2017, at which time federal Health Minister Jane Philpott stated 'we now have a pan-Canadian agreement.'¹⁰⁴ With thirteen separate bilateral agreements each with its own terms and conditions, to call the result a 'pan-Canadian agreement' seems to take a rather liberal view of that term.

As the evidence laid out in the preceding pages would seem to indicate, national public health insurance in Canada has by and large been made possible and maintained, and

¹⁰¹ 'Divide and conquer: How the feds split the provinces in health talks,' *The Hill Times*, <<https://www.hilltimes.com/2017/02/01/feds-prepared-health-talk-failures-last-chance-meeting/94177>>.

¹⁰² *Ibid.*

¹⁰³ 'Ontario welcomes new 10-year health accord with Ottawa,' *thestar.com*, <https://www.thestar.com/news/canada/2017/03/10/ontario-quebec-reach-health-deals-with-ottawa-after-months-of-negotiations.html>.

¹⁰⁴ 'Manitoba final province to sign health-care pact with feds,' *cbc.ca*, <<http://www.cbc.ca/news/canada/manitoba/funding-health-manitoba-1.4255391>>.

is at base, a partnership between two co-equal orders of government. But the past twenty years have seemingly brought a fundamental change in that assumption: health care has become less a partnership and more a battleground. Tension and acrimony have always been a natural part of the political life of the Canadian federation, and the achievement of national hospitalisation insurance and national health insurance did not come without significant unrest and discord. The key difference between the present situation and that prevailing during the implementation of national public health insurance, however, is that in the latter case both orders of government engaged with one another in an ultimately mutually beneficial intergovernmental process which was to the greater good of all Canadians. The past twenty years have seen a reversal of that paradigm.

2.8 Conclusion

This chapter has been an overview of the relevant history in the field of health care and federal-provincial roles and relations. What should have emerged clearly in the preceding paragraphs is a picture of cooperative beginnings which have over time degraded into a situation of deepening dysfunction in the federal-provincial health care stewardship relationship, a dysfunction which is not only hampering needed reform to the health care system as it currently exists, but may actually threaten its demise. Of course, there is no shortage of differing opinions and schools of thought as to which direction the two orders of government ought to proceed in relation to one another on the health care file. The next two chapters will proceed to examine the two major schools of thought which surround this issue of federal-provincial relations regarding health care funding moving into the future.

Chapter 3 – Proposals for Future Directions: The Decentralist School

3.1 Introduction

The preceding chapter examined the developmental trajectory of the Canadian health care system from its early constitutional underpinnings to the present. The next objective moving forward is to examine the different proposals which have been advanced as to what the proper direction for the Canadian health care system ought to be in years to come i.e. what form federal-provincial intergovernmental relations ought to take, and what the implications of those differing conceptions of the proper relationship between the two orders of government will be, with an emphasis on fiscal relations.

For the purposes of the present analysis, there are two broad schools of thought in play when it comes to the question of the future of Canadian health care. One vision, advocated by figures such as former Royal Commissioner on Health Care Roy Romanow and academics such as Gregory P. Marchildon, is a predominantly centralist one. The other, espoused by figures such as the Calgary School of Public Policy's Ronald Kneebone and Kenneth Boessenkool, has an undeniably decentralist bent. This chapter will examine the positions of the 'decentralist school' on the question of intergovernmental fiscal relations and the future direction of the health care system in Canada and explore the potential implications thereof. It will begin by examining the basic theoretical underpinnings of the decentralist school, move to an exposition of the decentralist vision of federalism and the Canadian federation, and end by undertaking an analysis of the actions of the Conservative government of Stephen Harper prior to its defeat in the 2015 general election as a model of 'open federalism' with regard to health care.

3.2 Theoretical Underpinnings – Boessenkool, the Calgary School, and (Fiscal) Federalism

In the December 2010 issue of the University of Calgary's School of Public Policy Research Papers, Kenneth Boessenkool published an article entitled 'Fixing the Fiscal

Imbalance: Turning GST revenues over to the provinces in exchange for lower transfers.’ In this article, he proposed that the federal government completely phase out its transfers under both the Canada Health Transfer (CHT) and the Canada Social Transfer (CST), effectively ending any federal funding in the field of health and social policy.¹⁰⁵ In place of this, Boessenkool proposed the transfer of an entire tax field, namely that currently occupied by the federal Goods and Services Tax (GST), from the federal order of government to the provinces. This, he asserted, would allow the provinces to fund and to better shape their health and social expenses from own-source revenues.¹⁰⁶ To deal with the inevitable inequality in the fiscal capacity of the various provinces to raise the necessary revenue through the GST, Boessenkool proposed a series of ‘equalisation adjustments,’ potential models for which he presented in two separate proposals. Under the first proposal, the GST transfer would be equalised to the national average so that the combination of the GST transfer and additional equalisation would give each province at least \$767 *per capita*.¹⁰⁷ However, this would still leave some provinces getting more, so his second proposal would use the same system (transfer of the entirety of the GST), but with equalisation both ‘up and down.’ Under this second proposal, the ‘have’ provinces would have their transfers adjusted downward to the national average (whereas under proposal one they would keep any additional revenue they raised); while as before, the have-not provinces would be equalised upward to ensure that, between the revenue they had raised through the GST and equalisation paid out by the federal government, they had at least \$767 *per capita* of so-called own-source revenue to spend on health care and social programs.¹⁰⁸

¹⁰⁵ Kenneth J. Boessenkool, ‘Fixing the Fiscal Imbalance: Turning GST revenues over to the provinces in exchange for lower transfers,’ *University of Calgary: The School of Public Policy Research Papers*, Vol. 3, No. 10, 12.

¹⁰⁶ *Ibid.*

¹⁰⁷ *Ibid.*

¹⁰⁸ *Ibid.* Please note this is a condensed summary of Boessenkool’s GST tax-point transfer proposals. For a complete and detailed rendering of his proposal, including comparative financial statements for all orders of

Boessenkool's proposal for a one-time full transfer of a currently federal tax field to the provinces is not the first of its kind in the Canadian political discourse. Decentralist academics have primarily concerned themselves with what might be termed the questions of 'fiscal federalism.' They have tended to eschew larger questions about national unity, meaningful social citizenship, and so on, instead emphasising normative analyses and theories of federalism which focus on the fiscal relations between the federal and provincial/territorial orders of government. For decentralists in the field of health care, this has tended to manifest itself on a consistent basis in a preference for the federal government to remove itself from the field of health care.

Boessenkool's GST tax-transfer proposal is the most dramatic manifestation of this phenomenon because it would represent a total and likely final federal withdrawal from a meaningful policy role in the health care field. While the federal government would maintain some nominal level of equalisation transfer under either of Boessenkool's proposals, this would certainly not be the sort of conditional transfer which is currently in place under the terms of the federal *Canada Health Act*. Rather, it would represent merely a non-conditional equalising of provincial fiscal capacities, with the provinces free to spend that revenue, once equalised up to a given point, exactly as they saw fit. In other words, although Boessenkool suggests that the federal government would continue to transfer to the provinces and could place conditions on them by means of what he calls a 'GST tax collection agreement,'¹⁰⁹ this does seem to have the nature of an attempt to pay lip service to the position of those who have raised concerns about the implications of a total federal withdrawal from the health care

government between the *status quo* and his proposals, see his 'Fixing the Fiscal Imbalance' article cited here, in particular pp. 12-15.

¹⁰⁹ 'The federal government will, even after it transfers GST revenues and reduces transfers, still have a federal transfer to the provinces. Ottawa could make that transfer partly conditional on the provinces not stepping outside of a federally administered, collected, and enforced GST. Indeed, the federal government has a much stronger constitutional argument for making these kinds of conditions, which are related to trade and commerce, than they do for making conditions under the *Canada Health Act*. Ottawa could threaten to withhold transfers for any province who violates the GST tax collection agreement.' Boessenkool, 9.

field. Almost certainly any sort of ‘GST collection agreement’ of the sort envisioned by Boessenkool would not include the level of conditionality encapsulated in the CHA. In short, despite the lip service he pays to the idea of a continuing federal transfer, Boessenkool clearly envisions a federation where the federal government no longer has a significant role to play in health care, a marked departure from the past trajectory of the system.

Boessenkool and other decentralist thinkers justify the withdrawal of the federal government from health care based on a number of rationales – some are primarily economic, while others also incorporate political considerations and theories of federalism to a certain degree. The clearest statement of the decentralist rationale in terms of economics can be gleaned from a reading of Ronald Kneebone’s June 2012 article in the University of Calgary School of Public Policy Research Papers series, entitled ‘How You Pay Determines What You Get: Alternative Financing Options as a Determinant of Publicly Funded Health Care in Canada.’ In this article, Kneebone suggests that because Canadian citizens do not pay for their medical care out of pocket, and furthermore have difficulty understanding precisely how much they pay in taxes toward specific programs (e.g. Medicare), there is a systematic tendency for them to underestimate the true cost of health care in Canada.¹¹⁰ Therefore, Kneebone argues, they will not play the ‘traditional role of consumers’ by ‘guarding against waste and inefficiency’ and by that means contributing to ‘a more efficient and effective publicly-funded health care system.’ He terms this phenomenon of citizen misunderstanding/confusion the fiscal illusion.¹¹¹

According to Kneebone, a fiscal illusion arises when there is a gap between the expenditures of a government and the amount of taxes paid by its ‘voter-taxpayers.’ This gap must then be subsequently filled by sources of revenue other than that of direct taxation of

¹¹⁰ Ronald Kneebone, ‘How You Pay Determines What You Get: Alternative Financing Options as a Determinant of Publicly Funded Health Care in Canada,’ *University of Calgary School of Public Policy Research Papers*, Vol. 5, No. 21 (Jun. 2012), 1.

¹¹¹ Kneebone, 1.

those voters, thus contributing to their perception that they are receiving a service (in this case, medical care) at little to no, or at least lower, cost to themselves.¹¹² Intergovernmental transfers are the most serious contributors to the fiscal illusion in Kneebone's view. He argues that federal transfer payments to provincial governments clearly reduce the price that provincial taxpayers perceive that they pay for health, for the obvious reasons that part of the tax revenues funding these transfers are collected from taxpayers across Canada – provincial government spending therefore appears to be cheaper to provincial taxpayers since 'others' are covering some fraction of the cost.¹¹³ Kneebone's ultimate conclusion is that what is really needed, in light of his findings, is for provincial governments to face tighter budget constraints. Once this is the case and provincial voters are able to clearly perceive the true costs of health care without the effect of the fiscal illusion caused by federal transfers, then these voters will act as a brake on provincial spending and force increased efficiency and effectiveness into the system.

The other half of the picture is provided by Ken Boessenkool in his 'Fixing the Fiscal Imbalance' article. Boessenkool continues certain threads from Kneebone's article, while expanding Kneebone's primarily economic arguments to encompass other facets which he feels strongly point towards the best solution for Canadian health care being an enhanced provincial role and a greatly diminished or perhaps even completely absent federal role.

The arguments underlying Boessenkool's proposal for a final transfer of an entire tax field to the provinces can be summarised in his own phrase – better alignment of provincial spending responsibilities and provincial revenues.¹¹⁴ He begins his rationale for decentralisation by putting forward the perennial issue of the 'fiscal imbalance' in Canada. This refers to the idea that at current tax rates, the federal government has substantially more

¹¹² *Ibid.*, 11.

¹¹³ *Ibid.*, 12.

¹¹⁴ Boessenkool, 1

revenue than it needs to meet its expenditure responsibilities; meanwhile, the provinces, as a group, have less, and in some cases, substantially less, than they need to meet their expenditure responsibilities.¹¹⁵ Canada, Boessenkool says, ‘has closed the resulting gap by converting large amounts of federal revenues to provincial revenues through intergovernmental transfers.’¹¹⁶ Regarding the magnitude of the ‘fiscal imbalance,’ Boessenkool cites the findings of the 2002 report of Québec’s Séguin Commission on the Fiscal Imbalance, which stated that ‘For Canada as a whole, the need for resources that the Commission has quantified implies that the provinces should receive an adjustment to their financial resources of at least \$8 billion in the short term.’¹¹⁷ He continues, ‘Given that federal transfers for social programs (not including the federal equalization program) increased from just over \$19 billion in 2002-2004 to nearly \$35 billion in 2009-2010, this condition has clearly been satisfied.’¹¹⁸

For Boessenkool, equalising federal transfers to provide joint federal-provincial programs is, as he terms it, not a ‘cure’ but instead a ‘treatment of symptoms.’¹¹⁹ He believes that these federal transfers are a negative aspect of the Canadian federal system, stating that ‘*Growing federal transfers set the stage for perpetual fiscal imbalances and continuing political instability* [emphasis added].’¹²⁰ Reinforcing his negative view of this practice, Boessenkool labels this facet of federal-provincial intergovernmental relations in Canada as transfer games:

Under our current system, the fiscal gap between Ottawa is large and persistent. Currently the federal government raises some \$50 billion in taxes each year that it simply transfers to the provinces. The result is what can only be described as Canada’s ‘co-dependent’ constitutional relations...Ottawa raises the money and the provinces spend it. The result of this fiscal churning is that no government has clear responsibility for delivering key programs and both sides readily blame the other when something goes wrong.¹²¹

¹¹⁵ *Ibid.*, 2.

¹¹⁶ *Ibid.*

¹¹⁷ *Ibid.*

¹¹⁸ *Ibid.*

¹¹⁹ Boessenkool, 2.

¹²⁰ *Ibid.*

¹²¹ *Ibid.*, 3.

This forms the nucleus of Boessenkool's opposition to a continued federal role in the field of health care. He rejects the traditional view of a federal government which does good by actively involving itself in the funding and regulation of Medicare in favour of a view that federal transfers to fund health and social programs are instead themselves encouraging a 'dysfunction' in the federation, with negative consequences for its effective functioning as well as for the health care system being the result. He labels the exercise in intergovernmental relations implicit in the CHT and CST transfer games because he sees the federal government and the provinces continually engaging in a negative and unproductive back-and-forth blame-shifting exercise; and it is clear that he believes that the impetus to that behaviour is inherent in the way that federalism itself is structured and has developed in Canada (i.e. a system of transfers between the two orders of government funding joint federal-provincial programs).

Central to the concerns of Boessenkool and the decentralists is the fact that both the federal and provincial governments have a role in health care, which in their view translates to neither being held properly to account by the electorate for health outcomes, since the electorate is unsure where to place blame for unsatisfactory health outcomes. The consequence of this, decentralists believe, is that provinces have no impetus to control their health care spending and to find efficiencies. Instead of being forced to raise taxes to meet these expanding expenditures and facing the ire of their own voters for that decision, the provinces instead are content to argue for and spend the dollars raised nationally via taxation which are then transferred to them. 'When the premiers call for more federal transfers, they pretend this could be done without increasing the federal tax and debt burden on their own citizens. Naturally, the premiers would like to spend more without raising taxes themselves. It is only the current system of murky shared responsibility that makes this seem like more

than a pipe dream [i.e. the fiscal illusion].¹²² Provinces, Boessenkool argues, are loathe to bring order to their own fiscal houses because that weakens their case for increasing or continuing federal transfers. So long as the option to argue for increased transfers exists, provinces have no incentive to embark down the difficult and potentially politically dangerous road to reform.¹²³ For its part, the federal government has little incentive to encourage reform so long as voters seemingly reward it for doing nothing more than, in Boessenkool's phrase, writing larger and larger cheques.¹²⁴ It gets worse, however, because of what he terms the 'common property resource' problem:

Of course, federal bailouts of provincial spending inevitably come at the expense of federal taxpayers – who are provincial taxpayers and voters as well. Shouldn't this eliminate incentives for the provinces to attempt to finance provincial spending with federal revenues? Not in the current environment, given the extent to which federal transfers are disproportionately borne by more wealthy taxpayers who reside in greater numbers in a few provinces...and the evidence that each province may obtain its own deal from Ottawa through bilateral negotiation. In these circumstances, federal tax revenues are in effect a common pool of resources that is available to whoever is the first to exploit them. Like all poorly managed common property resources, the result is an inevitable tendency to exploitation. We end up with a race among provincial governments to exploit taxpayers who reside in other provinces through federal transfer negotiations.¹²⁵

Lastly, Boessenkool states that 'the critical point is that, in the absence of clean lines of accountability in tax and spending decisions, the current policy stance of both federal and provincial governments is self-reinforcing: Canada is stuck in a sort of low-level intergovernmental fiscal equilibrium.'¹²⁶ This is the case despite the fact that the federal government has clearly been unable/unwilling to commit to a clear, consistent, and stable system of transfers for health care funding. Federal transfer funding levels have varied wildly from the nadir of the 1990s, when the federal government severely constrained spending due to the prevailing fiscal climate, to the rapid expansion of unconditional federal transfers following Martin's 2004 'Fix for a Generation.' It is clear that reform is needed –

¹²² Boessenkool, 4.

¹²³ *Ibid.*, 4.

¹²⁴ *Ibid.*

¹²⁵ *Ibid.*, 3.

¹²⁶ *Ibid.*, 4.

the question becomes, as Boessenkool acknowledges, how can reform be achieved without wrecking Canada's sometimes precarious regional and political equilibrium?¹²⁷

Boessenkool argues that his GST tax-transfer proposal provides such a solution. It would at a stroke end the 'blame game' of shifting responsibility between the federal and provincial governments in the field of health care, and the seemingly endless battles implied in the continuing need for renegotiation of the federal transfer arrangements.¹²⁸ This in turn would mean an end to the fiscal illusion for provincial voters; no longer would provincial premiers be able to issue never-ending calls for more federal dollars, pretending, as Boessenkool puts it, that this could be done without increasing the tax burden on those same voter-taxpayers, who of course are simultaneously federal voters and taxpayers.

The provinces would obtain access to a large, comparatively stable tax field where the growth trajectory in terms of the amount of funds collected has been steadily upward over time, suffering none of the uncertainties that are associated either with the CHT or with the income tax route, since consumption is less variable than income (whether personal or corporate), and since the provincial fiscal capacity for the GST varies less than that for personal income taxes.¹²⁹ The result would be the provision of more stability over time to provincial budgets.¹³⁰ He also makes a more ideological argument, stating that 'given that the provinces have exclusive responsibilities; they should be matched with tax bases that are exclusively in their jurisdiction.'¹³¹ From a provincial perspective, however, the rationale for the GST tax-point transfer does not end at a view of constitutional provincial primacy (or

¹²⁷ Boessenkool, 4.

¹²⁸ *Ibid.*

¹²⁹ *Ibid.* The fiscal capacity for the GST varied from 81% of the national average for Newfoundland to 132% for Alberta in 2007. For 2007-2008, the Dept. of Finance estimates that the personal income tax (PIT) fiscal capacities of the provinces ranged from 57% for Prince Edward Island to 142% for Alberta. The lower variability of the GST figure would mean that Ottawa would have to pay less to equalise any transfer of GST points than PIT points.

¹³⁰ Boessenkool, 10.

¹³¹ *Ibid.*, 11.

even exclusive jurisdiction) in health care. The provinces also face the prospect that federal transfers (including those for health) have more than likely reached the top of their cycle for the foreseeable future.¹³² With the economic outlook gloomy, the provinces should, in Boessenkool's view, recognise that transfers such as the CHT are likely to move in only one direction – down – and take the opportunity to 'lock in' their gains with a permanent tax-point transfer.¹³³ From the point of view of the federal government, the supporting rationale for an end to its role in health care through a tax point transfer is obvious: immediately it limits any future growth in transfers which it can be held to. More indirectly, it would mean that federal dollars transferred for health would no longer seem in the eyes of the taxpayer to vanish into thin air due to the unclear lines of accountability in the present health care funding regime.¹³⁴

To summarise, Boessenkool believes his GST tax-point transfer is the right solution for Canada and the Canadian federation. In one fell swoop, it would end the fiscal illusion on the part of voters, allowing them to see the true price of health care in Canada, which is currently obscured by the byzantine joint-funding federal-provincial transfer system under the CHT. The provinces would gain a stable revenue source, free of any fear of sudden withdrawal of federal largesse. At the same time, they will be forced to work within hard budget constraints imposed by their need to ask their voters for money to spend on health care directly. Reform would be the likely result as provinces finally have an incentive to face the problems that, under the current system, they are content to let rest unaddressed.¹³⁵ This, in turn, would likely spur innovation as the provinces try to find a way to maximise efficiency and positive outcomes in their individual health care systems; under the GST tax-transfer, with Ottawa effectively out of the picture, they would be free of the limitations of

¹³² *Ibid.*, 16.

¹³³ *Ibid.*

¹³⁴ *Ibid.*, 4.

¹³⁵ Boessenkool, 17-18.

the *Canada Health Act*, which the decentralists see as potentially stifling needed innovation.¹³⁶ For its part, with the onerous burden of funding transfers for health and social programs largely removed, the federal government would be disencumbered of the need for protracted and painful intergovernmental negotiations and free to concentrate on what decentralists such as Boessenkool see as properly national concerns: defence, international trade, etc. The result, in the decentralist view, is a more efficient, effective, rationally structured federal system, one with strong incentives to address the identified shortcomings in Canada's health care system.

3.3 Application & Implications - Open Federalism & 'The Harper Doctrine'

That Boessenkool's ideas on health care funding and reform were percolating in the Conservative Party of Canada (CPC) caucus is evidenced by the fact that, shortly before his 'Fixing the Fiscal Imbalance' article was published in autumn 2010, Maxime Bernier, then federal Minister of State for Small Business & Tourism, spoke frankly during a luncheon speech at Toronto's Albany Club of the possibility of the then-Conservative government replacing the Canada Health Transfer with a one-time tax transfer, and leaving health care as an exclusive provincial responsibility.¹³⁷

There is clear evidence that when the Conservative Party came to power in January 2006 with Stephen Harper as Prime Minister, it did so with a party upper echelon which had some very definite ideas about Canadian federalism and the proper structure and operation of the Canadian federation. Harper labelled his new vision for the Canadian federation 'open federalism.' Understanding, as far as possible, what 'open federalism' is, and more importantly what it means, is vital in order to analyse the impact of decentralist ideas on the

¹³⁶ *Ibid.*

¹³⁷ See 'Tory MP suggests scrapping Canada Health Transfer,' *Global Edmonton*, Oct. 13, 2010, <<http://www.globaltvedmonton.com/tory+mp+suggests+scrapping+canada+health+transfer/85813/story.html>>.

trajectory of the last government's policies towards federalism and health care more specifically.

The first indication of Harper's vision for Canadian federalism came in a letter to former Alberta Premier Ralph Klein, which appeared in the Jan. 24, 2001 edition of the *National Post* as 'An open letter to Ralph Klein.' The letter was signed by Mr. Harper as President of the National Citizens' Coalition, and five other 'academic and political right-wingers':¹³⁸ Tom Flanagan, Ted Morton, Rainer Knopff, Andrew Crooks, and Ken Boessenkool.¹³⁹ In this letter, Harper and his compatriots excoriated the federal Liberal government for their 'attack on Alberta's health care system,'¹⁴⁰ stating that it was time for Alberta to 'resume control of the powers that we possess under the constitution of Canada but that we have allowed the federal government to exercise.'¹⁴¹ Intelligent use of these powers, they continued, would help Alberta build a prosperous future in spite of the attempted intrusions into provincial jurisdiction by a 'misguided and increasingly hostile federal government.'¹⁴² The comments of the letter on the health care file, in particular, are worth quoting at length here:

...Resume provincial responsibility for health-care policy. If Ottawa objects to provincial policy, fight in the courts. If we lose, we can afford the financial penalties that Ottawa may try to impose under the Canada Health Act. Albertans deserve better than the long waiting periods and technological backwardness that are rapidly coming to characterize Canadian medicine. Alberta should also argue that each province should raise its own revenue for health care – i.e., replace Canada Health and Social Transfer cash with tax points as Quebec has argued for many years. Poorer provinces would continue to rely on Equalization to ensure they have adequate revenues.¹⁴³

¹³⁸ Errol P. Mendes, 'Building Firewalls and Deconstructing Canada by Hobbling the Federal Spending Power: The Rise of the Harper Doctrine,' in *Canada: The State of the Federation 2008: Open Federalism and the Spending Power*, John R. Allan, Thomas J. Courchene, Marc-Antoine Adam, and Hoi Kong, eds. (Montréal & Kingston: McGill-Queen's University Press, 2008), 301.

¹³⁹ "The famous Alberta 'firewall' letter," as published in the *National Post* on Jan. 24, 2001, headlined 'An open letter to Ralph Klein,' found at <<http://www.cbc.ca/canadavotes2004/leadersparties/leaders/pdf/firewall.pdf>> (Accessed Feb. 27, 2013).

¹⁴⁰ *Ibid.*

¹⁴¹ *Ibid.*

¹⁴² *Ibid.*

¹⁴³ *Ibid.*

Also relevant were their comments on equalisation, best captured via direct quotation, and the letter's closing paragraph:

In addition, we believe it is imperative for you to take all possible political and legal measures to reduce the financial drain on Alberta caused by Canada's tax-and-transfer system. The most recent Alberta Treasury estimates are that Albertans transfer \$2,600 per capita annually to other Canadians, for a total outflow from our province approaching \$8 billion a year. The same federal politicians who accuse us of not sharing their "Canadian values" have no compunction about appropriating our Canadian dollars to buy votes elsewhere in the country... The precondition for the success of this Alberta Agenda is the exercise of all our legitimate provincial jurisdictions under the constitution of Canada.¹⁴⁴

Clear from the above is that Harper and his associates had some definite visions about federalism which were radically different from those which were prevailing at the time. In particular, one notes that they clearly view health care as a matter of exclusive provincial jurisdiction. Also noteworthy is their harsh condemnation of the principles of equalisation and their suggestion that the relevant 'sharing community,' for Alberta anyway, is not pan-Canadian, but intra-Albertan. And one cannot help but note the language used to describe the role of the federal government – 'misguided' and 'increasingly hostile' are the terms used to describe a federal government which sees itself as having a role in health and social policy. In the 1937 *Labour Relations* case,¹⁴⁵ which pre-dated the rise of the Canadian welfare state, the Judicial Committee of the Privy Council's (JCPC) Lord Atkin put forth the famous 'watertight compartments' interpretation of Canadian federalism when he said: 'While the ship of state now sails on larger ventures... she still retains the watertight compartments which are essential to her original structure.'¹⁴⁶ As Errol P. Mendes notes, this early restrictive interpretation, which did not anticipate the vast expansion of both federal and provincial responsibilities occasioned by the rise of the welfare state, and militated against *any* intrusion by one level of government into the jurisdiction of another, seems to have found

¹⁴⁴ *Ibid.*

¹⁴⁵ *Reference Re Weekly Rest in Industrial Undertakings Act, Minimum Wages Act and Limitation of Hours of Work Act*, [1937] 1 D.L.R. 673 at 684 (P.C.) (*sub nom. Canada (A.G.) v. Ontario (A.G.)*), [1937] A.C. 326 [*Labour Conventions*].

¹⁴⁶ Quoted in Mendes, *Building Firewalls*, 301.

its resurrection in the 2001 letter. ‘Harper’s rhetoric is the modern-day equivalent of Lord Atkin’s naval metaphor,’ Mendes asserts – the language may have changed from ‘waterproof compartment’ to ‘firewall’ – but the effective meaning would seem to be the same.¹⁴⁷

The next piece of the puzzle to understanding what ‘open federalism’ is and its implications for the Canadian federation (and for health care) fell into place in a Dec. 2005 speech by Harper in Québec City. In it, he condemned previous Liberal governments for their use of the federal spending power, stating that ‘this outrageous spending power gave rise to a domineering and paternalistic federalism.’¹⁴⁸ In addition, Harper, if he became Prime Minister, promised to:

- Develop mechanisms to give the provinces a greater role in their own jurisdictions in the international arena;
- Recognise and respect provincial autonomy;
- Respect federal and provincial jurisdictions, and
- To curb the use of the ‘outrageous’ federal spending power.¹⁴⁹

This speech clearly reflected its venue, with Harper making generous references to the unique social and cultural responsibilities of the Québec government, and promising to act in ways that reflected Québec’s severe antipathy to the use of the federal spending power and federal intrusion into what Québec viewed as areas of exclusive provincial jurisdiction. By implication, Harper clearly embraced asymmetry – the idea that some provinces might rightly have responsibilities and exercise powers which others might not – as part of his vision of federalism.¹⁵⁰

On January 13, 2006, Harper wrote a letter to the Council of the Federation, saying

¹⁴⁷ *Ibid.*

¹⁴⁸ Peter Leslie, ‘The Two Faces of Open Federalism,’ in *Open Federalism: Interpretations, Significance*, Keith G. Banting, Roger Gibbins, Peter M Leslie *et al.*, eds. (Kingston: Queen’s University Press, 2006), 40-1.

¹⁴⁹ *Ibid.*, 41.

¹⁵⁰ Marchildon, Interview Transcript

‘It is my hope as Prime Minister to initiate a new style of open federalism,’ which would, he said, have the following three features:

- Working more closely and collaboratively with the provinces and the Council of the Federation to develop Canada’s economic and social union;
- Clarification of appropriate federal and provincial policy responsibilities;
- Acknowledgement of the existence of a Vertical Fiscal Imbalance (VFI) in Canada, and a commitment to resolving the fiscal imbalance between the federal and provincial-territorial orders of government.¹⁵¹

In the same vein, in its 2006 election platform, *Stand Up for Canada*, the Conservatives promised that a ‘Conservative government will support the creation of practical intergovernmental mechanisms to facilitate provincial involvement in areas of federal jurisdiction where provincial jurisdiction is affected, and enshrine these practices in a ‘Charter of Open Federalism.’¹⁵² However, during the election campaign the Conservatives placed by far the greatest emphasis on enhancing the policy role of the provinces – little if any attention was paid to seeking the collaboration of the provincial governments in a joint endeavour with Ottawa to achieve national goals in areas where federal powers were not, in themselves, adequate to the task.¹⁵³

Although there was no unilateral federal withdrawal from the health care field of the sort envisioned by Boessenkool during the term of the last Conservative government, there is nevertheless evidence that Harper chose a subtler way to implement his particular vision of Canadian federalism. Already in 2008, Errol P. Mendes first suggested this in his chapter in the *State of the Federation 2008* volume:

Prime Minister Harper claims that he is determined to end what he terms the “domineering and paternalistic federalism”...of the previous government and promote...severe restrictions on federal spending on areas of provincial jurisdiction. While the Harper government has not publicly

¹⁵¹ Leslie, 40.

¹⁵² *Ibid.*

¹⁵³ *Ibid.*

articulated how it intends to proceed with this agenda, it may be by slowly suffocating the spending power by making sure that there is very little money to spend.¹⁵⁴

This assertion is supported by the statements of Tom Flanagan, who was quoted in the media as stating that ‘tightening the screws’ on the federal government would leave more money in the taxpayer’s pocket and make it harder for the government to spend.¹⁵⁵ This agenda, points out Mendes, while left unspoken by Mr. Harper himself, was furthered by a series of budgets in which the federal government significantly increased spending in areas of exclusive federal jurisdiction, such as defence, while simultaneously slashing the federal government’s capacity to raise revenue.¹⁵⁶

Within its first two years in government, the Conservative Party cut the federal GST by two percentage points – a move that, by itself, denied the federal coffers some \$11 billion annually – close to \$60 billion over a five-year period.¹⁵⁷ Corporate and income tax cuts, new tax credits, and the new tax-sheltered savings account brought in by the Conservative government further emptied the federal purse.¹⁵⁸ Flanagan expressed his considerable satisfaction with these developments in a 2008 article, stating that through this dismantling of the federal revenue capacity, the Harper government has ‘gradually re-engineered the system.’¹⁵⁹ He continued:

I’m quite impressed with it...they’re boxing in the ability of the federal government to come up with new program ideas...The federal government is now more constrained, the provinces have more revenue, and conservatives should be happy.¹⁶⁰

¹⁵⁴ Mendes, 302.

¹⁵⁵ Mendes, 302.

¹⁵⁶ *Ibid.*

¹⁵⁷ *Ibid.*

¹⁵⁸ *Ibid.*

¹⁵⁹ *Ibid.*

¹⁶⁰ *Ibid.* For the full text of the article, see <http://www.thestar.com/news/canada/2008/03/02/harper_gradually_tightening_screws_on_government_advisor_says.html>. From the article: “A mentor and advisor to Stephen Harper applauds the prime minister for working toward a long-standing conservative dream – a less-present federal government – and for doing it without any backlash...It’s really quite a performance, I think...Over a period of a few years they’ve got all this in place and they never appeared – at any one point – they never appeared to be making a radical shift. But the cumulative impact of all these together is creating a new profile.’ Not only are the Conservatives boxing in the federal spending power in general, said Flanagan, ‘they’re also boxing in the Liberals from being able to campaign on expensive promises.’

A final piece of the puzzle can be found in a letter published by Mr. Harper entitled ‘My Plan for Open Federalism,’ published in the Oct. 27, 2004 edition of the *National Post*. In this letter, Harper unequivocally stated that ‘Conservatives seek to re-establish a strong central government that focuses on *genuine national priorities* like *national defence* and *the economic union, while fully respecting the exclusive jurisdiction of the provinces* [emphases added].’¹⁶¹ Tellingly, no mention is made of health and social programs, traditionally the largest single areas of federal spending. This direct quote from Mr. Harper’s letter perhaps more than any other allows one to capture and summarise the essence of open federalism: it is in a sense, it appears, a compartmentalised federalism, in which the provinces stick to provincial responsibilities (which clearly includes health and social programs), and the federal government tends to national priorities such as defence and the economy.

Against the backdrop of this steady contraction of federal revenue sources, there was also a refusal by Harper to personally engage with provincial leaders throughout his tenure, coupled with the events of December 2011 referenced in the opening of this thesis. Early on, academics formed the impression that Harper’s ‘open federalism’ rhetoric about ‘collaboration and cooperation with the provinces’ might imply a new, more engaged relationship between the two orders of government. The events in Victoria sharply belied that interpretation, with then-Finance Minister Flaherty unilaterally springing upon the unsuspecting provinces a new funding structure for Canadian health care. There was no collaboration and certainly not any consultation. The effects of the new arrangements were to be as follows:

- The six per cent per annum escalator clause for the CHT put in place by the 2004 Health Accord (PM Martin’s so-called ‘Fix for a Generation’)

¹⁶¹ Stephen Harper, ‘My plan for open federalism,’ *The National Post*, October 27, 2004.

would be continued until 2016-17, at which time the terms of that Accord would end.

- Going forward from 2016-17, rather than a fixed six per cent escalator clause, the CHT would instead grow in line with a three-year moving average of nominal GDP growth, with a minimum ‘floor’ of three per cent growth per annum guaranteed.
- The transfers would be unconditional.
- The CST would continue to grow at three per cent annually.¹⁶²

The Parliamentary Budget Office analysed the effects of these changes in its 2012 *Fiscal Sustainability Report*. According to the PBO’s predictions, nominal GDP would likely average 3.7 per cent annually from 2017-2024, which corresponded to 3.9 per cent growth based on a three-year moving average over the period 2017-18 to 2024-25. To put this into meaningful terms, this meant that in the PBO’s *Fiscal Sustainability Report* 2011, when the 6-per cent per annum escalator was assumed to be in effect, federal CHT cash was projected to average 21.6 per cent of provincial-territorial health spending over 2011-12 to 2035-36.¹⁶³ In contrast, under the new formula, that figure dropped to an average of 18.6 per cent from 2011-12 to 2035-36 – a decline of three per cent.¹⁶⁴ In any case, the 3.9 per cent annual escalator was well below the PBO’s projections for the growth in provincial-territorial health expenditures, which were predicted to increase 5.1 per cent year over year.¹⁶⁵ As the report states, therefore, ‘the projected increase in consolidated program spending relative to the size of the economy – resulting from population ageing and assumed program enrichment – now

¹⁶² ‘Renewing the Canada Health Transfer: Implications for Federal and Provincial-Territorial Fiscal Sustainability,’ Ottawa: Office of the Parliamentary Budget Officer, Jan. 19, 2012 (Accessed Feb. 27, 2012), found at <http://www.parl.gc.ca/PBO-DPB/documents/Renewing_CHT.pdf>, p. 1.

¹⁶³ *Ibid.*

¹⁶⁴ *Ibid.*

¹⁶⁵ *Ibid.*

falls squarely on provincial and territorial governments'¹⁶⁶ – already by far the more ‘fiscally challenged’ order of government.¹⁶⁷ In other words the Harper government’s transfer arrangements regime, implemented unilaterally without any input by the provinces, significantly decreased the federal government’s commitments to funding health care, and offloaded this burden primarily onto the provinces.

Bringing together all of the foregoing, it would appear that the Harper government, in addition to its stated positions on the issue, did in fact have a differing vision of federalism than previous governments. It now appears that ‘open federalism’ should be primarily understood as a classical variant of federalism in which the federal government focusses on clearly federal responsibilities such as defence and the economic union, and distinctly steps away from involvement in the health and social arena. This accords both with statements by Mr. Harper and others in the Conservative camp, and with the evidence of what happened in Victoria regarding the implementation of a new health care funding regime, one which significantly reduced the fiscal burden on the federal government even as it would have the effect of ‘putting the screws to’ the fiscally challenged provinces, presumably forcing them to innovate and find efficiencies in their delivery of health services. As Mr. Flanagan has essentially said, public opinion may have prevented the kind of abrupt federal withdrawal envisioned by Boessenkool in his tax-points transfer proposal – but it seems that the Harper government may well have been aiming at similar decentralising objectives in the field of health and social policy, just by more gradual and less dramatic means.

3.4 Conclusion

This chapter examined some of the tenets of the decentralist school of thought and its proposals for the direction for health care in Canada moving forward. Essentially, the

¹⁶⁶ *Ibid.*

¹⁶⁷ Parliamentary Budget Office 2012, p. 1.

decentralist school asserts that the manner in which health care is structured and paid for in Canada encourages a fiscal illusion wherein provincial taxpayers systematically underestimate the true cost of health care in Canada. In other words, the system of federal transfers for health creates a situation where provinces spend more profligately than they would if they had to fund their health expenditures from own-source revenue, and where they have little to no incentive to undertake needed reform to the system. For this reason, the current regime is not a desirable way to structure the federation. In place of this structure, the decentralists propose that the best course of action is for the federal government to get out of the business of health care entirely, and transfer a robust tax field, such as the GST, to the provinces. This would allow the provinces to set their own fiscal priorities, protect them from the vagaries of federal transfer arrangements, reduce intergovernmental friction, clarify policy roles and areas of authority, foster innovation and reform by forcing provincial governments to face tighter budget constraints, and allow the Canadian electorate to more clearly hold their governments to account for health outcomes.

Secondly, this chapter provided an analysis of the record of the last Conservative government of Stephen Harper in light of the tenets of the decentralist school. It does strongly appear based upon available evidence that the Harper government inclined and took steps toward implementing a classical view of Canadian federalism, one in which health and social policy are areas of provincial authority and responsibility with which the federal government wishes to minimise its involvement, freeing it to concentrate on what are seen in this conception to be truly properly national and federal concerns: trade, international relations, the economy, and defence, to name the salient policy sectors.

This conclusion is based not only on explicit statements by Harper, former ministers of the Conservative caucus, and conservatives such as Tom Flanagan; but also on the decision of the Harper government to slash its revenue sources while strongly expanding

spending in areas of federal authority, while in effect, without consultation halving its contribution to Canada's largest social program – health care – and, in the words of the PBO's report, off-loading that burden on to the provinces, which are already fiscally overburdened. It is assumed that this was intended to have the dual function of allowing the federal government to operate more freely within its sphere of strict constitutional competence, while also simultaneously satisfying the decentralist objective of both clarifying policy roles and responsibilities and 'tightening the screws' on the other order of government, weaning the provinces off federal transfers and forcing them into innovation and reform of their individual health care systems. It is therefore the tentative conclusion of this chapter that the ideological position of the recent Conservative government was indeed a decentralist classical federalist one, and that while public opinion considerations may have prevented the sort of dramatic decentralist solution that Boessenkool proposed from being implemented, it is a distinct possibility that Harper simply took a more subtle, indirect route over a long time frame to accomplish what would amount to the achievement of many of the same goals which Boessenkool and the decentralist school identified as central to the reforms which in their view are needed in the Canadian health care system.

Chapter 4 – Proposals for Future Directions: The Centralist School

4.1 Introduction

This chapter will examine the second broad normative vision for renovating the Canadian health care house for the 21st century: the centralist vision. It commences with an examination of the basic theoretical underpinnings of the centralist school, then proceeds to examine the vision which centralists hold for Canadian federalism and the Canadian federation in terms of intergovernmental relations, and for the structure of Medicare specifically within the context of the federation. It concludes with some observations about the implications of this vision, and the importance which centralists feel it holds not only for the future of the Canadian health care system, but for the Canadian federation and the broader notion of a common Canadian identity and citizenship.

4.2 Theoretical Underpinnings – Health Care, System Renewal, and a National Vision

To comprehend the centralist position with respect to health care, a starting point can be found in the most comprehensive expression of its key tenets to date: the recommendations contained in the Final Report of the 2002 Royal Commission on the Future of Health Care in Canada, entitled *Building on Values*. Out of the Commission's research programme emerged forty-seven recommendations across eleven broad thematic areas. Of these, four are of particular significance to the present analysis:

1. Vision and Direction

- a. Establish a new Canadian Health Covenant as a tangible statement of Canadians' values and a guiding force for the Canadian publicly-funded health care system. This should clearly outline the collective vision for the future of health care in Canada, and the responsibilities and entitlements of individual

Canadians, health providers, and orders of government in regard to the system.¹⁶⁸

- b. Create a Health Council of Canada to facilitate cooperation and provide national leadership in health among the provinces, territories, and the federal government, by setting common indicators and benchmarks and measuring and tracking the performance of the health system.¹⁶⁹

2. The Canada Health Act

- a. Renew, strengthen, and clarify the five existing principles of the CHA by:
 - i. Confirming the principles of public administration, universality, and accessibility.¹⁷⁰
 - ii. Enhancing and strengthening the principles of portability and comprehensiveness.¹⁷¹
- b. Establish a new principle of accountability, which will confirm the importance of accountability to the Canadian citizenry for health outcomes and the operation of the system; and confirm that all orders of government have a collective responsibility to: clarify the roles and responsibilities of each of them, establish harmonious intergovernmental processes, and put in place adequate, stable, and predictable funding mechanisms.¹⁷²
- c. The ‘basket’ of insured CHA services (which currently covers ‘medically necessary hospital and physician services’) should be reviewed and expanded to reflect the realities of 21st century medicine as this becomes fiscally feasible, but as a start:

¹⁶⁸ Commission on the Future of Health Care in Canada, *Building on Values: The Future of Health Care in Canada – Final Report*, Saskatoon: Commission on the Future of Health Care in Canada (2002), xxiv.

¹⁶⁹ *Ibid.*

¹⁷⁰ Commission on the Future of Health Care in Canada, *Final Report*, 59-61.

¹⁷¹ *Ibid.*, 61-3.

¹⁷² *Ibid.*, 63.

- i. Revise the CHA to include coverage for medically necessary home care services in the areas of home mental case management and intervention services, post-acute home care, and palliative home care.¹⁷³

3. Health Care Funding

- a. The federal government must provide stable, predictable, and long-term funding via a new dedicated transfer for Medicare, established as part of a revamped Canada Health Act, with the federal government contributing a large enough share to have a reasonable claim to a stake in the system.¹⁷⁴ To enhance predictability and stability, this transfer is to have an escalator provision, set in advance for five years, commensurate with economic growth.¹⁷⁵
- b. This federal funding will be targeted and conditional in order to galvanise systemic renewal and change, focussing in particular on five priority areas, in which provinces will be required to match if not exceed the federal financial contribution:
 - i. Rural and Remote Access;
 - ii. Diagnostic Services;
 - iii. Primary Health Care;
 - iv. Home Care;
 - v. Catastrophic Drug Coverage.¹⁷⁶

4. Pharmacare

¹⁷³ *Ibid.*, 63-5; 248.

¹⁷⁴ Commission on the Future of Health Care in Canada, *Final Report*, 65-73.

¹⁷⁵ *Ibid.*

¹⁷⁶ *Ibid.*

- a. Use the newly created Catastrophic Drug Transfer, item 3(b.)(v.) above, to offset the cost of provincial and territorial drug plans and thereby reduce serious inter-regional disparities in terms of catastrophic drug coverage; and to encourage the provinces to expand their catastrophic drug coverage.¹⁷⁷
- b. Establish a new National Drug Agency to evaluate new and existing drugs, with a national formulary of prescription drugs to provide consistency across the country, ensure objective assessments of drugs, and contain costs. This would replace the current system under which every province and territory has its own list of prescription drugs which are covered (or not) under its respective provincial drug insurance plan.¹⁷⁸

First and foremost, it is impossible to miss the emphasis on the central role played by the federal government. Each one of the Royal Commission's recommendations in one way or another strongly implicates the federal government. What is clear is that the federal government is not only to have a role, but a role greater, nor lesser, than what it has played in the field of health care during roughly the past two decades in particular – a position which stands in marked contrast to the decentralist vision.

Clearly implied by the scale and structure of the recommendations was the Commission's concern that action be taken to bring about substantive renovation and reform to Canada's health care system, a point on which it agreed with the voices of decentralists. The problem faced by centralists is that those defending an enhanced federal role are perceived as doing so on the basis of the past, while the future is perceived to belong to those arguing in favour of a more vigorous role for the provinces.¹⁷⁹ In the view of centralists,

¹⁷⁷ *Ibid.*, xxxiii; 252.

¹⁷⁸ *Ibid.*

¹⁷⁹ Gregory P. Marchildon, 2013, 'The Future of the Federal Role in Canadian Health Care,' in *Health Care Federalism in Canada: Critical Junctures and Critical Perspectives*, Katherine Fierlbeck and William Lahey, eds., Montreal & Kingston (McGill-Queen's University Press), p. 178.

however, a return to the past – or at least, to a version of past arrangements, slightly modified and updated to reflect the natural evolution of the health care system – is precisely what is needed to ensure the continued well-being of Canadian Medicare. Centralists view a resurgent federal government – one that is a true partner in the Medicare enterprise – as *the* central plank of their ideology and vision for Canadian health care in the 21st century.

This is undergirded by two lines of reasoning. The first is purely practical. Providing health care in a 21st century world is an enterprise vastly more complicated, technical, and far-reaching than the framers of the *British North America Act, 1867* could ever have possibly imagined. As such, in the centralist view, decentralist arguments about a return to watertight compartments and/or to a more original or faithful interpretation of the Canadian Constitution (which would move health care to exclusive provincial jurisdiction) are not only sterile, but fundamentally unhelpful. In the centralist view, the idea that health care is exclusive provincial jurisdiction is not only incorrect from the point of view of constitutional interpretation, it would be difficult if not impossible to achieve given the way the health care system has developed over time. Canadian Medicare is not merely a product of dry by-the-letter constitutional interpretation but is an organic entity that has developed along a unique trajectory over time as a complicated and involved intergovernmental partnership in response to political and social needs and considerations. Centralists stress the need to remember this fact and to not reduce debates surrounding Medicare to issues of dry constitutional interpretation.

However, there is, in the view of centralists, a larger issue in play. While rejecting arguments of constitutional interpretation and compartmentalisation of constitutional responsibilities in favour of viewing health care as a dynamic, engaged intergovernmental partnership which has grown up over time, centralists also believe that the federal government has an indispensable role to play in the health care enterprise. Marchildon

provided a nuanced examination of this issue by dividing his analysis of the matter by looking at the facets of Medicare not only from a purely public policy standpoint, but also from a broader perspective. In a 2012 interview, Marchildon expressed his centralist views in this way:

I would view my perspective as one between those two extremes [decentralism/open federalism and extreme federalist-centralism], where I feel that the federal government should be involved in certain areas, and in other areas, the provinces both constitutionally and from a perspective of public administration are better suited to doing certain things. And in other areas, the federal government has a constitutional foothold and because it's the national government it's in a better position to do certain things. And there are times where even though one or the other order of government is doing the heavy lifting, that they still need to work together in an intergovernmental way to make the system work effectively and an example of that is in fact in the area of Medicare, universally insured hospital and physician services, where the provinces do the heavy lifting but the broad national standards if you like are set by the federal government.¹⁸⁰

In other words, Canada's health care system as currently constituted actually strikes a good balance and represents an effective partnership. In the centralist view, there is no need for decentralisation because all the day-to-day particulars are in fact already in the hands of the provinces. It is the provinces, not Ottawa, which have individual authority and which daily administer and run their thirteen separate health and drug insurance programs. They individually decide which specific hospital and physician services and drugs will or will not be covered under the auspices of those plans, for example. As the previous chapter set forth, one of the major arguments which decentralists employ in advocating that authority and control over health care ought to be passed exclusively to the provinces is that the federal role as currently constituted stifles innovation and prevents meaningful reform to the program. In the decentralist view, the *Canada Health Act* and the federal role is a negative and limiting one, shackling the provinces who, without these restraints, would implement appropriate reforms. Centralists reject the arguments of Boessenkool and others that the CHA and the federal role are stifling and limiting to the provinces. Again, the remarks of Marchildon are apropos:

¹⁸⁰ Marchildon, Personal Interview Transcript, 4 Dec. 2012, p. 1.

I cannot possibly see how five high-level conditions which [as things stand at present] are [and have been] barely enforced [by the federal government under the auspices of the CHA] impede any kind of innovation. What they do impede is governments from getting rid of universal health care. So to that extent, if that's your target, innovation in the sense of allowing private insurers and private funding to replace public funding, then yes it does [stifle innovation]; but outside of that it doesn't prevent any innovation whatsoever. There's no rule on delivery, there's hardly anything on the way in which you administer the system – so it's open book what you do as a province.¹⁸¹

Indeed, even though it is true that the CHT is technically speaking a conditional federal transfer, and the CHA technically empowers the federal government to enforce all of its five conditions by withdrawing CHT funds for *any* violation of any of the five principles, in fact (other than in the earliest beginnings) the federal government has never engaged in a minute or even particularly thoroughgoing regulation of the delivery and administration of Canadian health care, only ever concerning itself with enforcing the terms of the CHA – and then only in the case of very egregious transgressions such as those which were represented by extra-billing and user fees. The individual provinces have generally been left to their own devices as far as the day-to-day regulation and administration of Medicare is concerned.

Centralists believe that Boessenkool and others in the decentralist camp miss the mark in another, more critical respect: a failure to appreciate the larger picture. It does not end at considering that either the provinces or the federal government might be better suited to look after certain aspects of the Medicare system. What the 2002 Royal Commission on Health Care clearly implied, and Marchildon explicitly states, is that there are certain aspects of the Canadian health care system which centralists believe only the federal government is in a position to ensure. Thus, a continued and indeed a renewed federal presence in the health care field is not only to be welcomed and encouraged, it is necessary to the very well-being of the Canadian health care system.

This is why, above all, centralists reject the prescription put forward by Boessenkool and others in the decentralist camp as not just wrong-headed in terms of their suggestions for reform and the rationale underlying them, but a potential disaster for universal health care as

¹⁸¹ *Ibid.*, 10.

it currently exists. That this should be so is because like decentralists, centralists believe that a major determinant of how the Canadian health care system will function in terms of intergovernmental and fiscal relations is the incentives which the structure of the system present to the various actors who have a stake in that system, principally the two orders of government: federal and provincial-territorial. Centralists believe that the proposal to further decentralise Canadian health care and place exclusive responsibility for this social field into the hands of the provinces will create negative incentives which will have a detrimental impact on the health care system as a whole.

It is easy to identify examples of how the Canadian health care system functions as a system largely because of the influence of incentives. For instance, in the beginning, Ottawa used the offer of 50-50 cost-sharing of provinces' hospital and later health care costs (according to a mutually agreed-upon framework) to entice the subnational governments to buy into a broadly national health care project, an offer the provinces each individually found too good to refuse. Similarly, when Established Programs Financing (EPF) was put in place, some provinces responded to the freer hand they perceived this gave them by instituting extra-billing and user fees. Finally, when in response the federal government moved to position itself as the guardian of what were broadly conceived to be Canadian values of equality, it did so by using its discretion under the spending power to withhold federal funds from provinces which allowed extra-billing and user fees within their jurisdictions. By this negative incentive, the provinces were compelled to return to a more equitable health care delivery model, free of any financial barriers to access.

This last example is critical because it demonstrates the importance that the *Canada Health Act* and the federal government hold for centralists. They reject the arguments of Boessenkool that even under his new tax-point transfer proposal, the federal government would still retain a form of transfer of equalising transfer of fiscal resources to the provinces.

Boessenkool confines himself to arguing that the provinces are clearly the best stewards of health care from the standpoint of fiscal responsibility and public policy, and therefore decentralisation is both necessary and desirable. Left unsaid is the fact that under Boessenkool's framework, the *Canada Health Act* would in all probability become a dead-letter law. The *Act* could not be of any meaningful effect if the provinces were given the ability to raise their own revenues sufficient to fund health care. This would remove the entire public policy purpose of the Canada Health Transfer and render ineffective any exercise of the federal government's spending power, i.e. withdrawal of federal transfer dollars to bring provinces into accord with the five CHA values. Boessenkool's insistence that the federal government would retain a transfer under his proposal is met with rejection by centralist proponents, because the transfer which Boessenkool envisioned would not be a conditional transfer, but merely an equalising transfer with no conditionality. As Marchildon argues, this is not an equivalent situation. Boessenkool's model of health care funding retains a federal transfer, technically speaking, but it still results in a situation where the original public policy purpose of a federal transfer for health – namely, protection of the CHA principles – has been lost. What then will protect the keystone values of universality, accessibility, portability, public administration, and comprehensiveness?

For his part, Boessenkool does not directly address this centralist critique of decentralist proposals in his article. A common decentralist counter-position however has been to argue that the conditionality of the *Canada Health Act* and its enforcement by the federal government is not only a negative influence, but actually unnecessary. Marchildon summarised these decentralist assertions as follows: '...[A decentralist may argue that] the federal spending power in health care has outlived its early usefulness...Medicare is here to stay as an 'established program,' and provincial governments, irrespective of their ideological

proclivities, will be prevented by their own voters from subverting or eliminating the national dimensions of the system.’¹⁸²

Centralists take the opposite view: that it is perfectly possible that the provinces would not uphold the core values currently protected by the CHA legislation, largely because they would have little incentive to do so. Centralists argue that the majority of the incentives for the provinces under the new arrangements would encourage the provinces to limit and perhaps even abrogate, not protect, strengthen, or progressively reform, the five core principles. This, centralists suggest, would be a phenomenon which would occur across the subnational governments of the federation, both centre-left and centre-right – some would act out of ideological conviction, and others out of political or economic necessity. Three of the five conditions, in particular, would be under immediate threat: portability, universality, and accessibility. Marchildon identifies portability as the condition which would face the most imminent threat under a hypothetical tax-transfer arrangement such as that proposed by Boessenkool. Already in 2001/2, the Royal Commission on the Future of Health Care in Canada found that, while all provinces were meeting their obligation under the CHA to provide medically necessary hospital services to Canadians who move from province to province or to visitors from another province, not all provinces were covering medically necessary physician services, meaning that some people might still have to pay directly.¹⁸³ In addition, five provinces, for ‘financial reasons,’ did not provide out-of-country coverage as required by the CHA at the time the Royal Commission published its report.¹⁸⁴ Given that even with the *Canada Health Act* having been in force since 1984, a number of provinces have continuously failed to fully comply with the guarantees implied in the portability principle, it does not seem unreasonable to suppose that absent any legislative protection,

¹⁸² Marchildon, *Three Choices*, 11.

¹⁸³ Royal Commission on Health Care in Canada, p. 62.

¹⁸⁴ *Ibid.*

further derogation of previously enjoyed health care portability rights across provinces would be the end result. One need look no further for the type case for this sort of behaviour than Québec's refusal to recognise portability for certain medical services, a decision to which Ontario reacted by retaliating in kind – and this while the *Canada Health Act* was in effect.¹⁸⁵

It is not difficult to imagine that provinces which for ideological and political reasons or for simple expediency decided not to honour their portability commitments for either hospital and/or physician services, would quickly cause other provinces – even those which might be ideologically inclined to preserve the traditional Medicare principles – to respond in kind. It seems unrealistic to expect that a province would continue to provide portability benefits to the citizens of other provinces when they travel and/or move, if other provinces did not offer that same guarantee. Even Saskatchewan, which had universal publicly-funded health insurance for years before the national Medicare program came into being, did not offer portability to its residents, simply because to do so would have required agreements with the other provinces, which had dissimilar (private) systems and thus had little to no interest in such a reciprocal arrangement; and even if they had, such an agreement would have been extremely difficult to negotiate.¹⁸⁶ Only the advent of Medicare, spurred on by federal leadership and with provincial cooperation, created a situation where Canadians would come to enjoy portability of their insured health care benefits across provincial boundaries. Absent that protection, which was later strengthened by the passing of the *Canada Health Act*, centralists assert that it would be more likely to see a situation more akin to that pre-national Medicare than a continuation of the current status quo. The difficulties of inter-provincial negotiation and the past record of the provinces in that regard both indicate that in the absence of a national framework such as that currently provided by the CHA,

¹⁸⁵ Marchildon Interview, 17.

¹⁸⁶ Marchildon Interview, 14.

decentralisation will likely equate with a loss of health benefits portability over time. Certainly it is difficult, particularly in light of the dismal history of past inter-provincial initiatives and the many differences and divisions which exist in Canada, to imagine a situation where all provinces and territories could meet and agree together on reasonably uniform and consistent terms and conditions for portability.

The potential negative impacts of health care decentralisation do not end at the question of portability of benefits, however. The concerns of centralists about a loss of the *Canada Health Act* protections also extend in particular to two other of the five conditions and the health care guarantees they safeguard: accessibility and universality.¹⁸⁷ These two conditions together form the nucleus of the constellation of values at the centre of Canadian Medicare. Briefly put, the principle of accessibility permits no barriers, financial or otherwise, to access to medical care in Canada – in other words, access to care must be based solely on need for services, not on financial considerations or ability to pay. Coupled with accessibility is the guarantee of universality – this condition requires that all Canadians, regardless of their particular backgrounds, medical histories, or geographical location, must receive (as nearly as possible) a basic uniform standard of medically necessary care under a uniform set of terms and conditions.

A centralist would point out that the entire reason that the *Canada Health Act* was originally set in place, with provisions for financially penalising provinces which violated its terms and conditions, was due to the practices of extra-billing and user fees put in place by Alberta and a few other provinces, and this despite the fact that the values underlying Medicare (including barrier-free access based on need and according to uniform terms and conditions) have been widely accepted and indeed embraced by Canadians consistently since the 1950s. As such, the common decentralist argument that ‘Medicare is here to stay as an

¹⁸⁷ Marchildon Interview, 13-14.

established program’ seems a good deal less convincing when placed into this larger context. Indeed, absent the protections of the CHA and the incentives it provides for provincial governments of every stripe to continue to respect the principle of barrier-free access, it is not outside the bounds of reason to suggest, given historical experience, that centre-right provincial governments in particular might exercise their new-found freedom of action by instituting practices which, under the present Medicare regime, would not be permitted.

Then there is the issue of comprehensiveness – the principle which provides that all provincial/territorial public health insurance plans must fully cover all medically necessary hospital and physician services.¹⁸⁸ As things stand presently, the provinces and territories largely offer the same ‘basket’ of medically necessary health care services on a universal basis across the federation, with a few minor differences between provinces. Removing the requirement for comprehensiveness under the *Canada Health Act* would free every provincial/territorial government from the incentive to offer the same ‘basket’ of health care services. In more centre-right provinces, there would be a definite potential for services which are guaranteed under the current regime to be de-listed, and perhaps moved to the private sector to increase ‘efficiency’ and cut down on what is perceived to be excessive public expenditure. All provincial governments regardless of their ideological bent however might have another strong incentive to shrink the basket. The provinces are perennially the more ‘fiscally challenged’ order of government, a situation which exists in the context of the fact that health care is consistently near, if not at, the top line of any list of provincial expenditure responsibilities; and further that, due to the nature of medicine, the rapid pace of technological change, and other factors, health care costs are continually expanding over time. Thus, in a situation where the *Canada Health Act* was removed, it would be very tempting for the provinces to ease the growing burden of steadily expanding health care

¹⁸⁸ Royal Commission on the Future of Health Care in Canada (2002), pp. 62-3

expenditures by de-listing certain items from their ‘baskets’ of publicly-insured health care services. In other words, what an individual Canadian ‘got’ in terms of health care – i.e., which health care services remained publicly-insured instead of being paid for out-of-pocket or by private insurance – would vary depending on which province he or she happened to find themselves in. How much it would vary remains open to conjecture, but it is not unreasonable to argue that the level of variation across the Canadian federation would be potentially significant.

In short, a centralist would argue as follows. While it may be true that decentralists have advanced a coherent framework which would theoretically enhance fiscal responsibility (cause governments to spend less) while simultaneously reducing corrosive conflict between the federal and provincial governments and making the federation function better by clarifying (i.e. compartmentalising) roles and responsibilities, it would be at a cost which should warrant serious concern. Specifically, where currently Medicare represents one of the great unifiers of Canadian citizenship in that it is based upon widely accepted values and entitles every Canadian to the same publicly-insured health benefits wherever in the country they might reside, a more decentralised system would almost certainly have more of a patchwork appearance. Such a system would be characterised more by the inevitable inter-provincial differences which would arise than the current situation, where the knowledge that every Canadian is entitled to the same publicly-insured health care benefits contributes to a sense of identity which is more truly national in character. There may be thirteen individual provincial/territorial public health insurance plans, but needs-based access to medically necessary health care is without question an entitlement which people conceive of within a truly national dimension as being a feature of a uniquely *Canadian* social citizenship, not their citizenship within the particular subnational jurisdiction in which they happen to live.

This is particularly the case because as has been examined thus far in laying out the position of centralists, greater decentralisation of health care could quite possibly equate with greater differentiation among provinces, i.e., a more decentralised federation may equate with a more regionalised one. This is concerning for centralists because there are so few common ties which bind Canadians together into one true national identity. For example, economically speaking Canada is essentially a collection of unique regions rather than a homogenous whole. The economic interests of British Columbia are very different from those of Alberta, and those of the Maritimes, different again. Political values also tend to diverge noticeably depending upon what region of the country one examines. Centralists caution that in a country that is already defined a great deal by what sets one region apart from another economically, politically, geographically etc., careful consideration should be given before adopting any proposal the potential effects of which included weakening the national dimensions of one of the few aspects of Canadian citizenship which is broadly shared across the country. Health care alone is one area where citizens, regardless of their province of residence, can agree that their interests coincide with those of Canadians in other regions. The vast majority of Canadians identify with the principle of needs-based barrier-free access to health care. That level of consensus and commonality of interests is not found in almost any other area of Canadian public life. Centralists therefore believe that it is vital that before changing Canada's health care system, time is taken to carefully consider the potential negative impacts of removing the federal government's ability to exercise any truly national influence on the character of health insurance in Canada – negative impacts in the form both of the substantive differences that might emerge in terms of the medical care Canadians could expect across the country, and in terms of the negative consequences this differentiation could have for Canadians' sense of national unity, identity, and shared social citizenship.

Centralists believe an alternative and, in many respects, superior way to go about bringing substantive, systemic, transformative change to the Canadian health care system is by means which are precisely the opposite of what decentralists propose: namely, a resurgence, not a retreat, of the role of the federal government in the health care enterprise. Centralists believe that this will produce substantive reforms while avoiding the pitfalls they associate with the decentralist approach. Centralists propose change, but in their view, it ought to be change and reform which takes place within the existing framework of public health insurance in Canada. Centralists believe that the proposals of decentralists such as Boessenkool are too extreme – in seeking to accomplish worthwhile goals (efficiency, cost control, fiscal responsibility, a more ‘rationally structured federation’) these proposals go too far in terms of their potential negative impacts.

4.3 An Alternate Vision: A Substantive, Centralist Alternative to Decentralisation

To find the alternative centralist vision for Canadian health care, one need look no farther than the recommendations of the 2002 Royal Commission on the Future of Health Care in Canada. To summarise, the Commission recommended that:

- The original ‘50-50 Medicare bargain’ should be restored; however, taking into account the 1977 permanent transfer of tax room, the federal contribution should in fact equal roughly 25 per cent.
- This federal contribution should take the form of an all-cash, conditional federal transfer payment (with payment contingent on adherence to the *Canada Health Act* conditions).
- This transfer was to expand over time according to a fixed escalator provision in effect for five-year periods, the precise details of which were to be determined in negotiations between the two orders of government.

- There was to be targeted federal funding (i.e. cost-sharing) in identified priority areas to encourage transformational systemic change.
- The *Canada Health Act* was to be renewed, strengthened, updated, and expanded by:
 - Clarifying the principle of portability and comprehensiveness;
 - Maintaining the principles of public administration, universality, and accessibility;
 - Adding a new principle of accountability. Substantively this would mean both orders of government clarifying roles, expectations and responsibilities, recommitting to the principles of the CHA, and making the governance, negotiations, and fiscal structure of health care more open and transparent to Canadians.
 - Expanding the basket of CHA services to meet the evolving health care needs of Canadians. Two solid beginning steps would be by including home care and pharmacare in federal-provincial cost-sharing arrangements in the same manner as other services currently in the provincial ‘baskets.’

A slight variation on the proposals of the 2002 Royal Commission was set forth by Marchildon. In keeping with the Royal Commission recommendations, Marchildon argued that the best way forward was for Ottawa to once again ‘become a real partner in Medicare.’¹⁸⁹ In theoretical terms this meant that both orders of government should substantively engage and negotiate with one another not only to recommit to the foundational principles of Medicare, but also to reach a substantive, long-term agreement on its future direction and operative principles.¹⁹⁰ Further, the federal government should end the use of non-conditional block transfers for health care, which lack a clear policy purpose or rationale

¹⁸⁹ Marchildon, ‘Three Choices,’ 12.

¹⁹⁰ *Ibid.*

because they impose no accountability on the provinces which receive them. Instead, the provinces should receive a set per-capita all-cash transfer based on a national average which would increase according to a fixed, agreed-upon escalator provision, as the Royal Commission recommended.¹⁹¹ This transfer would be conditional, with infringement of the agreed-upon CHA principles resulting in ‘dollar-for-dollar’ penalties such as those that were assessed against user fees and extra-billing.¹⁹² Increasing the federal contribution to a reasonable, reliable level, Marchildon argued (in line with the proposals of the Royal Commission), would give the federal government a meaningful stake in ‘fiscal risks’ of the system, and provide it with the moral legitimacy to initiate the consultative intergovernmental dialogue required for the process of recommitment to core values and reform of Canada’s Medicare system.¹⁹³ Further, it would allow this reform, renewal, and expansion effort to be a truly pan-national undertaking with truly national dimensions and direction, rather than a piecemeal effort among provinces with no input from the over-arching national government – the one and only government which represents all citizens as ‘Canadians,’ rather than as inhabitants of a particular province or region. The significance of it being a truly pan-national undertaking is that only the federal government has the ability to provide national leadership and direction, to stand above the fray and represent the greater whole of Canada rather than its diverse regions with their divergent interests, and to guarantee that health services remain at consistent levels across the federation and respect the keystone principles which have come to define the system – barrier free access based on need and without differentiation based on geographical location.

Marchildon’s proposal does deviate from the recommendations of the 2002 Royal Commission Report in one significant respect, however. While the Royal Commission

¹⁹¹ Marchildon, ‘Three Choices,’ 12-13.

¹⁹² *Ibid.*

¹⁹³ *Ibid.*

recommended that the federal transfer contribution for health should not be greater or less than 25 per cent of the national average per-capita health care costs, Marchildon suggested that a better alternative might be for the federal government to actually reduce the total transfer under the CHT to the minimum needed to maintain the policy purpose of that transfer, namely, ensuring the terms of the CHA remained meaningful – he reckoned this to be equivalent to roughly one-half the amount of the present CHT.¹⁹⁴ He continues,

Second, I would reinvest the money thus freed up to both reinforce and extend our half-century old Medicare house to ensure public health care is more sustainable for the 21st century. This could be accomplished by the federal government cost-sharing an expanded basket of universal services which the provincial governments would be responsible for administering. In exchange for federal funding, Ottawa would enact an appropriate set of national standards or principles through an extension of the Canada Health Act or, if co-payments and user fees were to attach to the new services, through another parallel (though not identical) law.¹⁹⁵

However, he surmises that many provinces in this era of increasingly assertive subnational jurisdictions might balk even at the suggestion of the imposition of any national standards.¹⁹⁶ Furthermore, the potential alternative of having intergovernmental agreements to regulate national standards has had a long shadow cast over it by the utter failure of three previous health accords, which were notable for their ambiguity, poor accountability, and near-total lack of enforcement.¹⁹⁷ Given these considerations, Marchildon proposes that a workable alternative might be for the federal government to ‘take an ownership position in public health care by funding and administering a national Pharmacare program.’¹⁹⁸ This proposal would have a number of advantages, he asserts. First, it would achieve the goal of expanding Medicare in a significant way which would better the lives of ordinary Canadians, since drug costs are one of the most rapidly expanding areas of personal health expenditure, while drug coverage for Canadians is largely private (often through work plans) and highly

¹⁹⁴ Marchildon, ‘The Future of the Federal Role in Health Care,’ 246-7.

¹⁹⁵ *Ibid.*

¹⁹⁶ *Ibid.*

¹⁹⁷ *Ibid.*

¹⁹⁸ *Ibid.*, 248.

inconsistent across the country. Second, this is the one health sector where the federal government's constitutional footing is all but uncontested, and in many respects stronger than that of the provincial governments.¹⁹⁹ Third, with the separate provincial prescription drug programs being one of the largest single cost drivers in health care since the 1970s and this trend likely to only accelerate, a federal Pharmacare program would have the effect of lifting an enormous cost-burden from the shoulders of the fiscally challenged provinces.²⁰⁰ Fourth, although the costs of a truly national Pharmacare program would no doubt appear to represent a major burden to the federal treasury, this is offset by the fact that the regulatory machinery is already largely in place to control cost more effectively than could ever be done at the provincial level.²⁰¹ Fifth, there are already relevant type cases/examples in operation, with central government-run Pharmacare programs in place in both Australia and New Zealand.²⁰² Sixth, the federal-only Pharmacare plan would be essentially a coverage plan, avoiding the complexities of service delivery found in other health care sectors.²⁰³ And finally but perhaps most importantly, Pharmacare would 'provide a direct accountability relationship [which has previously been absent] between the Government of Canada and individual Canadians, a program that could over time become a national unifier in an already highly decentralised and asymmetrical federation.'²⁰⁴

4.3 Conclusion

These proposals, although they differ slightly in the means they suggest, clearly reflect the strong centralist belief that the federal government has an important role to play in

¹⁹⁹ *Ibid.* '...The federal government already has the machinery to regulate the market entry, monopoly protection, and the prices of branded prescription drugs through Health Canada, the Patent Act, and the Patent Medicine Prices Review Board. I would argue that it also has the capacity, unexercised since the late 1980s, to regulate generic prescription drug prices through licensing or other means.'

²⁰⁰ *Ibid.*

²⁰¹ *Ibid.*

²⁰² *Ibid.*

²⁰³ *Ibid.*

²⁰⁴ *Ibid.*

revitalising Canadian health care. More than that, however, they believe that in their insistence on speaking only of efficiency, accountability, rationality of structure, and improved intergovernmental harmony, decentralists miss the larger potential for nation- and identity-building that is an inherent, and important, part of the Canadian Medicare enterprise. Centralists argue that there is an opportunity here not just to renew and expand Canada's health care system, but also to strengthen the truly pan-Canadian national dimensions of the system through a thorough-going re-engagement of both orders of government when it comes to the enterprise of health care.

Centralists believe that the way forward is for the federal government to reverse the trend of the past two decades and to step forward to take a greater ownership stake in the Canadian health care system once again. In substantive terms this means making conditional transfers for health that are at a meaningful level, one high enough to ensure the broad conditions of the *Canada Health Act*, but not so high as to encourage provincial fiscal irresponsibility. By virtue of taking a meaningful fiscal stake in the Medicare enterprise, the federal government will have the moral legitimacy to begin to provide leadership and a national direction to health care once again, encouraging both orders of government to come to the table to recommit to the core values of health care in Canada, and to determine what principles will guide health care into the future. Unlike decentralists, centralists believe that the broad structures of Medicare which are already in place are workable, and while there are negative incentives present in its current structure, these are not insurmountable. Instead, all that is needed is to modify the structure so as to make the intergovernmental health partnership more open and accountable to public scrutiny, and for both orders of government to re-engage with one another in a substantive dialogue about the direction of the Canadian health care system and their respective roles within it. Above all this means that both orders of government must be clearer in the way that they communicate with each other and with the

public. Both orders of government must end the sterile debates over the level of transfers, respect the role of the other in the federal-provincial balance that comprises the Medicare partnership, and end the blame-shifting and buck-passing that have characterised the intergovernmental relationship in Medicare. Changing this does not require changing the structure in the dramatic way that decentralists have proposed; it merely requires governments, premiers, finance Ministers, and prime ministers, to be more transparent, less politically motivated, and more engaged in the way they communicate, both intergovernmentally and with the public.

For a centralist, Medicare is more than mere policy or a program, it is also a focal point of Canadian identity and the idea of a shared Canadian social citizenship. It speaks to a country which is not just an economic union but also a social union, one where Canadians across the country receive the same standard of social entitlements which they identify as being linked to their citizenship not in their province, but in their country. This is critical because economically and politically, Canada is by and large more diverse than it is united. Decentralising proposals may indeed have the effect of reducing intergovernmental friction and forcing provinces to trim their spending on health by having the federal government walk away from health care and leaving the thirteen diverse subnational units to ‘figure it out’ amongst themselves – but centralists ask at what cost this seemingly eminently simple solution might come? Their answer is the risk of a country which is defined by difference and by the potential for inequalities of access to vital public services. By contrast, centralists feel that their proposals will avoid the negatives centrifugal incentives of decentralisation, and instead lead to a return to a healthy, balanced intergovernmental partnership, resulting in a more comprehensive, equitable, and consistent health care system with a firmer and more pan-national sense of its underlying principles and direction, existing within a country with a stronger sense of a shared, and uniquely Canadian social citizenship and identity.

Chapter 5 – Summary, Analysis & Conclusions/Recommendations

5.1 Summary

The preceding two chapters examined two quite different visions of the direction the Canadian health care system ought to proceed in the 21st century. Chapter 3 laid out a decentralised vision of Canadian health care, one in which primary responsibility for health care would be devolved to the provinces and territories. Consequent to this, the federal government would have little to no role in this new version of the health care enterprise. Instead, it would simply transfer more tax room to the provinces in order to allow them to raise their own revenues for health care. This would help better control costs by ending the fiscal illusion caused by provinces ‘spending another order of government’s money,’ and would allow provincial governments to be more directly held to account by their voters for the health care dollars they spend.

Chapter 4 set out a sharply contrasting vision of a second school of thought – one which believes that a resurgent federal role in the Canadian health care system is vital to the continued stability and well-being of the system, and also has implications for Canadian unity and identity. Centralists believe that a preoccupation with simplicity of structure and division of responsibilities has the capacity to develop into a situation where access to care and equality of care might become uneven across the country. This would be due to both the differences in fiscal capacity of the provinces, but more so the lack of over-arching, truly national standards which would be consequent to a decentralisation of health care responsibilities and authority to the provinces and territories. With a total transfer of GST revenue-raising capability, the federal government would lose the ability to act as a guarantor of broad national standards in health care through its federal legislation, the *Canada Health Act*. In the absence of these guarantees, it is likely that the five conditions which form the health guarantees of equality of access across the federation and with which Canadians have

come to identify would begin to break down. Centralists therefore caution against the adoption of proposals which advocate for watertight divisions of authority, responsibility, and revenue-raising when it comes to the structure of Medicare in Canada. While these may seem simple and intuitively attractive on their face, centralists warn, the result of such proposals could well be the degradation of the health care guarantees which Canadians have come to expect, at least in some jurisdictions

Consequent to a lack of over-arching national direction and increasing differentiation in the health care received from one region to another, centralists suggest that Canadians would have a weaker sense of a truly national Canadian social citizenship, one where their medical care, which was once conceived of being a distinguishing feature of being Canadian, would now necessarily be more identified with their province of residence. As such, the sense of Canadian identity might be weakened, and the sense of inter-regional political, economic, and social difference exacerbated, leading to a less unified federation.

Centralists suggest that all this can be avoided by the federal government moving to take an ownership role in health care once again. They suggest that the federal government should again fund Medicare at an ‘ownership stake’ benchmark, using conditional cash transfers based upon the values captured within a new, updated *Canada Health Act*. The structure overall would be an arrangement more akin to the ‘original bargain’ in Canadian health care laid out in Chapter 2, modernised, expanded, and updated to meet the challenges and priorities of the 21st century. While this would be a less drastic solution than decentralist proposals for a final transfer of GST points and near-total devolution of health care to the provinces, centralists believe it would both avoid many pitfalls of the decentralist approach while simultaneously strengthening Medicare more effectively than ever could be done by decentralist proposals, all while protecting and even strengthening national unity and a sense of truly national Canadian citizenship and identity.

This chapter will comprise an analysis of the strengths and shortcomings of each school of thought set out in the previous two chapters. Consideration will also be given to some of the potential impacts of each school of thought in terms of the future of the health care system itself, as well as more broadly the effective functioning of the Canadian federation and the question of Canadian unity and identity. The chapter will end by drawing some conclusions and fielding some arguments about which school of thought, based on the analysis undertaken in the context of this chapter, offers the best option for Canada's health care system to effectively continue its evolution moving into the 21st century.

5.2 The Decentralist School – Analysis

The decentralist proposal for health care in Canada undeniably has a number of strengths. First, the implementation of such a system would indeed bring greater clarity of roles, authority, and responsibilities in health – health would be declared an area of de facto exclusive provincial jurisdiction and authority, and the federal government would of necessity under this new structure withdraw entirely from the field, leaving no ambiguity as to which level of government bears total responsibility for health care. Both levels of government would be left free to concentrate their spending and attention on areas which, at least in the decentralist view, are most appropriate to their respective order of government. For the provinces, this would mean above all health and education, while the federal government would play no part in these provincial matters and would instead focus on more 'genuine' national priorities, such as trade and commerce and national defence.

If the objective is to create a situation of greater intergovernmental harmony, free governments to focus on 'appropriate' priorities and end federal-provincial bickering, the decentralist proposal is a theoretically excellent one. Like a well-placed pass of a scalpel, the decentralist proposal would in one fell swoop compartmentalise federal and provincial authority, and by this means remove what has historically been perhaps the largest single

irritant in the Canadian intergovernmental relations regime. No longer would there be a need for the federal and provincial governments to engage in unending and unproductive funding negotiations and blame-shifting such as that which characterised the health care field in the 1990s. It can thus plausibly be argued that the result will be a more harmonious, more efficient, more rationally structured federal system, one where the orders of government will not be bogged down by intergovernmental conflict, but will instead stick to responsibilities which are most appropriate to their position in the political regime. A more decentralised (i.e. compartmentalised) federation is quite plausibly a more harmonious one.

Second, there is the issue of the costs of health care. Health care is already at the top line of expenditures for provincial governments. Further, the ongoing march of medical technology, an aging population, and the steady proliferation of prescription drug patents (among other factors) mean that health care expenditures as a percentage of public expenditure will foreseeably continue to expand rapidly over time. Given that almost all the provinces are currently narrowly skirting deficits or running deficits, cost control will be a necessary priority in health care moving into the 21st century. A major strength of decentralisation proposals is that they provide a concrete mechanism for dealing with this identified problem in publicly-funded health insurance. Since the provincial government would be granted sole responsibility for health care, there would be no question among citizens of a given province about which level of government was responsible for health care outcomes, and the public spending that was done in comparison to the health outcomes that were obtained. Further, the citizens of a province would no longer be under the influence of the fiscal illusion – that phenomenon which occurs when there is a gap between the levels of expenditures of a government, and the taxes paid by that government's taxpayers to finance those expenditures. As such, it is very plausible that if provinces were required to raise all their own revenues to meet expenditures, including health expenditures, provincial citizen-

taxpayers would be more likely to act as a ‘brake’ on those expenditures. Thus, the decentralist framework should be credited with providing a hypothetically workable structure of incentives to bring about needed cost control in publicly-funded health insurance.

Further, both the federal government and more particularly the provinces have good reasons, especially from a pragmatic perspective, for embracing the decentralist vision of health care in Canada. From the perspective of the federal government, ending its transfers for health will mean it will no longer bear the burden of transferring massive amounts of federal money to the provinces for health care in return for very little thanks. From the perspective of the provinces, they face the spectre that federal transfers may well have reached their zenith and will likely remain the same, if not decline, for the foreseeable future. A decentralising framework such as that put forward by Boessenkool would provide the provinces with an opportunity to ‘lock in’ a steady source of own-source revenue, without having to rely on the vagaries of federal transfer payments, another problem which has dogged the health care funding regime, particularly in the last one to two decades. Indeed, the decentralist proposal would in some respects be a dream come true for the traditionally fiscally challenged provinces, granting them exclusive control over an entire tax field and giving them the latitude to make spending decisions free of any constraining federal conditionality. This in turn would allow them the freedom to innovate and experiment as much as they saw fit when it comes to health care delivery – which would theoretically result in finding greater efficiencies and reducing costs.

In short, the vision of the decentralist school of thought for the future of Canadian health care is a strong one in a number of respects. This conclusion is supported by the fact that it correctly identifies a number of issues which have affected universal publicly-funded health insurance in Canada, particularly within the last two decades. The proposals of decentralists should be credited as representing a wide-ranging attempt to respond to these

issues. Furthermore, although it is of course impossible to tell as any analysis will necessarily be dealing in hypotheticals, as has been argued here it is highly plausible that the decentralist proposal would represent not only a meaningful framework for change, but would have a quite high probability of achieving most of the aims that the framework is intended to achieve, most of which are worthy goals. By these measures, the decentralist proposal does have merits.

The decentralist vision is not without its weaknesses, however. While it may be theoretically excellent on its own terms from the point of view of structuring the federation more ‘rationally’ or ‘logically,’ and by this means achieving better cost control in Canadian health care and a better-structured federal system with more harmonious relations between the orders of government (which is to say, less for the two orders of government to have to relate with one another about), it is a vision which is overwhelmingly preoccupied by economic concerns. In this respect, the centralist criticisms of the decentralist vision are on-point: proposals such as Boessenkool’s give very little, if any consideration to what the larger impacts of their particular proposals might be. In other words, while the Boessenkool proposal is hypothetically excellent on its own terms, Boessenkool gives almost no consideration whatsoever to any impacts which might occur were his proposals to be implemented, outside of his stated goals of reducing public sector expenditure, enhancing accountability, and rationalising the Canadian federal structure.

First and foremost, if the decentralist vision for health care were to become a reality in Canada, it would unquestionably be a radical departure from the entire history of the system so far. As laid out in Chapter 2, Medicare has been built up organically over time as evolving partnership between the two orders of government, with a federal-provincial balance where each stakeholder in the system has had a role to play appropriate to its position. Particularly since the passage of the *Canada Health Act* in 1984, the provinces have been left with a

largely free hand to administer and oversee the day-to-day operation of the system; and the federal government has been responsible for providing an over-arching national direction, and ensuring that the various provincial health insurance plans are broadly consistent in terms of their philosophy and the level of services offered, regardless of where in Canada the citizen who is seeking medical care might be located. The decentralist proposal would mean a dramatic and unprecedented change in this regime and an end to this federal balance which, while it has not been without its problems, has represented an example of federal-provincial engagement and co-operation to achieve public policy goods which were being demanded by the Canadian public. This legacy would be decidedly ignored should a proposal such as Boessenkool's be adopted for Canadian Medicare. Further, it should be noted that though it may be true that this balance has functioned less effectively of late because the federal government has increasingly shirked its responsibilities and failed to provide that leadership and financing, this is not in itself an argument for the federal government to get out of the business of health care entirely, since Ottawa could assume the mantle of leadership and responsibility again if it so chose – a possibility decentralist proposals pre-emptively dismiss.

Indeed, the decentralist vision is open to criticism because it gives little or no consideration of what a total federal withdrawal or abdication of responsibility in the field of health care would mean for the future of the Canadian health system. Here the criticisms of centralists are very much on point. If the provinces receive a final transfer of tax points, and the federal government no longer makes transfers for health, the *Canada Health Act* will indeed be a dead-letter law, as the transfers are the mechanism by which the *Act* is enforced. The removal of the conditionality imposed by the CHA would almost invite the provinces to make changes to their particular public health insurance schemes – the motivation for which could either be purely pragmatic (fiscal considerations in the case of the poorer provinces, even more 'left-leaning' ones), or linked to their own ideological proclivities and ideas about

personal responsibility and the proper role of the state. In some provinces, a citizen might find that their health care needs were being met very well within the context of a not-for-profit public health insurance system. In another, however, a citizen might find that the services they had previously been guaranteed by the protection of the CHA had been cut or moved to the private for-profit sector. To invite this possibility fundamentally offends the core values which have come to identify the Canadian approach to providing health care and opens the gates to inequality of access and quality of medical care available amongst sectors of the Canadian population. Such a situation is morally objectionable and not to be countenanced.

The decentralist vision gives no consideration to the potential consequences of compartmentalisation of authority and responsibility that would occur were such a framework to be put in place. While such a regime might well make the federation more harmonious at one level by removing one area where there has traditionally been a great deal of tension in intergovernmental relations, it might well also make the federation a more fractured one at a more fundamental level. Under the new decentralised regime, health insurance would be tied to province of residence, and with no health guarantees such as those which currently exist through the *Canada Health Act*, the services one received would likely be different, and of differing quality, depending on which province one happened to live. In effect, this end to the national dimensions of health care would re-define the appropriate ‘sharing community’ in this field as being not national, but provincial. In a country which is as immensely economically, politically, and culturally diverse – not to mention territorially dispersed – as Canada, this invites a sense of regionalism and differentiation into a field which was before considered to be one of the major unifying features of Canadian citizenship. While economically, politically, and culturally a British Columbian feels little in common with an Albertan, and an Albertan even less in common with a Québécois(e) or a Maritimer and vice-

versa, one thing that unites them all under the current Medicare regime is that they are all entitled to the same standard of basic medical care under uniform terms and conditions on the basis of need, not ability to pay. Given that Canada is massively diverse and sometimes seems to be defined more by its differences than by its similarities, any proposal which invites a greater sense of inter-regional or inter-provincial differentiation should be weighed very carefully.

Decentralist advocates are content to argue that public opinion will hold provincial governments to account, preventing them from making any changes to the system such as delisting certain items of care from the field of public health insurance, instituting user fees, etc. In fact, however, the historical record does not support this position. Fairly significant violations of the five health care principles have occurred even when those principles were well-established and had broad public support. For example, this was seen when a few provinces instituted extra-billing and user fees, necessitating the passage of the *Canada Health Act* to end this practice. Extra-billing and user fees were very clearly in contravention of values which, based upon polling and the findings of two Royal Commissions, most Canadians support and have consistently supported in the five decades since national public health insurance began in Canada. Indeed, the decentralist preoccupation with accountability for health spending and outcomes is almost ironic in a sense because its vision for Canadian Medicare removes the most powerful tool of accountability which exists in the system – the *Canada Health Act*. In place of this clear-cut regulation, accountability for health care services and outcomes would be left to the highly indirect mechanism of provincial elections, which are fixed in most provinces at every four years. Exactly how public policy decisions of a government translate into electoral outcomes is a massively complex subject far outside the scope of the present inquiry. Suffice it to say, however, that the link between public policy decisions and electoral outcomes is a far more uncertain protection for health care

guarantees than the protections currently afforded by the five conditions of the *Canada Health Act*.

5.3 The Centralist School – Analysis

Centralists have a very different vision for the future of Canadian health care than that proposed by decentralists. Like the decentralist vision, the vision of centralists has a number of number of strengths and also its share of shortcomings. This section will consider first the strengths of centralist proposals, and then address the areas where these proposals may fall short.

The first thing that can be said for the centralist vision is that it is not, as with Boessenkool and other decentralist proposals, a dramatic departure from the past trajectory of the Medicare system as it currently exists. Thus, it is likely an easier option to implement than the alternatives which Boessenkool and others present. The centralist framework would respect the fact that Medicare grew up organically over time as an intergovernmental partnership – one where each level of government played a role that it was most suited to playing in the federation. This meant that the federal government provided a national direction and leadership (as well as needed funding in matching conditional grants to make the implementation of Medicare possible), and the provinces as well as providing funding were left to see to the detailed administration and operation of health care on the ground, constrained only by the bounds of a broad constellation of five general basic values. Critically, agreement upon this ‘constellation’ of five broad over-arching values was not imposed upon one order of government by the other, but was instead reached in intense negotiation between the two partners in the health care enterprise as representing or encapsulating the appropriate Canadian values respecting health care – values which the national order of government was then entrusted with ensuring. This resulted in an arrangement which is both balanced and logical, capitalising on the strengths and positions of

each of the stakeholders in the system and what roles they are best suited to play. The centralist proposal for Medicare moving forward would respect and continue this balance, while recognising that, as centralists argue, meaningful change could still take place within this framework.

The centralist proposal for health care would ensure continuity and avoid the need to alter the existing regime in fundamental and therefore disruptive ways, while simultaneously providing a framework by which the Medicare system could be expanded, modernised, and updated to provide new services, and improved overall in its structure and operation. This outcome would be achieved through a process of meaningful, constructive, and consistent engagement between the federal and provincial-territorial orders of government. Evidence for this assertion can be found in the simple fact that the prototype for this process already exists: it was the very process by which national publicly-funded health insurance for medically necessary hospital and physician services first came into existence in Canada. If the provinces and the federal government were able to constructively engage with one another and reach comprehensive agreement to create a wholly new, jointly funded national public health insurance program in the early 1960s, there is no reason to suppose that they cannot together reach an agreement to expand and improve that program to meet the changing health care needs of the Canadian populace today. While this proposition may be the subject of debate and may be flatly denied by decentralists who feel that their proposal is a more workable solution, the historical record is clear that such initiative is possible, especially since the relevant situational factors have really not changed that much in the intervening decades. The Canadian public still consistently rates Medicare as one of their top priorities and opposes any significant change to the existing health care system, and the situation of the two partners in the enterprise is basically the same as it was in the 1960s, especially fiscally speaking. That is to say, the provinces oversee the day-to-day operation of

the health care system but are more fiscally challenged than Ottawa, so a balance is struck wherein Ottawa provides transfers to the provinces to help meet the costs. In other words, based upon the foregoing arguments, it is possible that meaningful change and reform to Medicare could take place, while still maintaining the federal balance which allowed Medicare to be established and be successful as a program.

A centralist approach involving a federal government which once again assumes an ownership stake in the system by contributing a reasonable share of the costs of Medicare, something more akin to the original '50-50 bargain,' adjusted down to around 25 per cent to account for the 1977 permanent tax points transfer, has additional advantages. A federal government which once again acted as the guarantor of the five conditions of the *Canada Health Act* by making its enhanced transfers to the provinces for health conditional on stricter observance of the CHA principles would ensure that Canadians will continue to have some form of health guarantees. This would mean that the care they are entitled to receive, the terms on which they are entitled to receive it, and the quality of the care they do receive would be broadly the same regardless of which province or region of the country they happened to reside in, visit, or move to in order to secure employment. The fact is that outside the awkward instrument of entrenchment in the Charter, a remedy that would be protracted to obtain and would be the purview of those privileged few who could afford to absorb the costs of sustained litigation, there is no other way to ensure uniform health care services of uniform quality from coast to coast as effectively as the *Canada Health Act* has done. A great strength of the centralist proposal is that it provides a framework in which change and renovation to the Medicare house can take place, without sacrificing the protection of the five CHA principles.

Of course, the centralist proposal has its points on which it can be criticised. One argument that can be made against it is that the continuity it would entail is not a strength, but

instead a weakness. It can be argued that the centralist vision is lacking as a proposal because it doesn't really change anything, but merely advocates what some see to be a return to the past, or a continuation of the status quo. The centralist proposal can indeed be criticised for the fact that it does not, as the decentralist school does, provide a framework by which to reverse the incentives which have encouraged provinces to spend more on health care and not control costs. In this respect, the decentralist proposal more directly addresses these identified shortcomings of the Medicare system.

As a corollary to this, another criticism of the centralist proposal is that it requires placing a great deal of faith in the altruism of politicians in both orders of government. It must be acknowledged that much of the dysfunction that has come to characterise intergovernmental relations in health care has been the result of structural incentives of the system, something decentralists provide a definite series of solutions to with their proposals. By contrast, the centralist proposal would be heavily dependent on both federal and provincial leaders 'stepping up to the plate' to engage in a substantive, sustained, and effective dialogue with the other order of government across a wide spectrum of issues. For example, the centralist proposal calls for a renewed, strengthened, and expanded *Canada Health Act*, and to really make this effective the amount of coordination and dialogue between the federal and provincial-territorial governments would be significant. For this to be a truly worthwhile collaborative effort would require a level of sustained, constructive engagement between the two orders of government which Canada has not seen for perhaps half a century. It would require provincial politicians to go against the incentives of the system and forego blaming Ottawa for failures, or sounding an incessant refrain for more federal dollars. And it would require the federal government to have a clear idea of its role in this enterprise, a clear conception of a national direction, and to be similarly responsible in the way it communicated its position. In other words, it would demand a great deal. One of

the biggest arguments against the centralist position, therefore, may be to point out that, particularly in comparison to decentralist proposals, it may simply put too much faith in the ability, or the willingness, of politicians to undertake the difficult work of trying to cooperatively reform and improve the Medicare system.

5.4 Conclusions & Recommendations for Future Directions

Up to this point, an account has been provided of the past trajectory of Canada's health care system from its inception up to the present day. This was followed by a comprehensive review of the positions of two widely-divergent schools of thought as to what the proper direction for Canada's health care system in terms of intergovernmental relations should be moving forward into the 21st century. Strengths and shortcomings of each vision were then examined, recognising that any proposal will have both its positive and negative points, which must be balanced and considered within the larger context of Medicare in Canada. Only one task now remains in terms of the present project: taking account of all the foregoing, what conclusions can be drawn about the implications of each of the two visions for Canadian Medicare examined here? And based the analysis contained within these pages, what recommendations can be made as to which vision out of the two examined here offers the best overall choice for the future of the Canadian health care system and the Canadian federation? It is to that sole remaining inquiry that attention is now turned.

The decentralist vision, best exemplified by Ken Boessenkool's argument for a final transfer of GST tax points to the provinces, is without question a very strong proposal. It correctly identifies a number of shortcomings in the Canadian health care system – expanding costs; chronic intergovernmental tensions and dysfunctional federal-provincial relations; lack of clarity surrounding governmental roles and responsibilities on the part of the public; irrationality in the fiscal federal structure – and provides a very definitive framework, fundamentally different from the existing system, with a strong system of incentives designed

to combat those problems. The decentralist proposal should be credited for isolating these problems and providing solutions which are hypothetically workable. Indeed, in the final analysis, if the measure of excellence is to identify systemic problems in Medicare and to provide concrete, workable solutions which will address those problems, the decentralist proposal is an excellent one on its own terms. Further, not only does it achieve worthy goals, it provides a solution that both the federal and provincial orders of government could quite possibly find attractive for their own reasons.

However, the decentralist proposal is very weak in one critical respect: it gives little to no consideration of the larger impacts which might occur were its proposals to be implemented. First and foremost, decentralising health care would mean an end to a meaningful federal role in the field. It would mean granting the provinces exclusive jurisdiction over health, and providing them with an entire tax field, topped up by unconditional federal transfers which would, theoretically at least, equalise provincial fiscal capacity. As such, the *Canada Health Act* would, in fact be a dead letter law, since the Canada Health Transfer is and always has been the mechanism by which the CHA was of any effect. Therefore, the first major effect of the decentralist proposal would be to remove the health guarantees which Canadians now enjoy. Decentralists argue that the provinces would be prevented by ‘public opinion’ from changing any aspect of the health care system. The historical record, however, does not support this assertion. The provinces would indeed be left free to make changes to their health insurance plans, and likely would. Inter-regional and inter-provincial differences in health care quality and coverage would likely begin to appear. The door would be opened to inequality of access and to inequality in terms of medical services received based on what region of the country one happened to reside in. Such a situation is both contrary to the values that have come to define Canadian health care, and it is also morally objectionable. There would likely be problems with inter-provincial co-

ordination and portability of benefits. In short, there would be serious potential consequences, none of which are given the adequate consideration by decentralist school advocates.

In sharp contrast stands the centralist vision for the future of Canadian health care. It also recognises that there are problems in the Medicare system as it exists today and provides a comprehensive and well-articulated framework for change and reform. More than that, however, it provides a framework which respects the past development of the Medicare system as a partnership, a unique federal balance between two orders of government where each performs the role it is best suited to playing, and neither government bears the whole burden of fiscal responsibility. Even more than that, however, and in this respect, it is far superior to the decentralist proposal, it recognises the larger impacts of any changes to Canada's health care system, a consideration that does not enter into the calculus of decentralists, or does so only in a very inadequate way.

Centralists wish to reform, protect, strengthen, and expand the national dimensions of health care within the existing framework, recognising Medicare as being one of the few features which bind Canadians of all regions and provinces together into a larger self-identifying whole. Decentralists do not consider that Medicare is a focus of Canadian identity. Their proposal implies a situation where the *Canada Health Act* and its five principles no longer apply, and health care is an exclusively provincial concern. As centralists have argued, this invites a greater sense of inter-regional differentiation and regionalism in what is already very much a country of regions. It removes the health guarantees to which Canadians have become accustomed – to uniform medical care under uniform terms and conditions – and replaces this with the delayed and indirect mechanism of quadrennial provincial elections.

In terms of future directions, therefore, having weighed the pros and cons of both the decentralist and centralist proposals, it is the conclusion of the present inquiry that the single best option for Canadian Medicare moving forward into the 21st century is the adoption of the vision of the centralist school of thought. Decentralisation may indeed meet the objectives it sets out to achieve in terms of putting a brake on provincial expenditures or making the fiscal structure of the federation more ‘rational’ and clarifying lines of accountability for tax and spending decisions – but the true questions which need to be asked is at what *cost* these reforms might come? By contrast, the centralist vision provides a blueprint for reform, change, and expansion of the health care system, negotiated between both partners in the health care enterprise within the structure which already exists, and which historically has worked quite well. At the same time, it retains intact the health care guarantees which Canadians currently enjoy, and which ensure that they receive a uniform standard of medically necessary care on uniform terms and conditions from coast to coast to coast – guarantees which would be threatened if decentralisation were to take place. Finally, a resurgent federal role and renewed federal-provincial partnership in health care would unequivocally establish that Medicare is a feature of a uniquely Canadian social citizenship – not solely citizenship in one province.

Ultimately, the centralist proposal achieves more worthy objectives than the decentralist proposal and provides a better framework for achieving them, one which has far less potential for collateral damage while still providing a blueprint for meaningful change. What is needed for the centralist vision to be successful, however, are politicians who respond to the same altruistic principles which motivated those who first responded to the demands of the Canadian people and made national public health insurance a reality in this country. Today’s political leaders must forego the temptation of blame-shifting. They must be responsible and clear in the way that they communicate, clarifying their roles and

responsibilities towards health care in a manner that the public understands. And they must unreservedly commit to engage once again with one another in a sustained, messy, difficult, yet constructive manner in order to bring about real change in the health care system, reforming it, strengthening it, and expanding it to reflect the changing health needs of the Canadian populace while still making efforts to control costs. They must respect that health care is a partnership in which each partner has its role and expertise, such that the provinces are left as free as possible to change, innovate, and find efficiencies within the broad conditions of the CHA, and the federal government confines itself to providing broad national direction and protection of the core values of the *Act*. Above all, politicians must not succumb to the siren call of decentralism or open federalism. Solutions which seem too simple, too straightforward, too logical, and too good to be true, often are. While at a stroke decentralisation would remove the need for painful and protracted intergovernmental negotiation and perhaps render the intergovernmental arena and the federation a much more ‘peaceful place,’ while providing incentives for the provinces to control costs, the negative consequences of this course of action, so clearly set out here, are too numerous, and too serious, to be discounted. It is up to Canada’s politicians, both federal and provincial, to in partnership take the first steps towards renovating a Medicare house which will serve Canadians well for the next half-century – and beyond.

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