

## VERTICAL FISCAL GAP AND VERTICAL FISCAL IMBALANCE: WORKING CONCEPTS AND LINKAGES

The key issue in the debate over vertical fiscal imbalance is the relative capacity of each order of government to raise its own revenues to fund its own expenditures. In the economics literature, unfortunately, the term "vertical fiscal gap" is sometimes used interchangeably with the term "fiscal imbalance." These concepts, however, convey different ideas, and the distinction between them is quite important in the context of the present analysis.

In many federal systems, the constitution assigns greater revenue-raising authority to the central government than is required to meet its expenditure responsibilities, while state or provincial governments are assigned significant expenditure responsibilities but with less than corresponding taxing powers. This "mismatch" in the allocation of revenues and spending obligations can provide important benefits. Having more taxation take place via the central government fosters greater tax harmonization and reduces economic distortions and administrative costs. The "excess revenue" also enables the central government to pursue certain economic efficiency and equity objectives at a national level by transferring revenues to state or provincial governments in variety of ways. At the same time, having people-related public expenditures take place through regional or subnational governments allows them to better respond to local needs and preferences. The main drawback to this revenue/expenditure mismatch is that it makes it more difficult for citizens to determine which order of government is responsible for what. It may also result in less accountability and less local autonomy than would be the case if the government that spent was also the one that taxed (according to the principle of fiscal responsibility).

Although the extent of the mismatch differs widely among federations, the central government typically transfers a share of its revenues to the regional order of government to fill the gap. These intergovernmental transfers provide a measure of the "vertical fiscal gap." Generally speaking, the size of the vertical fiscal gap (VFG) is a function of the degree to which (a) public spending is decentralized and (b) revenue raising is centralized. Together, these two factors determine the extent to which subnational governments must rely on the central government to supplement their own-source revenues.

From that perspective, the concept of vertical fiscal gap is nothing more

than an accounting identity. The size of the fiscal gap between orders of government is defined by the magnitude of the cash transfers that flow from one order of government to another. Based on this definition, the vertical fiscal gap between the federal and provincial governments in Canada decreased steadily over the two decades that ended in the late 1990s. During that period, the size of federal government transfers to the provinces, as a share of provincial revenues, was declining. Stated differently, provincial reliance on own-source revenue was on the rise. To the extent that CHST transfers have increased over the last few years, however, the vertical fiscal gap has again begun to rise. This perspective on the actual VFG, it will be clear, provides no criteria for determining whether it is too large, too small, or about right.

One way to assess whether the actual VFG is adequate would be to compare it to the desired or optimal vertical fiscal gap between the two orders of government. To the extent that there is a difference between the *actual* and *optimal* level, this may be a way to identify and measure any fiscal imbalance that might exist. For instance, in an ideal model – one that assumes the existence of an optimal allocation of expenditure and taxation between orders of government – the size of the intergovernmental transfers would be such as to enable each level of government to meet its expenditure obligations and achieve budget balance. Unfortunately, there is no ideal model from which to determine the optimal size of vertical fiscal gap. Indeed such an exercise is very much of a normative nature. For instance, the way one views the nature of the federation would very much affect the way one weighs the benefits of centralized revenue collection and nation-wide programming against the benefits of decentralization (spending adapted to local needs and preferences) and fiscal responsibility. As for the balance between state and market, the larger (or smaller) the state's role the more (or less) concerns about the efficient allocation of tax powers and expenditure functions are likely to matter. Each of these considerations has different implications for the design and amount of intergovernmental transfers. In short, the range of views on the optimal vertical fiscal gap is likely to correspond to the range of views about the nature of the federation and the role of the government in the economy.

In chapter 1, Keith Banting and Robin Boadway describe three alternative views of the role of the federal government in health care. In effect, they provide three quite different visions of the Canadian sharing community and hence of the Canadian federation. In their model of a *predominantly Canada-wide sharing community*, they envisage the whole of Canada as the primary sharing com-

munity. While this model can apply in the context of either a large or a small role for the state, for our purposes it is useful to think of it initially in the context of a larger role. What might be the VFG implications in such a setting? For one thing, the federal government would want to *ensure* that important social programs were available in all provinces and territories on fairly comparable terms. Since key social services, including health care, are generally designed and delivered by provinces, Ottawa would almost certainly use conditional transfers to provinces to persuade them to design and deliver these programs on terms that are consistent with the idea of a country-wide sharing community. The federal authorities would also want to make sure that the size of the transfers was large enough that provinces would be reluctant to challenge the conditions. (This is not to say that there could not, and should not, be extensive federal-provincial dialogue before such a decision is taken.) The consequence of such an action, of course, would be to increase federal transfers to the provinces and territories and thus enlarge the vertical fiscal gap.

Under this same model, there might be other reasons for the gap to rise. For example, the five-province standard for Equalization could be improved to better ensure that less wealthy provinces are in a position to provide services consistent with pan-Canadian norms, leading to larger federal transfers to recipient provinces.<sup>20</sup> It is also consistent with this vision of the federation for the federal government to occupy the dominant role in the personal income tax field because this is the only large progressive tax base that allows Ottawa to effectively fulfill its redistributive role. In short, it would be consistent with the predominantly Canada-wide sharing community model of the federation, in conjunction with a large role for the state, to have a substantially larger vertical fiscal gap than exists today. From a normative viewpoint, this would be a desirable outcome.

There are, of course, many arguments against such an increase in the vertical fiscal gap. Perhaps the easiest way to understand them is to consider the other end of the sharing-community spectrum, the *predominantly provincial sharing community* and its related arguments. To begin with, if provinces were the primary sharing community, the political goal of *assuring* reasonably comparable levels of services across the country would disappear. Thus, large conditional intergovernmental transfers for specific purposes, like health and social services, would be unnecessary. Moreover, it would be consistent with this view to focus less on the efficiencies and other benefits of centralized revenue collection and to concentrate more on the accountability and other benefits that flow from having

the government that spends also be the government that taxes. Thus, the desired size of the vertical fiscal gap under this model would be considerably smaller than the current vertical fiscal gap and much smaller than that under a predominantly Canada-wide sharing community model. The *dual sharing community* – the third model in the Banting-Boadway analysis – falls somewhere between these two.

The Séguin Commission's proposal to abolish the CHST and have the federal government reallocate tax room (for example, the GST) to the provinces is consistent with the predominantly provincial sharing community model of the federation. In effect, the size of the vertical fiscal gap would be limited to the size of the Equalization program, which we assume to be a given (in one form or another) in light of constitutional requirements.<sup>21</sup> This means that, under the predominantly provincial sharing model of the sharing community, the richest province or provinces would not receive any cash transfers from Ottawa. There would thus be no vertical fiscal gap between, say, the federal government and the provinces of Alberta and Ontario. In effect, all remaining federal transfers might then be thought of as reducing or eliminating differences in fiscal capacity among the provinces (reflecting Canada's equalization commitment). That is, their purpose would be to reduce or eliminate horizontal fiscal imbalances.<sup>22</sup>

From the preceding discussion, it should be clear that determining the desired size of the vertical fiscal gap is not a technical exercise but a normative one, which could lead to different results depending on how one views the nature of the Canadian sharing community, federalism, and the appropriate role for the state. To the extent that policy on intergovernmental transfers, at any point in time, somehow effectively reflects and fairly balances these competing views, then the idea of VFG as an accounting identity and VFG as a normative concept may coincide. When the provinces argue that the federal government is not contributing a sufficient share of health care funding and question the legitimacy of its role in setting the course of reforms, they are in fact claiming that there is an imbalance between the actual and desired level of VFG. But if provinces are able to deal practically with the problem, by raising more revenues on their own or by reducing low priority spending, then this difference between the actual and desired fiscal gap is not necessarily a case of vertical fiscal imbalance, notwithstanding provincial claims to the contrary. In that situation, if a revenue shortfall did occur, it would be due to the provinces' own budgetary decisions. However, if making budgetary adjustments is not an option that is

practically available to provinces because the federal government is occupying an unduly large amount of tax room relative to its spending obligations (including transfers to provinces), and because citizens are demanding that provinces maintain or even enhance current expenditure programs, then the difference between the actual and desired VFG could indeed constitute evidence of VFI. This second interpretation reflects the provinces' position today. They view the current fiscal situation as a clear case of "vertical fiscal imbalance."

The concept of vertical fiscal imbalance, therefore, has to do with the idea that one order of government has less revenue (including the transfers it receives) than it needs and can readily raise to implement its expenditure responsibilities, while the other has more revenue than it needs (including what it may require for intergovernmental transfers). The problem with this definition is that it is very difficult to apply in a Canadian context. For instance, the first question that arises is whether VFI is even a meaningful concept in a federation such as Canada where both the federal and provincial governments have the constitutional right to levy taxes on all of the major tax bases – and in fact do so.<sup>23</sup> The response to this question is that, in practice, both orders of government – and governments of all political stripes – believe there are effective limits to taxation, and behave accordingly. Thus, if the overall tax burden (all levels of government combined) is equal to or exceeds the assumed limit, then having the constitutional power to tax is not of much value if, for practical economic or political reasons, it is not desirable to do so. In other words, despite the constitutional allocation of taxing powers, vertical fiscal imbalance can be a meaningful concept.

A second question has to do with how to delineate the expenditure responsibilities of each order of government. The spending obligations of Canadian governments today are more or less related to the responsibilities or jurisdictions laid out in the constitution, but the extent and the manner in which governments choose to fulfil these obligations are matters of public policy and democratic choice. They are also subject to change over time. Moreover, since the federal government can intervene in areas of provincial responsibility not only through intergovernmental transfers but also through its use of the direct spending power (for example, through transfers to individuals), it can be difficult to determine where its expenditure obligations end and where the fiscal imbalance begins at any point in time.

A related issue, given limited fiscal resources, is how one assigns priority among the various expenditure responsibilities of different orders of govern-

ment. In times of war, this may be relatively easy to establish, but in peacetime there is no obvious way to do so other than through the political process. In effect, the order of government that believes it lacks the revenue required to meet its obligations will appeal to the public. If it can make a good enough case, then the public will somehow pressure the other order of government to transfer revenue to the government that is being shortchanged, or to vacate tax room. In the current context, the provinces claim that they lack the funds required to finance their large and growing expenditure responsibilities for health care and other social and educational services. The fact that the provinces have campaigned publicly for an adjustment to the allocation of revenues indicates that they believe they can win public support for their position. The fact that the federal government has increased its CHST transfer substantially over the last few years indicates that Ottawa has, up to a point, understood the power of their case.

Thus in spite of the complexities involved, the issue of vertical fiscal imbalance is a pertinent one. The question is how to identify VFI and measure it. Presumably, the imbalance would manifest itself in the relative fiscal outcomes of both orders of government over time. For instance, vertical fiscal imbalance could be an issue when one order of government is able to achieve structural fiscal balance or surpluses on a consistent basis while the other order of government is in a precarious fiscal position. We use the words "could be" because there is nothing automatic about these circumstances being symptoms of vertical fiscal imbalance. As already discussed, it is only when the order of government with the weaker fiscal structure is effectively precluded from correcting this weakness on its own (say because the fiscally stronger level of government has occupied too much tax room or has unilaterally reduced its share of joint-program funding) that a VFI can be said to exist. The next two sections of this chapter deal specifically with these issues.

Assuming a VFI does exist, it can be corrected in several ways. First, the order of government with the stronger structural fiscal balance can transfer cash to the other order of government. When this technique is used, the vertical fiscal imbalance shrinks but, of course, the vertical fiscal gap increases. Second, the government with the budgetary surplus can assume some of the expenditure responsibilities of the other order of government. Third, tax room can be transferred from the surplus order of government to the other. The second and third techniques have no effect on the vertical fiscal gap. Choosing among these methods, or combinations of them, is related to the normative issues discussed above.

concerning the desirability of a vertical fiscal gap. There is considerable historical precedent for all three methods in Canada.

There are other conceivable ways of dealing with a vertical fiscal imbalance. For example, the government in surplus position could commit to transferring a fixed percentage of revenues from a particular tax base to the other order of government. Assuming the federal government is the one with the surplus, a formal revenue-sharing scheme would preserve the administrative and economic advantages of centralized revenue collection and could also help to reduce the negative aspects of tax competition while ensuring that provinces have access to a certain share of aggregate revenues. These are significant advantages. A disadvantage with this approach, however, is that it would give provinces less fiscal autonomy than a transfer of tax room would. There is less precedence for this revenue-sharing method in Canadian experience, but it is used in a number of other federations.

To sum up, the size of the current vertical fiscal gap (that is, the level of intergovernmental transfers) does not tell us whether it is adequate or appropriate. And it tells us even less about whether there is a vertical fiscal imbalance above and beyond the observed or even the desired level of VFG. And this is what is at issue in the current debate. One's view of what constitutes an appropriate vertical fiscal gap for Canada will depend on what is perceived to be the appropriate role of the state in general, and that of the federal government in particular. Irrespective of these views, however, one would presumably also take into account the extent of VFI, if the latter could be ascertained.

## VERTICAL FISCAL IMBALANCE: FROM CONCEPT TO APPLICATION

A number of Canadian studies produced since the early 1990s have attempted to quantify the extent of vertical fiscal imbalance between the federal and the provincial and territorial governments. These studies for the most part have taken a direct approach to the mismatch issue, based on a comparison of the structural fiscal balances of each level of government. In particular, Joe Ruggeri, Vaughan Chair in Regional Economics and Director of the Policy Studies Centre at the University of New Brunswick, has been publishing papers on this subject with his colleagues for a number of years.<sup>24</sup> More recently,

Ruggeri has updated some of this work at the request of provincial governments and produced new estimates. Many of the arguments put forward by the provinces on vertical fiscal imbalance are based on his reports.

The conceptual framework underlying Ruggeri's analysis was initially laid out in a paper by Ruggeri, Howard, and Van Wart in 1993. Their definition of structural fiscal balance focuses on the relationship between the built-in growth of existing expenditure programs and revenue sources for each order of government (1993a, 456). A structurally balanced fiscal system in this framework is one where the initial relationship between the built-in growth of spending and taxation is maintained through time. If it diverges, the fiscal system is deemed *structurally* unbalanced. Thus, in the absence of debt, structural balance can be defined simply as the maintenance of a balanced budget through time, which in turn requires that the growth rate of revenues and expenditures be equal (if they are not, the difference between the two is the measure of structural imbalance).

When deficit financing and debt are incorporated in the model, structural balance can be defined in one of two ways: (1) as a fiscal system that maintains constant deficit- and debt-to-GDP ratios; or (2) as one where the nominal value of the debt is kept constant, but its ratio relative to GDP falls over time toward zero. Assuming that the nominal interest rate is equal to the rate of growth of nominal GDP, maintaining structural balance under the first definition would require a balanced operating budget (i.e., revenues equal to program spending) and the same rate of growth in revenues and expenditures. Under the second definition, structural balance would require maintaining budgetary balance (i.e., revenues equal to program spending plus debt charges), that is, having an operating surplus which as a share of GDP is equal to the debt-to-GDP ratio times the nominal interest rate. If the nominal interest rate is greater than the growth rate of nominal GDP, the requirements for maintaining structural fiscal balance are more onerous, and *vice versa*. Under the first definition, an operating surplus equal to the level of debt times the difference between the interest rate and the growth rate of GDP would be required. Under the second definition, the surplus required is equal to the debt times the nominal interest rate plus the differential between the nominal interest rate and the growth rate of GDP. In a recent paper, Thomas Courchene (2002) describes the dramatic impact of the differential between the nominal interest rate and the GDP growth rate on the federal government fiscal position in the postwar period. For illustration, he notes that in 1994, when the interest rate was 3 to 4 percentage



points above the GDP growth rate, an operating surplus of \$20 billion was required just to keep the debt-to-GDP ratio constant.

For analytical purposes, Ruggeri, Howard, and Van Wart (1993a) prefer the first definition of structural imbalance (based on a constant debt-to-GDP ratio), because it allows one to distinguish between two sources of structural imbalance: that which is due to the initial mismatch between revenue and expenditure *levels* and that which results from the ongoing mismatch in revenue and expenditure *growth rates*. As the authors point out, each source of imbalance requires a different policy response. Whereas the first type of imbalance simply requires an adjustment in the level of revenue and/or expenditure, the second type could only be corrected by making structural changes on either the tax or expenditure side that would affect the built-in growth rates (for example, altering the tax mix or the rate structure, or changing program eligibility criteria). It is the second type of imbalance that is the focus of their analyses on vertical fiscal imbalance.

The basic methodology consists of projecting fiscal balances assuming steady economic growth and no change in government policy. The object is to examine separately the budgetary outcomes of the fiscal structures of the two orders of government in the absence of cyclical effects and discretionary government actions. In order to do so, the taxation and expenditure structures of each order of government in the base year are taken as given and their respective growth path projected based on the different built-in growth rates assigned to particular revenue sources and program expenditures. For each revenue and expenditure component the growth rate is assumed to be related in some particular fashion to growth in one or a combination of independent variables such as GDP, consumer price index (CPI), labour productivity, population growth, or aging.

The first column of Table 1 reports selected growth rates underlying Ruggeri's most recent estimates of vertical fiscal imbalance (Ruggeri 2001). These updated estimates incorporate significant policy changes implemented since the author's earlier report to provincial premiers in July 2000. The changes include income tax reductions by the federal and provincial governments and the CHST increases announced as part of the September 2000 Health Accord, as well as other spending initiatives and economic growth adjustments as of mid-2001. Based on Ruggeri's estimates, federal revenues are expected to grow an average of 4.1 percent per annum versus 3.6 percent for the provinces between 1999/2000 and 2019/20. Given that the federal government and the provinces share access

to most of the main revenue sources, the discrepancy between the two in terms of overall growth in revenues stems primarily from two sources: 1) the federal government's greater reliance on the fastest-growing revenue source, the personal income tax (PIT) – 47 percent relative to 27 percent for the provinces; and 2) the significant share of provincial revenues (15 percent) that comes from slow-growing federal transfers. Ruggeri takes into account the effects of announced tax cuts and transfer increases in coming fiscal years, but after that assumes that PIT revenues will continue to grow at a rate of 1.25 times the growth in nominal GDP, and that CHST cash payments in real terms will only be kept constant at their 2005/06 level.

The opposite occurs on the expenditure side. Provinces have a relatively large share of their program spending in rapidly growing expenditure areas. Health and education, which combined make up for more than half of total provincial spending, are projected to grow at a faster rate than nominal GDP.<sup>25</sup> On the other hand, Old Age Security (OAS) is the only large federal expenditure program expected to grow rapidly, and it accounts for only 10 percent of total federal spending.<sup>26</sup> Transfers to provinces, which in aggregate account for 17 percent of total federal spending, are only projected to grow at a rate of 2.2 percent. Moreover, under the “no policy change” constraint, debt charges are assumed to remain constant. As a result, close to 25 percent of federal expenditures has a zero built-in growth rate (compared with less than 15 percent for the provinces).

Provincial spending is thus projected to grow at an average annual rate of 3.5 percent over the twenty-year period, whereas the corresponding rate for federal spending is 2.2 percent. Federal government revenues, on the other hand, are expected to grow almost twice as fast as its expenditures, while the provincial revenue growth rate is only marginally higher than that of expenditures. Ruggeri refers to these differential federal/provincial growth rates on the revenue and expenditure side as the *roots* of vertical fiscal imbalance. These growth rates are then applied to actual base-year fiscal parameters to project the budget position of the federal and provincial governments (Ruggeri 2001, 7). As Charts 1a and 1d show, relatively small growth rate differentials generate a substantial fiscal impact when projected forward ten and twenty years. According to Ruggeri's calculations, the federal surplus is expected to increase to \$39 billion by 2009/10 and to triple to \$126 billion ten years later, while the provinces will only manage to achieve budget balance in 2009/10 and a \$5.5-billion surplus in 2019/20. The difference in the size of federal and provincial budget balances over

Table 1

## SUMMARY OF ASSUMPTIONS IN RECENT STUDIES ON FISCAL IMBALANCE

	Ruggeri (2001)	Conference Board of Canada (July 2002)	Matier, Wu, and Jackson (2001)
Nominal GDP	4.7	4.2	4.3
Inflation	2.0	2.0	2.0
Interest rate on debt	7.0 <sup>1</sup>	7.2	7.0
<b>Federal revenues</b>			
Total revenues	4.1	3.5	3.8
PIT	5.0	3.9	3.9
CIT	3.7	3.5	3.2
GST	4.7	4.0	4.7
<b>Federal expenditures</b>			
Total expenditures	2.2 <sup>2</sup>	2.5	3.7
Program expenditures	2.9	3.9	4.7
OAS	4.6	4.2	6.2
CHST	1.9	4.5	4.1
Equalization	2.5	3.5	4.3
<b>Provincial revenues</b>			
Total revenues	3.6	3.4	4.1
PIT	5.1	3.8	3.9
CIT	3.7	3.3	3.4
RST	4.7	4.0	4.4
<b>Provincial expenditures</b>			
Total expenditures	3.5 <sup>3</sup>	4.0	3.6
Program expenditures	4.0	4.1	4.4
Health care	5.3 <sup>3</sup>	5.2	5.2
Education	4.5 <sup>3</sup>	3.2	3.1

Note: The figures reported are the average annual percentage change over the period 2000/01 to 2019/20 in Matier, Wu, and Jackson and in the Conference Board of Canada, and average growth rates over the period 1999/2000 to 2019/20 in Ruggeri. The figures reported for Matier, Wu, and Jackson were calculated from data provided to us by the authors based on their alternative simulations incorporating announced revenue measures.

<sup>1</sup> In Ruggeri, the interest rate on the federal debt is assumed to fall slowly from 7.5 percent in 1999-2000 to 7.0 percent in 2005/2006 and remain at that level thereafter. For the provincial debt, it is assumed to decrease from about 8.9 percent in 1999-2000 to 8.25 percent in 2005/2006.

<sup>2</sup> Growth rates reported here for total expenditures and debt service at the federal and provincial levels correspond to the case in which surpluses are not used to reduce the public debt.

<sup>3</sup> The underlying growth rate, excluding announced changes, is 5.1 percent for health care and 4.2 percent for education.

Sources: G.C. Ruggeri. A federation out of balance: update. Department of Economics, University of New Brunswick, Fredericton, 2001; Conference Board of Canada. *Fiscal prospects for the Federal and Provincial/Territorial Governments*. July 2002; Chris Matier, Lisa Wu, and Harriet Jackson. Analysing VFI in a framework of fiscal sustainability. Working paper 2001-23, Department of Finance Canada.

Chart 1a

GOVERNMENT EXPENDITURES AND REVENUES—RUGGERI (2001)  
(average annual growth rate)

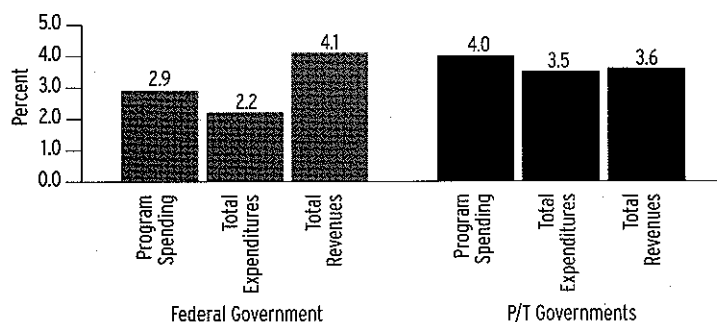


Chart 1b

GOVERNMENT EXPENDITURES AND REVENUES—CBoC (JULY 2002)  
(average annual compound growth rates)

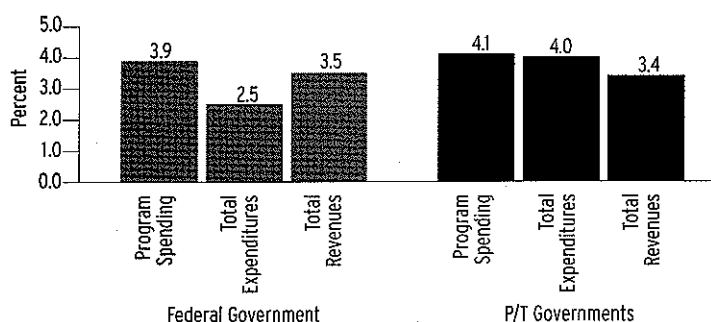


Chart 1c

GOVERNMENT EXPENDITURES AND REVENUES—MATIER, WU,  
AND JACKSON (2001) (average annual growth rates)

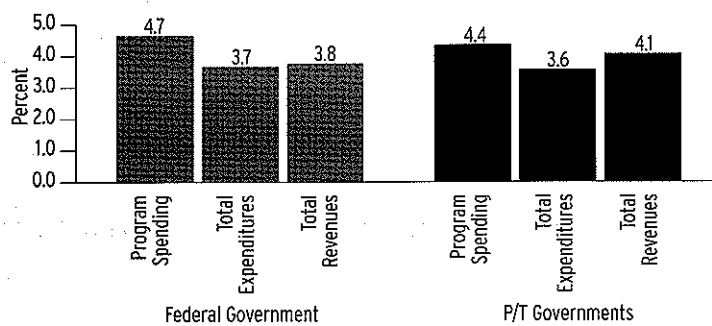


Chart 1d

PROJECTION OF FEDERAL AND P/T BUDGET BALANCES—RUGGERI (2001)  
(billions of dollars)

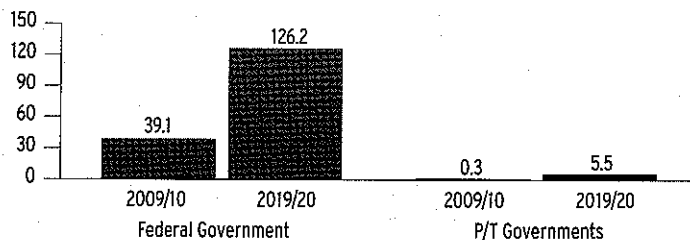


Chart 1e

PROJECTION OF FEDERAL AND P/T BUDGET BALANCES—CBoC (JULY 2002)  
(billions of dollars)

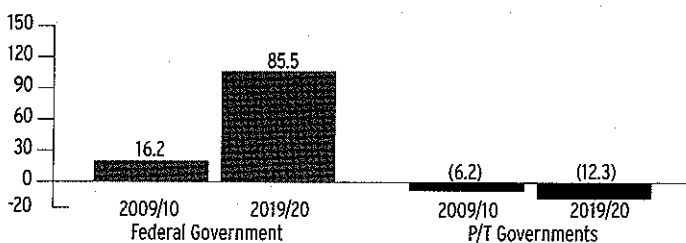
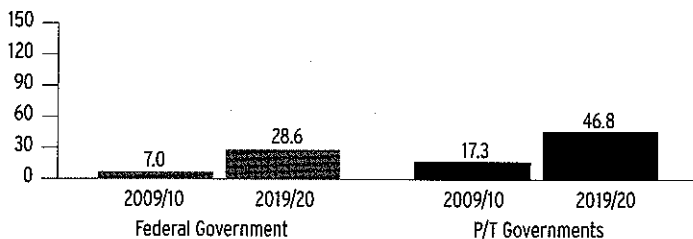


Chart 1f

PROJECTION OF FEDERAL AND P/T BUDGET BALANCES—MATIER, WU,  
AND JACKSON (2001) (billions of dollars)



Sources: G.C. Ruggeri, *A federation out of balance: update*, Department of Economics, University of New Brunswick, Fredericton, 2001; Conference Board of Canada, *Fiscal prospects for the Federal and Provincial/Territorial Governments*, July 2002; Chris Matier, Lisa Wu, and Harriet Jackson, *Analysing VFI in a framework of fiscal sustainability*, Working paper 2001-23, Department of Finance Canada.

time is what Ruggeri describes as the *path* of vertical fiscal imbalance. According to his estimates, approximately 80 percent of the difference between the federal and provincial fiscal positions stems from the divergent growth paths on the spending side.

In his alternative scenarios, Ruggeri illustrates the precarious state of the provinces' fiscal position. For instance, he shows that adding half a percentage point to the annual growth rate of health care spending transforms small provincial surpluses into a string of growing deficits (up to \$10 billion by the end of the twenty-year period). The size of federal surpluses provides a much greater cushion against unforeseen circumstances, a situation that, Ruggeri's estimates show, is further reinforced when allowing for a portion of these surpluses to go to debt repayment. An assumption that half of any surplus goes to debt repayment increases the federal surplus (relative to the base case reported in Chart 1) by \$14.7 billion in 2014/15 and by \$35.8 billion in 2019/20, at which point the federal debt would be eliminated. Since the option of paying down the debt is not widely available to the provinces (for lack of the necessary surpluses), this self-feeding mechanism leads to an even greater vertical fiscal imbalance.

The Conference Board of Canada (CBoC) (2002a), in a report prepared for the Commission on Fiscal Imbalance, uses a similar approach to project the public accounts of the federal and Quebec governments out twenty years to the year 2019/20. In July 2002 the Conference Board extended the study prepared for the Séguin Commission to cover all of the provinces and territories.<sup>27</sup> The Conference Board's results are based on its own long-term economic forecasts for basic macro-economic variables, as well as two separate forecasting models developed to estimate specific changes in per capita spending on health care and education. They also adopt a status quo benchmark with respect to fiscal and budgetary policy (except for measures announced in the 2000 and 2001 federal budgets and economic update). But in contrast to Ruggeri's work, their base case assumes that government surpluses in any given year are allocated entirely to debt repayment. As stated in the report, this assumption allows one "to evaluate the governments' room-to-manoeuvre and thus to indicate the degree of latitude available to them to implement new initiatives or, conversely, the budgetary actions needed to balance the books" (Conference Board of Canada 2002b, 28).

Table 1 (column 2) reports the Conference Board's estimates of average annual compound growth rates for selected variables. Estimates of budgetary revenues from direct taxes are calculated using the CBoC's personal income and

corporate profit forecasts, and revenues from indirect taxes are based on growth in consumer spending or general economic activity. Other than recent budget measures, federal program spending for the most part is assumed to grow in line with two factors: growth in nominal GDP and the rate of growth of population and inflation combined (the growth rate is the mean of these two rates). OAS benefits are linked to projected demographic changes and indexed to inflation. Growth in equalization payments is tied to growth in nominal GDP (in the same way as observed in the past), and CHST payments increase as planned to 2005/06 and are then assumed to grow in line with population growth and inflation. While federal budgetary revenues are expected to increase by 3.5 percent annually and program spending by 3.9 percent, the reduction in interest payments that follows from having budget surpluses used to pay down the debt has a dramatic effect on the overall rate of growth of federal expenditures, which is only 2.5 percent.

Assumptions regarding growth in provincial and territorial revenues and program spending are generally consistent with those for federal revenues and spending. As mentioned earlier, health care and education spending are estimated separately. Health care spending is projected to increase at an average annual growth rate of 5.2 percent over the twenty-year period (much faster than the expected rate of growth of nominal GDP of 4.2 percent). Of the 5.2 percent, 2.1 percentage points per year is attributable to inflation, 1.7 to demographics (population growth and aging) and 1.4 to real increases in the volume of services provided due to technological change, broader access, and other factors.<sup>28</sup> As a result, provincial health care spending is expected to increase from \$63.5 billion in 2001/02 to \$166.5 billion in 2019/20, by which time it will represent close to 45 percent of budgetary revenues (compared to 32 percent currently). In the case of education, spending is projected to increase by only 3.2 percent per year on average, reflecting the decline in population in the relevant age groups. As Chart 1b shows, overall provincial and territorial program spending is expected to increase at a slightly faster rate than federal spending (4.1 percent relative to 3.9 percent). However, since provincial and territorial governments collectively are unable to reduce their interest charges due to ongoing deficits, their budgetary expenditures increase by 4.0 percent per year over the twenty-year period, compared to 2.5 percent at the federal level.

The main conclusion of the Conference Board report is that: "With current fiscal regimes in place, the vertical fiscal imbalance will widen in the future"

(2002b, 28). At the federal level, the results reveal a steady string of ever-growing budget surpluses reaching \$16.2 billion in 2009/10 and \$85.5 billion in 2019/20 (see Chart 1e). As a result, the federal government is able to pay down more than 90 percent of its interest-bearing debt by the end of the forecast period (from \$589 billion to \$53 billion) and see its annual interest charges reduced from \$42 billion to \$11 billion. The reduction in interest payments is largely responsible for the growing budgetary surplus and the fast decline in interest-bearing debt at the federal level.

Meanwhile, the combined budget balance of provincial and territorial governments is projected to remain negative throughout the forecast period, with the deficit peaking at \$12.3 billion in 2019/20. By that time the aggregate provincial/territorial debt level will have increased by 54 percent from \$251.5 billion to \$386.9 billion<sup>29</sup> and the debt-servicing charges will be 3.5 times those borne by the federal government (Conference Board of Canada 2002b, 28). The CBoC report points to the expected rate of growth of health care expenses (5.2 percent) as particularly problematic given the expected average rate of growth (3.4 percent) in provincial and territorial budgetary revenues.

Researchers at the federal Department of Finance have also put forward their own analysis and estimates of vertical fiscal imbalance. The approach taken by Matier, Wu, and Jackson (2001) differs from the preceding two studies in three respects. First, they develop an indicator of vertical fiscal imbalance that incorporates explicitly the notion of fiscal sustainability; that is, the existing debt of each order of government is included directly in the measurement of structural fiscal balance. Second, they use a generational accounting framework that allows them to capture the impact of population growth and aging on all affected revenue sources and expenditure categories.<sup>30</sup> Third, based on their definition, a vertical fiscal imbalance is only deemed to exist if one order of government has fiscal room to reduce taxes or increase program spending and satisfy its intertemporal budget constraint, while the other order of government's fiscal structure is such that it would need to permanently increase taxes or reduce program spending to restore fiscal sustainability.<sup>31</sup>

A government's fiscal structure is considered to be sustainable if it satisfies its intertemporal budget constraint. This means that government debt must not grow faster than the rate of interest over time. In an intertemporal framework, this condition is satisfied if the present value of future operating budget balances (revenues minus program spending) equals the initial level of (net)



debt. If a government's initial debt is larger than the present value of its projected primary balances, this constitutes a fiscal gap. If the initial debt is smaller than the present value of projected primary balances, the government has fiscal room at its disposal to implement new measures. Based on this model, a vertical fiscal imbalance exists only if one order of government is found to have fiscal room while the other suffers from a fiscal gap.

Matier and his colleagues estimate the extent of fiscal gap/room for each order of government based on long-term fiscal projections that take into account the effects of population growth and aging on government revenues and expenditures (using a generational accounting framework). The methodology used is the following: the first step consists of allocating GDP and each category of government own-source revenues and program spending among 91 single-year age groups. Real average per capita levels for each age group are then assumed to grow at the same rate as productivity growth (the model assumes a constant annual rate of productivity growth of 1.5 percent and a constant rate of inflation of 2 percent). Using projections of population growth by age group, it is possible to then project the growth of each fiscal variable. Thus, for the most part, the growth path for each revenue and expenditure category is determined by productivity growth, population growth, population composition, and inflation.<sup>32</sup> However, since productivity and inflation growth rates are constant, the key components determining different revenue and expenditure growth patterns are population aging and growth.

Table 1 (column 3) reports the underlying average annual growth rates for selected revenue sources and expenditure categories based on data provided by the authors. Although Matier et al. focus their analysis and conclusions on the results obtained in their benchmark case, the estimates reported here are those derived from one of their alternative simulations which takes into account federal and provincial tax measures announced in recent budgets and therefore provides a better basis of comparison with the Ruggeri and the Conference Board studies. Total federal revenues are projected to grow at an average annual rate of 3.8 percent relative to 4.1 percent at the provincial level between 2000/01 and 2019/20. Their estimates suggest that overall, demographic change is of relatively little consequence for tax revenues.

Program expenditures are projected to grow at an average annual rate of 4.7 percent at the federal level and 4.4 percent at the provincial level. As expected, the programs in which spending is skewed toward the elderly grow much

faster relative to GDP than other less age-sensitive programs. For instance, in the benchmark case, the projected average annual growth rate of health expenditures from 2000/01 to 2019/20 is 5.1 percent. The authors observe that at this rate, provincial health spending as a share of GDP would rise from 6.1 percent in 2000/01 to 9.3 percent by 2040/41. Federal spending on Old Age Security is projected to rise even more rapidly at 6.2 percent per year over the next twenty years. In the case of education, an aging population has the opposite effect; spending is projected to grow at only 3.1 percent on average.

Based on these growth projections for revenues and spending, the authors calculate projected primary balances for both orders of government and estimate the size of the fiscal gap/room for each as an indicator of vertical fiscal imbalance. According to their estimates in the "announced revenue measures" case, the federal and provincial governments both have fiscal room equal to 0.33 percent and 0.30 percent (respectively) of GDP.<sup>33</sup> This suggests that both orders of government could permanently reduce taxes and/or increase spending by these amounts and still maintain fiscal sustainability. Consequently, they conclude that there is no indication of vertical fiscal imbalance. "Thus, the initial projected path of federal intergovernmental transfers is sufficient in this framework because it ensures that the provincial/territorial governments have the fiscal capacity to meet their projected spending in a fiscally sustainable manner" (Matier, Wu, and Jackson 2001, 24).

The results of the Matier et al. analysis produce opposite federal-provincial fiscal trends from those projected by Ruggeri and the Conference Board, with provincial revenues growing at a faster rate than federal revenues and federal program spending increasing more rapidly than provincial program spending (see Chart 1c). This somewhat counterintuitive outcome translates into projected budget surpluses that are expected to be higher at the provincial level (\$17.3 billion by 2009/10 and \$46.8 billion by 2019/20) than at the federal level (\$7 billion by 2009/10 and \$28.6 billion by 2019/20). However, this result is very much a function of the underlying assumptions and methodology used in their model. By having all real per capita/per age-group own-source revenues and spending grow at the same rate as productivity, the authors do not take into account the particular elasticities of different tax and expenditure categories (apart from those that result from population aging and growth). Their fiscal projections are entirely driven by changes in the age profile of the population. The advantage of such an approach is that it clearly highlights the relative effects of demographic change on particular

revenue and spending categories for a given fiscal structure, all things being equal. But it also implies, for instance, that all social benefits (EI, OAS, social assistance, etc.) are not only indexed to inflation but are assumed to grow (in real terms and on a per capita basis) at a rate of 1.5 percent per year from their initial levels. Indeed, the same applies to all other spending categories and revenue sources. Thus, if we remove the age-profile effects, all categories of revenue (from income taxes to fuel and liquor taxes) and expenditure (from welfare benefits to defence spending) are projected to grow at the same rate. It can be argued that the same assumptions apply for both orders of government, thereby removing any potential arbitrariness in making selective assumptions about the relative growth paths of particular revenue sources and spending categories. However, it produces results that are somewhat removed from observed fiscal patterns in the past and from likely resource allocation in the future.

In the context of the vertical fiscal imbalance debate, the analysis produced by Matier and his colleagues is a useful contribution in the following sense. It broadens the debate by pointing out the need to take into account existing debt levels and the prudence factor required to ensure fiscal sustainability, when comparing the structural fiscal balances of both orders of government. It also advances the argument that vertical fiscal imbalance is only an issue if one order of government has excess fiscal room while the other suffers from a fiscal gap (as they define it). This reasoning is quite different from what is inferred in other studies, which is that there is VFI any time one order of government is in a more favourable structural fiscal position than the other. And finally the Matier et al. study produces estimates of the relative fiscal impact of population growth and aging on each order of government (all other things being equal). Other than these demographic effects, however, the study does not consider how, as a result of a different revenue mix and types of expenditures, the fiscal structure of each order of government is likely to evolve in the coming years. This is what is at the heart of the current intergovernmental debate, and it is the focus of both the Ruggeri and the Conference Board analyses.

These two studies also project fiscal balances based on the current fiscal structure of each order of government and assuming no policy change. Each attempts to model the particular growth path of each component of revenue and spending and its implications for future government budget balances. However, each draws quite a different portrait of the fiscal landscape. This is a classic example of "small differences that matter."

The Ruggeri results are driven by the following factors. On the revenue side, the relatively high projected growth rate for nominal GDP is a significant factor that affects the growth of certain tax revenues (in particular the PIT, which is assumed to grow 1.25 times GDP growth) and in turn favours the growth of federal revenues; at the same time the projected low rates of growth for federal transfers and other non-primary sources of revenue work in the opposite direction for provincial revenues. On the expenditure side, the Ruggeri model assumes relatively high rates of growth for health and education (representing half of provincial spending) and for OAS, but essentially assumes no real growth in the remaining categories.<sup>34</sup> This, combined with constant debt charges (which are larger at the federal level) and slow-growing federal transfers, results in a higher projected growth rate for provincial expenditures.

The Conference Board's estimates for revenue growth, which are based on their own macroeconomic forecast of projected growth in personal income, corporate profits, and consumption, among other factors, generate very different results than those reported in the Ruggeri study, with federal and provincial/territorial own-source revenues projected to grow at roughly the same rate (3.4 percent).<sup>35</sup> Overall federal program spending is expected to grow more rapidly than is assumed in the Ruggeri study, as it is partially linked to GDP growth in addition to inflation and population growth. Provincial/territorial program spending in aggregate is estimated to grow only at a slightly faster rate than federal program spending. The CBoC projected growth rate for education spending is considerably lower than the rate used by Ruggeri. The growth rates for total expenditures are not comparable since the Conference Board assumes all surpluses are allocated to debt repayment and debt charges are reduced accordingly, while the latter are held constant in Ruggeri's base case.

The results illustrate how important these small differences are when projected twenty years forward. Ruggeri's estimates of the difference between the built-in growth rates in federal revenues and expenditures generate a federal surplus of \$39 billion by 2009/10 and \$126 billion by 2019/20. When it is assumed that half of the federal surplus is allocated to debt, this surplus increases to \$162 billion at the end of the twenty-year period. The Conference Board study, which assumes all surpluses go to debt reduction, also reports growing federal surpluses, but of a lesser magnitude at \$16.2 billion in 2009/10 and \$85.8 billion in 2019/20.

This overview of three studies on vertical fiscal imbalance in the Canadian context indicates that the results from such analyses need to be inter-

puted with caution. Since the fiscal projections are highly sensitive to the underlying model specification and empirical assumptions, it is important to understand and take these into account. In each case the authors stress the fact that the results they present are *projections* of given fiscal variables in a given year based on assumptions about trends in economic and demographic variables and are not *forecasts*. This means that changes in the economic environment, which can and do have a determining and often long-term effect on revenue growth and particular spending requirements, are not considered.

Moreover, these analyses are meant to examine and compare the *structural* rather than the *actual* balances inherent in the current tax and expenditure configuration. In order to do this, it is assumed that revenues and expenditures grow from their initial levels at a given built-in rate and that no policy change or adjustment takes place even if a pattern of cumulative surpluses or deficits emerges which creates its own set of fiscal dynamics. For instance, the Conference Board study indicates that in the absence of cyclical fluctuations and policy changes, the federal government's current fiscal structure would likely produce a steady stream of budget surpluses even under fairly conservative assumptions about growth rates. But these surpluses can only materialize if economic growth is sustained, taxes are not further reduced, new spending measures are not implemented, and the entire surplus goes to debt payment, thus reducing debt charges as projected. However, as recent federal budgets demonstrate, governments do adjust to both economic and fiscal circumstances on an ongoing basis. It is therefore important to recognize that the fiscal position of both orders of government in any given year is inevitably the outcome of cumulative fiscal effects and adjustments to changing circumstances over a number of years. For instance, any assessment of where we are now in terms of vertical fiscal imbalance has to take into account how federal-provincial fiscal relations have evolved over the years and how this history has affected the relative fiscal positions of each order of government.

## FEDERAL AND PROVINCIAL PUBLIC FINANCES: RETROSPECTIVE AND PROSPECTIVE

**T**he current fiscal position of both orders of government has been greatly influenced by the evolution of federal-provincial fiscal relations over the past several decades. This influence stems from the manner in which

major national social programs were first established in the postwar years, the changes in the respective role and relative importance of each order of government that have taken place over time, and the various channels through which the fiscal status of one order of government affects that of the other.

Looking back on this history one observes that intergovernmental fiscal relations in Canada have essentially been in a continuous state of flux and adjustment. It is not clear that a state of vertical fiscal balance was ever achieved which could in turn be seen as a benchmark from which we have somehow derogated. Also, while there is clear evidence of structural fiscal imbalance over significant periods of time for both orders of government, the situation may or may not have been related to vertical fiscal imbalance issues. Indeed, notwithstanding the effects of cyclical fluctuations, the recurrence of substantial budget deficits or surpluses over a considerable length of time would indicate either: (a) a failure on the part of the government involved to make the necessary revenue or expenditure adjustments to achieve sustainable budget balances; or (b) an inability to do so because of a structural imbalance between revenue-raising capacity and expenditure responsibilities. The issue of vertical fiscal imbalance only comes into play in the second instance and only to the extent that the budgetary stance or actions of one order of government affect the other or in some way limit its capacity to adjust to its own circumstances.

An overview of the evolution of Canadian public finances and federal-provincial fiscal relations over the last four decades provides a useful historical perspective on the current vertical fiscal imbalance debate.

### The Growth of the Welfare State and the Rise of Provincial Governments

One of the main characteristics of the Canadian federation is the degree to which it is decentralized. As in many other industrialized countries, there was a dramatic increase in the size of the public sector in Canada in the decades following the Second World War as governments laid the foundations of the welfare state and took on a more active role in the economy. What was particular in the Canadian case was that most of that increase occurred at the provincial level where constitutional responsibility for health, post-secondary education, and social assistance has been assigned. Thus the establishment of major social programs not only resulted in a rapid expansion of the role of provincial governments but also led to a significant increase in their importance relative to the

federal government. In little more than a decade, the provinces became the dominant player in terms of public expenditures.

Charts 2 and 3 illustrate the trends in the relative size of the two orders of government over time and the repercussions on both expenditures and revenues. It is important to note that the data consist of current revenues and expenditures on a National Accounts basis (that is, they do not include investments in fixed capital, inventories, and net capital transfers). The reader should also note that the data for the provincial and local levels of governments have been consolidated in order to focus exclusively on the fiscal relationship between the federal government and the provinces. Since the division of responsibilities between provincial and local governments varies significantly from province to province, provincial grants to local governments are difficult to treat in a consistent fashion.<sup>36</sup> Moreover, the local government data include not only municipalities, but also universities, schools, and hospitals, which are relevant to this discussion.

As Chart 2a shows, the size of the public sector as a share of GDP essentially doubled from 22 to 44 percent between 1957 and 1982.<sup>37</sup> The provincial/local government sector, which grew from 9 to 26 percent of GDP during that period, accounted for about 80 percent of that increase. As for the federal government, the figure shows the rapid and substantial decline from wartime expenditures.<sup>38</sup> By 1957 the federal government's own expenditures had settled at about 14 percent of GDP and they remained in that range until the recession of the early 1980s when spending reached 18 percent of GDP. However, federal own-expenditures do not include transfer payments to the provinces, which were an important catalyst for the development of provincial social programs. Indeed, much of the growth in provincial expenditures coincides with the implementation of major cost-sharing transfer programs. These include the *Hospital Insurance and Diagnostic Services Act* in 1957; the various federal grants implemented in the 1950s to share the cost of provincial programs of social assistance to the blind, the aged, the disabled, and the unemployed, which were eventually combined and extended as part of the Canada Assistance Plan in 1966; the *Medical Care Act* in 1966; and various funding provisions for post-secondary education beginning in the early 1960s. The Equalization program, introduced in 1957, also increased the ability of recipient provinces to establish social programs.

Chart 2a also shows a levelling-off of public sector spending and even a slight decline throughout most of the 1980s, followed by a significant upswing that coincides with the recession of the early 1990s when government expendi-

Chart 2a

FEDERAL AND PROVINCIAL/LOCAL GOVERNMENTS' EXPENDITURES  
FOR OWN-PURPOSES, 1945-2000 (as % of GDP, National Accounts)

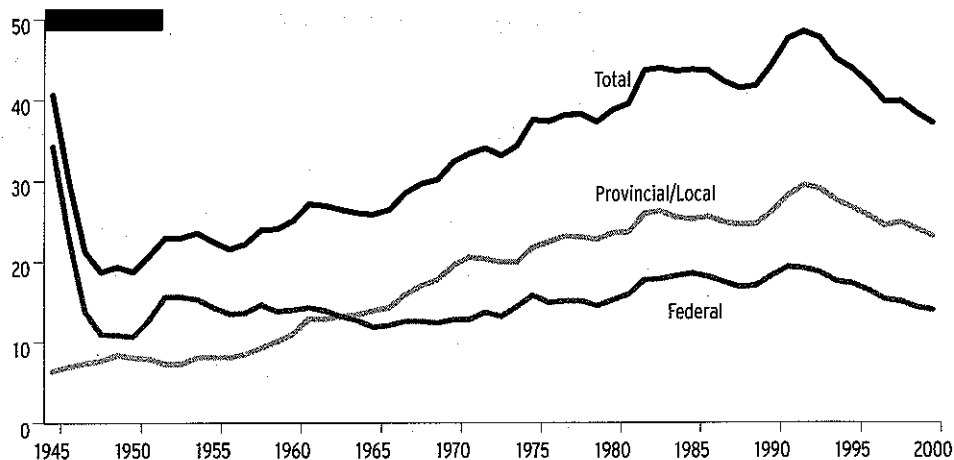
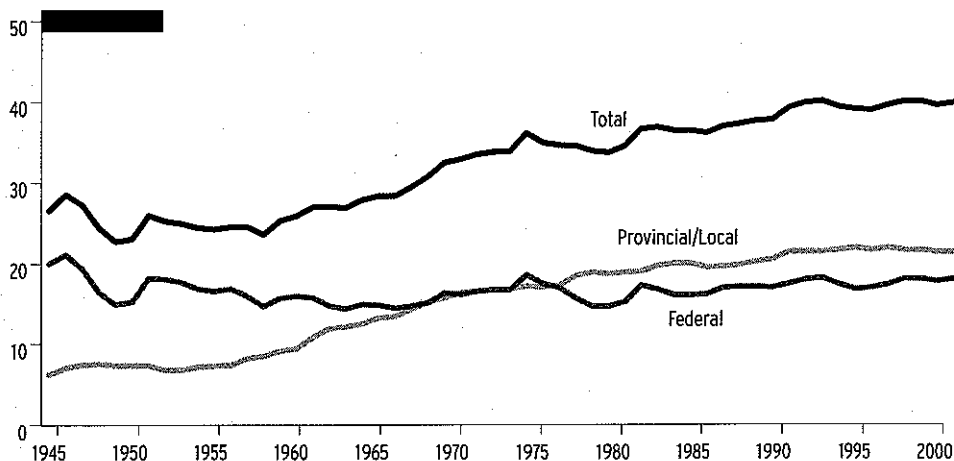


Chart 2b

FEDERAL AND PROVINCIAL/LOCAL GOVERNMENTS' OWN-SOURCE REVENUES,  
1945-2000 (as % of GDP, National Accounts)



Source: Statistics Canada, Cansim matrices 6581, 6582, 6585, 8629, and *National Income and Expenditure Accounts*, STC 13-531.



tures peaked at 48 percent of GDP, again with most of the increase taking place at the provincial/local level. The extent of the spending restraint efforts that followed in the 1990s is also evident. Aggregate public spending dropped from 48 percent of GDP in 1992 to 37 percent in 2000 (back to 1980 levels), a reduction of 11 percentage points overall (6 percentage points of GDP at the provincial/local level and 5 percentage points at the federal level).

Chart 2b shows the trends on the revenue side. The pattern in the first decade or so after the war reflects the Wartime Tax Agreements whereby provinces had agreed to have the federal government collect personal and corporate income taxes and succession duties in return for tax rental payments. These payments continued (with some modifications) for most provinces until 1957, at which time the federal government gradually began shifting income tax room back to the provinces leading up to the federal-provincial tax collection agreements in 1962. As part of this process, Ottawa purposively reduced its income tax rates to enable provinces to raise theirs without imposing an overall increase on taxpayers. The small decline in federal revenues (relative to expenditures) in the immediate postwar years reflects the fact that the federal government accumulated large operating surpluses in order to pay down a substantial amount of war-related debt. As was the case with expenditures, we see the effects of the rapid growth of the public sector, and here again most of the increase is at the provincial/local level. Notwithstanding a marked decline between 1974 and 1979 (a drop of 2.4 percentage points), the federal government's own-source revenues have remained more or less in the range of 15-19 percent of GDP since the early 1950s. Provincial/local revenues (excluding federal transfers), on the other hand, doubled from 8.5 percent to 17 percent of GDP between 1957 and 1972, and continued to increase over the next two decades, levelling off at 22 percent of GDP in 1992.

Overall, revenue growth more or less kept pace with expenditures until the mid-1970s and then rapidly lost ground and failed to recover in spite of significant increases during the economic recovery in the 1980s. Between 1981 and 1992, expenditures rose from 40 to 48 percent of GDP, while revenues only increased from 37 to 40 percent, resulting in a significant shortfall that had detrimental long-term effects on public finances. Although Chart 2 suggests that this revenue shortfall occurred only at the provincial/local level, this does not reflect the actual impact on the respective governments' budget balances. As will be shown further on, the fact that expenditures at the provincial/local level are par-

tially funded through revenues raised by the federal government and transferred to the provinces under various fiscal arrangements produced a very different outcome than is apparent here. Finally, while expenditures declined sharply after 1992, revenues as a share of GDP remained relatively constant, having apparently reached a plateau at that level.

Chart 3 reports the changes in the shares of current public expenditures and revenues by level of government over the past several decades.<sup>39</sup> Chart 3a shows the dramatic reversal in the relative importance of each order of government which took place between 1953 and 1971. The federal government, which accounted for 68 percent of public expenditures at the beginning of the period, saw its share reduced to 39 percent by 1971, while provincial/local governments' own expenditures had grown to 61 percent. These federal/provincial ratios have remained remarkably stable ever since (38/62 percent in 2001). The pattern is similar on the revenue side. The federal/provincial-local shares of own-source revenues went from 72/28 percent in 1952 to 44/56 percent in 1978 and have also remained in that range ever since (46/54 percent in 2001).

### The Role of Federal Transfers

As already mentioned, federal transfers played an important role in the initial establishment and development of major social programs at the provincial level. Given that, with the exception of the Equalization program put in place in 1957, most of these were initially cost-sharing grants, their relative size and growth rate was very much related to the magnitude and expansion of the social programs in question. Between 1950 and 1962, specific-purpose transfers and equalization payments quickly supplanted federal tax rental payments to the provinces under existing tax arrangements as these were being phased out.<sup>40</sup> By 1959 federal transfers represented 23 percent of provincial/local government current expenditures, and they remained in the general range of 21 percent until 1975 (see Chart 3a). The marked increase in 1958/59 reflects the implementation of hospital insurance and Equalization, which were introduced in 1957. As for the increase in 1969-71, it follows the introduction of the Canada Assistance Plan (CAP), medicare, and fiscal arrangements for post-secondary education in 1966/67. In 1970 these five transfer programs accounted for 87 percent of federal transfers to the provinces.

As Chart 3a shows, the relative importance of federal transfers to the provinces has been in steady decline from the mid-1970s onward, dropping from

Chart 3a

## FEDERAL AND PROVINCIAL/LOCAL GOVERNMENTS' SHARE OF GOVERNMENT SECTOR EXPENDITURES (National Accounts), 1945-2000

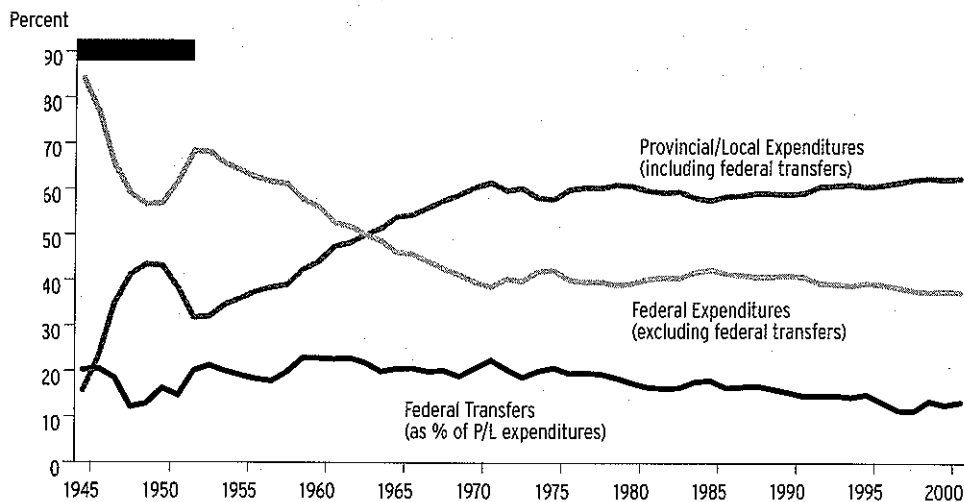
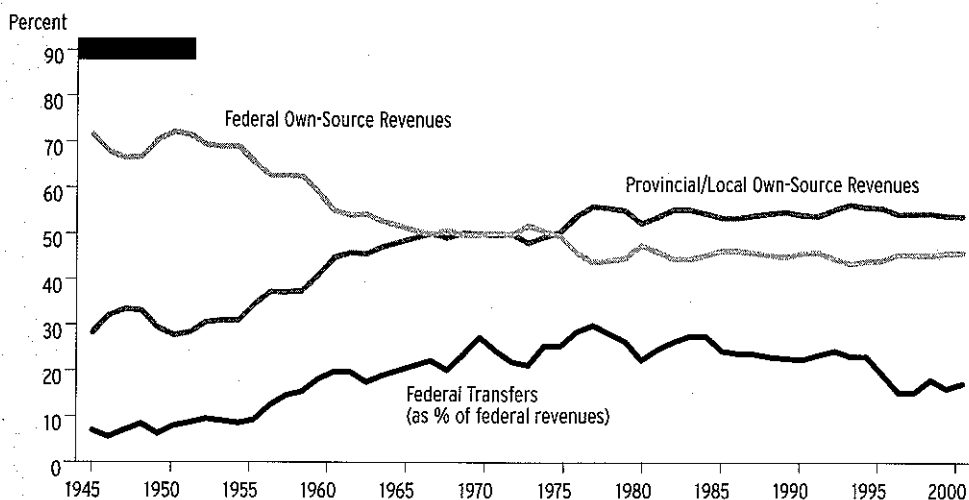


Chart 3b

## FEDERAL AND PROVINCIAL/LOCAL GOVERNMENTS' SHARE OF GOVERNMENT SECTOR REVENUES (National Accounts), 1945-2000



21 to 15 percent of provincial/local government expenditures by 1995 to a low of 11.4 percent in 1998. The 1977-82 drop in cash transfers coincides with the conversion from cost-sharing grants for health and post-secondary education to block funding in 1977. Under Established Programs Financing (EPF), approximately half of the value of the previous transfers for health and education was shifted permanently to the provinces as tax room. The other half was converted to a block fund transfer, which was initially set to grow in line with GNP rather than according to provincial spending in these areas. The latter had been growing at a faster pace than the economy and in the case of health care has continued to do so at an average rate of 0.8 percent higher than the rate of growth of GNP since 1977. (More details on EPF are provided in the following chapter.) The further decline from the mid-1980s to the mid-1990s came as a result of a series of measures imposed by the federal government to curb the growth of transfer payments in a context of rapid deterioration of its own finances. This process began in 1982. Equalization underwent important changes with new ceiling and floor provisions and the replacement of the ten-province standard with a five-province standard as the benchmark for entitlement. The EPF growth formula was also amended such that the escalator would no longer apply only to the cash transfer but to the combined value of the tax and cash transfer. Since the value of income tax points grows at a faster rate than the economy, this significantly reduced the rate of growth of the cash transfer, which from then on was calculated as a residual. This was followed in subsequent years by a number of reductions in the EPF escalator, culminating in a freeze from 1990 to 1994. The 1990 federal spending restraint measures also included a 5-percent annual growth limit on CAP payments to Ontario, Alberta, and British Columbia (the cap on CAP). However, the drop in the relative size of federal transfers from 1995 to 1998 was even more dramatic. This reflects the impact of the ten-province freeze on CAP payments in 1995/96 and the cuts (in excess of 30 percent over two years) associated with the introduction in 1996 of new block-funding arrangements under the CHST to replace CAP and EPF. Moreover, it is important to note that these cutbacks in federal transfers took place in a context of significant reductions in provincial spending, which fell from 29 to 24 percent of GDP between 1992 and 1997. As we can see, the impact of the cuts had been partially reversed by 1999.

Chart 3b traces the evolution of federal transfers from the federal government's perspective. Transfers as a share of current federal revenues rose sharply from 10 percent in 1957 to 27 percent in 1971, with a marked upswing between

1969 and 1971. After 1971 transfers as a share of federal expenditures (not shown) experienced a steady decline, similar to that shown as a share of provincial/local budgets in Chart 3a. Between 1971 and 1998, transfers to provinces as a share of federal expenditures dropped by approximately 11 percentage points to 15.6 percent. The somewhat different trend reported in Chart 3b for transfers as a share of revenues is a function of the significant revenue shortfall at the federal level that persisted from the mid-1970s to the mid-1990s.

### Structural Fiscal Imbalance

A number of factors and issues need to be considered in order to assess whether or not vertical fiscal imbalance is a problem in Canada. First, it is important to have a sense of the relationship between each order of government's own-source revenues and expenditures. Significant discrepancy between the two over time could be an indication of structural fiscal imbalance. Second, a comparison of the relative fiscal position of each order of government might also indicate whether a situation of vertical fiscal imbalance exists, for instance, if the difference between revenue-raising ability and expenditures at one level is related to an opposite set of circumstances at the other level. But structural fiscal imbalance can also be due to other factors unrelated to VFI. The imbalance may be the result of policy (i.e., the budgetary impact of policy decisions on either the revenue or expenditure side of the ledger) or it may be structural in nature (e.g., the budgetary impact of a recession or a rise in interest rates). If there is evidence of a vertical fiscal imbalance, then one needs to look at the role of intergovernmental transfers and other policy factors in reducing or increasing that imbalance.

Charts 4a and 4b compare the relative fiscal balances of the federal and provincial/local governments in terms of their own revenues and expenditures (FFBEX and PFBEX) and including net federal transfers (FFBIN and PFBIN) over the last five decades. Again it is important to note that the data only include current transactions.<sup>41</sup> From the federal government's perspective, FFBEX indicates the difference between current own-revenues and expenditures (excluding transfers to the provinces) as a percentage of expenditures (also excluding transfers). For most of the period under consideration, the data indicate the extent to which the federal government raised revenues in excess of its own spending needs. The large federal revenue balances in the early postwar years (ranging from 40 to 52 percent of own-expenditures between 1946 and 1951) were used to reduce the federal debt from levels in excess of 100 percent of GDP to less than 40 percent

by the mid-1950s. In the period that followed, the federal government gradually began shifting tax room back to provinces and established major cost-sharing transfer programs. By the early 1970s, federal revenue balances were still in the 30 percent range. This could be viewed as reflecting the extent of the vertical fiscal gap at that time, a gap that was essentially eliminated as all excess revenues were transferred to the provinces (see FFBIN). However, as Chart 4a shows, 1974 marked a definite turning point, with a significant five-year drop in federal revenue levels followed by a substantial and prolonged deterioration of the state of federal finances. In most years from 1982 to 1995, revenues were not even sufficient to cover the federal government's own spending and debt charges. The strength of the post-1995 turnaround is equally noteworthy, with current revenue balances once again in the 30-percent range.

Chart 4b tracks the fiscal position of the provincial/local governments with and without federal transfers. PFBEX represents the percentage of provincial/local current expenditures not covered by own-source revenues. While in most years during the 1950s and 1960s the provinces are within a range of 5 percent of fiscal balance, the revenue shortfall increases steadily beginning in 1969, reaching a high of 26 percent in 1992 before returning to a 5-percent level in 1999.

A very different picture emerges when one looks at the relative fiscal balances of both orders of government in the presence of federal transfers. FFBIN and PFBIN represent federal and provincial/local budget balances (based on current transactions) as a percentage of expenditures, with net federal transfers included as part of federal expenditures and provincial revenues, respectively. With federal transfers to supplement their own-source revenues, provincial/local governments consistently recorded current budget surpluses in the range of 5 to 18 percent of expenditures until the mid-1970s, when their fiscal position also suffered a marked deterioration (see PFBIN, Chart 4b). Over the following twenty years they struggled to maintain budget balance and ended up posting a deficit on their current transactions almost every year (except for two) from 1980 to 1995. Compared with the 1980s recession when the federal government bore the brunt of the economic downturn, the impact of the 1991/92 recession was mostly felt at the provincial level as deficit levels reached almost 12 percent of expenditures.

The federal government has fared much worse by comparison (see FFBIN, Chart 4a). From a surplus position in the 1940s and 1950s, federal current budget balances dropped markedly in 1957/58, although deficits remained

Chart 4a

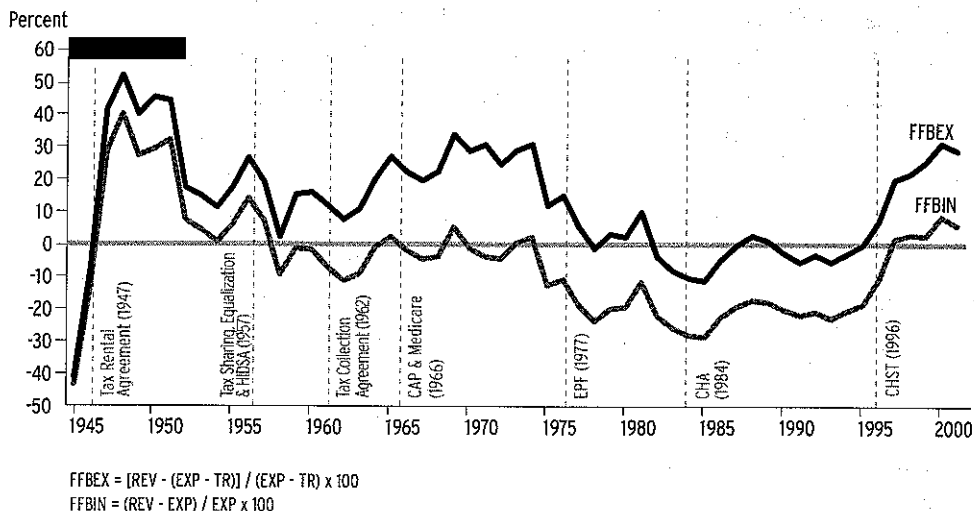
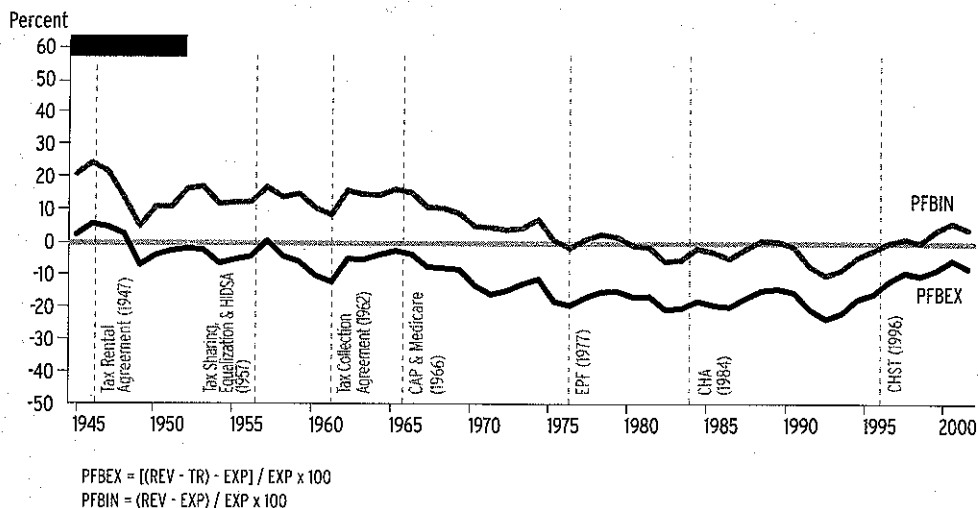
FEDERAL GOVERNMENT'S FISCAL BALANCE, EXCLUDING AND INCLUDING  
FEDERAL CASH TRANSFERS, 1945-2000

Chart 4b

PROVINCIAL/LOCAL GOVERNMENTS' FISCAL BALANCE, INCLUDING AND  
EXCLUDING FEDERAL CASH TRANSFERS, 1945-2000

within a range of 5 percent of expenditures for most of the next 15 years. The federal government's fiscal position took a definite turn for the worse in the mid-1970s. By 1978 the revenue shortfall had reached 24 percent of current expenditures. The situation improved considerably over the next three years as current deficit levels dropped by half to less than 12 percent in 1981, but the subsequent recession had a dramatic impact on federal finances. By 1985 federal current deficit levels had reached the highest level yet since the end of the war, with current expenditures exceeding revenues by close to 29 percent. Moreover, by that time the federal government had been running substantial deficits on its operating budget (in the order of 1 to 4 percent of GDP for the better part of a decade), which meant that revenues were insufficient to cover program spending let alone the debt charges, which were also increasing rapidly. Spending reductions and tax increases implemented over a number of years beginning in 1982 only succeeded in bringing the level of the deficit down to 17 percent of expenditures by 1988. In the following years the situation at the federal level would once again regress as the economy went through another recession, although this time the relative fiscal impact was more pronounced at the provincial/local level. The data also show that, even with relative deficit levels almost double those found at the provincial/local level, the federal government finally managed to restore budget balance in as little as four years.

Chart 5a shows how this actually played out in terms of overall budgetary balances (including capital transactions) for both orders of government. Except for a few years in the 1950s, when the federal government was still in the process of shifting tax room back to the provinces, provincial/local governments combined had better fiscal outcomes throughout most of this period. For the federal government, this translated into modest budget deficits in most years up until 1974. However, given that it maintained an operating surplus almost every year in a context where the rate of growth of the economy was consistently in excess of the rate of interest, this was not a problem. Indeed, the difference between the rate of growth of GDP and the rate of interest during this period of time was increasing steadily from approximately 4 percentage points in the early 1960s to a peak of close to 7 percentage points in 1974. As a result, even if the federal operating budget balance had been zero, the federal government's debt-to-GDP ratio would have still continued to fall rapidly (Courchene 2002). In fact, the debt-to-GDP ratio dropped 17 percentage points between 1960 and 1974 – from 31 percent to a postwar record low of 14 percent (see Chart 5b).



Chart 5a

# FEDERAL AND PROVINCIAL/LOCAL GOVERNMENTS' BUDGET BALANCE, 1946-2001

(as a % of GDP, National Accounts)

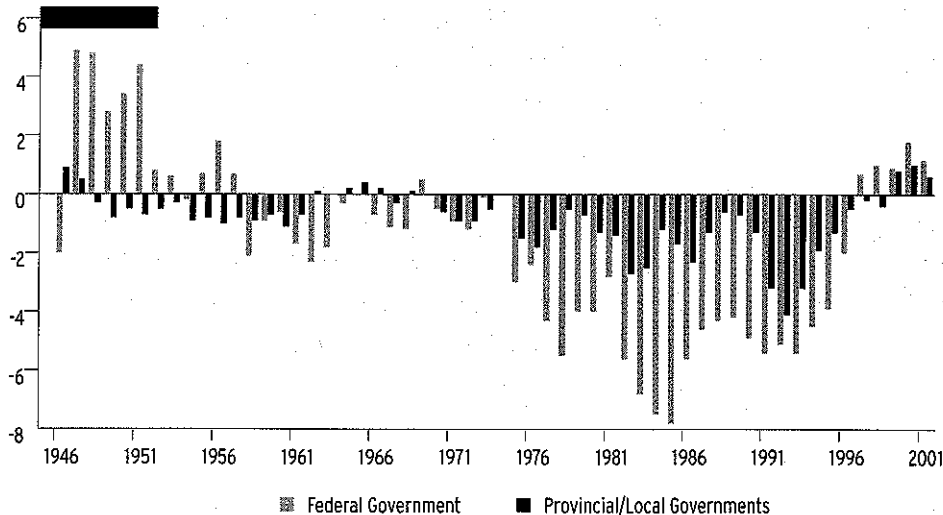
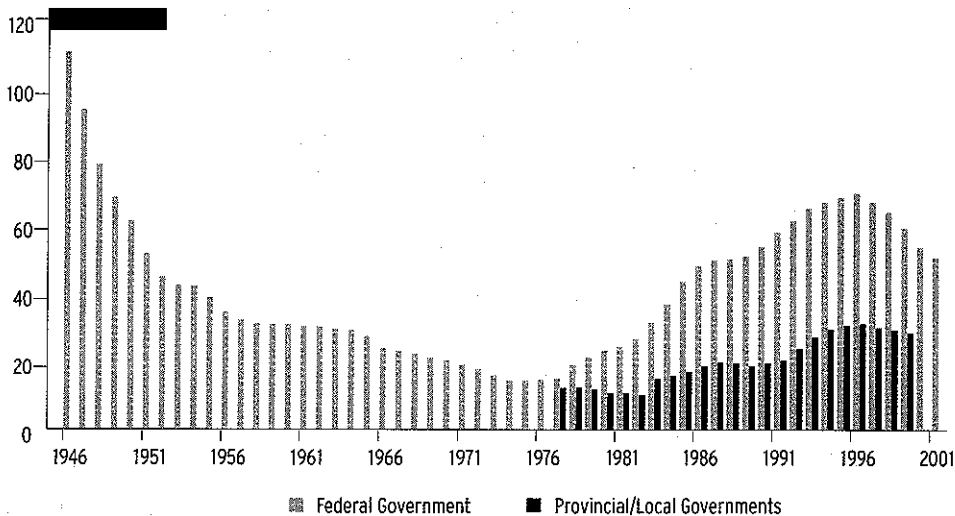


Chart 5b

# FEDERAL AND PROVINCIAL/LOCAL GOVERNMENTS' NET DEBT, 1946-2001

(as a % of GDP, National Accounts)



However, as Courchene points out in his analysis of Canada's fiscal turnaround in the 1990s (2002), a combination of policy and structural factors in and around 1974 dramatically altered the fiscal dynamics that had prevailed in 1950s and 1960s. Courchene refers in particular to the federal government's decision in 1972 to index the personal income tax against inflation<sup>42</sup> while at the same time indexing many transfer programs for inflation, a measure which caused a simultaneous drop in revenues and upward shift in expenditures. But macroeconomic factors and a failure to adjust to a new fiscal environment are singled out as the main culprits. The change in fiscal dynamics began with the first oil shock in 1973/74, which provoked slower economic growth and higher interest rates and reversed the favourable pattern described in the preceding paragraph. The GDP growth-interest rate differential thus began to decline, and it continued to do so at an even faster rate as a result of the second oil shock in 1979 and the 1981/82 recession. By 1984 the rate of interest exceeded the rate of economic growth, and five years later the difference was over 4 percentage points.<sup>43</sup> This in turn meant that running small operating deficits was no longer consistent with a falling debt-to-GDP ratio. Indeed, progressively higher operating surpluses would be required to achieve budget balance. Not only did the federal government fail to make this adjustment, it also ran substantial deficits on its operating budget from 1975 to 1986 (see Chart 6).

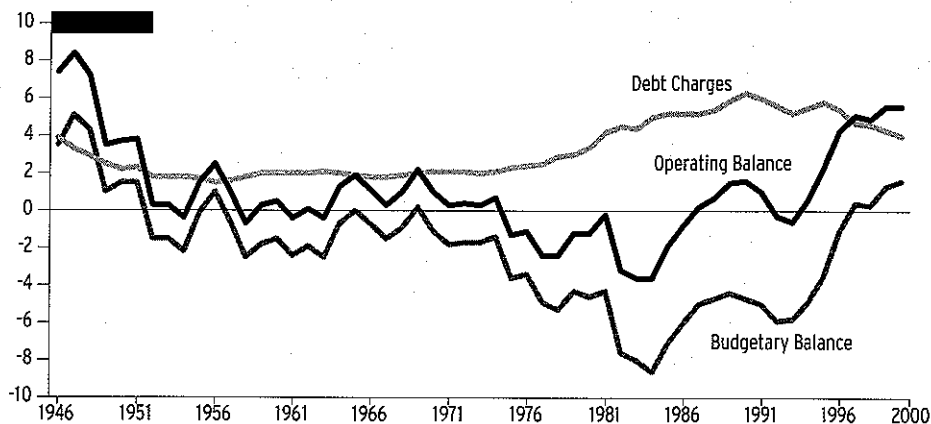
The combined effects of higher interest rates, slower growth, and ongoing operating deficits had devastating consequences on federal budget balances and debt-to-GDP ratio (see Chart 5). These results can be seen as evidence of deep structural fiscal imbalance under any definition. By 1985 the federal deficit had reached its highest level since the war at 7.8 percent of GDP (up from 2.4 percent in 1976), and the level of debt had more than tripled from its 1975 level to 43 percent of GDP. Moreover, the debt-to-GDP ratio continued to climb over the next decade up to 69 percent of GDP in 1996, this in spite of significant operating surpluses in most years, beginning in 1987. As Chart 6 illustrates, operating surpluses of close to 2 percent of GDP prior to the 1990s recession were more than offset by the debt-servicing charges, which at that point were in the order of 5 to 6 percent of GDP.

The provinces fared relatively better than the federal government throughout the 1980s. For instance, while their deficits doubled through the 1980s recession, they tripled at the federal level. Ongoing budget deficits nevertheless caused their debt-to-GDP ratio to double over the decade (see chart 5).

Chart 6

# FEDERAL GOVERNMENT OPERATING AND BUDGETARY BALANCE, 1945-2000

(as a % of GDP)



Source: Department of Finance Canada. Fiscal Reference Tables, various years.

The real setback, however, came in the 1990s. With the combined impact of the 1990s recession and the freeze in federal transfers, provincial/local deficits climbed from \$4.8 billion in 1989 to over \$28 billion (4.1 percent of GDP) in 1992. This time it was the provinces that bore the brunt of the recession. More than 70 percent of the fiscal impact took place at the provincial level (Courchene 2002). The 1990 federal measures to scale down the revenue stabilization program and the capping of CAP payments (social assistance) to the three richer provinces were major factors in explaining the larger impact on the provinces compared to the previous recession. This was particularly the case in Ontario where the effects of the economic downturn were most strongly felt. As a result the provinces saw their combined debt-to-GDP ratio increase from 20 to 30 percent in five years.

The fiscal turnaround for Canadian governments took place in two stages. The first stage was marked by the dramatic drop in budget deficits, beginning in 1994. The federal government managed to eliminate a deficit of close to \$40 billion (5.4 percent of GDP) in four years, while the provinces went from a deficit of \$23 billion (3.2 percent of GDP) to a surplus of more than \$7 billion in 1999. The second stage occurred in 1997, which marked the end of two decades of continuous

increases in the level of federal debt as a share of GDP, following a four-year run-up in the operating surplus to 5 percent of GDP (Chart 6). This was also a turning point, although much more modest, for the provinces. The pace and extent of the fiscal recovery were due not only to the significant restraint measures undertaken by both orders of government but also to a return to a more favourable macroeconomic environment. By 1997 the negative difference between the rate of economic growth and the rate of interest, which had slowly begun to decline in the first half of the 1990s, was falling rapidly. And by 1999/2000, the rate of growth finally exceeded the rate of interest for the first time since 1984, with positive consequences in terms of the requisites of structural fiscal balance. This return to favourable fiscal dynamics, combined with the fact that the federal government has continued to run large operating surpluses (\$59 billion or 5.6 percent of GDP in 2000/01) and managed to make payments on the debt, has had a significant impact on the debt-to-GDP ratio, which dropped from 69 percent in 1996 to 50 percent in 2001.

### Vertical Fiscal Imbalance in Retrospect

In the preceding overview, we have described the rapid and constant evolution of fiscal relations between the two orders of government since the Second World War. While intergovernmental fiscal relations have played an important role, it is also clear that structural factors have been the dominant factor affecting public sector fiscal balances for the past twenty-five years. Both orders of government faced the same dramatic change in fiscal dynamics post-1974, but the federal government's fiscal structure was evidently more vulnerable to a changed fiscal environment. Its failure to adjust was a reflection of both weakness on the revenue side and inherent rigidities on the expenditure side, including a lack of control on the growth of large budget items such as social programs based on universality and cost-sharing transfers. The substantial vertical fiscal imbalance, which had enabled the federal government to foster the establishment and development of major provincial social programs in the areas of health, welfare, and post-secondary education in the previous two decades, quickly vanished and gave way to a situation of deep structural fiscal imbalance at the federal level. Large operating budget deficits and rising debt levels became chronic. By the early 1980s, it was the federal government that was complaining of a vertical fiscal imbalance in favour of the provinces as it began to implement increasingly effective measures to control the growth of intergovernmental transfers.

The provinces' fiscal position also deteriorated during this period but

remained more or less under control until the recession in the early 1990s. It was at that time that the impact on the provinces of federal spending restraint measures became most apparent. The combined effects of the ongoing freeze on EPF transfers, the 5-percent annual limit on growth of CAP payments for social assistance to Ontario, Alberta, and British Columbia, the scaled-down federal revenue stabilization program, and Unemployment Insurance (UI) reforms translated into a much larger fiscal impact on the provinces as they faced the second recession in little over a decade. The effect of these changes was structural – they affected the provinces' fiscal balances both on the revenue and on the expenditure side and made them more vulnerable than in the past to unfavourable economic circumstances.

Both orders of government came out of the recession with unprecedented and unsustainable levels of debt and deficits and took drastic action. The provinces, one after another, had already begun to cut back spending, focusing for the most part on public sector wage freezes, cutting welfare benefits and/or eligibility, closing hospital beds, and shifting costs and responsibilities to the municipalities. The federal government also followed suit with cuts to the federal civil service, a program review process to reduce operating costs, and some transfer of responsibilities to the provinces. However, its most significant deficit-cutting measures came after 1995 with the introduction of the CHST and the associated \$6-billion cut in cash transfers to the provinces, and the 1996 reform in UI (renamed Employment Insurance). The budgetary impact of the EI reforms resulted both from new measures to further reduce benefits and limit eligibility and from the decision to withhold corresponding adjustments to contribution rates. This has allowed the federal government to collect contributions of between \$5 and \$7 billion in excess of benefits paid each year since 1995.

According to the 2001 federal budget, federal program spending as a share of GDP fell from 17.5 percent in 1992/93 to 11.3 percent in 2000/01, while for the same period combined provincial-territorial spending fell from 20 percent to 15.1 percent of GDP (Department of Finance 2001, 191). Presumably the provinces would have been able to balance their budget a few years earlier had it not been for the transfer cuts. As it turned out, they only managed to achieve an overall surplus in 1999. The situation differs quite considerably across provinces, however. For instance, provincial governments posted a combined budgetary surplus of \$11.5 billion in 2000/01. But as Table 2 indicates, Alberta (\$6.4 billion) and Ontario (\$3.2 billion) accounted for the bulk of that. For fiscal year 2001/02, the ten provinces combined reported a budgetary deficit of

Table 2

## PROVINCIAL GOVERNMENTS' CURRENT FISCAL STATUS

	Deficit (-) or Surplus (million \$)	Deficit (-) or Surplus (million \$)	Debt Charges As a % of Total Revenues 2001/02	Net Debt (million \$) 2001/02	Net Debt As a % of GDP 2001/02	Forecasted Deficit (-) or Surplus (million \$) 2002/03
	2000/01	2001/02				
Nfld	-33	-64	15.5	5,674	40.8	-93
PEI	-7	-15	10.9	1,050	30.7	29
NS	-199	-106	18.5	11,538	46.3	1
NB	33	37	12.7	6,519	32.3	21
Que	500	22	14.4	81,970	35.9	0
Ont	3,192	58	14.3	110,507	25.1	0
Man	26	54	6.1	7,041	20.1	13
Sask	58	1	10.2	7,010	21.2	45
Alta	6,388	772	3.5	-5,043	-3.4	724
BC	1,498	-1,233	3.3	13,376	10.3	-4,400
10 Provinces	11,456	-474	11.4	239,642	22.2	-3,005

Source: The first three columns are public accounts data from Department of Finance Canada, Fiscal Reference Tables, 2002. The fifth column is calculated using provincial GDP at market price from Statistics Canada, CANSIM matrices 9001 to 9010. Forecast deficits or surpluses for 2002/03 are from the 2002 provincial budgets.

\$474 million overall. Four provinces were still in deficit, while the remaining provinces were only in surplus by a very slim margin and the outlook for 2002/03 is not encouraging.

## THE FISCAL CONTEXT AND THE FISCAL IMBALANCE DEBATE IN 2002/03

Even though the provinces have more or less succeeded in balancing their budgets in recent years, the fiscal position of the federal government appears significantly stronger at the present time than that of the provinces. It has managed to run operating surpluses in excess of 4 percent of GDP since 1996 and even made substantial payments on the debt (\$46.7 billion). The 2002 *Economic and Fiscal Update* indicates that the government expects operating surpluses to remain well above \$40 billion in coming years (Department of Finance 2002). More importantly, these projections take into account federal commitments in 2000 to increase

transfer payments to the provinces by \$23.4 billion and cut taxes by \$100 billion over five years, as well as other spending measures announced since. Moreover as a result of declining debt levels and lower interest rates, the share of revenues allocated to debt-servicing charges, while still considerably higher than that of the provinces, has been reduced to less than 22 percent from 36 percent in 1993/94. Finally, given the much better than anticipated performance of the economy, the federal government's 2001 fiscal outlook calling for balanced budgets and no surplus over the next three fiscal years turned out to be overly pessimistic. For instance, the surplus recorded for 2001/02 was \$8.9 billion and was also expected to be in that range for 2002/03.<sup>44</sup>

In many ways the current fiscal environment resembles that which prevailed prior to 1974 in terms of the requirements of structural fiscal balance, although there is still some uncertainty as to how the relationship between the rate of economic growth and the rate of interest is likely to evolve in coming years. The main difference of course is the current level of federal debt, which is still substantial and will require a greater degree of fiscal prudence. However, as events in recent years demonstrate, any continuing progress on that front will quickly translate into a sizable fiscal dividend. Also, many of the measures undertaken by the federal government over the past two decades to achieve the levels of operating surplus required to restore fiscal balance have been structural in nature. For instance, there is no doubt that the federal government is now much better positioned than it was in the mid-1970s in terms of controlling the rate of growth of its expenditures. It is no longer tied to cost-sharing transfer arrangements with the provinces, most transfer programs to individuals are now needs-tested or have clawback provisions, and the coverage of employment insurance has been substantially reduced. On the revenue side, the surtaxes and de-indexing provisions of personal income tax have been removed, but Ottawa still benefits the most from this source of revenue, which continues to grow at a faster pace than the economy.

The provinces' fiscal position, on the other hand, is more precarious. They only recently restored budget balance (all provinces combined) in 1999 and were back in deficit in 2001/02. For provinces with balanced budgets, surplus levels are best described as modest. Even a relatively mild economic slowdown could mean a return to deficits for many of them as the budget balance forecasts reported in Table 2 suggest. Indeed, both Alberta and British Columbia show a marked deterioration in their fiscal outlook. And although the provinces have a lesser debt burden, they have not made nearly as much progress as the federal government

in reducing their combined debt-to-GDP ratio, which has only declined by 5.5 percentage points since 1997 compared to 19 percentage points for the federal government. More importantly, the same structural changes that have made the federal government less vulnerable on the expenditure side have had the opposite effect on the provinces. As the last recession showed, they have become much more vulnerable to an economic downturn. Finally, there is also evidence that provincial cuts to health care imposed in the early and mid-1990s did not fundamentally alter the cost-drivers in the system. In the last few years, health care costs have once again started to grow at a faster rate than the economy and are expected to continue to do so, given the high cost of many technological and medical improvements, rising public expectations, and an aging population. It is in this context that the issue of vertical fiscal imbalance arises.

### Summary

The structure of federal public finances is at present stronger than that of most provinces. This appears to have been the case since the mid-1990s. For most of the preceding twenty years the opposite was true. These shifts are integral to the history of Canadian federalism. They occur with changing economic circumstances and changing revenue and expenditure policies of both orders of government.

While the stronger state of federal finances can be viewed as an indication of vertical fiscal imbalance, as we have seen in this chapter, assessing the extent of the imbalance is another matter. The relative fiscal strength of the federal government arises from a dramatic turnaround in fiscal dynamics over the past decade. Recent budgets have succeeded in reversing an entrenched pattern of growing operating deficits and rising debt levels and interest charges, making way for substantial budget surpluses, reduced debt levels, and declining debt charges. With the provinces in a more precarious fiscal position, the prospect of ongoing fiscal dividends at the federal level and ever-rising health care costs at the provincial level inevitably raises issues of resource allocation. This in turn, however, opens up a much larger debate regarding appropriate levels of public debt, tax burden, and other competing claims on the public purse. It is in this context that VFI issues must be considered and resolved as matters of political assessment and policy choice. Such a deliberation must consider the public sector as a whole and how to best capture the advantages of a federal system. Inevitably this also implies a re-examination of the federal role in funding health care, a task we undertake in the following chapter.



## NOTES

- 1 See Department of Finance Canada (1995b). Numbers are derived by subtracting Equalization line from the cash transfers line in the table on page 13. Note that the anticipated effects of the CHST on the cash transfers to the provinces changed over time because of changes in the estimated value of the tax point component of the transfer.
- 2 The spending cuts had a direct effect and may have also contributed to reduced borrowing costs as debt instruments were rolled over. The strength of the United States economy, and the related growth of Canadian exports to that market, was probably an even larger factor.
- 3 See Department of Finance Canada (1995b), "The Canada Social Transfer."
- 4 Provincial and Territorial Premiers (1995, 2).
- 5 Ibid.
- 6 See Provincial and Territorial Finance Ministers (1997, 6).
- 7 Ibid., 8.
- 8 Ibid., Executive Summary, i.
- 9 Provincial and Territorial Finance Ministers (1998).
- 10 First Ministers (1997).
- 11 Provincial and Territorial Premiers (1998).
- 12 Provincial and Territorial Premiers (2000).
- 13 First Ministers (2000b).
- 14 See Provincial and Territorial Finance Ministers (2002).
- 15 These excerpts are from Provincial and Territorial Finance Ministers (2001, 4-6).
- 16 These paragraphs are drawn from the summary of the report. See Commission on Fiscal Imbalance (2002, viii-ix).
- 17 The Department of Finance first released a paper entitled *The Fiscal Balance in Canada* in August 1999, presenting initial counter-arguments to the provinces' claim of a VFI. This document was subsequently expanded and updated in April 2002 (see *The Fiscal Balance in Canada: The Facts*). The federal government's perhaps more formal response to the ongoing VFI controversy can be found in a document produced by the Privy Council entitled *Fiscal Balance and Fiscal Relations between Governments in Canada* (May 2002).
- 18 Department of Finance Canada (April 2002), *The Fiscal Balance in Canada: The Facts*.
- 19 See Government of Canada (2002), *Fiscal Balance and Fiscal Relations between Governments in Canada*.
- 20 The concept of horizontal fiscal imbalance relates most directly to these differences in revenue-generating capacity resulting from significant disparities in regional economic circumstances. But inevitably in the Canadian context, the objective of providing "comparable levels of services" also brings into consideration differences among provinces related to need and costs of delivery.
- 21 Note that the Séguin Commission calls for a strengthened Equalization system. That would have the effect of increasing the vertical fiscal gap if its proposals were implemented on this point. Of course, if all of its recommendations were implemented, the net effect would be a significant reduction in VFG.
- 22 While Equalization is specifically designed to reduce horizontal fiscal imbalances, the CHST is another matter. Although it is designed primarily as a VFG-related transfer, it has a significant redistribution effect. This is due to both its design as an equal per capita transfer financed out of general federal revenues and the method used to calculate the cash transfer (i.e., as a residual after subtracting the value of the EPF tax points from the total entitlement). Eliminating the CHST would therefore exacerbate horizontal fiscal imbalances.
- 23 The personal and corporate income taxes and the GST/retail sales taxes now account for 80 percent of federal tax revenues and 64 percent of provincial/territorial tax revenues. In addition both levels

- of government also collect payroll taxes, fuel taxes, and tobacco and liquor taxes.
- 24 See Ruggeri (1998, 2001); Ruggeri and Howard (2000); Ruggeri, Howard, and Van Wart (1993a); Ruggeri, Van Wart, Robertson, and Howard (1993b); and Ruggeri, Van Wart, and Howard (1995).
- 25 The estimated built-in growth rate of health spending is based on CPI growth plus the rate of growth of population plus an aging factor and an additional cost pressure factor of 1.2 percent per year. Education spending is assumed to grow at a rate .9 times nominal GDP growth.
- 26 Most of the remaining federal and provincial spending categories are assumed to remain constant in real terms or, in the case of the wage component, linked to a combination of the rate of growth of inflation and labour productivity.
- 27 See Conference Board of Canada (2002b). This report was released following the submission of our work to the Romanow Commission. We have since then updated this section of our report using the latest Conference Board estimates for the provinces and territories as these provide a better basis of comparison with the other two sets of estimates analysed. This update does not change in any way our conclusions from this exercise.
- 28 As measured by a trend variable in the forecast model.
- 29 Although as a percentage of GDP it will have decreased from 23.3 to 16.4 percent.
- 30 The authors point out that "the 'growth ratio' approach [as used by Ruggeri] to projecting government revenue and spending – only indirectly and somewhat partially – incorporates the structural demographic determinants of revenue and spending. The projected rate of GDP growth incorporates assumptions about population and employment growth and these components enter into most of the revenue and spending categories. In some cases, such as a federal OAS payments and provincial health spending, there is an attempt to incorporate, more explicitly, the impact of demographics. However, the remaining spending categories and all revenue categories capture only the impact of population growth and do not account for the changes in the age structure of the population on spending and revenue" (Matier, Wu, and Jackson 2001, 12).
- 31 The authors also point out that a VFI indicator based on the differential between the fiscal balances across levels of government implies that a vertical fiscal balance can only exist in a situation where those fiscal balances are equal (See Matier, Wu, and Jackson 2001, 8–9).
- 32 The main exceptions relate to intergovernmental fiscal arrangements. Equalization payments are projected to grow in line with nominal GDP. CHST payments are set to increase as announced in recent budgets to \$21 billion in 2005/06, and then are projected to grow at an annual rate of 3.5 percent based on the average annual rate of increase in CHST cash over the period 2001/01 to 2005/06.
- 33 The results in the benchmark case (i.e., prior to incorporating recently announced tax reductions) are much larger, with fiscal room estimated at 2.11 percent of GDP at the federal level and 1.21 percent at the provincial. According to the authors' estimates, announced reductions in the personal and corporate income tax along with other recent tax measures (e.g., cuts in EI contribution rates at the federal level) reduce the overall average revenue growth rate over the first twenty years from 4.4 to 3.8 percent for federal revenues and from 4.3 to 4.1 percent for the provinces.
- 34 Except for the wage component, which is partially adjusted for increases in labour productivity.
- 35 Revenues are also lower than Ruggeri's estimates, reflecting the lower projected average growth rate for nominal GDP.
- 36 It can also be argued that the local government sector can essentially be viewed as an administrative arm of provincial

governments (they have no constitutional status and their policy directives and mandate come from the province in many instances).

- 37 We used GDP at market price (income-based).
- 38 The defence expenditures of the federal government went down from \$2891 million (67.5 percent of total expenditures) in 1945 to \$847 million (28.4 percent of total expenditures) in 1946 and \$227 million (10.7 percent of total expenditures) in 1947. They went back up to \$1157 million (37.3 percent of total expenditures) in 1951 and \$1800 million (41.9 percent of total expenditures) in 1952 (Source: STC 13-531 *National Income and Expenditure Accounts*).
- 39 Data for 2001 in Charts 2 to 4 are preliminary estimates.
- 40 Under the 1947 Tax Rental Agreement and the 1957 Tax Sharing Agreement, the National Accounts include personal income taxes as federal revenues and show the payments to provincial governments as intergovernmental transfers. However, for the corporate income tax, the provincial share is presented as provincial revenue. Starting with the 1962 Tax Collection Agreement, personal and corporate income taxes collected by the federal government on behalf of provincial governments are presented as provincial revenues. As for the Quebec abatement, the National Accounts do not include it as federal revenues.
- 41 Cansim data do not provide sufficient detail on capital transactions, which are reported on a net basis and therefore cannot be properly allocated between revenue and expenditures.
- 42 This was introduced as part of a tax reform package that also included substantial new tax expenditures.
- 43 As Courchene points out, monetary policy and the exchange rate appreciation also exacerbated the situation (2002).
- 44 In January 2003, the Conference Board of Canada announced that it expected the

federal government to post a surplus of \$8.7 billion for 2002-03 and \$11.2 billion for 2003-04 in the absence of new spending measures.

## FEDERAL HEALTH CARE FUNDING: TOWARD A NEW FISCAL PACT

HARVEY LAZAR, FRANCE ST-HILAIRE,  
AND JEAN-FRANÇOIS TREMBLAY

### CONTEXT AND ISSUES

The long-standing dispute between Ottawa and the provinces regarding the role of the federal government in funding health care has been greatly exacerbated by rapidly rising health care costs since the mid-1990s. For many years following the enactment of the federal *Hospital Insurance and Diagnostic Services Act*, 1957 (HIDSA), the federal *Medical Care Act*, 1966, and related provincial legislation, expenditures on provincial health care services grew more rapidly than the rate of economic growth and the rate of increase in spending in other provincial programs. While provinces were able to exercise considerable restraint on their health expenditures during the first half of the 1990s, the rate of growth of health care spending has since then spiked again.

This recent increase in provincial health care costs has re-ignited political debate about the financial sustainability of Canada's universal, publicly insured health care system. As discussed in chapter 3, it has also given rise to a broader debate on the issue of fiscal imbalance between the two orders of government. In the case of health care, provinces have been demanding that the federal government cover a larger share of their costs.<sup>1</sup> Through the *Canada Health Act* (CHA), the federal government effectively requires provinces to operate a universal, accessible, portable, and publicly administered system of medical and hospital insurance.<sup>2</sup> Regulations under the Act also allow Ottawa to financially penalize provinces if they introduce or allow user charges or facility fees as a way of raising revenues or controlling use. From the provinces' viewpoint, the federal government exercises far too much influence over provincial policy choices,

given the relatively small amount of funding it provides. In their view, if Ottawa wants to remain a player at the health policy table, it will have to ante up considerably more money.

In this chapter we examine the debate over the federal role in financing health care for Canadians by assessing the current federal contribution to health care relative to current provincial health care costs and to the federal contribution in the past. We also propose alternative federal funding options for the Canadian health care system. In so doing, we acknowledge that there is no consensus within Canada about the appropriate federal role in health care. Rather, as Keith Banting and Robin Boadway have described in chapter 1, there are a number of competing views based on different definitions of the sharing community within the federation.<sup>3</sup> We delve further into their alternative conceptions of the federal role and propose funding options that might be appropriate under each of the three models they discuss.

### Provincial Health Care Costs

Provincial spending on health as a share of total provincial program spending varies widely across the country, ranging from 32 percent in Alberta to 43.5 percent in Ontario (see Table 1). For all provinces, however, health care is the largest item in their operating budget. Moreover, the pressure to spend more is very strong and growing across the country.

One should be cautious, however, when comparing data on health spending across provinces. For instance, the province that devotes the largest share of its budget to health care does not necessarily spend more on a per capita basis than the other provinces. To illustrate, Table 1 shows that even though Ontario devotes a larger share of its program spending to health care than all other provinces, it spends less than most in per capita terms. Nor does the growth of health spending as a share of provincial expenditures mean that provinces are allocating too much money to their health ministries. For one thing, the growing share of health spending in some provinces has as much to do with cutbacks in other programs as with increased outlays for health. It may also be the case that the need for additional public spending in health care is greater than in other parts of the provincial public sector. What is not in dispute, however, is that provincial health spending has in fact risen sharply since 1997 after flattening in the first half of the 1990s (Figure 1). Clearly, the financial pressures from health ministries are making it more difficult for finance ministers to meet the needs in other policy areas.<sup>4</sup>

Table 1

PROVINCIAL GOVERNMENTS' HEALTH SPENDING  
AS A PERCENTAGE OF PROGRAM SPENDING, 1975-2001

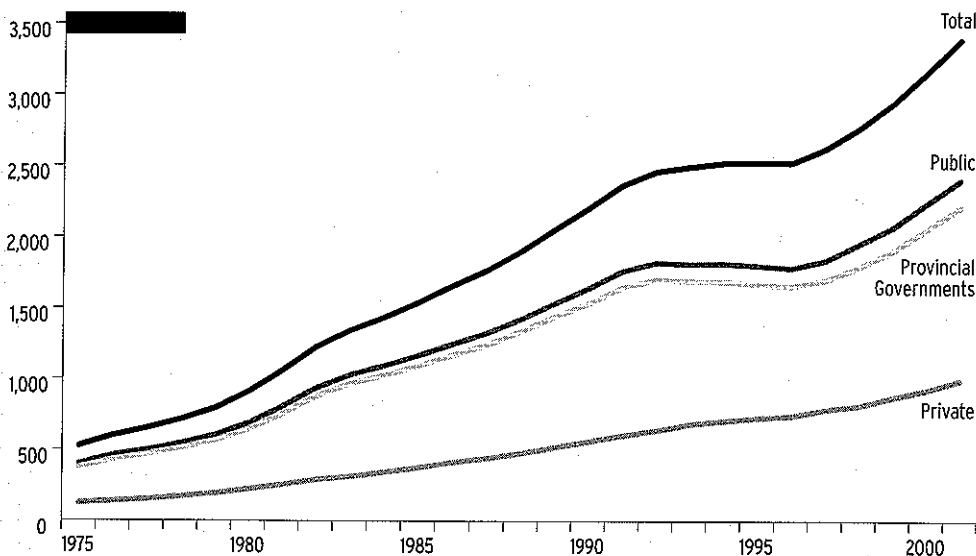
	Nfld	PEI	NS	NB	Que	Ont	Man	Sask	Alta	BC	Can
1975	23.4	22.6	27.3	22.4	29.6	30.8	30.2	25.3	25.1	26.6	28.4
1980	25.1	24.0	26.6	26.7	27.5	32.7	31.9	26.5	23.2	30.8	28.7
1985	28.2	27.7	31.2	28.7	29.4	34.4	31.2	27.7	23.8	31.1	30.2
1990	29.8	26.3	33.2	29.9	29.7	36.2	35.2	34.1	30.1	34.6	32.8
1995	30.0	28.8	31.3	31.5	29.4	35.0	35.8	33.9	30.0	33.4	32.3
2000	37.1	29.9	38.2	32.4	32.1	42.8	40.4	36.4	31.3	38.6	36.9
2001	38.6	32.4	38.6	35.1	32.2	43.5	41.2	39.0	32.0	41.3	37.8
\$ per capita	2,551	2,066	1,967	2,125	2,077	2,146	2,436	2,210	2,331	2,479	2,212

Note: Program spending refers to total provincial government expenditures less debt charges, calculated in current dollars. Percentages for 2001 are only forecast. The numbers for Canada include territorial governments.

Source: Canadian Institute for Health Information (CIHI), Preliminary Provincial and Territorial Government Health Expenditure Estimates, Table A.4.

Figure 1

PER CAPITA HEALTH EXPENDITURES, CANADA, 1975-2001 (Current \$)



Source: Canadian Institute for Health Information

Thus, even if the level and growth of expenditures on provincial health services were satisfying the public that their health care needs would be adequately met in the future, the sheer magnitude of this spending would still pose serious challenges for provinces in their budget-making process. But much of the Canadian public appears to lack confidence that the current system of public health insurance is affordable in the medium term and hence is politically sustainable. There is also a perception among many Canadians that the quality and availability of health services have been deteriorating in recent years.<sup>5</sup>

All of these concerns have led provincial governments to undertake extensive analyses of the underlying factors driving health care costs and ways of getting them under better control. These were discussed in other reports for the Romanow Commission.<sup>6</sup> Suffice it here to observe two points. The first is that provincial governments are in receipt of many recommendations about how to better control costs, be it through primary care reform, more cost-efficient purchase of pharmaceuticals, or techniques for managing demand and encouraging more patient treatment on an outpatient or home-care basis. The second is that provinces are looking for additional sources of revenue to meet their needs. It is the revenue side of the equation that is the focus of this chapter.

### The Federal Contribution to Health Care Funding

The history of federal financial contributions to provincial governments to maintain a universal publicly insured system is discussed in considerable detail below. It is important to recall it was the federal government that, to varying degrees, helped persuade provincial governments to introduce hospital and medical insurance between 1958 and 1970 through cost-sharing incentives.<sup>7</sup> For every dollar a province spent on insurable hospital and medical services, the federal government paid around 50 cents.<sup>8</sup> If a province chose not to join in these arrangements, its residents would effectively be subsidizing, through the federal taxes they paid, the residents of the provinces that did participate. Therefore, for practical reasons, provinces could not afford to remain outside such arrangements. A block transfer replaced the federal cost-sharing formula in 1977 through the *Federal-Provincial Fiscal Arrangements and Established Programs Financing* (EPF) Act.<sup>9</sup> The Canada Health and Social Transfer (CHST) in turn replaced that financing instrument in 1996. At the time of EPF, Ottawa decided to "pay for" some of its fiscal contribution through the transfer of equalized tax

points to the provinces in combination with a cash component.

During the first year of EPF, the total federal transfer for health (cash plus tax points) is estimated to have represented 41 percent of total provincial health expenditures with the cash component at 25 percent.<sup>10</sup> Although current estimates of the cash component vary widely, the federal share of provincial health care spending for 2001/02 was, according to some reports, only 12 percent. This represents a slight increase from the 11 percent estimate for 1999, but it is still significantly lower than the provincial estimate of 16.5 percent for 1994/95, the year before the CHST was implemented. While it is not always clear what level of federal health funding would be considered fair by the provinces, their position has in general tended to be that Ottawa should restore its cash funding to the pre-CHST share of provincial spending by 2004/05. The federal contribution would then be expected to grow annually on the basis of an agreed formula. This increase in funding for health care, of course, should not come at the expense of that portion of the CHST notionally allocated for social assistance and services and for post-secondary education. In this wider context, the overall federal CHST cash contribution would thus have to rise to 18 percent of provincial costs for all the services that CHST is intended to cover, namely, health care, social assistance and services, and post-secondary education.

Following the very large cuts in cash transfers to the provinces implemented in 1996 with the introduction of the CHST (\$6 billion over the next two years), the federal government slowly began to reverse the course set more than twenty-five years before when it initiated a series of progressively effective measures to reduce the burden of transfer payments. The first decision Ottawa took in this regard was to reduce the potential impact of measures announced in its 1995 budget plan on the provinces by setting an \$11-billion CHST cash floor guarantee in the 1996 budget and raising it to \$12.5 billion in the 1998 budget. Then, in its 1999 and 2000 budgets and again in September 2000, the federal government announced significant increases in CHST transfers to provincial governments. (The September 2000 announcement of additional increases in transfers for health was interpreted by many as a way for the federal government to reduce the profile of health care financing as a sensitive issue in the general election campaign that followed.) Some of these increases were presented as one-time injections of funds, while others were built into the CHST base. Under current federal law, CHST cash transfers are scheduled to increase annually until 2005/06, when they will reach \$21 billion. While there is disagreement between



Ottawa and the provinces as to whether these increases have restored cash transfers to their pre-CHST levels, there is no doubt that the cumulative impact of these increases has been substantial.

From September 2000 until the release of the report of the Commission on the Future of Health Care in Canada in late 2002, the federal government balked at further increases, at least in part because it appeared unconvinced that more federal money would improve the financial sustainability of provincial health care systems. The concern was that additional federal funding would take the pressure off the provinces to implement the reforms that were necessary but politically difficult to achieve. Ottawa worried that additional cash transfers would be largely passed on to existing health care providers (physicians and nurses, in the main) and in no significant way lead to reforms that were desirable from the perspective of fiscal sustainability or quality of care.

The current situation is thus one in which the federal government is contributing about \$5 billion less annually under CHST than provinces believe to be fair and reasonable (not all of which is dedicated to health care). Provinces are also critical of the fact that the 1999 and 2000 transfer increases provide no guarantees for the long run, since there is no explicit escalator provision beyond 2006.

This intergovernmental dispute about the size of the federal cash transfer to the provinces for health care has become linked in recent years to a broader dispute about whether there is a "vertical fiscal imbalance" in Canada between federal and provincial governments. What is meant by vertical fiscal imbalance (VFI) has been discussed and analysed in some detail in the previous chapter. Essentially, the provinces argue that the amount of revenue they are collecting is insufficient relative to their expenditure responsibilities, whereas the federal government is collecting more revenue than is necessary relative to its spending responsibilities. This "imbalance," they claim, should be corrected through the transfer of additional tax room or cash to the provinces. When provinces make this argument, they point to their increasing health care costs as one of the main factors leading to this imbalance. The federal government, for its part, dismisses the provinces' argument, suggesting instead that the finances of both orders of government are in reasonable shape and that if the provinces indeed require additional revenues, they should increase their own taxes. Provincial governments have the constitutional right and political freedom to do so. Instead, Ottawa points out, some provinces have been lowering their tax rates and then calling on the federal government to make up for their

revenue shortfalls.<sup>11</sup> The origins of this dispute, however, are also very much related to the role that the federal government has played historically in financing health and health care programs in Canada.

## A HISTORICAL PERSPECTIVE ON THE HEALTH CARE FINANCING IMPASSE

### The Expansionary Period

Just as it is important to examine the evolution of intergovernmental fiscal relations as a backdrop to the recent fiscal imbalance debate (see chapter 3), it is also useful to provide some historical perspective on the role of the federal government in financing health care in Canada. Indeed the current controversy regarding the appropriate federal role in shaping the future of health care in Canada – and the related financing dispute – can only be understood by examining how Canadian governments reached the current impasse.

The federal government's interest in promoting public health insurance dates back to a pledge of the federal Liberal Party in 1919.<sup>12</sup> This commitment remained on the back-burner in the interwar years but was revived in the context of Ottawa's wartime planning for the postwar peace. Thus, in 1942 the federal government appointed an Advisory Committee on Health Insurance. Its ideas were carried forward in the subsequent Marsh Report on "the principal matters involved in the consideration of comprehensive social security legislation for Canada."<sup>13</sup> The Marsh Report examined the link among the various elements of social insurance, constitutional and administrative issues, and questions related to financing.<sup>14</sup>

Nation building was also an important objective of the government in Ottawa at that time. When it introduced its social security proposals in its Green Paper, the dominion government stated three purposes. The first two were to provide a network of protection for the Canadian people that "justif[ied] itself on social and humanitarian grounds" and would "buttress the economy as a whole in times of stress and strain." The document then declared: "Less tangible perhaps, but in some ways most important of all, they [the social security proposals] would make a vital contribution to the development of our concept of Canadian citizenship and to the forging of lasting bonds of Canadian unity."<sup>15</sup>

In other words, elements of the Canada-wide sharing community described in chapter 1 were already embedded in the policy orientation of that era. The words "social union" were not part of the lexicon then, but the dominion government saw the idea of the country as a sharing community as a concept upon which to build. This document helped define Ottawa's approach to social security and to federal-provincial fiscal relations in the postwar period.

The federal government included proposals for public health insurance on the agenda of the Dominion-Provincial Conferences on Reconstruction in 1945 and 1946. Specifically, the federal government undertook to assist the provinces in setting up an approved health insurance scheme and to pay for 60 percent of its operating costs. Since, under this proposal, Ottawa was to remain the only government to tax personal and corporate income and inheritances, it suggested that provinces pay for their share of operating costs (40 percent) through a poll tax on all residents. Ottawa's sweeping Green Paper proposals for social security and related tax-sharing arrangements encountered stiff resistance, however, from the governments of Ontario and Quebec in particular.

As for its specific proposals on public health care insurance, the resistance of the largest provinces meant that the federal government once again had to wait to implement its agenda. In the meantime, however, Ottawa judged that it would be easier to eventually secure provincial support for such a major health initiative if provinces had the necessary physical and service infrastructure to provide health care programs.<sup>16</sup> To this end, it began in 1948 to issue National Health Grants to the provinces for hospital construction, general public health, tuberculosis control, mental health, professional training, cancer control, and public health research. The transfers for hospital construction and cancer control required matching provincial dollars, while the others were non-matching. All had some form of cap. The National Health Grants marked a significant step in the evolution of a comprehensive health system, even though this initiative was initially introduced on a piecemeal basis (Smiley 1963, 8-10).

While the federal government was encouraging provincial investment in health, some provinces began to move forward with their own hospital insurance plans. The Government of Saskatchewan instituted a premium-financed plan in 1947. When Newfoundland entered Confederation in 1949, it already had a government-financed health plan. At that time, Alberta provided hospital coverage for polio and maternity cases and, beginning in 1950, the province assisted municipalities that wished to establish their own prepaid hospital plans. In 1954

British Columbia replaced its premium-based health plan with a plan that was financed through a sales tax and general revenues.

While the provinces initially rejected the federal government's Green Book proposals, intergovernmental dialogue continued with respect to the underlying objectives. In 1955 a standing committee of federal and provincial ministers of finance and health was set up to study a national health insurance scheme. Finally, after much deliberation, "general agreement between the federal and provincial governments was reached" (Smiley 1963, 32). In April 1957 Parliament passed the *Hospital Insurance and Diagnostic Services Act*. Under its provisions, federal grants-in-aid or transfers were to be paid to provinces with universal, publicly administered insurance plans for acute hospital care, including in-patient and outpatient services. The plan, which was to come into effect when six provinces with a majority of the Canadian population were willing to participate, was not yet in place when the Liberal government of Louis St. Laurent was defeated in the 1957 general election. There was wide support for HIDSA among federal MPs at that time, however, and, at the urging of the provinces that had already implemented hospital insurance schemes, the legislation was amended by the Progressive Conservative government led by John Diefenbaker in 1958 to allow for the entry of the five provinces that were ready – Saskatchewan, Newfoundland, Alberta, British Columbia and Manitoba. By 1961 all provinces had joined.

The federal financial contribution to the provinces under HIDSA was set at 25 percent of the national average per capita cost plus 25 percent of the individual province's per capita costs, less any direct charges to patients for services, multiplied by the province's population. As a result of this formula Ottawa covered a little over 50 percent of costs in provinces with below-average per capita costs, and it paid for a little less than 50 percent in provinces with costs above the national average. Thus, the financing scheme featured some implicit equalization.

As for the provinces, they chose to pay for their share of the costs in a number of different ways, including earmarked sales, income and property taxes, premiums, and general revenues.<sup>17</sup> Alberta and British Columbia also imposed co-insurance or deterrent charges on patients at a rate of \$1-2 per day.

Not all hospital services were covered by HIDSA. In particular, treatment for mentally ill and tubercular patients was excluded, as were long-term convalescent services, unless they were provided in facilities that were licensed as hospitals by a province – in which case their costs were deemed sharable (Canada 1956-57, 3123). Capital depreciation and interest on capital debt were

also excluded from federal cost sharing. To qualify for cost sharing, HIDSA required that insured services be made available to all provincial residents under uniform terms and conditions. Provinces also agreed to maintain adequate financial records in accordance with federal regulations.

Although the Government of Quebec was a signatory to HIDSA, during the years in question it was engaged in an ongoing dispute with the federal government regarding the overall tax-sharing arrangements in the federation and the legitimacy of the federal spending power. This dispute ultimately led to the *Established Programs (Interim Arrangements) Act*, which was passed in 1965. Under the provisions of this law, provinces could opt out of two categories of federal programs. For the first category, which included HIDSA and health grants, tax point abatements were available. In the case of provinces that chose to opt out of these programs, the federal government abated fourteen equalized personal income tax points to the province for HIDSA and one equalized tax point for health grants. For the second category, cash compensation was available for provinces that offered programs similar to those supported by the federal government. The hospital construction program was in this grouping. Only Quebec availed itself of these opting-out arrangements.

While these legislative provisions altered the form of the federal-Quebec financial arrangements, they did not change the policy content. Thus, for any program from which Quebec had opted out, it had "to undertake to continue the program along the same lines as the joint program for a specified interim period ranging from two to five years and to submit 'information and accounts in the form and manner prescribed in the authorizing instrument' as well as 'permit such federal inspection and audits as are necessary for the purposes of the opting-out agreement.'"<sup>18</sup> In effect, Quebec had to account for insurable hospital expenses, since the federal legislation stipulated that if the equalized abatement provided more than the federal contribution would have been had the province not opted out, a cash recovery would be made. Conversely, if the equalized abatement fell short, Ottawa would make an additional payment to the province. The federal government and the provinces subsequently renewed this opting-out arrangement for the 1967-72 period and beyond.<sup>19</sup> It should also be noted that these abatement arrangements marked the beginning of the confusion regarding the value of the federal contribution to the provinces for health care.

As HIDSA was being enacted, some provinces were calling for a more comprehensive hospital cost-sharing scheme, one that would cover most of the

excluded services referred to above. Given the dominant federal role in taxation at that time, provinces were also asking Ottawa to pay for more than half of insurable expenses.<sup>20</sup>

In 1962 the Government of Saskatchewan introduced a publicly insured medical care plan for residents of that province. Then, in December 1966, Parliament passed a bill to authorize the federal government to contribute funds for medical services provided under provincial medical care insurance schemes that met certain conditions. To qualify for federal cost-sharing for medical care as of 1967, provincial plans had to be comprehensive (cover costs for both general practitioners and specialists), universal (cover at least 95 percent of residents within two years, and not impose more than a three-month waiting period on new residents), accessible (provide reasonable access to insured services), publicly administered (be administered and operated on a non-profit basis by a public authority), and portable (make benefits available to insured persons temporarily absent from the province and to individuals who move to another province until such time as the second province would provide coverage).

Under the *Medical Care Act*, the federal government committed to pay each province half the national per capita costs of providing insured services multiplied by the average number of insured persons in that province in the year in question. By calculating the payment only on the basis of national per capita costs rather than on the basis of combined national and provincial per capita costs as with HIDS, an even larger element of implicit equalization was included in the federal funding arrangements for medicare. Newfoundland and Nova Scotia, the first provinces to join the plan, entered in April 1969. By November 1970 all the remaining provinces had joined, including Quebec, which was the last to come on board.

As with HIDS, provinces were free to raise their share of the funding as they saw fit. Some provinces relied exclusively on general revenues. Others imposed premiums (with relief for low-income families) or earmarked taxes, usually combining the premium or tax for medical care and hospital insurance.

### The Era of Fiscal Restraint and the Decline of the Federal Contribution to Health Care Funding

Publicly insured hospital and medical services were introduced to improve the economic and social security of Canadians as part of the revolution

in thinking in the aftermath of the Great Depression and the Second World War that gave rise to the welfare state. The overarching goal was to provide Canadians a better future.

The inauguration of these services also fundamentally changed the role of the public sector in Canada. It put government at the centre of a web of relationships involving individuals, families, churches, charities, and the private sector. It also created a new relationship between government and health providers. And it made government much larger in financial terms.

For the federal government, the last result was the most significant; Ottawa's expenditures rose dramatically. Thus, within a few years of implementation of the *Medical Care Act*, Ottawa began to express concerns about the high cost of its share of health care services. A large proportion of federal program spending was being determined by the provincial expenditure budgets for hospital and medical services and other cost-shared programs for welfare and post-secondary education. Transfers to the provinces as a percentage of federal expenditures were increasing dramatically, having risen from 9.5 percent of federal spending in 1955 to over 24 percent of federal expenditures in 1973.<sup>21</sup> To curb this trend, the federal finance minister announced in the June 1975 budget speech that the growth of federal transfer payments for medicare would be limited to 14.5 percent, 12 percent, and 10 percent for 1976/77, 1977/78, and 1978/79, respectively. The relevant legislation was subsequently amended to apply only to the first two years.<sup>22</sup>

The cost-sharing arrangements also raised difficulties for provinces. Donald Smiley traced provincial concerns back to the federal-provincial conference of July 1960 (1963, 12-14). By the early 1970s, provincial governments were generally worried about the effects that cost sharing might have on their own priorities. Programs that were half-funded by federal transfers were more likely to be allocated incremental funds than programs that were fully funded by provincial treasuries.<sup>23</sup>

Federal worries about uncontrollable federal expenses and provincial concerns about the distortion of their resource allocation process generated intense federal-provincial dialogue in the 1970s, leading ultimately to a new set of financing arrangements for joint programs. As already noted, the 1977 *Federal-Provincial Fiscal Arrangements and Established Programs Financing Act* rolled the two health and post-secondary education cost-sharing programs into a single block transfer. The base year for determining the amount of the new federal transfer was 1975/76.

The EPF transfer consisted of a combination of tax and cash contributions. The transfer of tax room was set at 13.5 personal income tax points and one corporate income tax point.<sup>24</sup> The provincial receipts from the tax points were equalized to the national average so that they had close to the same value for all provinces, including those with less than average fiscal capacity. The size of the cash transfer was initially set equal to 50 percent of the national average per capita federal contribution for the three programs in the base year (1975/76), plus a small dollar amount, multiplied by provincial population and adjusted by an escalator linked to the rate of growth in per capita Gross National Product (GNP).<sup>25</sup>

The *Established Programs Financing Act* marked a fundamental change in Canadian fiscal federalism in respect of health care and post-secondary education. It ended cost sharing, thus giving the provinces more incentive to manage health and education costs efficiently and leaving them with much more flexibility to determine their own priorities. No longer would the provinces have to maintain books that the federal government could audit. At the same time, EPF also removed the federal government from its direct involvement in provincial hospital and medical services. This reduced Ottawa's ability to ensure that the principles that had underpinned public hospital and medical insurance would be maintained. For those who believe that a strong federal role is essential in maintaining Canada-wide social programs, it was a setback. For those whose conception of the federation gives more weight to provincial autonomy, it was a large step toward the classical federalism that they preferred. (The implications of these differing views have been discussed in more detail in chapter 1.) In terms of the present discussion, however, the main point is that EPF represented a milestone in the history of public health insurance in Canada. And while the EPF arrangement was federal legislation and not a formal contract among governments, it was nevertheless the product of prolonged and intensive federal-provincial negotiations in which Ottawa worked hard to achieve agreement with the provinces. The result, unlike the CHST, was not presented as a *fait accompli* sprung on unprepared provinces in the context of a federal budget.

The changes in funding arrangements for health care and post-secondary education under EPF were also a major factor adding to the *fiscal confusion* that persists to this day regarding the size of the federal contribution to provincial health care programs that had begun with the Quebec abatement. Thus, it is necessary to pause at this point and clarify what the federal financial role was immediately before the end of cost sharing.



At the time, the federal share of *insurable* hospital and medical costs was roughly 50 percent, if the tax points abated to Quebec in 1965 are included. As mentioned earlier, the federal share was somewhat higher in low-cost provinces and vice versa. The share of *total* (not just insurable) hospital and medical costs was somewhat lower, however, given that several categories of hospital and medical services were not eligible for cost sharing. Moreover, provinces were incurring health costs outside of the hospital and medical care areas, notably for public health and other services. Based on available data, it is estimated that the federal share of provincial health spending *prior* to EPF was in the 41 percent range.<sup>26</sup> In the first year of EPF, the notional value of the federal cash transfer for health as a share of provincial health spending was 25 percent according to one estimate<sup>27</sup> and just under 27 percent according to another.<sup>28</sup> For purposes of this discussion, we settle on 26 percent. Again the reader should bear in mind that this percentage relates to total provincial health expenses, not just health expenses that had been cost-shared prior to EPF. If the federal cash contribution in the first year of EPF is compared to what had previously been sharable costs, then the federal share in that year is equal to well over 26 percent.

Our objective here is to shed some light on the share of provincial health care expenses that was covered by the federal government when cost sharing was ended. The federal share, at that time, was not necessarily a "fair" share. But it was a proportion that reflected 30 years of federal-provincial bargaining that had begun with the federal government Green Paper proposals in 1945 and the provinces' initial rejection of them. In recent debates on health care financing there are occasional references to the fact that Ottawa used to pay 50 percent of provincial costs, but that is not a valid benchmark – for two reasons. First, the 50 percent federal share pertains only to what were sharable costs at the time. Second, under EPF the provinces were given additional tax room that converted approximately half of the value of pre-EPF transfers into own-source revenues for the provinces. Therefore, from that point on, the only relevant benchmark is the cash portion of the transfer. Thus, for those who believe that Ottawa should return to its traditional share of total provincial health spending, the appropriate benchmark is around 26 percent.

Both the federal and provincial governments expected that the value of the 1977 EPF tax transfer to the provinces would grow faster than GNP, whereas the federal cash contribution was legislated to grow in line with the rate of increase in GNP. It was also expected that provincial health care costs would grow faster than GNP, which was part of the reason for transferring fast-growing

tax points to the provinces. For both reasons, it appears that federal and provincial governments recognized that the federal cash contribution would likely shrink both as a share of provincial health spending and as a share of the total EPF compensation. Therefore, while we by no means exclude 26 percent as an appropriate benchmark for the federal cash contribution, for today's circumstances, we would suggest that this number is best considered as the upper end of a range of possible options.<sup>29</sup>

With the severe recession of the early 1980s and the continuing deterioration of federal finances as context, the federal government amended the EPF legislation in the early 1980s, even though provinces had expressed general satisfaction with the 1977 arrangements (Perry 1997, 260). From the provinces' perspective, a major advantage of the 1977 funding provisions was that they provided long-term stability, which enabled them to make their own long-range plans. At the same time, as noted in the preceding chapter, by the early 1980s the federal fiscal position had worsened much more than that of the provinces, and there was great pressure on Ottawa to take fiscal action. But despite expressed federal concerns, provincial governments were reluctant to voluntarily give up their privileged fiscal position. In the event, for 1982/83 and subsequent years, federal legislation reset the value of the EPF per capita entitlement (cash plus tax transfer) based on the national average per capita federal contribution in 1975/76 with the growth escalator (a three-year compound moving average of GNP growth per capita) applying to that amount rather than the cash portion only, as had been the case since 1977. Under the new formula, the total EPF compensation was to be the same in per capita terms for all provinces (whereas under the initial formula, the cash and tax components grew separately, which meant that total per capita compensation varied among provinces). The per capita cash contribution was to be calculated by subtracting the per capita value of the equalized tax points for each province from the established per capita entitlement. An important consequence of applying the growth escalator to the total entitlement rather than to the cash component was that the federal cash payment was significantly reduced in comparison to what it otherwise might have been.

These new transfer arrangements were then subjected to Ottawa's anti-inflationary "6 and 5" program in 1983/84 and 1984/85, but this only applied to the notional post-secondary education component, not health care. While the federal action may well have been justified by the worsening fiscal situation, it is

important to point out that, unlike the 1977 arrangements, the new EPF provisions that took effect in 1983 did not have provincial concurrence. Ottawa imposed them unilaterally and, in this sense, the early 1980s also marked a turning point in federal-provincial fiscal relations. As will be seen below, a case can be made that a return to the more collaborative approach to federal-provincial/territorial fiscal relations that prevailed up to that point would be helpful in improving the outlook for public health insurance in Canada.

At the same time as the federal government was reducing the rate of increase in EPF transfers for fiscal reasons, it was also increasingly concerned about the erosion of the principles stipulated in the *Hospital Insurance and Diagnostic Services Act* and the *Medical Care Act*. These principles remained in force when EPF was enacted in 1977, and Ottawa expected provinces to preserve the key Canada-wide elements of the two programs. But, there were no enforcement measures or penalty provisions available to the federal government in the event that provinces breached them. By the early 1980s, faced with ongoing cost pressures and often-difficult negotiations with provincial medical associations, some provinces began to allow physicians to employ extra-billing and hospitals to impose user fees. In the 1981 federal budget the federal finance minister expressed his concern about these trends. He also restated several federal goals in relation to health care, including: greater visibility for the federal financial contribution, increased accountability to Parliament, greater emphasis on minimum levels of performance, a greater federal voice in provincial administration, and assurances of adequate provincial funding (Perry 1997, 260). This statement is of interest here because it clearly indicates the federal government's intention to sustain its influence in public health insurance at the outset of a long period of fiscal restraint. Provinces resisted the federal initiative, and this difference of opinion, which was not resolved through negotiation, ultimately led to the passage of the *Canada Health Act* (CHA) in 1984 (again without provincial concurrence). The CHA enacted the broad principles for the provision of public health care in Canada that still apply today, and it also authorized the federal government to withhold EPF payments in the event of extra-billing or user charges. In terms of the financing needs and options discussed in this paper, the latter provision is very significant because it makes it impractical (or has to date) for provinces and territories to use fees of this kind to manage demand or to increase revenues.<sup>30</sup>

From the early 1980s until the introduction of the *Canada Health and Social Transfer* in 1996, the federal government tightened its transfers to the

provinces on several other occasions, as its own fiscal position worsened. The EPF growth escalator was set at 2 percentage points less than the rate of growth of per capita GNP from 1986/87 to 1989/90 and was expected to be scaled down yet another percentage point for 1990/91, although this reduction was pre-empted by the 1990 federal budget announcement that per capita entitlements were to be frozen at the 1989/90 level. This freeze was subsequently extended into the mid-1990s.

In 1994/95, the year before CHST came into effect, cash payments to provinces in respect of insured health services under EPF (as notionally calculated at that time) were \$8.1 billion, or just over 16 percent of total provincial health care outlays.<sup>31</sup> Thus, as a result of both the high rate of growth in health spending in the years prior to CHST (notwithstanding the fiscal restraint provinces exercised in the early 1990s) and the EPF tightening by Ottawa, the cash share of federal contributions had fallen from 26 percent of provincial health expenses just before EPF was introduced to around 16 percent just before CHST came into effect. For those who consider that the appropriate benchmark for a "fair" federal cash contribution today is an amount equal to its pre-CHST share, the 16 percent figure might be the one to use. Just as we suggested above that 26 percent represents the high end of a conceivable range, however, we think that 16 percent is at the low end if Ottawa is to sustain its political position as a major player at the national health policy table. As the events we have just described indicate, federal and provincial governments were unable to agree on the federal policy role in health care in the early 1980s, at a time when Ottawa's cash contribution for health care was much larger and the fiscal benefits from the tax transfer were still fresh in the minds of the provinces. It seems unrealistic to expect, therefore, that a 16 percent funding share would provide the federal government with the political legitimacy it needs to sustain its policy role in 2003 and beyond. (As noted above, provinces have argued that a figure of 18 percent is the pre-CHST benchmark but this estimate is linked to the combined amount of EPF and Canada Assistance Plan (CAP) cash transfers as a share of a wider basket of provincial expenditures.)

In the run-up to the 1994 federal budget, the federal finance minister cautioned his provincial counterparts that federal cash transfers to the provinces would have to be further reduced. He effectively gave them one year's notice that some fiscal action would take place. The 1995 budget announced that new fiscal arrangements were to be introduced the following year along with additional cuts in transfer payments.

## The Current Controversy over the Federal Financial Contribution for Health Care

In the context of the present chapter, the main implications of the changes in transfer arrangements under the CHST are twofold. First, by folding CAP, the only remaining cost-sharing program, with EPF into a single block-funding instrument, the federal government gained full control of the rate of growth of its contributions to provincial social programs and a greater capacity to effect reductions. Second, the fact that federal transfer payments for health, post-secondary education, social assistance, and social services are now combined under a single block grant (which still carries the tax-point and entitlements features of EPF) has made it even more difficult to decipher what Ottawa effectively contributes to each of these programs. In recent years, there has been a change in direction, with the federal government once again committing to transfer increases over five-year horizons and making explicit attempts to earmark new funding mostly for health care. Table 2 summarizes the history of the CHST to date.

What is relevant for our purposes here, however, is the impact of the CHST on Ottawa's cash contribution to the provinces for health care. As is well known, the federal government continues to calculate its share of provincial health care, post-secondary education, and social programs on the basis of the value of the 1977 tax transfer, associated Equalization, and cash. Provinces have long challenged the federal position on this point. One of the more persuasive provincial analyses of this issue was set out in the 2000 report of the provincial and territorial ministers of health.<sup>32</sup> We won't restate their case in detail here. In summary, the position of the provinces and territories is that the tax points that were transferred twenty-five years ago cannot reasonably be held to be a federal contribution today. After all, for the last quarter-century, it has been the provinces that have levied the relevant taxes, not Ottawa. When Ottawa asserts that these provincial tax revenues are a federal contribution, it simply confuses the facts and hampers public deliberation on the future funding of these crucial public services. We find these arguments convincing.

There is, however, a major qualification to our support for the provincial position. It is that the current share of federal cash transfers for provincial and territorial programs for health care alone – or for health care, post-secondary education, and social assistance and services programs combined – cannot fairly or reasonably be compared to the pre-EPF 50 percent federal cash share. This is,

Table 2

## THE HISTORY OF THE CHST, 1995-2000

1995	Budget announced that EPF and CAP transfers would be replaced by the CHST, with entitlements allocated among provinces in the same proportion as combined EPF and CAP transfers in 1995/96. Total entitlements (cash and tax transfers) were set at \$26.9 billion for 1996/97 and \$25.1 billion for 1997/98. Cash transfers were to be calculated as the difference between the total entitlement and the value of the tax transfer for each province.
1996	Budget announced a cash floor of \$11 billion per year. Total entitlements were fixed at \$25.1 billion for 1998/99 and 1999/2000 and then set to grow at GDP less 2 percent, GDP less 1.5 percent and GDP less 1 percent for the next three years. New allocation formula was moving halfway to equal per capita entitlements by 2002/03.
1998	Cash floor was increased to \$12.5 billion for years 1997/98 to 2002/03.
1999	Budget announced additional CHST funding of \$11.5 billion over five years, earmarked for health care and allocated on an equal per capita basis among provinces. Allocation formula to move to equal per capita transfers by 2001/02.
2000	February budget announced the creation of the CHST Supplement Fund of \$2.5 billion, allocated on an equal per capita basis among provinces. Provinces to draw their share any time between 2000/01 and 2003/04. Additional funding, announced in September, of \$21.1 billion over five years, including \$2.2 billion for early childhood development, resulting in cash transfers equal to \$15.5 billion for 2000/01; \$18.3 billion for 2001/02; \$19.1 billion for 2002/03; \$19.8 billion for 2003/04; \$20.4 billion for 2004/05; and \$21.0 billion for 2005/06.

Source: Adapted from Department of Finance Canada, budget documents; and Standing Senate Committee on Social Affairs, Science and Technology, *The Story So Far*. Vol. 2 of *The Health of Canadians - The Federal Role. Interim Report* (Ottawa: Queen's Printer for Canada, March 2001).

of course, because Ottawa transferred tax room to the provinces in 1977 to replace a large part of its cash contribution. This bears repeating because when provincial spokespersons occasionally use the 50 percent figure as a benchmark for an appropriate federal contribution today, they are being as misleading as the federal government is when it continues to claim the 1977 tax transfer as an ongoing federal transfer.<sup>33</sup> The provinces' argument that the federal government has re-occupied tax room it vacated in 1977 is also irrelevant, because the federal government had the constitutional and political right to do so and it presumably assumed the political price for imposing these tax increases.

What this ongoing intergovernmental dispute demonstrates, more importantly, is that there is a need to re-establish an appropriate benchmark for

the federal CHST cash contribution for provincial health care programs at a level that informed Canadians would consider "fair." While there may be no objective basis that would point toward a particular number, there is at least some rationale to the 16-26 percent range we have identified, even though, for reasons already stated, the 16 percent figure seems much too low to be sustained politically for any length of time.

Before giving our view as to what might be considered a fair federal government contribution to provincial health care, however, we try to clarify how much Ottawa is now paying. What share of provincial health care costs is Ottawa currently bearing with its CHST cash contribution? Unfortunately, there is no single correct answer to this question. Or, stated differently, there is a range of possible answers to this question.

To provide these answers, we proceed as follows. First, we estimate the percentages of CHST cash that can be attributed to health care based on different rationales. Second, we apply these percentages to the \$18.3 billion in CHST cash for 2001/02 in order to determine the amount of CHST cash contribution to provincial health care expenditures in that year. Third, we compare these CHST cash amounts for health care to total provincial health care spending in 2001/02.

The first step is to establish the percentage of CHST cash that can be seen as representing federal health care funding. There are at least five ways of dealing with that issue. From a first perspective, the CHST can be seen as a block transfer that can be used by the provinces however they see fit. The transfer goes into each province's general revenue fund and there is no effective way of tracing the federal dollars to any particular provincial program. In provincial hands, the money is fungible. When the federal government declares the funds to be for health, post-secondary education, and social assistance and services, it is really only perpetuating a myth. No fixed share of the CHST base transfer is assigned to health care – or indeed to any other provincial program – and there is therefore no way of determining what percentage of provincial health care spending Ottawa covers. From a second and somewhat different perspective, the CHST may be thought of as being used by the provinces for its stated purposes only, which include health, post-secondary education, and social assistance and services. But even with this different starting point, there is still no effective way of determining which shares are allocated for each of the stated purposes. The money remains fungible across this basket of services. From a third perspective,

one can notionally divide the CHST among its various purposes using the allocations from the cost-sharing era and carrying them forward (which is the approach Ottawa has used for many years). From yet a fourth perspective, the method of notional allocation can be modified to take account of the fact that increases in the CHST since 1999 have been intended mainly to supplement provincial health care budgets. Thus, according to this fourth perspective, the current share of CHST cash that is notionally allocated to health care is greater than the share for health care based on the third perspective. Examining the current allocation to provincial expenditures among the relevant program categories introduces a fifth way of dealing with this question. Under this perspective, we calculate the share of provincial spending for health care as a percentage of provincial spending for health care, post-secondary education, and social assistance and services and infer that the resulting percentage is the federal CHST cash share for health care. These perspectives are summarized in Table 3.

In our view, there is no clear-cut or objective basis for arguing that any one of these methods is evidently superior to the others. Each has its merits and weaknesses. The third, fourth, and fifth perspectives result in estimates of the health component of CHST of 43 percent, 50 percent, and 68 percent, respectively.<sup>34</sup>

The second step in estimating Ottawa's current contribution consists of applying these three percentage shares to the \$18.3 billion allocated to CHST for 2001. This generates federal CHST cash contributions for health care in the order of \$7.9 billion, \$9.1 billion, and \$12.4 billion, respectively. As this analysis of different (and each partially valid) perspectives – and the fairly wide range of estimates it produces – should make clear, *there is no single number and no right number that objectively represents the federal CHST cash contribution for provincial health services.*

The final step entails comparing the amounts in the last column of Table 3 to the estimated \$68 billion in total provincial health care spending in 2001. Based on these calculations, it can be argued that CHST cash notionally covered between 12 and 18 percent of total provincial health care spending in that year, depending on which of the allocation perspectives one prefers.

It is interesting to compare our estimates of the federal cash share to recent estimates put forward by the provincial and territorial governments and by Ottawa. According to the report of the provincial and territorial ministers of health released in August 2000, federal cash transfers had dropped to a level of just over 10 percent of provincial health care costs in 1998/99 following the introduction of the CHST. However, as a result of the 1999 and 2000 budget



increases, they were projected to rise to almost 14 percent in 2000/01 (Provincial and Territorial Ministers of Health 2000, 19). In a more recent document released on 25 April 2002, the provincial and territorial finance ministers stated that the cash component of CHST was equal to 14 percent of provincial-territorial health care and social costs in 2001/02 (Provincial and Territorial Finance Ministers 2002). (The 14 percent number appears to include provincial costs for primary and secondary education that were never eligible for cost-sharing. If the provinces had excluded expenditures on primary and secondary education, the number might have been closer to 17 percent.) In any case, the provincial and territorial finance ministers claim that in 1994/95 (pre-CHST), federal cash transfers under EPF and CAP represented 18 percent of this same basket of provincial social expenditures. If the 18 percent share had been preserved, this would have entailed a CHST cash contribution in the order of \$23.5 billion for 2001/02, or \$5.2 billion more than the actual federal cash outlay that year. Of this \$5.2 billion, around \$2.2 billion would be attributable to health care, if one assumes that 43 percent of the federal transfer is for health, or \$3.5 billion if the 68 percent allocation estimate is used.

Not surprisingly, the federal view is different. In a document dated 29 April 2002 (Department of Finance Canada 2002b), Ottawa argued that calculations of the federal share of provincial health care spending should take account of the 1977 tax transfer and the flexibility inherent in a block fund. It also made the argument that a share of Equalization payments can be allocated to health care, and it drew attention as well to federal direct spending on health. In a subsequent document a few weeks later, the federal government produced a pie chart showing the federal share of provincial health spending at 40 percent (with 15 percentage points from CHST tax points, 14 percentage points from CHST cash, and 11 percentage points from Equalization).<sup>35</sup> For the most part, however, Ottawa focuses on the absolute increase in the size of its cash transfer in recent years, not on the share of provincial costs that it covers. This approach is understandable, given that CHST is purposively not a cost-sharing instrument.

To recap, our estimates indicate that CHST cash notionally covered between 12 and 18 percent of provincial health care spending in 2001/02. These percentages are not far from the provincial estimates, although they are much different than the federal calculations. This is not surprising, given that Ottawa usually chooses to include the value of the tax transfer in its estimates and has even begun to include a portion of Equalization payments. It is also worth noting that

Table 3

FIVE PERSPECTIVES ON FEDERAL CHST CASH TRANSFERS  
TO PROVINCES FOR HEALTH CARE

Perspective	Implicit Share of Federal CHST Cash Transfer Targeted for Health Care	Estimated Share of \$18.3 Billion in CHST Cash for Provincial Health Care in 2001/02
(1) Block funding: general revenues	Can't be determined	Not applicable
(2) Block funding: social programs	Can't be determined	Not applicable
(3) Notional shares: cost-sharing era	43 percent	\$7.9 billion
(4) Notional shares plus earmarked health transfers	50 percent	\$9.1 billion
(5) Provincial program allocation	68 percent	\$12.4 billion
Source: Authors' calculations.		

adding an amount of \$2.2-3.5 billion to satisfy provincial claims in respect of health care would have raised Ottawa's share of funding to between 15 and 23 percent. These estimates can also be examined in relation to the 16-26 percent benchmark range proposed earlier as the basis for determining a "fair" federal cash contribution, a subject we return to later in this chapter.

By this time, the reader may be understandably frustrated by the ambiguity and complexity involved in answering what at first glance is a simple question: How much is the federal government contributing to provincial health care programs? And both orders of government have been making the issue even more obtuse by recent initiatives in their quarrel of numbers. As already noted, provinces, for example, have begun to include their spending on primary and secondary education as part of social program expenditures when calculating the share of provincial costs covered by the federal CHST cash contribution. Primary and secondary education were never cost-shared by Ottawa and it is hard to see how their inclusion helps to clarify what is already a very complex issue. Moreover, provinces have been implying recently that a fair federal contribution

would be equal to half of their costs. The federal government, on the other hand, is now including a portion of its Equalization payments as part of its overall contribution to provincial health care funding, although this argument had not been part of the federal position in the past. This new perspective is unlikely to help clarify matters. While it can be argued that the unconditional Equalization payments must be paying for some share of provincial health programs among recipient provinces, their explicit purpose is to fulfil the federal government's constitutional obligation to enable provinces with lower fiscal capacity to provide comparable services (overall) at comparable levels of taxation. Clearly, the dispute about numbers has escalated to a point where it has become difficult even for the most careful analyst to follow. And it most assuredly makes the arcane world of fiscal federalism even less transparent than it was just a few short years ago.

### Concluding Observations

There are number of key observations that follow from this tortuous tale of events and developments in federal-provincial fiscal relations pertaining to health care. The first is that there is, and has been for some time, an imbalance between the federal government's cash contribution to provincial health care and the amount of policy influence it seeks to exert. Since 1999 the federal government has redressed the imbalance somewhat through improvements in the CHST. At the same time, however, it has also been attempting to discredit the idea that any imbalance remains, by claiming that its contribution to the provinces is larger than what strikes us or the provinces as reasonable. As for the provinces, they occasionally seek to overstate the imbalance by ignoring entirely the significance of the 1977 tax transfer under EPF. Having worked through the rhetoric on both sides, however, the impression of a policy/funding disconnect remains.

Second, and related to this first point, there is evidently an urgent need to secure intergovernmental agreement (we stress the word agreement, about which more below) on what would constitute a "fair" federal cash contribution to provincial health care. As we have demonstrated, there is simply no objective basis for determining what share of provincial health care costs CHST cash covers or should cover. Meanwhile, the federal-provincial conflict on what Ottawa's cash contribution is and should be is highly damaging to the cause of health care reform in Canada. This counterproductive dispute is both hindering and detracting from the provincial planning process at a time when important reforms are required. It is unhelpful as well to the functioning of the federation and therefore

does not in any way serve the public interest.

Ambiguity is often a useful device for securing agreement on a contentious issue. It enables both parties to an agreement to put their own spin on it and somehow claim victory. In this case, however, ambiguity is harmful. Both parties must come to *agree* not only on what Ottawa's share of funding of provincial health care costs is, and should be, but also exactly how it is to be measured. Otherwise, within months of a new fiscal arrangement, provinces will claim that the new transfer amount is too small and the federal government will argue the opposite. In other words, unless the two orders of government can *agree* explicitly on what goes into the numerator and denominator when calculating the percentage of provincial health care costs covered by the federal government's transfer, the best that can be hoped for is a series of brief ceasefires in an ongoing federal-provincial dispute. And that dispute will continue to hamper both health care reform and intergovernmental relations. What is required, therefore, is essentially the equivalent of a peace treaty.

The third observation is that there is a disconnect between the expressed public desire for federal-provincial cooperation on public health insurance, on the one hand, and the way in which the federal government has made decisions regarding its financial contribution, on the other. Without being naive regarding the cost-sharing agreements of the 1950s and 1960s, and the 1977 EPF arrangements (hard negotiations were involved), it is fair to say that they were the product of a prolonged and genuine intergovernmental dialogue. In contrast, the experience since then has been one of Ottawa acting largely unilaterally. At the same time, the federal government may not be entirely responsible for the current unilateral process. During the years of escalating federal budgetary deficits (from the very late 1970s to the mid-1990s), provinces may have viewed federal proposals for reductions in planned rates of increase in transfers as efforts to co-opt them into sharing the political blame for unpopular federal decisions. They may have thus preferred to be seen as the victims of federal budgetary measures, despite knowing that federal fiscal restraint was necessary. However the blame is allocated, the current dynamics of intergovernmental fiscal relations are not conducive to effective intergovernmental relations on health care issues. A return to more collaborative federal-provincial relations will be in order if Ottawa wishes to use fiscal arrangements to encourage a Canada-wide approach to health care reform.

This last point on Ottawa's unilateral approach is also linked to the issue of predictability raised earlier, and brings us to our fourth observation: a formal

growth escalator for the federal health care cash contribution is needed. Under current arrangements, the law sets annual CHST payments until 2006. But there is no explicit provision as to what is to come after 2006. Nor is there a set of principles that would provide general guidance to the provinces as to what they might expect. This lack of explicit arrangements regarding the longer-term federal cash contribution unduly and unnecessarily complicates the task of long-range planning for the provinces at the very time when predictability is most essential, namely, when provinces are attempting major reforms. The requirement for a built-in growth escalator will need to be addressed in the context of any new fiscal arrangements pertaining to health care.

A fifth and final observation is that the current impasse around health care financing and how to calculate the federal contribution erodes the quality of Canadian governance. The public has no idea how much Ottawa contributes to provincial health care because contribution levels can be (and are) calculated in many different ways. Transparency is absent. Accountability is confused. Thus, regardless of which direction the two orders of government eventually take with respect to the future of health care in Canada, it is essential that they find a way to extract themselves from this unproductive and ultimately futile battle.

## DETERMINING A "FAIR SHARE" BENCHMARK FOR FEDERAL HEALTH FUNDING

**I**n this section we make some suggestions for determining what might be considered a fair federal cash contribution for health care. For a number of years, the federal government used the notional allocation of 43 percent to identify the health component of CHST. Although provinces were not required to approve this number, they appeared to have tolerated it. But when provinces began to base their political claim for more CHST dollars heavily on their escalating health care budgets, and Ottawa agreed to CHST increases mainly or exclusively for health care purposes, the 43 percent allocation began to lose its saliency.

As already observed, there is no objective basis for preferring the 43 percent, 50 percent, or 68 percent allocation as the health component of the CHST, although the 43 percent number now seems to be the one that is least grounded in reality. A number close to the middle of the range (i.e., 55 percent) is arbitrarily adopted here as a base for other calculations and to illustrate new

financing options in the remainder of this chapter. Based on this assumption, the federal cash contribution for health care in 2001/02 amounted to just over \$10 billion of the \$18.3 billion in CHST cash payments that year. This is equal to a little under 15 percent of provincial health care costs, which is less than the 16-26 percent minimum-maximum range proposed earlier.

We have already suggested that 16 percent is too small a share to be politically sustainable. As for the upper end of the range, on the other hand, it could be argued that a federal cash share in excess of 25 percent of provincial health care costs would in some sense result in the federal government contributing twice for the same provincial expenses. Ottawa was paying for one-half of insurable hospital and medical costs before EPF. When Parliament enacted EPF, the federal government converted about half of its share of funding of insurable provincial health costs into a transfer of tax points. In our view, it is neither fair nor reasonable for the provinces to negotiate with the federal government to transfer tax points to them so that they can cover more of their own health costs, as they did in the 1970s, and then imply that the federal government should pay the same share in cash as it did before the tax room was transferred, as occasionally happens today.

In discussing possible fair-share benchmarks, we make a distinction between what might be a fair federal cash contribution under current *Canada Health Act* conditions and what might be fair in the event of more substantial conditions that limit provincial flexibility and imply further costs. Under current conditions, a figure of 20 percent strikes us as a reasonable and politically sustainable compromise.

We also proceed on the assumption that an appropriate federal share should be linked to total provincial health care costs, not just to costs that were eligible under the pre-1977 cost-sharing regime. Two reasons have led us to this position, although we acknowledge that a case can be made for the opposite point of view. The first and main reason is that provincial hospital and medical costs would be much higher today than they are now if provinces had not invested as much as they have in home care and pharmaceutical programs (programs that were not cost-shared). It seems inappropriate to ignore this fact in determining a fair federal share. Second, the early federal proposals to the provinces on health care went well beyond medical and hospital costs, and it was always implied that full health care coverage was the long-term federal plan. As a point of reference, the reader will recall that the federal cash contribution in the immediate aftermath of EPF was

equal to 26 percent of total provincial health care spending.

In the event that a new funding agreement on health care is reached between the federal and provincial governments, there might be a case for increasing the federal contribution beyond the 20 percent benchmark. In particular, if the conditionality of the federal transfers were to become more restrictive or demanding from the provinces' perspective (even assuming that these new conditions were the outcome of an intergovernmental agreement), then the case for moving toward, or even to, a 25 percent share would be much stronger. At the same time, other factors might also influence the choice of a "right" number. For example, direct federal spending on health research and information, public health, and Aboriginal health are likely to provide payoffs in terms of improved quality and efficiency in Canada's health care system. It could be argued that these kinds of federal spending should be taken into account in any negotiation of the benchmark for the federal funding contribution to provincial health care.

If the 20 percent benchmark had been in force in 2001/02, it would have added \$3.5 billion to the federal CHST cash contribution. An amount in this order of magnitude is not inconsistent with the historical federal role, and we speculate that it is large enough to secure the federal government a seat at the table, should that be Ottawa's wish. For our purposes in the remainder of this chapter, this amount is arbitrarily rounded up to \$4 billion. This is our *base case*, the minimum we suggest is required to sustain any significant role for the federal government in the health care area. And we use it as a starting point to help illustrate some further options. Under more demanding or enhanced CHA conditions, the \$4 billion would probably have to increase, but determining a precise amount is difficult, given the range of possible changes to the CHA. The larger federal contribution might be necessary for two reasons. First, the enhanced conditions might impose added costs on provincial delivery systems. Second, if the federal government was strongly determined to obtain new conditions, provinces would sense a bargaining opportunity. At the upper end of the proposed range, the federal cash contribution for 2001/02 would have been \$17 billion (25 percent of \$68 billion), adjusted downward perhaps to reflect some direct federal spending. In short, under alternative scenarios in which CHA conditions are strengthened, the increase might be in the range of \$4.5 (half a billion above the \$4 billion base) to \$7 billion. These scenarios are summarized in Table 4.

Again, we do not argue that these are the "right" numbers for an enhanced federal cash contribution but rather that they do reflect a reasoning

Table 4

SCENARIOS FOR THE FEDERAL CONTRIBUTION  
TO PROVINCIAL HEALTH CARE SPENDING, 2001/02

		Federal share of provincial health care costs	20 percent	25 percent
Required federal contribution			\$14 billion	\$14.5-\$17 billion
Additional federal contribution in 2001/02 above notional \$10 billion			\$4 billion	\$4.5-\$7 billion

process that takes into account some of the considerations that strike us as relevant. Of course there are other factors to consider that have more to do with the "how to" rather than the "how much" side of things. For instance, it seems clear that the federal government worries that additional federal transfers may do too little to improve either the quality of care or the fiscal sustainability of provincial health care systems. The concern is that additional funds will flow in large measure into the compensation package of current health care providers without contributing to the health care reforms that provinces are trying to achieve but that are politically difficult for them to secure. To reduce this risk, increased federal funding should be accompanied by other actions that enhance the probability that provinces will be successful in their reform efforts. We cannot design the elements of such a risk-reduction strategy but will state its purpose, which is for Ottawa to become a more genuine partner of the provinces by helping them to overcome the difficult political obstacles to the health care reforms they are seeking to implement.

The idea of Ottawa as "a more genuine partner" of the provinces is admittedly vague. The tangible ways of breathing life into such a partnership would have to be worked out among the affected governments. However, it would probably require that Ottawa be willing to absorb some of the political heat that would otherwise be directed exclusively at provincial governments. If provinces could count on federal political support when they embark on politically difficult reforms (for example, primary care reform), this support would at least assure them that they have a powerful ally. Provinces might then be able to say to local interests that are resisting proposed reforms: "We have no choice.



National policy requires us to do it." or, "We are sorry but federal funds are not available for that purpose." This strategy fits well with opinion polls that indicate that the Canadian public wishes both orders of government to work together to help make public health insurance viable.

At the same time, this idea of partnership is not intended to imply that all provinces need to make the same reforms in the same way. Individual provinces have much more direct knowledge of their health care system than does Ottawa. They also have the constitutional and operational responsibility for delivering health care (with some exceptions). Our idea is therefore not for the federal government to dictate provincial reform initiatives or become involved in the way delivery systems work but that it be available as an ally in helping to make provincial reform objectives a reality.

Several of the considerations we have highlighted can be summarized neatly using an analogy suggested by Claude Forget. At the moment the federal government is contributing financially to provincial health care programs like a bondholder. Like a bondholder, it is in the health care business with a fixed financial commitment only, sharing neither the fiscal risks of uncertain future costs nor the political risks of alienating powerful interests. Nonetheless, Ottawa wishes to retain its place at the policy table as if it were an equity shareholder, casting votes on crucial issues. By re-basing its financial contribution, and working politically in partnership with the provinces to make it easier for them to achieve their reform goals, the federal government would be better able to justify its continued status at the policy table. Recent federal investments in health research and information can be seen, in this regard, as important down-payments on this partnership role.

## FEDERAL FINANCING OPTIONS

We have taken two different scenarios into account in considering the future of the Canadian public health care system. The first scenario assumes that there will not be an expansion of the current system and that efforts will be focused instead on consolidating core services and programs and on improving the financing and the quality of the care provided by Canada's hospital and medical insurance programs. We call this the improved status quo or *maintenance* scenario.

The second scenario assumes that the main emphasis of future reforms will be to broaden the publicly insured system to cover a wider range of services, including possibly pharmacare or home care, or both. This we refer to as the *transformation* scenario. Of course, the financing objectives and the best use of fiscal instruments would differ considerably in each scenario. We present these considerations and the resulting federal financing options in the next two sections.

In discussing the role of the federal government in health care in chapter 1 of this volume, Banting and Boadway argue that the extent of this role would differ significantly depending on the view of the federation and the definition of the sharing community that was espoused. Thus in the discussion that follows, we outline an appropriate federal role in financing health care for each of the three models of the sharing community identified in their analysis: (1) the *predominantly Canada-wide sharing* model, (2) the *predominantly provincial sharing* model, and (3) the *dual sharing* model that lies between. There is substantial support within the country for all three conceptions of the federation. But each has different implications for the federal role in financing the health care system and the degree of policy flexibility available to the provinces, and so we treat each separately.

Before turning to financing options under each of these models, in both the maintenance and transformation mode, we lay out a number of principles or points of departure that guided us in all of the considerations set out below. For the most part, these principles are based on the preceding analysis, and they are repeated here mainly to reinforce the weight that we attach to them.

First, the options presented are not premised on the existence of a vertical fiscal imbalance, but reflect the view that there is a need to overcome the discrepancy between the federal government's desired policy role in health care and the extent of its financial contribution.

As indicated in the preceding chapter, the structure of federal public finances is currently stronger than that of the provinces. While the difference in fiscal prospects between the two orders of government can be interpreted as evidence of a vertical fiscal imbalance, assessing the extent of the imbalance is another matter. In chapter 3, we describe the limitations and conceptual difficulties involved in producing such estimates. We conclude that while ongoing federal surpluses are indeed a likely scenario in coming years, the fact is that decisions regarding the use of these surpluses will have to take into account numerous and legitimate competing claims on these resources – be they debt or

tax reduction or new spending needs, including increasing transfers to the provinces and in particular the level of federal contribution to health care. Ultimately, we do not need to define the magnitude of any fiscal imbalance mainly because we believe that the discussion about federal health financing should focus on another type of imbalance, that between the federal government's desire to have a substantial role in health care policy and its unduly modest financial contribution.

Second, as already noted, we suggest that the size of the increase in the federal cash transfer should be linked to the nature of the federal conditions associated with the transfer. The more the conditions restrict the scope for provincial flexibility and control, the larger the transfer should be.

Third, the process of reaching a new fiscal agreement between Ottawa and the provinces should be based on the pre-1980s model of intergovernmental negotiation, not on the unilateral approach of recent years. While this will require changed behaviour on the part of the federal government, it will also require that provinces bargain in good faith. It is simply unrealistic to expect that the federal government can sustain its policy role over time unless its fiscal relationship with the provinces becomes more collaborative.

Fourth, a substantial improvement in federal funding should be associated with new coordinated provincial-federal strategies that will make it easier for provincial governments to successfully implement the health care reforms they want. To this end, a new political partnership among the provinces and with Ottawa may be essential.

Fifth, a new fiscal pact between federal and provincial governments must enhance the transparency of the federal contribution to health care, if the federal government is to continue to make transfer payments to the provinces. To this end, we support a separate block transfer for health and a precise agreement between governments as to how each order of government is to interpret the federal transfer. Any effort toward greater transparency would also require that the issue of the 1977 EPF tax transfer be set aside once and for all.

The case in favour of a separate health transfer is not one-sided. By splitting the CHST into two or three block funds, there would be less money in each of them than there is in a combined transfer. Consequently, from a federal perspective, there would be less leverage to enforce the conditions of the transfer. Perhaps more important, in a context in which health care has high priority, the end result could be a much enhanced federal contribution for health care and

much less generous federal payments to provinces for social assistance or post-secondary education. At the same time, a separate health transfer improves the visibility of the federal contribution and may result in greater accountability. If the federal government is inclined to reduce or be restrictive in respect of cash transfers for social assistance and post-secondary education, separating the transfers at least allows everyone to be aware of this and to hold the federal government accountable for its decision. On balance, the case for a separate Canada Health Transfer (CHT) seems strong.

We also hold to the view that the health block fund should have a built-in growth escalator that is predictable and that corresponds to a certain degree to the growth in provincial health care costs. The escalator should have the following characteristics. First, the overriding goal of an escalator should be to provide provinces with a reasonable measure of predictability regarding the growth in transfers. Second, the escalator should be set out in law and be based on an indicator that is expected to grow at a rate that is similar to the anticipated growth rate in national health care costs. The escalator might be linked to changes in GDP or to growth in income tax revenues. Implicit in this last point is a judgment that a return to an explicit cost-sharing agreement does not offer enough benefits to be worth the disadvantages it entails (for instance, the administrative costs of determining which provincial expenses are eligible for sharing, the administrative costs of audit, the political downside of such federal intrusion, and the potential distortion of the provincial resource allocation process). Third, with appropriate notice (say, two or three years), it should be possible to adjust the escalator if the trend in the rate of growth in provincial health care costs changes. Fourth, the legislation should allow Ottawa a necessary degree of flexibility in the face of an unexpected financial crisis.

The federal government will understandably be concerned that an escalator with the above characteristics would weaken its control of its expenditures. At the same time, if Ottawa wishes to continue to play a major role in national health care policy, it seems only reasonable that it assume some of the related risks. And provinces would still have a significant interest in managing health costs efficiently given that, under all conceivable fiscal arrangements, they would pay the lion's share of costs. We deal with this issue of risk more fully below.

Sixth, the requirements for asymmetrical arrangements between the provinces and the federal government depend on the vision of the sharing

community that is embraced. The scope for opting out of federal conditions is greatest in the *predominantly provincial sharing* model. In the *dual sharing* model, the federal government might be somewhat more flexible with respect to non-participating provinces than it would be under the *predominantly Canada-wide sharing* model. For example, for a province that does not opt in, the federal government could still make transfer payments as long as the money was used for provincial health programs and met the conditions that apply to the hospital and medical services. The emphasis on uniformity or harmonizing of services is strongest under the *predominantly Canada-wide sharing* model of the federation. For provinces that participate in the national community, the asymmetries that now exist in relation to hospital and medical services would shrink in a maintenance scenario. Under a transformation strategy, the federal government could play "hard ball" with non-participating provinces and decline to transfer funds until a reluctant province decides it can no longer afford to stay out, as was the case in the early days of hospital insurance and medicare.

In the options that follow, we focus mainly on the parameters identified below, although we occasionally address additional factors and considerations as they arise:

- > The form of the transfer (cash *versus* tax *versus* other options)
- > The nature of the transfer (whether conditional or not, whether cost sharing or block funding)
- > The size of any increase
- > The escalator provisions
- > Considerations related to equalization

### Maintenance Context

The options presented in this section apply in the maintenance context where the principal objective of health care reforms is to improve the financing and quality of currently insured services (for CHA purposes). The different types of fiscal federalism arrangements that might fit best under the three models of the sharing community in this scenario are examined in turn. In each case our objective is to present options that improve the fairness of the federal contribution while facilitating provincial reform objectives. The result is three distinct sets of policy options, but they are perhaps best viewed as points on a continuum and as illustrations of the range of possible policy choices.

### *Predominantly Provincial Sharing*

Under this particular conception of the federation the province is the principal community for sharing and redistribution. This model nevertheless rests within the framework of the constitutional provisions for equalization. As Banting and Boadway note in their chapter, section 36(2) of the *Constitution Act* states that provinces should all be able to provide reasonably comparable levels of public services at reasonably comparable levels of taxation. Thus, even in the predominantly provincial sharing model, some national redistribution is required. However, it is not the job of the federal government to ensure inter-personal equity among all Canadians in respect of health care. It satisfies its constitutional obligations in relation to health care mainly, if not exclusively, through Equalization. As we will describe below, the main implication of this model for the future funding of health care is a realignment of revenues between federal and provincial governments.

*A) Form, nature, and size of transfer* The federal financial contribution for health care under this model could be in the form of cash, tax room, or a share of a particular federal revenue base. While all three are conceivable, the cash transfer option is the one that is the least suited to this vision of the sharing community. In what follows, therefore, we focus only on the other two options.

The first option entails a transfer of tax room from the federal government to all provinces as a replacement for the health component of the CHST, or the entire CHST, perhaps along the lines proposed by the Quebec Commission on Fiscal Imbalance. The size of the transfer would be negotiated between federal and provincial governments. Based on our earlier analysis, the tax transfer could be equal in value to the current federal cash transfer for provincial health care (around \$10 billion) plus up to another \$4 billion annually. We say "up to" \$4 billion because it would make little sense to maintain the *Canada Health Act* and all of its conditions under this model. Without the conditionality of the CHA, provincial autonomy and flexibility would be increased and thus the case for a smaller transfer of tax room rather than the full \$14 billion might reasonably be part of the negotiations. (The focus here is on the health component of CHST but if the entire CHST were to be eliminated, the size of the tax room transfer would be correspondingly larger.)

An important question, under the predominantly provincial version of the sharing community, is what would happen to the Canada-wide system of

publicly insured hospital and medical services if this vision prevailed. The answer is that it would depend mainly on the political will of provincial governments. All provinces have repeatedly declared their support for the five principles of the *Canada Health Act*. This option would put that support to the test since Ottawa would lack the teeth to enforce its provisions, suggesting that the CHA should in fact be removed from the federal statute books. Tom Courchene, a few years ago, wrote about a Canadian social union whose principal partners would be the provincial governments (Courchene 1996, 3-26). This option would also test the Courchene scenario.

To the extent that the transfer of tax room entailed income tax points, one unfortunate possible side effect would be the erosion of the federal-provincial income tax collection agreements and the tax harmonization associated with those agreements. This is a risk because the capacity of the federal government to effect this harmonization is linked to a continuing federal occupancy of a substantial share of total income tax room and this share would be reduced under this option. Another downside of this approach is that it would put additional strain on the federal Equalization program (about which more below). These particular drawbacks could be avoided, or at least mitigated, by transferring to the provinces a tax base other than the income tax (such as GST).

A second (and preferred) option would be a federal-provincial/territorial revenue-sharing arrangement. Under this approach, the federal government would pay a pre-determined share of a specified federal revenue base to the provinces as its fair-share contribution for health care. In collecting the revenues, the federal government would have the option of labelling the share to be transferred to the provinces as revenues collected on behalf of the provinces for health care. An advantage of this option is that it would maintain the size of the federal tax take and the importance of the federal role as a tax collection agency. Thus, it does not entail the risks to tax harmonization referred to above. From the viewpoint of equalization, this approach also has advantages, as will be discussed below. The disadvantage of revenue sharing, as compared to a transfer of tax room, is that it is vulnerable to changes in federal tax policy. Thus the revenue base under this option is somewhat less secure for the provinces.

Even under the predominantly provincial sharing model of the federation, a revenue-sharing arrangement could provide efficiency (in addition to sharing) advantages, since it could be made conditional on portability and mobility provisions being respected. With a tax transfer, this would be difficult to enforce.

The federal government would have to put in place an alternative mechanism that would enable it to maintain this aspect of the internal economic union. That mechanism could be a relatively small cash transfer (for example, a transfer equal to a quarter or a third of the value of the tax transfer considered under this option). In that eventuality, the \$14 billion tax transfer envisaged above might have to be reduced to, say, \$10 billion, with the rest provided as a cash transfer.

*B) Escalator considerations* This issue does not arise under the tax room and revenue-sharing options in the predominantly provincial sharing model. In each case it is up to the federal government to choose a tax base (whether to be transferred or shared) that will grow at a rate that resembles the growth in provincial health care costs, at least to some significant degree.

*C) Equalization considerations* Implementing a tax room transfer could have some adverse effects from the viewpoint of almost all provinces, including those that receive Equalization. One reason is that current CHST payments are based on an equal per capita entitlement, with the cash transfer calculated as a residual. This means that transfers to provinces are fully equalized to the level of the highest province. Under the tax transfer option, the equalization associated with the tax point transfer would almost certainly be limited to the current five-province standard. Thus, the allocation of revenues among provinces would be much less equal than it was under the CHST.

A second consideration is that with the end of CHST, the only remaining major federal transfer program would be Equalization and, if additional tax points were equalized, that program would grow. The consequence is that the wealthiest provinces would no longer receive large federal transfers, while the other provinces would receive even larger payments under Equalization than they now do. This change may leave the Equalization program more vulnerable to political attack from those who view such inter-provincial redistribution as undesirable. (With the CHST, the federal government can defend Equalization by discussing the two major transfer programs as a package and pointing out the benefits they bring to all provinces.)

Under the tax transfer option, it would be possible for the federal government to adjust the equalization associated with the tax room transfer to take into consideration differences in need among provinces that result from demographic and geographic differences. The case for doing so is weaker here than



under the other two models of the sharing community. Even under this model, however, such a needs-based adjustment would help to ensure that the allocation of federal funds took account of the fact that demographic and geographic factors may impose higher costs on some provinces than others.

A needs-based adjustment could also be implemented under the revenue-sharing option. Alternatively, the allocation of shared revenues could be designed to replicate the current equal per capita allocation under CHST. In any event, the formal Equalization program would not grow. Revenue sharing is thus a more attractive option from an equalization perspective.

*D) Other considerations* While the predominantly provincial model of the sharing community does not require any changes in the direct federal role in health and health care, it would be entirely consistent with this vision for the federal government to carve out for itself a much enhanced role in health areas that leaves provincial health care services untouched. The Senate Committee categorizes the federal roles in health and health care, excluding transfers to provinces, as follows: research and evaluation (funding for innovative health research and evaluation of innovative pilot projects); infrastructure role (support for the health care infrastructure and the health infostructure, including human resources); population health role (health protection, health and wellness promotion, illness prevention, and population health); and service delivery role (the direct provision of health services to specific population groups, including Aboriginal peoples) (Standing Senate Committee on Social Affairs, Science and Technology 2001b, X). The federal government could assume a much larger role in these broad areas, as a way of assuring Canadians that the decision to end the CHST (should this be the option that is pursued) and to leave decisions about Canada-wide standards to the provinces was made in pursuit of a different vision of the federation, and was not an abdication of interest in the health or health care of Canadians. Indeed, given the evidence that health protection and wellness promotion are instrumental to long and healthy lives for Canadians, these would be logical areas in which Ottawa might choose to play an enhanced role both because of the potential economies and spillovers. Similarly, given that improvements in evidence-based health care require better information systems than are in place today, it makes sense that these costly systems not be duplicated across the country. Once again, there is a strong rationale for greater federal leadership in this area.

### *Dual Sharing*

This model of the sharing community is perhaps closest to the current situation in the country. It features a countrywide framework that defines some basic parameters of major social programs but leaves room for provincial variation in program design and delivery. It acknowledges the coexistence of both complementary and competing visions of the federation.

*A) Form, nature, and size of transfer* Perhaps the main difference between this model and the predominantly provincial sharing model is that the federal government retains an important role, in cooperation with the provinces and territories, in preserving and improving the Canada-wide publicly insured health care system. For this reason, it is important that the federal government continue to transfer a considerable amount of money to the provinces to help them meet the costs of delivering health care. The transfer payments would remain conditional on the principles and other rules of the *Canada Health Act* being respected, with appropriate sanctions for non-compliance.

While federal CHST dollars flow into provincial governments' general revenues and can be allocated by provinces as they see fit, when Ottawa transfers this money its purpose is to support provincial efforts for health, social assistance and services, and post-secondary education. What is confusing when the federal government talks about this transfer, however, is that it cannot be precise about the share of the transfer that is for health care and the share that is for other purposes. This is not by accident: CHST as a block fund is in fact intended to leave provinces with the flexibility to allocate the transferred funds as they see fit.

In the context of a continued substantial role for the federal government in health care, this ongoing ambiguity is not helpful. Our key argument here is that the federal transfer should be redesigned to clarify what is the federal government's contribution for health care without reducing provincial flexibility. As long as the federal transfer is not based explicitly on cost sharing, that is, as long as it is a block fund, whether it be a single block or not, provinces have this flexibility. They can use a block fund transfer for its stated federal purpose, say, health care, but they can also use it for any other purpose. Even with funds being fungible in this fashion, as discussed earlier, there would be advantages to having the CHST split into two or three block transfers. It would then become clear, to citizens and others, how much Ottawa is transferring to the provinces specifically for health (and for other purposes), and, even though provinces would be

effectively free to use the money as their own priorities required, greater public accountability might ensue. Also, from a federal government viewpoint, visibility would be somewhat improved. In short, for the dual sharing community, we suggest a separate Canada Health Transfer (CHT).

As for the size of a new CHT, the notional \$10 billion base (the estimated health component of CHST in 2001/02) together with an adjustment of \$4 billion as suggested earlier, is an appropriate starting point under existing CHA conditions.

It is also possible, under this model, that CHA conditions would be modernized to include considerations like quality, timeliness, affordability, and accountability. To the extent that this occurred, it might be necessary to go beyond the \$14 billion. However, we envisage any additional conditions as emerging from a federal-provincial negotiation that is based on mutual respect of constitutional competencies, not unilateral federal imposition. Thus, moving the base amount beyond \$14 billion would not be a *quid pro quo* for Ottawa's imposition of extra conditions but rather, to the extent that it were true, because the added conditions imposed further costs on the provinces. Since we have no way of knowing the actual costs of these hypothetical additional conditions, we arbitrarily assume that the upper end of such a cost increase would be \$2 billion. The total CHT transfer in this context would be in the range of \$14-16 billion.

The simplest way of allocating such a transfer is on an equal per capita basis, but this would reduce the share being transferred to the poorer provinces relative to the current CHST arrangements. As noted in our discussion on the predominantly provincial sharing model, all provinces except the wealthiest one currently receive more cash per capita now than the latter. This issue is discussed below under Equalization considerations.

**B) Escalator considerations** We propose a built-in escalator for the CHT that would be carefully designed to reflect the growth in national per capita health care costs. This might entail a formula based on GDP or tied to personal income tax revenue increases.

It is unrealistic to expect that the federal finance ministry would commit to an enhanced health transfer with a built-in escalator unless it had some freedom to alter the terms of the arrangement in the face of a financial emergency. The relevant legislation might therefore provide for some form of federal flexibility. At the same time, it is also unrealistic to expect that provincial govern-

ments would support such a provision unless the conditions under which it could be exercised assured them of fairness in the way that the federal government allocated expenditure reductions between federal programs and provincial transfers. Thus, the legislation might prescribe that the percentage reduction in federal transfers to the provinces should be no greater than the percentage reduction in other federal program spending.<sup>36</sup>

*C) Equalization considerations* The CHST equalizes in two distinct ways. First, since the total CHST per capita entitlement (tax and cash) is equal across the country, nine provinces receive more cash per capita than the province with the highest fiscal capacity. This is an important form of equalization. Second, the cash transfer is paid out of general federal revenues, and wealthier provinces contribute more to federal coffers on a per capita basis than do the less wealthy provinces.

In the context of a dual sharing model, in principle we can think of no reason to weaken the equalizing properties embedded in the CHST. Yet as a result of a shift to an equal per capita cash transfer, most provinces would see their *share* of the total transfer decline relative to the current allocation of transfer payments under the CHST. (In effect, they would lose the benefit of having their transfer revenues equalized to the level of the richest province because the value of EPF tax points would no longer be relevant in calculating transfer payments to provinces.) Therefore, the case for adjusting the federal cash contribution to reflect demographic and geographic differences is even stronger for the dual sharing model than it is for the predominantly provincial sharing model. In the predominantly provincial sharing case, we argued that such a needs-related component could be associated with the transfer of tax room or the revenue-sharing arrangement to make it easier for provinces with greater than average needs to meet their obligation to provide a reasonably comparable level of services at reasonably comparable levels of taxation. The case for adjustment is stronger under the dual sharing model because provinces are also subject to certain national conditions that might make it even more difficult for them to meet this challenge. To take an extreme hypothetical example: if all provinces were required to provide comprehensive hospital services, and one province had a very old population and another a very young population, an equal per capita transfer would make it relatively harder for the province with the old population to meet its obligation, and vice versa.

This option does not mean that poorer provinces would lose all of the

benefit associated with the equal per capita entitlement (and unequal per capita cash) under the CHST. They would not, however, directly obtain these particular equalization advantages through the CHT (except to the extent that the inclusion of a needs-based component happened to benefit the provinces that have less fiscal capacity). Nonetheless, they might be able to recoup these benefits through the allocation formula devised for the non-health component of the CHST. This could be a separate Canada Social Transfer (CST). If this transfer were allocated wholly or in part on a basis that reflected real differences in welfare incidence across the country, the provinces with higher welfare rolls would receive relatively more cash per capita than the provinces with lower rates of social assistance. Indeed, having the separate CST dedicated solely to social assistance and services might make sense, especially as the federal government has been spending on post-secondary education in recent years through alternative instruments (Canada Research Chairs, new funding for research granting councils, and Millennium Scholarships, for example) (see Hobson and St-Hilaire 2000). It is unclear whether an equal per capita transfer that was adjusted for differences in need among provinces would achieve a greater or lesser degree of equalization than is now implicit in the CHST. This would depend on the outcome of the needs-based adjustment.

*D) Other considerations* Under the dual sharing model, we argue that at least \$4 billion (and conceivably as much as \$6 billion) annually should be added to the federal contribution to provincial health care programs under a new CHT in the maintenance scenario. It is unlikely, however, that the federal government would accept a reform of this magnitude, regardless of what we consider to be its inherent fairness, without some *quid pro quo*. There are two conditions that Ottawa might want. The first is some assurance that the re-basing of the federal financial contribution is the new "permanent" deal and that it will *not* be seen as just another improvement in transfers heading inexorably, even if in the very long-term, toward a 50 percent federal CHT cash contribution. As noted previously, a 50 percent federal cash contribution is not a relevant benchmark given the 1977 tax transfer under EPF, whereas a cash contribution in the order of 20-25 percent of provincial expenditures would be consistent with the federal government's historical role in funding health care. Using the language suggested above, the federal government might justifiably insist on a peace treaty, not just a ceasefire. The second is an assurance of visible improvements in the kind of

"quality of service" items referred to in the communiqué on health emanating from the 11 September 2000 First Ministers' Meeting (for example, "access to 24/7 first contact health services" and reduced "waiting times for key diagnostic and treatment services"), or at least tangible initiatives that ensure such improvements. This might entail having some of the increases in funding initially tied to specific provincial initiatives, say for five years, with the funds subsequently being rolled over into the CHT base.

With regard to the direct federal role, the same considerations that were raised under the predominantly provincial sharing model apply here.

### *Predominantly Canada-Wide Sharing*

This concept of the sharing community is at the opposite end of the continuum relative to the predominantly provincial sharing perspective. It sees Canada as a whole as the primary sharing community for Canadians in matters related to health care and requires strong countrywide standards with respect to the kinds of services and redistribution policies that should be available across the country.

In this model, a relatively precise package of health care services would be provided by provincial governments all across the country, and these services would be more or less equally accessible and of similar quality. While it may be impractical to think that a person living in northern Quebec or northern Ontario can have as easy access to certain specialized services as someone living in the Montreal or Toronto areas – and this is equally true for northerners and southerners in other provinces as between provinces – the same minimum package of services with the same standards is provided for under this model.

A) *Form, nature, and size of transfer* Implementing this vision of the sharing community would require a substantial increase in the conditions associated with the federal health transfer to the provinces – the new Canada Health Transfer – since there would be a much greater commitment to uniform health care services across the federation. Questions thus arise as to how governments would determine what would be contained in the Canada-wide package of services, the ease of accessibility rules and any other conditions that may be required, and how to enforce whatever is decided. Fortunately, the Social Union Framework Agreement (SUFA) provides some guidance. The introduction of substantive new health care conditions attached to a CHT is

analogous to introducing a new Canada-wide program, and Ottawa would need to satisfy the SUFA rules to that effect. In turn, this would provide provinces with considerable bargaining power that they might be expected to use to ensure that the new conditions met their needs as well as Ottawa's. For example, they might wish to negotiate some clear understanding of how the federal government would interpret key terms like "covered services" or "accessibility." We also believe that the full 25 percent federal CHT cash contribution would be essential in this case. Under this benchmark, for instance, the federal cash contribution for health care in 2001/02 would have been \$17 billion (and possibly even more given that additional provincial costs likely would have been incurred under increased standards).

One place where we consider the SUFA rules too weak is in relation to the minimum level of provincial support required for such an initiative to proceed. In this scenario, we suggest a 7/50 rule (at least two-thirds of the provinces representing at least one-half the population) is the minimum threshold needed. In some sense, if that measure of provincial support is not available, then the support for this vision of the sharing community may also be lacking.

**B) Escalator considerations** The same considerations apply here as in the dual sharing model.

**C) Equalization considerations** Given the sharing principles involved, we believe the case for a needs-based adjustment to the per capita contribution is strongest under this model of the federation. In other respects, the considerations are similar to those in the dual sharing model.

**D) Other considerations** It would be consistent with this view of the sharing community to convert CHT from a block fund to a cost-sharing transfer. Cost sharing would certainly give the federal government more leverage to achieve its goals. However, we think that this would be a retrograde step in intergovernmental relations, not to mention the possibility that all the difficulties that led to EPF in 1977 (problems for Ottawa in controlling its costs, potential distortion of provincial resource allocation, and administrative headaches regarding what is eligible for cost sharing) would reoccur. We do not recommend it. In other respects, the points made in the dual sharing case also apply here.

## Transformation Context

This section presents the federal financing options that would be appropriate in a context where a broadening of the Canadian health system was judged to be a priority and it was decided to extend the range of services covered. From a legal point of view, this decision could entail amendments to the CHA or entirely new legislation that would supplement the CHA and deal only with the newly covered services. There are a variety of political considerations that would influence the choice of legislative strategy. This chapter does not attempt to analyse them. Rather, we arbitrarily assume, for analytical purposes only, that the newly covered services would be included in the CHA. But if an alternative legislative strategy were preferred, this would make little difference in terms of the financing options discussed below.

As a starting point it is assumed under this scenario that a decision would be made in implementing the recommendations of the Romanow Commission's final report to include pharmaceuticals, home care, or both, wholly or in part as newly covered Canada-wide services. The main concern in setting out potential options under this scenario is what the federal government can or should do financially to make this happen. From the perspective of fiscal federalism, how does Ottawa ensure that these new services are provided? And how can it do so in a way that is fair to provinces and fiscally sustainable?

We consider these questions only with respect to two of the three sharing community models. (We doubt that the transformation scenario is consistent with the predominantly provincial sharing model and therefore exclude it from our analysis.)<sup>37</sup> But before we do so, an important proviso is in order. It must be recognized that the potential demand for insured health care services is almost limitless. Thus in the context of a broadened CHA, in one fashion or other, a fiscal cap or constraint will have to be enforced by governments, either directly or indirectly. Determining what this constraint should be is beyond our mandate. In the real world, the political process will determine the outcome, and one would expect the claims of the health care system on the public purse to be in competition with demands for tax reductions, a strengthened military, farm relief, and various other pressures with respect to social services and education. Our analysis is based on a hypothetical example of extended insured health services and therefore can only provide a general indication of the magnitude of the costs involved. The more important aspect of this analysis is to indicate the ways in which the tools of fiscal federalism can be used to facilitate the introduction of the expanded health insurance provisions envisioned in the hypothetical example.



Thus, for illustrative purposes, we include both home care and pharmacare under a broadened CHA. We do not know with certainty what these would cost (the definition of insured services is crucial) but, based on a quick examination of available data and choosing a figure for purposes of discussion, we assume here that together they would amount to \$16 billion annually (three-quarters for prescription drugs and one-quarter for home care). We further assume that, while physician and hospital services would still be completely covered, the newly insured services under the CHA would only be partially (perhaps half) covered. Note that provinces are already covering, to varying degrees, some prescription drug and home care costs.<sup>38</sup> Thus, the new insurance requirement (i.e., 50 percent coverage) would not imply an additional \$8 billion in provincial costs. (In fact, if each province were already covering exactly one-half of prescription drugs and home care, the incremental cost to them would hypothetically be zero.) We arbitrarily assume that, in total, the incremental costs to the provinces to secure partial (50 percent) coverage of the extended benefits would be half of that amount, that is \$4 billion. Among the reasons why provinces would incur added costs, we note three. First, there is unevenness in current provincial coverage of drugs and home care, with some provinces offering relatively little coverage. For those provinces, there would be substantial incremental costs. Second, part of the costs that provinces currently incur is for coverage that, in respect of certain client groups, exceeds the 50 percent coverage that the new CHA would require. But for other client groups there may be no existing coverage, and thus providing the latter with 50 percent coverage would add to provincial costs. Third, the new CHA public insurance coverage might trigger additional demand. In other words, in addition to what provinces and individuals or families are now paying for insured home care and pharmaceuticals, \$4 billion might be required to ensure that all provinces cover half of the costs. We repeat that these hypothetical numbers are for illustrative purposes only, and additional research and analysis on a province-by-province basis would be required to provide accurate estimates.

Of course, our purpose here is not to provide the detailed design of newly extended health programs. Rather, we are laying out some principles for consideration should such a scenario become a possibility. Based on our earlier analysis, we believe the following fiscal federalism principles should guide the implementation of extended CHA insurance coverage:

- > Initially, the extended coverage should be financed through a separate block fund (or funds). But this separate funding should be maintained only until provinces have some experience with the new programs and they are deemed established. Once experience/maturity is achieved, the separate block fund (or funds) should be folded into the main CHT suggested above.
- > During the initial phase, the separate block fund (or funds) should increase annually based on a growth formula that reflects the rate of growth in provincial expenditures for these new programs. However, there should be no explicit cost sharing.
- > In general, the conditions associated with the extended insured services should be similar to those that apply to hospital and medical insurance.

#### *Predominantly Canada-wide Sharing*

We begin by discussing the predominantly Canada-wide sharing model. In the transformation scenario, the federal government would extend the current health insurance arrangements to include some or all of uninsured services. Following our hypothetical case, the extended coverage includes 50 percent of the costs of the \$16 billion in prescription medications and home care services. It is assumed that the actual incremental costs to provinces would have been \$4 billion in 2001/02.

Given the provincial governments' current concerns over escalating health costs and their position that there is a vertical fiscal imbalance in Canada that favours the federal government, it seems highly improbable that provinces, as a group, would be willing to sign on to such new expenditure obligations. How, then, might Ottawa encourage provinces to agree to cover such costs as part of their publicly insured health care programs? The answer is that it might be able to do so if there was no net cost to the provinces. Put differently, if this were a high priority for the federal government, it might have to pay disproportionately to secure provincial compliance.

**A) Form, nature, and size of transfer** This scenario entails both extended health insurance (additional covered services) and a much greater degree of similarity of coverage across provinces (associated with the predominantly Canada-wide sharing model). Thus, insured services and conditionality are both increased relative to the current context. This requires a federal cash transfer, not a tax transfer.

While the case for cost sharing is strongest under this model of sharing, we maintain that the benefits of block funding outweigh the benefits of cost sharing. (The reasons for this were noted earlier and are not repeated here.) We also suggest that there should be separate block funds, as noted above, for the extended services (pharmacare and home care) until these programs are well established and governments have a reasonable sense of the costs involved and their rate of growth. Finally, we propose an equal per capita grant as the appropriate instrument, subject to some equalization considerations that will be discussed below.

One way to secure provincial agreement for such extended services would be for the federal government to pay for 100 percent of the assumed incremental costs to the provinces, that is, the \$4 billion referred to above. While we lack the data to be precise, it is likely that this would create windfalls for some provinces, whereas others would more or less break even. More to the point, detailed knowledge of all aspects of provincial programs for home care and pharmaceuticals would be required in order to determine the minimum amount of the federal transfer needed to make this proposal fiscally attractive to the provinces. In practice, this would entail extensive information exchange among governments and prolonged negotiation. In any case, given that the \$4 billion is a hypothetical number, it is possible that figure might have to be increased to ensure that no province is at a fiscal disadvantage as a result of the extension, although it is also possible that it could be reduced. We understand, of course, that the federal government might be very reluctant to pay all of the costs of new programs. Short of doing so, however, it may be very difficult to persuade provinces in the present context.

Thus under this scenario and this model of the sharing community, the combined cost of the CHT and the transfers for newly covered services could be as high as \$21 billion (including the current \$10 billion federal contribution, up to \$7 billion associated with the predominantly Canada-wide sharing model for maintenance, and around \$4 billion for the newly covered services). Note that in these circumstances, the share of provincial health care costs financed by the federal government would likely exceed 25 percent.

**B) Related strategic considerations** By now it will be clear that this scenario implies very large expenditures on the part of the federal government and that it would also impose substantial new obligations on the provinces. For this type of scenario to become reality, it could require widespread public support. But even

with this level of support, it could not happen without the federal government deciding that such an initiative was really its highest fiscal priority and without the provinces feeling assured that it would not make them more vulnerable fiscally. This would no doubt entail a difficult and lengthy negotiation, in which both orders of government would attempt to maximize their goals at minimum cost.

Again in this case we would argue that SUFA-type rules regarding joint planning between federal and provincial governments are appropriate, given the magnitude of such an extension, but with the higher 7/50 threshold for provincial support. Without this level of concurrence, adequate national support for such an initiative might be lacking.

In the context of this transformation scenario – which would include both more stringent Canada-wide standards and broader insurance coverage – the question arises as to whether the enhanced federal financial contribution proposed in the maintenance scenario should be combined with the increased funding envisaged for new services to improve federal leverage in achieving broadened health coverage. Indeed, it might make sense for Ottawa to try to leverage all the additional funds (\$11 billion) to convince provinces to accept the broadened scope of the CHA. In other words, while we have developed separate financing rationales for the enriched maintenance context (\$7 billion) and the transformation context (\$4 billion), the federal government, were it in the transformation mode, might well view the amount as a single envelope to be used to win provincial support.

Conversely, provinces would likely seek the opposite. They could well demand more federal funding for services covered under the current CHA before considering any broadening of insurable services. However, at this point, one can only speculate on these dynamics and the likely outcome of the negotiation process that would unfold.

What is certain, on the other hand, is that the provinces will want to minimize the risk that on some future occasion the federal government will act as arbitrarily as it did in respect of both the cap on CAP and the CHST. Provinces will want assurances that Ottawa will continue to pay its fair share as the future unfolds and will not unilaterally change the funding deal five or ten years down the road. On this point, a proposal from Richard Zuker merits attention. Zuker proposes an approach that borrows from the federal-provincial decision rule for amending the Canada Pension Plan legislation.<sup>39</sup> Based on this idea, whatever the new federal-provincial fiscal agreement for extended health insurance coverage,

Ottawa would legislate that it would not amend its financial commitment without the consent of seven provinces representing 50 percent of the population. While one Parliament cannot legally bind another, it would be politically very difficult for a new Parliament to unilaterally breach this kind of commitment.

What might Ottawa get in return? It might convince the provinces to legislate provincial health care acts based on an agreed model bill. The model would enshrine the scope and principles of the new CHA. The provinces would commit not to amend their legislation without the agreement of the federal government and at least six other provinces (comprising half the Canadian population). All provinces claim to support the principles of the current CHA; provinces that agreed to a broadened CHA might find it attractive politically to be seen to be implementing and enforcing their own legislation. Of course, in this case too, a future legislature could amend such legislation.

*C) Escalator considerations* It is suggested that a separate growth formula be used for the transfers associated with newly insured services until such time as the pattern of growth in these services becomes relatively predictable. This escalator should reflect growth rates in Canada-wide (all-province) costs for the new programs. For the first few years, until the pattern of growth in provincial costs became clear, the escalator might require several adjustments; thus it would effectively behave as a cost-sharing instrument. Eventually the CHT escalator would apply, as the separate block fund (or funds) is integrated into it.

*D) Equalization considerations* An equal per capita grant, as already seen, redistributes revenues from provinces in which taxpayers pay more federal taxes than the national average to those whose taxpayers pay less. This redistribution effect helps to equalize fiscal capacity. But, of course, this approach focuses on assuring equal levels of service across provinces. An equal per capita grant would not address the fact that some provinces have costlier health care needs, due to the presence of older and perhaps more rural populations. As we indicated under the maintenance scenario, the predominantly Canada-wide sharing vision is the one in which the case is strongest for adjusting the equal per capita grant to take account of differences in need.

*E) Other considerations* Even if the federal government were to assume most of the costs of an extension of universal publicly insured health care ser-

vices, it should not be the delivery agent. In addition to the obvious constitutional objections, there are also more pragmatic considerations that motivate this judgment. The main one is that the health care system should be seamless. The various forms of intervention (medical, pharmaceutical, and surgical, for example) and modes of delivery (hospital, long-term care, and home care) should be managed as part of a coherent whole. The provinces should therefore remain the jurisdiction with broad management responsibility.

Finally, depending on the fiscal situation of the federal government, Ottawa would have the option in this scenario of offsetting its large costs by levying an added tax – call it a health premium. For individuals who would be paying lower premiums to private insurers for drug and home-care coverage, the result would be smaller private and larger public insurance payments. For some without existing private coverage, taxes would be higher and coverage enhanced. The tax policy implications of such a move are well beyond the scope of this chapter. The point we are making is that to the extent that Canadians continue to find a public health insurance system attractive and are willing to pay more taxes to ensure its viability, this option may be worth considering. It is thus not inconceivable that a part of the incremental cost of the predominantly Canada-wide sharing model in a transformation context would be covered through additional tax levies.

### *Dual Sharing*

The dual sharing model resembles most the current balance that exists in the social policy roles of both orders of government and the extent of countrywide sharing that prevails. Under this model in a context of transformation, we start from the same principles and hypothetical scenario as described above. The main difference is that there is not as stringent a requirement that Ottawa “enforce” countrywide norms and standards for the enhanced services as there is in the predominantly Canada-wide sharing model.

*A) Form, nature, and size of transfer* Under this model, a federal cash transfer would remain the appropriate instrument for promoting the extension of insured services. It is much harder, if not impossible, to enforce conditions with a transfer of tax room. For reasons discussed above, a separate block transfer (or transfers) in respect of the newly insured services seems appropriate to us, at least initially.

As for conditionality, the scenario is consistent with a modernization – and perhaps expansion – of CHA conditions, but is expressed in broad and general terms, since there is a weaker commitment to uniformity of health care services from province to province than there is in the predominantly Canada-wide sharing model. There is considerably more room for individual provinces, working from certain basic principles that are applied Canada-wide, to interpret or adapt those principles to correspond to local conditions and preferences.

The size of the transfer would be consistent with the amount set out in the case of the predominantly Canada-wide sharing model. Thus, for 2001/02, it would add a hypothetical \$4 billion onto the \$14-16 billion associated with dual sharing under the maintenance scenario.

**B) Related strategic considerations** Many of the considerations raised under the predominantly Canada-wide sharing model also apply here. The main difference is that the provinces have much more scope to determine how to implement their obligations under the CHA, perhaps as much as they have today. Given the lesser constraint on provincial operational discretion, the 7/50 standard might be unduly onerous for federal action. The SUFA requirement for majority provincial support, meaning at least six provinces, might suffice for some, but our view is that there should be compliance with the 50 percent of the population requirement.

**C) Escalator considerations** Our comments regarding the predominantly Canada-wide sharing model also apply here.

**D) Equalization considerations** The existence of an equal per capita mechanism would mean that the CHT would help equalize fiscal capacity across provinces. The same would apply to the equal per capita contribution for the newly insured services. The case for adjusting the equal per capita grant to reflect needs is similar to that under dual-sharing in the maintenance scenario.

**E) Other considerations** Our comments regarding the predominantly Canada-wide sharing model also apply here.

Table 5 below summarizes the financing options under the three models of the sharing community, in both a maintenance and transformation context, that were presented in this part of the chapter.

## A FRAMEWORK FOR RENEWAL

While the federal-provincial dispute over the federal role in funding health care in recent years has focused almost exclusively on the issue of fiscal imbalance between the two orders of government, our main conclusion is that what is really at issue is the imbalance between the role the federal government appears to want to play with respect to the countrywide dimensions of health care policy and its financial contribution to the Canadian health care system. In our view, Ottawa's current level of funding is insufficient, particularly if it wishes to continue to exercise its influence on the future direction of the system. As things stand now, a disproportionate share of the financial and political risk associated with the uncertainties of the health care enterprise is borne by the provinces. The federal government must contribute more financially and assume more of the risk to maintain the political and moral right to play the policy role it has historically played.

But the amount of money is not the only issue. The way in which the two orders of government relate to one another on fiscal matters is inconsistent with the kind of intergovernmental partnership arrangement on health care that Ottawa appears to want and the Canadian public expects. Therefore most of our proposals are aimed at outlining the framework of a renewed intergovernmental fiscal relationship in relation to health care. This framework is based on four general principles: (1) establishing what would be deemed by both orders of government and the Canadian public to be a "fair share" federal contribution; (2) ensuring transparency in any new fiscal arrangements for health; (3) ensuring a measure of predictability that will allow the provinces to undertake the necessary long-range planning and reforms; and (4) moving toward a more collaborative form of intergovernmental partnership.

For the most part these four principles apply across the range of federal financing options presented in this chapter, irrespective of whether the future direction for health care is focused on consolidating and improving the existing system or involves expanding the range of services and insurance coverage. The following paragraphs highlight the implications of this new framework, focusing on the dual sharing model of the federation, which relates most closely to our current system.

To begin with, the federal financial contribution to the provinces for health care purposes should be re-based through a process of federal/provincial/territorial negotiation. Given the large tax transfer that Ottawa provided to



Table 5

## SUMMARY OF FEDERAL FINANCING OPTIONS

Sharing community	Predominantly Provincial Sharing (PPS)	Dual Sharing (DS)		Predominantly Canada-Wide Sharing (PCWS)	
		Maintenance	Transformation	Maintenance	Transformation
Form and nature of transfer	Could be effected either through a transfer of tax room to provinces or a revenue-sharing scheme. Revenue sharing is preferable due to possible adverse effects on tax harmonization and increased potential pressure on Equalization with tax transfer. If tax room transfer preferred, a small cash transfer is also needed to protect portability and mobility (with reduction in size of tax transfer).	Equal per capita cash transfer. Separate block fund for health, Canada Health Transfer (CHT).	New equal per capita block fund for newly covered services in addition to separate CHT.	Equal per capita cash transfer. Separate CHT block fund.	New adjusted equal per capita block fund for newly covered services in addition to CHT. New fund to be folded into CHT once program is mature.
Condition of transfer	No conditions except portability and mobility	Minimum is continuation of current CHA conditions. Might seek to modernize and improve conditions but conditions remain general. Not standards.	Conditions for extended services to be similar to current CHA conditions. Otherwise same as in DS maintenance scenario.	Conditions entail same health care services across country. Much more onerous than today. More like standards.	As in PCWS maintenance scenario with standards. Conditions for extended services to be similar to hospital and medical standards.
Size of transfer	Up to \$4 billion on top of existing notional \$10 billion for 2001/02 and escalated forward.	With current CHA conditions, add \$4 billion to existing notional \$10 billion (2001/02). With added conditions that impose costs on provinces, \$4 billion would increase, up to maximum of \$6 billion.	Hypothetical \$4 billion for new services on top of \$14-16 billion from maintenance scenario.	Re-base federal cash contribution at 25% of provincial health care costs (\$17 billion in 2001/02).	Hypothetical \$4 billion on top of \$17 billion from maintenance scenario. Result might move Ottawa's contribution to slightly over 25% of provincial costs.

Table 5 (continued)

Escalator	Tax transfer or revenue sharing means that escalator is not an issue	Escalator that reflects growth in national health care costs.	Separate escalator for new programs to reflect their cost pattern until folded into CHT. Otherwise same as in DS maintenance scenario.	Escalator that reflects growth in national health care costs.	Separate escalator for new programs to reflect their cost pattern until folded into CHT. Otherwise same as in PCWS maintenance scenario.
Equalization considerations	Tax room is equalized on basis of current Equalization formula but possibly with needs component. If revenue sharing is preferred, it could be designed to provide equal per capita revenues to provinces, with a possible needs adjustment.	CHT equalized, with needs taken into account in CHT. Case for needs-based adjustment stronger than in PPS.	Same as in DS maintenance option.	Same as in DS model but case for needs-based adjustment even stronger.	Same as in PCWS maintenance scenario.
Other considerations	Possible for federal government to play larger direct role in health via spending on research and information, public health, and Aboriginal service delivery.	Federal government will require <i>quid pro quo</i> for added funds, including accepting that new funding deal is "permanent." Larger direct federal role still possible.	Federal government may levy a health tax. Otherwise as in DS maintenance scenario.	Same <i>quid pro quo</i> as in DS model. Would require minimum level of provincial support (7/50 rule)	Federal government may levy a health tax. Otherwise same as in PCWS maintenance scenario. This scenario would also require firm commitments from Ottawa on funding (might have to assume the bulk of the cost). Proposed Canada Pension Plan decision model. Similar provincial commitments through model health care act.

the provinces in the 1970s for health care and post-secondary education; a fair and reasonable federal cash contribution for health care should be in the range of 20-25 percent of total provincial health care costs, with the actual share to be determined through a process that takes certain factors into account, such as the nature of the conditions associated with the transfer and the amount of direct federal spending. Our best estimate of the current federal cash contribution is in the order of 15 percent.

The federal cash contribution should be in the form of a separate block fund for health care (the Canada Health Transfer) allocated on an equal per capita basis. We propose this approach in part because of its equalizing properties. It should not be an explicit cost-sharing arrangement. The new transfer should be visible and understood by all Canadians to be the federal contribution for health. The current CHST arrangements make it impossible to know, and to agree on, what the federal contribution is, and the ongoing dispute between the two orders of government on that issue is not only counterproductive but has become detrimental to the health care reform process and the functioning of the federation.

This federal health transfer should have a built-in growth formula (an escalator) that is designed to reflect the growth in national health care costs. It should be predictable and transparent. Consideration should also be given to adjusting the equal per capita transfer on the basis of differences in need among provinces and territories as determined by measurable demographic and geographic factors. While such a needs-related adjustment can be justified in all scenarios, it is strongest in the case of the predominantly Canada-wide sharing model.

If the federal government decides to propose Canada-wide legislation for newly insured services, the federal-provincial/territorial negotiations should be guided by the principles set out in the Social Union Framework Agreement, but with seven or more provinces representing 50 percent of the population as the minimum threshold for extending the Canada-wide health care programs. In this scenario of a broader range of insured services, consideration should be given to the kind of fiscal leverage that the federal government might use to encourage provincial support. Given the provinces' current concerns over escalating health care costs and their view that there is a vertical fiscal imbalance that favours Ottawa, it appears that the incremental costs of the added coverage to the provinces may have to initially be borne by the federal government. An interim measure that could be considered would be for the funding allocated to the new

national health care programs to be placed in a separate block fund (separate from the CHT), with a separate escalator that reflects anticipated cost increases in the new programs without being an explicit cost-sharing instrument. The funding for new programs should be folded into the CHT when they become mature.

More generally, whatever direction governments choose to take regarding the future of the Canadian health system, the fiscal relationship between the federal and provincial/territorial governments must be re-examined with a view to establishing a new partnership. The model of federal-provincial fiscal relations that prevailed for more than two decades from the 1950s to the 1970s was characterized by tough negotiations but with a determination to reach agreement. Returning to the earlier model or finding an alternative that gives provinces more influence over outcomes is highly desirable. This requires that the federal government become more collaborative. It also requires that provinces and territories negotiate in good faith with Ottawa whether the federal treasury is in serious difficulty or in strong surplus.

Finally, consideration should be given to ways in which the federal government could cooperate strategically with the provinces and territories in order to help them overcome some of the difficult political obstacles they face in moving forward with health care reform. As a general proposition, both orders of government support the idea that comprehensive reform is necessary. Yet they do relatively little together to overcome the barriers to such reform. We understand that provinces may be nervous that "partnership," in this kind of situation, risks becoming "intrusion." But given the pace of progress so far, it is hard to believe that some form of intergovernmental cooperation would not help advance the common agenda.

## NOTES

- 1 The Premiers' Council on Canadian Health Awareness was created by the premiers as part of their multi-media campaign to disseminate information about health financing challenges to citizens and put pressure on the federal government to increase its share of funding. Their print and television advertisements can be viewed on their website: <http://premiers-forhealth.ca/communicate.php>.
- 2 We realize that there is also a requirement for comprehensiveness but there is so much uncertainty about the meaning of this term that we chose to exclude it here.
- 3 See the first chapter of this volume by Keith Banting and Robin Boadway.
- 4 See, for example, Provincial and Territorial Ministers of Health (2000). See also Commission on Fiscal Imbalance (2002, 33-37).
- 5 For a summary of public opinion, see Standing Senate Committee on Social Affairs, Science and Technology (2001a, 45-50).
- 6 For example, see Morgan and Hurley (2002).
- 7 We say "most" provincial governments because some provinces had implemented hospital insurance before national legislation was introduced by the federal government, and one province had also done so in respect of insured medical services.
- 8 The cost-sharing formulas were somewhat more complex but this description is adequate at this stage of the analysis.
- 9 At the time of the 1977 legislation, the federal government also introduced a new program to cover extended health services, such as nursing home intermediate care, lower-level residential care for adults, aspects of home care and ambulatory health services not covered by the hospital insurance agreements. The payments were initially \$20 per capita and were intended to escalate by the rate of growth of per capita GDP. Some of these expenses had previously been covered under the Canada Assistance Plan.
- 10 EPF was a block transfer that was intended to replace federal cost sharing for hospital and medical insurance and for post-secondary education operating costs. Thus, these are notional estimates only. See Commission on the Future of Health Care in Canada, (2002, Appendix E2, 313).
- 11 Some provinces might argue that the lower taxes were required due to competitive economic pressures and that they were faster out of the gate than the federal government.
- 12 According to Proposals of the Government of Canada to the Dominion-Provincial Conference on Reconstruction, (August 1945, 29), in "both federal and provincial circles, health insurance has been under active consideration since the last war."
- 13 The quotations are from the letter of transmittal of the report, dated February 17, 1943, from Leonard C. Marsh to the Chairman of the Advisory Committee on Reconstruction, F. Cyril James.
- 14 Ibid.
- 15 Ibid, 28.
- 16 Donald Smiley quoted Prime Minister Mackenzie King to the effect that these grants were in aid of several health functions as "fundamental pre-requisites of a nation-wide scheme of health insurance." See Smiley (1963, 29).
- 17 For a snapshot of how provinces financed their share of costs, see Canadian Tax Foundation (1965, 115-17).
- 18 Canadian Tax Foundation (1972, 136).
- 19 In the 1972 amendments to the opting-out arrangements, the tax abatement for HDSA was increased to 16 percent of the federal individual income tax.
- 20 Carter cites an Ontario proposal at a 1955 federal-provincial committee to the effect that Ottawa should pay for 60 percent of a wider scheme, Carter (1971, fn 32).

- 21 The numbers cited here are derived from Canadian Tax Foundation (1978, 23, Table 2-11).
- 22 Canadian Tax Foundation (1976, 112-13).
- 23 For a good discussion of this issue, see Standing Senate Committee on Social Affairs, Science and Technology (2001a, 7-10). We are aware that, from a theoretical viewpoint, individual provinces could not significantly increase their access to federal funding simply by increasing their expenses on insurable items, since the greater part of the funding formula was linked to national average per capita costs and not the costs of individual provinces. At the same time, in a setting where all provinces are experiencing rapidly rising costs, this consideration may not be as important as theory would suggest.
- 24 The federal government vacated 9,143 points of the personal income tax at the time. Revenues from these points and the 4,357 points that had been vacated earlier, plus 1 point of corporate income tax under previous post-secondary education arrangements were to replace part of the former cash payments.
- 25 For a good factual discussion of these issues, see Perry (1997, chapter 17). The cash transfers were also augmented to include both transitional and, for some provinces, leveling payments. The latter was a provision under which the cash contributions were to become equal per capita over a five-year phase-in period.
- 26 This figure was initially estimated using Table 11-1 from the Canadian Tax Foundation (1979, 202). It shows gross provincial expenditures at \$9.73 billion for health (excluding a small amount paid for by local government without provincial transfers). It shows federal conditional transfers to provinces at \$3 billion. However, only \$246 million for Quebec is included in this \$3 billion. We have assumed the value of the Quebec transfer, including the abatement, to be equal to 85 percent of the Ontario transfer, which increases it by \$987 million. This raises the amount of the federal conditional transfer from \$3 billion to \$4 billion. The latter number is around 41.5 percent of provincial health spending. Note that we subsequently located data from the federal Department of Finance. The Finance number was almost identical to our initial estimate.
- 27 Based on transfer data from the federal Department of Finance and provincial expenditure data from CIHI.
- 28 Provincial and Territorial Ministers of Health (2000, 19).
- 29 On this point, there are two contrary arguments. On the one hand, given the rapidly deteriorating state of federal finances by the early 1980s (discussed in some detail in chapter 3), it is unrealistic to think that the escalator could have been improved. On the other hand, provinces argued that the rate of increase in health costs would exceed the growth rate of GNP and that the escalator would therefore be inadequate. With the benefits of hindsight, the former argument seems to have more weight (although both can be supported). As it turned out, federal finances were badly out of control in the 1980s and Ottawa found it necessary to lower the escalator. Had a more generous escalator been in place, the structural fiscal imbalance of the federal government would have been even worse. The conclusion that we draw from this is simply that if one is going to use a 1970s benchmark as one input into the determination of a "fair" share for federal cash contributions to provinces for health, the 26 percent number is at the upper end of a range.
- 30 This comment is not intended to pass any judgment on the efficacy or fairness of such fees.
- 31 These data are drawn from both federal and provincial sources. They do not seem to be in dispute.
- 32 See Provincial and Territorial Ministers of Health (2000, 10-13).

- 33 For example, the 50:50 cost-sharing argument was put forward by the Ontario Minister of Health in an interview on *Newsworld* following the F/P/T Meeting of Finance Ministers in Corner Brook, Newfoundland, on 25 April 2002. In late 2002, provincial premiers undertook an advertising campaign that compared federal CHST cash contributions for health care to the 50 percent figure that had prevailed prior to EPF.
- 34 Note that the 68 percent figure represents provincial health care expenditures as a share of provincial expenditure on health care, post-secondary education, and social assistance/services, using FMS data for post-secondary education based on "general" provincial and territorial expenditures. If "total" expenditures for post-secondary education had been used, the 68 percent number would have dropped to 62 percent.
- 35 Presented at the conference on "Canadian Fiscal Arrangements: What Works, What Might Work Better," 17 May 2002, Winnipeg, Manitoba, by Louis Levesque, a PCO official.
- 36 The legislation might also increase federal flexibility even further in the event of war.
- 37 In principle, the provinces could take the initiative and seek to expand coverage of insured health care services. And in practice individual provinces have selectively expanded coverage. To the extent that the expanded services are targeted at provincial populations, then the coverage will differ in scope and nature from province to province. And this does not raise any issues related to fiscal federalism. As for the possibility of provinces acting collectively to create a Canada-wide program, there is no persuasive historical evidence that we are aware of that suggests that provinces are likely to wish to choose to follow this course. Indeed, in the past, provinces that played a leadership role in introducing public health insurance looked to the federal government to turn their initiatives into Canada-wide programs.
- 38 According to CIHI, the public sector share of prescribed drugs in 2001 was likely to be equal to 49.2 percent. See Canadian Institute for Health Information (2002).
- 39 Commentary presented at the conference on "Canadian Fiscal Arrangements: What Works, What Might Work Better", 16-17 May 2002, Winnipeg, Manitoba.

## FEDERAL-PROVINCIAL RELATIONS AND HEALTH CARE: RECONSTRUCTING THE PARTNERSHIP

HARVEY LAZAR, KEITH BANTING, ROBIN BOADWAY,  
DAVID CAMERON, AND FRANCE ST-HILAIRE

Federal and provincial governments have been jointly involved in the provision of universal, publicly insured and administered health care to Canadians for decades. In the early postwar decades, federal and provincial governments agreed on the use of conditional intergovernmental grants as the means to build the system of health care that exists in Canada today. What was done in the 1950s, 1960s, and 1970s was a considerable achievement both in policy and fiscal terms and from the viewpoint of cooperative intergovernmental relations.

Today, however, there is a series of "disconnects" between the federal government's approach to health care financing and intergovernmental relations, on the one hand, and its policy role in promoting a countrywide system of health care for Canadians, on the other. These disconnects are contributing to the difficulties provinces face in reforming their health care systems and are serious irritants in intergovernmental relations.

The main purpose of this final chapter is to lay out a range of possible reforms to the federal financial contribution to provincially operated health care systems. The second and related object is to shed light on ways of improving intergovernmental relations, in particular the process for federal-provincial dispute resolution in the area of health care policy and its financing. These ideas and proposals, which are based on conclusions from the earlier chapters, are intended as contributions to the wider debate about sustaining and improving health care for Canadians. While these issues are fairly technical in nature, they also raise broader political questions about the appropriate role for the federal government in Canadian health care.

To foreshadow our conclusions, we suggest that certain broad principles should guide the federal government's position on these issues. We do not consider,



however, that there is a single correct approach to future fiscal arrangements for health care or to intergovernmental relations more generally. Rather, different visions of the federation embody different values, and, depending on which vision is espoused, certain approaches to funding and dispute resolution make better sense than others. Thus, we conclude this chapter with a set of proposals for using the tools of fiscal federalism to sustain and improve Canadian health care in ways that are consistent with three different models of the sharing community and the Canadian federation. We also lay out alternative dispute resolution models that could be used to resolve intergovernmental conflicts or disagreements in health care.

## THE CONSTITUTIONAL AND POLITICAL SETTING

The *Constitution Act*, 1867 reflected nineteenth-century ideas about the appropriate role of government. The health and social needs of Canadians were seen then as the responsibility of individuals, families, churches and charities; the state offered only basic forms of poor relief through local agencies. With the expansion of the social role of the state in the twentieth century, Canada had to rethink the intergovernmental division of roles in new areas of state intervention.

Although the Constitution did not assign jurisdiction over health exclusively to one level of government, section 92 of the *Constitution Act*, 1867 did give the provinces the primary role in the field. Section 92(7) specifically grants them authority over hospitals. In addition, their jurisdiction over health was inferred from other broader provincial powers, in particular by section 92(13) dealing with property and civil rights and section 92(16) dealing with matters of "local or private nature." In the early decades of the twentieth century, the courts held that these sections empowered provincial governments to regulate the medical professions and private insurance plans. This authority was extended to the new instrument of social insurance during the late 1930s.

In chapter 1, Keith Banting and Robin Boadway set out the constitutional basis for a federal government presence in health care. While several constitutional heads of power are cited, they make clear that Ottawa's largest role has been through the use of conditional intergovernmental transfers. In turn, these transfers have their basis in the principles set out in section 36(1) of the *Constitution Act*, 1982 on equalization as well as in the doctrine of the federal spending power.

The principle of the spending power holds that the federal government "may spend or lend its funds to any government or institution or individual it chooses, for any purpose it chooses; and that it may attach to any grant or loan any conditions it chooses, including conditions it could not directly legislate" (Hogg 2000, 6.8a). The use of the spending power has been controversial and has been challenged politically by both the Tremblay Commission (1956) and the Séguin Commission (2002) as well as in the courts. To date, at least, the courts have upheld the concept, although it is probably also true that it has not been tested fully.

### The Evolving Federal Role in Funding Provincial Health Care

During the war years, the federal government developed ambitious proposals for a postwar system of social security, including public health insurance. Many of these proposals were linked to the court decisions regarding the powers of the two orders of government. But this package of federal proposals was rejected at the postwar Dominion-Provincial Conference on Reconstruction in 1945, with Ontario and Quebec as the principal opponents. Some other provinces, however, favoured quick action on the hospital insurance component. Thus, in 1947, Saskatchewan introduced public hospital insurance, and, to varying degrees, British Columbia and Alberta followed in rapid succession. Newfoundland also had some form of public health insurance when it entered Confederation in 1949. With the support of a majority of provinces, which by this time included Ontario, the House of Commons unanimously enacted the *Hospital Insurance and Diagnostic Services Act, 1957* (HIDSA).

To qualify for federal cost sharing under the 1957 legislation, provincial plans had to cover each provincial resident on uniform terms and conditions, provide for specified diagnostic services, and limit co-insurance or "deterrent" charges so as to avoid placing an excessive financial burden on patients. All provinces had agreed to join the federal plan by 1961.

The introduction of medicare, extending coverage to include physicians' services, was more controversial. The medical profession and the insurance industry adamantly opposed it. Saskatchewan again took the lead, by introducing a universal model in the early 1960s and urging federal support. But this time governments in Alberta, British Columbia, and Ontario were initially opposed, at least in part because they preferred a system of private health insurance for the

majority of the population. In 1965 the federal government opted for the universal model of public health care pioneered in Saskatchewan. It undertook to cover half the costs of provincial expenses for physicians' services, although at the July 1965 federal-provincial conference the prime minister suggested that this need not be a formal cost-sharing arrangement, as was in place for hospital insurance. Following intergovernmental negotiations, the *Medical Care Act* of 1966 did, however, include a formal cost-sharing mechanism. For provinces to qualify for their share of federal financial support, they had to meet several conditions. Their medical plans had to provide for: administration and operation on a non-profit basis by a public authority; coverage of "all services rendered by medical practitioners that are medically required"; universal coverage of all provincial residents (at least 95 percent of eligible population) on equal terms and conditions; and portability of benefits. There are doubts as to whether "access" was viewed then as a co-equal fifth principle or condition, but the federal legislation did explicitly require that insured persons not be charged fees that might impede or preclude "reasonable access" to insured services. This provision for reasonable access was apparently intended to exclude *provincial* charges for physicians' services to patients but may not have applied to extra-billings by *physicians* that impeded or precluded reasonable access. In any case, to the extent that access may not have been a co-equal fifth principle then (the Prime Minister's speech to the July 19-20, 1965 federal-provincial conference had not treated "reasonable access" as a formal principle), it gradually evolved to that status. And despite the initial resistance of some provincial governments, all provinces had joined by 1970.

While the instrument of cost sharing was highly effective in creating a Canada-wide system of public hospital and medical insurance, it also had its downsides. Thus, by the early 1970s, the federal government had become very worried that its open-ended commitment to pay for half of provincial expenditures in a number of social programs, including hospital and medical care, was eroding its capacity to control its own expenditures. And by the mid-1970s provincial governments were also expressing frustration with the cost-sharing model, and in particular the extensive annual negotiations about eligibility issues (for example, which hospital beds were eligible for cost sharing). Provinces also argued that this form of cost-sharing was distorting their resource allocation process and priorities.

After extensive federal-provincial negotiations, a compromise emerged in the form of the *Federal-Provincial Fiscal Arrangements and Established Programs*

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

Today, there is controversy as to whether the end of cost sharing in health care was "a good thing." Most of the arguments, on both sides of this issue, were understood in 1977. (See, for example, Perry 1997.) For some, the shift to block funding was "good" because it removed the federal government from the business of determining the eligibility of provincial expenditures for cost sharing and auditing those expenses. This distancing was thought to be desirable because it was more respectful of provincial constitutional authority in relation to health care. For others, the shift to block funding broke the explicit link between federal cash contributions and provincial health care spending. This was perceived as "bad" because it had the potential to weaken Ottawa's ability to enforce the pan-Canadian principles associated with the hospital and medical insurance legislation (*Toronto Star*, 19 February 1977, A5). What was not anticipated then was the emergence of a serious federal-provincial dispute as to whether the federal tax-point transfer should continue to be "counted" as an ongoing federal contribution, even twenty-five years after the transfer occurred. This issue has since become a political football in the federal-provincial quarrel regarding the adequacy of the federal financial contribution to health care. And the ambiguities surrounding this question have served in recent years to confuse and obfuscate public deliberations about the adequacy of federal funding.

The early 1980s were marked by an increase in extra-billing by some doctors and facility fees by hospitals in some provinces. The federal government opposed both practices on the grounds that they prevented equal access to health care, but it lacked the legislative tools to enforce its view. Parliament therefore unanimously passed the *Canada Health Act, 1984* (CHA) to discourage such practices. The legislation amalgamated the previously separate hospital and medical insurance legislation. To qualify for federal financial support, provincial plans had to satisfy the conditions and principles set out in the 1966 legislation, including access. To facilitate enforcement of the "reasonable access" principle, the legislation also determined that such provincial charges would lead to dollar-for-dollar reductions in the federal transfer. Although all provincial governments had opposed and were angered by the legislation, they generally moved to compliance within a few years, recognizing perhaps that the federal government had broad public support for its action.

With the *Canada Health Act* on the statute books, questions arose about how it was to be interpreted and enforced. For the most part, especially after the election of a new federal government in 1984, senior officials did much of this necessary work on a cooperative intergovernmental basis behind closed doors. And by the late 1980s federal-provincial disagreements about user fees were, at least for the moment, largely on the back burner. During the 1993 election campaign, however, the federal Liberals campaigned on a platform that included the statement: We "will not accept user fees or other attempts to gut the medicare system" (Liberal Party of Canada 1993, 78). With the subsequent change in government in Ottawa and the re-emergence of the user fee issue, the interpretation and enforcement of the CHA again became contentious. And since then, the process through which the federal government has interpreted and enforced the legislation has become a serious concern of provinces in and of itself. As David Cameron and Jennifer McCrea-Logie point out in chapter 2, Ottawa is acting as both a prosecutor and judge when disagreements arise.

Had federal-provincial/territorial fiscal relations been harmonious during these years, dispute resolution might not have become such a substantive issue in intergovernmental health care relations. However, the federal government unilaterally tightened EPF and other transfers on several occasions in the 1980s and early 1990s, culminating in the 1995 announcement of a new blockfunding arrangement under the *Canada Health and Social Transfer* (CHST). The CHST

combined EPF and CAP (the previously separate cost-sharing transfer for social welfare) into a single block transfer and substantially reduced the size of the cash transfers to provinces (beginning in 1996) relative to what the previous legislation had anticipated. The impetus for this change was overwhelmingly fiscal. The federal government found itself in an untenable deficit and debt situation and engaged in a major expenditure-reduction plan, which included, among other things, these especially large cuts in transfers to the provinces.

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

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

## CONSIDERATIONS RELATED TO THE PUBLIC ROLE IN HEALTH CARE

Two critical characteristics set many forms of health care apart from other products and services: first, the need for health care is typically uncertain; second, the risk of ill health is unevenly distributed among the population as a whole. Markets can often be established to pool risk among members of the population at large, especially when outcomes are randomly distributed among the population. But good health is not randomly distributed. Some individuals or groups of individuals have a systematically higher

risk of illness than do others. Private insurance companies can therefore appropriately be expected to offer different insurance terms to persons with different levels of insurability, and those with a high risk of illness will only be insured at relatively high costs. Indeed, some people may be virtually uninsurable because their chances of becoming seriously ill are so high. Moreover, an individual's insurability can also change over time, especially with aging. Good health and illness are to a great extent determined by the luck of the draw, namely, genetic inheritance at birth.

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

Efficiency considerations supplement the equity reasons for a public role in health care. Health care providers, especially physicians, have much better information than people who require their services. Physicians also control the supply of health care. As a result, they have a kind of monopoly power. To avoid inappropriately high prices for services a counterweight is required, and the public sector is the obvious choice. For instance, as a single-payer system, the public sector can negotiate effectively to control costs. A single-payer system is also administratively more efficient than a multi-payer system. Thus, as Banting and Boadway conclude in chapter 1, the equity case for public health insurance is supported by a powerful efficiency case.

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

### The Rationale for a Federal Role in Health Care

Assuming agreement on the principle of social insurance, the question of the precise dimensions of the community within which sharing and

redistribution take place still remains open. In a *unitary* nation, a common standard of redistributive equity and sharing is presumed to apply to all citizens across the country, there being no particular reason to discriminate against citizens in one region relative to those in another. In a *federation*, matters are complicated by the fact that individuals are members of two political communities – the community of citizens across the country as a whole, and the community of residents within each province. The role of the federal government, in the context of health care, is thus defined by whether one takes the entire country or the province as the primary sharing community. In this context, it is useful to distinguish, as Banting and Boadway have done in chapter 1, among three versions of the relevant sharing community along a spectrum of possibilities.

#### *Predominantly Canada-wide Sharing*

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

#### *Predominantly Provincial Sharing*

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



### *Dual Sharing*

An intermediate conception of the sharing community is one in which a countrywide framework defines some basic parameters of major social programs including health care, but which leaves room for provincial variation in program design and delivery mechanisms that are consistent with the framework. According to this intermediate position, which is labelled here the *dual sharing community*, citizens across the country are assured of comparable, rather than identical, health care services. The possibility of differences among regions in the sense of attachment to community also raises the possibility of asymmetrical relationships between the federal government, on the one hand, and different provincial and territorial governments, on the other.

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

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

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

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

The preceding discussion of different visions of the sharing community provides a perspective on the equity considerations that are relevant in defining the federal role in health care. With regard to efficiency, there are arguments for and against centralization and decentralization that are also linked to arguments for and against different forms of intergovernmental relations. On both these matters (centralization/decentralization and forms of intergovernmental relations), the arguments (addressing spillovers, exploiting economies of scale and administrative efficiencies, on the one hand, and greater ability to reflect local preferences and tastes, and greater opportunity for innovation, on the other) are nicely balanced. If the efficiency arguments pointed powerfully toward centralization and a more federally dominated federalism, or toward

decentralization and a more provincially dominated federalism, they might have a major influence in defining the federal role. But given that efficiency arguments balance out, the federal role has in fact been determined mainly by the extent to which the country as a whole rather than the province is seen as the appropriate community for insuring against ill health. That is, redistributive equity considerations dominate.

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

### The Choice of Federal Instruments

There are several different types of instruments that can be employed by the federal government to sustain and improve health care for Canadians. Some instruments are relevant to all versions of the sharing community, whereas others are more appropriate for a particular version of the sharing community.

### *Direct Federal Delivery*

The main feature of direct federal provision of health insurance is that the same program would apply in all provinces. One benefit of this approach is that the efficiencies of the single-payer system would apply Canada-wide rather than at the provincial level only. The main case for direct federal provision, however, is equity-related. The country as a whole becomes the sharing community for health care, and Canadians are able to enjoy the same health care services no matter which province they live in.

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

### *Direct Federal Transfers to Citizens*

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

Direct transfers to citizens could be used to introduce some incentives into the use of health services by citizens by offering, for example, only partial reimbursement of expenses incurred. One advantage over direct user fees would be that if it was offered as a government program, reimbursement might be readily tied to ability to pay. This might be a way for the federal government to actually implement a countrywide income-contingent user fee system, given that health services are provincial programs. An alternative, more direct way might be to include some proportion of health expenses as taxable benefits for income tax purposes. Yet another proposal for injecting individual incentives into health insurance that has attracted some debate is the use of so-called *Medical Savings Accounts* (Ramsay 1998; Forget, Deber, and Roos 2002).

All of these options focus to some extent on strengthening incentives to avoid abuse of the system by patients or providers. Perhaps the reason they have not played a major role in Canadian health care to date is that there is a lack of

convincing evidence that the current emphasis on social insurance is in fact associated with a high level of abuse. In other words, these options could undermine the essential purpose of social insurance without sufficient offsetting benefits.

### *Federal Transfers to Provincial Governments*

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

It is useful to distinguish between the level, form, and predictability of the federal transfer. The moral and political authority of the federal government to sustain a meaningful countrywide framework through the CHA is clearly correlated with the level of its financial commitment. The federal government has to be a serious financial partner to be credible. Moreover, the more exacting the countrywide framework, the greater the level of federal support presumably needed.

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

There are some within the federal government and elsewhere who would prefer to make any further increases in the federal CHST contribution conditional on achieving specific health reform goals, whether related to primary care reform, home care improvements, hospital rationalization, or some other

chosen objective. There will be others in provinces and elsewhere who wish to see larger federal transfers for health care but only within the framework of the current broadly defined set of conditions. The second group considers block funding to be the appropriate form of transfer in our federation, as it leaves provinces with the freedom to assume their constitutional responsibilities within the parameters of the CHA. To the extent that this debate is joined, a possible compromise approach worth pursuing is the earmarked transfer; that is, new federal funding to be spent exclusively by provinces for certain designated health care reforms, but with the earmarking for a limited time only (say five years) and the increased funding subsequently being folded into the block fund.

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

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

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

### *Equalization Considerations*

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

These forms of revenue equalization alone, however, do not satisfy fully the principle of equalization as set out in section 36(2) of the Constitution (see chapter 1 for a more detailed discussion). Although revenue equalization goes part way toward enabling provinces to provide reasonably comparable levels of public services at reasonably comparable levels of taxation, provinces may also face different "needs" for public services. In the case of health care, there is a systematic difference in the costs of providing services to persons of different ages and other socio-economic characteristics. It can therefore be argued that some or all of the federal Equalization payments should be adjusted to reflect needs. And with regard to the CHST, it can also be argued that needs ought to be taken into account in its allocation. Needs equalization could be based on the cost of a national standard level of care for different demographic groups, where the costs could represent some average of actual provincial costs. As with revenue equalization, the idea would be to base the entitlement to needs-based equalization on objective measures that are outside the direct control of the recipient provinces.

### FEDERAL-PROVINCIAL POLITICAL DISPUTES RELATING TO HEALTH CARE

**T**he current federal-provincial dispute regarding the adequacy of federal funding for health care was triggered by the CHST announcement in the 1995 federal budget. That debate is familiar. It is sufficient here to note that from the outset the provinces have argued that the cuts in transfers associated with the CHST were grossly unfair. And since the late 1990s they have also insisted that a vertical fiscal imbalance favouring Ottawa has come to characterize federal-provincial fiscal relations.

Despite subsequent increases in federal CHST contributions, provinces remain of the view that the current amount of federal cash transfers for health, post-secondary education, and social assistance and services is neither adequate nor fair.

The substance of the provincial position on vertical fiscal imbalance has been stated in various documents prepared by the provincial and territorial finance ministers. Their argument is simple. First, the structure of federal finances today is stronger than that of the provinces and territories. The federal government enjoys substantial and recurrent budgetary surpluses; provinces and territories do not. Second, federal revenues are expected to grow faster than those of the provinces and territories, given the extent to which the two orders of governments occupy the different tax bases. Third, provincial and territorial expenditures can be expected to increase at a more rapid pace than Ottawa's. This is in part because of the relative importance that the public attaches to provincial programs such as health care and education and the cost drivers associated with them, especially health care (Standing Senate Committee on Social Affairs, Science and Technology 2001b).

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

The federal government has all along disputed provincial arguments, citing several considerations. First, public debt is much higher at the federal than the provincial level. Second, both orders of government have access to all the major tax bases and can set their own tax rates. Third, provinces have been simultaneously cutting taxes and claiming revenue shortages. Fourth, federal cash transfers to provinces are expected to grow at a faster rate (6.1 percent) between 2000/01 and 2005/06 than federal revenues (1.9 percent) over the same period. The federal government's general response to provincial arguments is that fiscal imbalance is a "myth" (Privy Council of Canada 2002). (For a more detailed analysis of vertical fiscal imbalance and the related concept of vertical fiscal gap, see Lazar, St-Hilaire, and Tremblay's discussion in chapter 3.)



The dispute regarding the adequacy of federal funding is compounded by disagreements between Ottawa and some provinces over the appropriateness of various forms of private funding for services covered by the *Canada Health Act*. With the federal government opposed to this source of financing, provinces that favour this approach find themselves doubly frustrated. They believe not only that the federal government is contributing insufficiently to health care but also that Ottawa is effectively depriving them of other potential funding sources. Moreover, they contest the federal government's exclusive power, *de jure*, to interpret and enforce the provisions of the CHA. This long-standing issue recently resurfaced on the agenda and led to the introduction of a new dispute avoidance and resolution process by the federal minister of health that reflects ideas that provincial governments have been advocating.

### The Issue of Dispute Resolution

Conflict and cooperation are inevitable in federal systems, and their consequences can be noxious or beneficial depending on the circumstances. An indicator of a mature form of government is its capacity to challenge non-beneficial cooperation, to accommodate useful conflict, and to resolve disputes that impede the effective functioning of the system. The importance of a dispute settlement mechanism in a particular policy field such as health depends on the tenor of intergovernmental relations more generally. *Dispute avoidance* is most likely to be an attractive option when the parties involved have shared policy goals and are engaged in a relationship characterized by a high level of trust and ongoing dialogue and negotiation. Parties may need to resort to formal and informal *dispute resolution* approaches when they have entrenched disagreements and when considerations of turf, status, credit-claiming, and blame avoidance take precedence over substantive policy concerns.

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

from the provincial perspective, the crux of the conflict has been the hierarchy implicit in the unilateral federal control over health care funding and over enforcement of the CHA conditions.

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

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

tionship with the provinces – and it has had the power to avoid it. It may also be because the federal government has objected to the idea of another order of government being involved in the interpretation of federal law and deciding on the appropriateness of federal expenditures.

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

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

Ideally, an "effective" dispute resolution mechanism in this field would meet the criteria proposed by Cameron and McCrea-Logie in chapter 2. It would be authoritative; hence the public and the disputing governments would accept its pronouncements as definitive and legitimate. It would be compatible with values of federalism, since it would recognize that both orders of government have constitutional status and have their own competences and policy-making capacities. Both orders of government would agree to participate in the design of the dispute mechanism, choose representatives to be a part of the body, and follow its procedures to bring an end to the destructive conflicts that sometimes impede the proper functioning of the health care system. It would be guided by clear rules, be perceived as transparent and impartial, and be accessible to all those who have a legitimate interest in the outcomes. It would also facilitate clear, efficacious, and timely settlement of a broad range of disputes, including those regarding federal fiscal transfers, since, as we have seen, this is an area where disagreements have been particularly intense.

Cameron and McCrea-Logie describe six dispute settlement models, organized from the least to the most highly developed:

- > Model 1, *federal withdrawal*, is consistent with the notion of predominantly provincial sharing communities and envisions Ottawa transferring tax room to the provinces, abrogating the *Canada Health Act*, and leaving it to the provinces to manage the health care system in accordance with the aspirations of their regional communities. This model would address the problem of destructive intergovernmental disputes by reducing the extent to which the two orders of government are in relationship with each other.
- > Model 2, the *base-case model*, is the status quo situation where no explicit conflict resolution regime applies to the fiscal and policy dimensions of the intergovernmental relationship. By most standards of conflict resolution, it would be judged deficient on several grounds: the relationship between the actors is paternalistic rather than egalitarian; only one party has recourse to the instrument; one of the parties acts as both prosecutor and judge; as a consequence, the process and the decisions, while they may be effective, are not regarded as legitimate by all of the government participants.
- > Model 3, the *Social Union Framework Agreement*, seeks to place the conflictual and cooperative behaviour of governments in an orderly frame of reference and to expose both forms of conduct to the fuller scrutiny of the public. Its provisions for dispute avoidance and resolution outlined in section 6 of the agreement are clearly intended to apply to the broad range of intergovernmental social policy matters, and not just to a particular program. The scope explicitly includes federal transfers. Although the provisions refer to dispute avoidance, fact-finding, mediation, third-party involvement, and public reporting, the details are not developed.
- > Model 4, the *McLellan dispute settlement process*, encourages the two orders of government to avoid disputes and, in cases where they do not, makes provisions for a third-party panel to release a public report with recommendations for resolving disputes. However, it does not fundamentally alter the play of intergovernmental forces, since the panel's report would be non-binding, and the federal government would retain the dominant role in enforcing the *Canada Health Act*. The procedure would be used exclusively to resolve disputes over interpretations of the *Canada Health Act*; it is not intended to apply to federal fiscal transfers.

Citizens and interest groups would be excluded as potential participants in the dispute resolution process.

- > Model 5, *interlocking legislation*, an approach mooted by Richard Zuker, effectively ties together the policy and fiscal components of the inter-governmental health care regime and imposes reciprocal obligations on all the actors in the system. It envisions the parties agreeing to a funding formula for a set period of time, which could not be changed without the approval of a certain number of provinces, and the provincial and territorial governments passing the equivalent of the CHA, with the provision that the legislation could not be amended without federal government approval. This model clearly reflects the underlying philosophy of dual sharing communities, in which representatives of the two orders of government find the means to work together on the basis of equality.
- > Model 6, *bringing the public in*, suggested by Richard Simeon, involves the creation of a jointly appointed advisory body, the Canadian Health Care Commission, which would review the federal government's decisions to withhold funds for CHA violations before they could go into effect. Similarly, no provincial health care legislation with significant implications for other provinces or for the national system as a whole could go into effect without the commission's review. The public would have the opportunity to be involved in its hearings and deliberations and could scrutinize its recommendations. The advantage of this model is that it would elevate the quality and expand the scope of public debate. Moreover, it would focus greater attention on citizens' needs in their health care system, and less on political considerations.

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

### The Issue of Fiscal Imbalance

The larger political dispute between the two orders of government relates to the magnitude of federal cash transfers for provincial health care pro-

grams. This issue is linked in turn to the broader question of whether there is indeed a vertical fiscal imbalance that favours the federal government, and to related concerns from less affluent provinces about horizontal imbalances. The concept of vertical fiscal imbalance entails the idea that one order of government has more revenue than it requires relative to its expenditure responsibilities, whereas the other order of government has less. To turn this concept into an operational tool for assessing whether the current allocation of revenues between the two orders of government is appropriate, it is necessary to form a view about the weight to be attached to their respective expenditure responsibilities. Since such a weighting task is value-laden, a largely political, rather than scientific, element necessarily attaches to the idea of vertical fiscal imbalance. Thus, it is not surprising that there are divided views within the research community about whether – and to what extent – a vertical fiscal imbalance now exists in Canada.

In this regard, over recent years, three major studies have been published that purport to document or disprove the existence of a vertical fiscal imbalance in the Canadian federation. In chapter 3 Harvey Lazar, France St-Hilaire, and Jean-François Tremblay carefully review these analyses. It is important to note that these studies differ in their conclusions; two argue that a vertical fiscal imbalance now exists, whereas the third makes a different assessment. And the two studies that argue that such an imbalance exists differ significantly from one another in their estimates. Although all three studies take as given the taxation and expenditure structure in place in the base year and assume steady economic growth and no policy change, they differ significantly in their treatment of interest payments on the debt and in their definition of fiscal imbalance. The variation in the results is also due in large part to the different assumptions made about the rate of growth of particular revenue sources and spending categories in projecting the fiscal balances of both orders of government over a twenty-year horizon. Of course, the results of long-term fiscal projections such as these are only of limited value, since governments must adjust to both economic and fiscal circumstances on an ongoing basis. This means that the relative fiscal position of the two orders of government in any given year is inevitably the outcome of cumulative fiscal effects and adjustments over time and therefore may not necessarily constitute a firm basis from which to assess what the situation might be in the future.

Indeed, a retrospective look at the relative strength of federal and provincial fiscal balances over several decades reveals a pattern of ebb and flow with important consequences for intergovernmental fiscal relations, which have been in a constant state of flux. As a result, it is not clear that a state of vertical fiscal balance was ever achieved that could reasonably be seen as a benchmark or standard to be attained. For instance, coming out of the Second World War, the federal financial position was stronger than that of the provinces, notwithstanding large accumulated war-time debts. Ottawa chose not to give up the revenue bases it had occupied during the war. Instead, among other things, it used its fiscal power, through cost-sharing transfers, to encourage provinces to create or expand provincial programs for health care, post-secondary education, and social assistance and services. The growth in federal transfer payments to the provinces did not necessarily improve provincial finances, however, as provinces were concurrently assuming major new expenditure responsibilities. In retrospect, it can be argued that the relatively strong federal fiscal position of the early postwar decades was used to help provide Canadians with the kind of economic and social security that they wanted at the time. During this period, governments created the modern welfare state to ensure that there would be no return to the massive hardships of the Great Depression.

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

Ottawa's deteriorating financial position led in turn to several increases in federal taxes and a growing emphasis on expenditure restraint through the 1980s and early 1990s, including substantial cuts in planned levels of transfer payments to provinces. Following the implementation of the 1995 federal budget measures and a return to a more favourable fiscal environment (in terms of economic growth and interest rates), the federal government was able to turn the fiscal corner, and by the end of the century Ottawa was once again in a strong financial position relative to the provinces. All of this is to say that the current fiscal strength of the federal government relative to the provinces follows a period in which their positions were reversed on two occasions.

Based on their analysis of these fiscal trends in chapter 3, Lazar, St-Hilaire and Tremblay conclude that, whether or not the term "vertical fiscal imbalance" is used to characterize the current situation, there are good grounds to be publicly debating alternative uses of the substantial federal surplus. Should it be used to pay down federal debt or reduce taxes? Should it be used to enhance spending on children, on the military, or on other forms of security? Or should it be used to improve health care in partnership with the provinces?

### Calculating the Federal Share of Health Care Funding

The latter question in turn leads to two related queries and long-standing objects of dispute. How much is the federal government now contributing annually to the provinces for health? And how much should it be contributing? Although the second question involves normative judgments, the first question, at least at first blush, appears simple. As was demonstrated in chapter 4, however, the answer to both queries is anything but simple. To understand why this is so, we need to look again at some of the history of the federal role in funding health care, including the controversy as to whether the federal tax transfer to the provinces in 1977 can and should be reasonably counted as part of the current federal contribution.

During the first year of EPF, the notional value of the federal cash transfer for health, as a share of total provincial health expenditures, has been estimated by Lazar, St-Hilaire, and Tremblay at 26 percent (see chapter 4). While the federal share at that transition point (1977) may not have been "fair" based on some objective measure of fairness, it did reflect thirty years of intergovernmental bargaining that dated back to the federal government's postwar planning. From this perspective, therefore, a federal cash contribution equal to 26 percent of total provincial health care spending would have some rationale. It is, however, a much larger percentage than Ottawa's recent contribution and also well beyond what provinces are now demanding. In fact, provinces have argued that Ottawa should now be paying an amount in cash (or equivalency) equal to its cash share of provincial costs for health care, post-secondary education, and social assistance and services in 1994/95, the year just prior to the announcement of CHST. According to provincial governments, the federal share in that year was 18 percent. For health care alone, Lazar, St-Hilaire, and Tremblay have estimated the federal share at 16 percent. This is another possible benchmark for



the federal cash contribution. In short, the 26 percent and 16 percent figures might be considered an appropriate maximum-minimum range for the federal contribution to provincial health care programs.

As for reckoning how much of provincial health care costs Ottawa is currently bearing with its CHST cash contribution, this calculation entails a number of steps. The first involves forming a view about what percentage of CHST cash can reasonably be attributed to health care. On this matter, unfortunately, there are at least five possible perspectives. These differing perspectives were laid out in chapter 4 and are not repeated here. As Lazar et al. point out, however, only three of them can be used as a way of estimating the number of federal dollars directed to provincial health care programs. Based on these three perspectives, the estimated health component of CHST cash varies quite considerably. The results are 43 percent, 50 percent, and 68 percent, respectively. If we then apply these percentages to the \$18.3 billion spent on CHST for 2001/02, we generate estimates of the federal contribution ranging from 11.6 to 18.2 percent of the \$68 billion in provincial health care spending in that year (see chapter 4, Table 3). The key conclusion from this analysis of different, and each partially valid, perspectives is that under the current transfer system *there is no single or correct number that objectively represents the federal CHST cash contribution for health*. Thus a number close to halfway between the high and low of these percentages — that is, 15 percent, or around \$10 billion for 2001/02 — is adopted as “no worse than any other estimate.” It is used as the starting point in discussing federal finance options for the future.

A number of other observations that flow from the analysis of the federal financial contribution to health care in chapter 4 and are central to our overall message are summarized here. First, there is clearly an imbalance between the federal government's cash contribution to provincial health care and the amount of policy influence it seeks to exert. The 15 percent federal cash share is low relative to previous levels of federal support and clearly low also in relation to the influence Ottawa seeks to exercise.

Second, there is a need to secure intergovernmental agreement on what would constitute a “fair” federal contribution to provincial health care. Unless the parties agree on what Ottawa's share of provincial health care spending actually is, what it should be, and also how it is to be measured, within months of a new fiscal arrangement, provinces will claim the new federal cash contribution is too small and the federal government will argue the opposite. In that event, the best

that can be hoped for is a series of brief ceasefires in an ongoing federal-provincial fiscal quarrel.

Third, there is a disconnect between the expressed public desire for federal-provincial cooperation on public health insurance, on the one hand, and the way in which the federal government has made decisions regarding its financial contribution, on the other. The cost-sharing agreements of the 1950s and 1960s, as well as the 1977 EPF arrangements, were the result of prolonged and often difficult federal-provincial dialogue and negotiations. They were not arbitrarily and unilaterally imposed by the federal government. Since the early 1980s, however, we have seen much more unilateralism ("take it or leave it") on Ottawa's part.

This last point is related to the issue of predictability of funding and the absence of built-in growth provisions (escalator) for federal transfers. Under current law, the size of the CHST is set year by year until 2006 but with no indication as to what is to come after 2006. Nor is there a set of principles that would guide the provinces as to what they might expect. This uncertainty regarding the longer-term federal contribution unnecessarily complicates the task of the provinces (and hospitals) in long-range planning at a time when major health care reforms are required.

Fifth, the current intergovernmental impasse regarding health care financing and how to calculate the federal contribution erodes the quality of Canadian governance. The public has no idea how much Ottawa contributes to provincial health care because of the multiplicity of ways of calculating the contribution. Transparency is absent and accountability is confused.

Given these observations, the normative question about what amount the federal government *should* be contributing to the provinces for health care remains. In answering this question we draw a distinction between what might be an appropriate federal contribution under current *Canada Health Act* conditions and what might be appropriate in the event of more substantial provisions that limit the flexibility of the provinces and impose additional costs on them. As indicated in chapter 4, under current conditions, a 20 percent figure strikes us as a reasonable and politically sustainable compromise. In making this judgment, we take account of the fact that this percentage is much closer to the 25 percent figure notionally associated with the 1977 EPF cash transfer and that the tax room transferred at that time was expected to grow at a faster rate than GNP. The 20 percent benchmark also appears to exceed current provincial demands, although whether it would do so in practice would also depend on the growth

in federal cash transfers for post-secondary education and social assistance and services, including early childhood development.

There would be a stronger case for setting the federal contribution above the 20 percent figure if the conditions attached to the transfer were to become more restrictive on the provinces (even if they were to agree to these conditions). Moving toward, or even to, a 25 percent benchmark might be appropriate in that situation. At the same time, other factors might come into consideration in deciding on the "right" number. For example, direct federal spending on health research and health information, and on public health, should have pay-offs in terms of the improved quality and efficiency of Canada's health care systems. It can be argued that these kinds of federal spending should be taken into account in any negotiation of the benchmark federal financial contribution to provincial health care. Similarly, consideration would also need to be given to the relevance of federal expenditures on Aboriginal health.

In summary, a 20-25 percent federal cash contribution strikes us as reasonable, given the large tax transfer from Ottawa to the provinces in 1977. The financial implications of a federal contribution within this range are significant, as shown in Table 1.

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

There may be some within the federal government who will be concerned that an escalator with the above characteristics would weaken Ottawa's capacity to control the growth of its expenditures. Given the federal government's long experience with deficits, such a concern is understandable. Yet, if Ottawa chooses to continue to participate as a player in setting Canada-wide health care policy, it seems only reasonable that it assume some of the related financial risks. Provinces would still have a considerable interest in managing health costs effi-

Table 1

## SCENARIOS FOR THE FEDERAL CONTRIBUTION TO PROVINCIAL HEALTH CARE, 2001/02

Federal Share of Provincial Health Care Costs	Under Current CHA Conditions - 20 percent	Under More Demanding CHA Conditions - Up to 25 percent
Required federal contribution	\$14 billion	\$14.5-\$17 billion
Additional federal contribution in 2001/02 above notional \$10 billion in CHST health cash	\$4 billion	\$4.5-\$7 billion

Source: Based on authors' calculations in chapter 4.

ciently, given that, under all conceivable fiscal arrangements, provinces would pay the lion's share of costs.

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

The federal government has, in recent years, made some of its transfers to the provinces conditional on certain end uses, such as the purchases of particular categories of equipment. It would not be surprising if Ottawa were to try to insist that future transfer increases also be earmarked for specific purposes, such as primary care reform. To the extent that this is done, it would be preferable if such special purpose funds were designated for their stated purposes for

a limited time period only, say five years, and then were folded into the general transfer for health care. This could be a useful middle ground between conditional and unconditional transfers.

## OPTIONS FOR THE FUTURE

How does the normative analysis presented above inform decisions to be made regarding the future of Canadian health care? In this regard, there are two sets of variables that need to be considered. One relates to whether the scope of Canada's countrywide universal publicly insured and administered health care system is to be expanded to include services that are not currently covered. We describe the case in which the health system might be broadened to cover items like prescription drugs and home care as the *transformation* scenario. We distinguish it from the *maintenance* scenario, where future reforms would focus more on improving the quality of care and the fiscal sustainability of currently insured hospital and medical services. If the scope of coverage is expanded, the political and fiscal dynamics will change markedly.

The second set of variables has to do with one's views on the different conceptions of the sharing community described earlier. There is no objective basis for asserting that any one of these is intrinsically superior to the other. While each has advantages and disadvantages relative to the other, deciding among them is much more a matter of societal consensus about values than it is about technical merit. What is relevant here, of course, is that each of these conceptions has significantly different implications for federal funding, with the largest difference being between the predominantly provincial sharing community and the other two models.

Taking account of these two sets of variables, the following points highlight key elements of the federal financing options outlined in chapter 4.

- > While a continuation of block funding with an equal per capita cash transfer for health care is appropriate under both the dual sharing and the predominantly Canada-wide sharing models of the federation, a revenue-sharing arrangement or tax transfer makes more sense in the predominantly provincial sharing model.
- > Under the predominantly provincial version of the sharing community, the conditions of the *Canada Health Act* should be dropped except for

those related to portability and mobility. The current CHA conditions (or an appropriately modernized version of them), are consistent with the other two models. Indeed, in the Canada-wide sharing version, the conditions would need to be buttressed with countrywide standards to assure similar levels of services across the country.

- > In the case of a maintenance scenario the federal cash transfer should be equal to at least 20 percent of provincial health care costs. The transfer should be closer to 25 percent in the Canada-wide sharing model, where more substantial countrywide conditions add to provincial costs. This option would entail increases in the federal contribution in the order of \$3.6-\$7 billion annually. For the predominantly provincial sharing model, the appropriate shift of resources would be at the bottom end of this range or slightly lower, as provinces would have fewer costs and constraints associated with a conditional federal transfer.
- > In options that entail a continued cash transfer, there are more advantages than disadvantages in having a separate block fund for health care alone – a Canada Health Transfer (CHT). In any case, assuming that the federal cash contribution is re-based at 20-25 percent of provincial health care expenses, it would be very desirable for the federal government to do away with the notion that the 1977 tax room transfer under EPF remains a part of current CHST funding for health care.
- > In options that entail continued cash transfers, there is also a strong case for adjusting the equal per capita payment on the basis of need. The same case can also be made, but less strongly, in the event of revenue sharing or of a tax transfer.
- > The transformation scenario would entail several billion dollars of additional public expenditure. The actual magnitude of the increase would depend on the scope of coverage. Given provincial views about the adequacy of current federal cash contributions for hospital and medical costs, it is probable that the federal government would have to commit to cover all, or almost all, of the incremental costs to secure provincial agreement to a much-broadened range of publicly insured health services. While one or more provinces might initially prefer not to participate in the broadened coverage and instead seek financial compensation, the prospects of achieving full provincial and territorial participation may be significant, given that Ottawa would be absorbing most of the additional costs.

- > The transformation scenario might be facilitated by the kind of interlocking federal and provincial legislation referred to above. Fiscal arrangements would be buttressed by statutory commitments not to alter the federal financial commitment without the approval of seven provinces representing at least one-half of the Canadian population. All provinces would pass Canadian health care provisions in provincial statutes, committing themselves to meet countrywide conditions and undertaking not to amend these commitments without the agreement of the federal government.
- > Where a cash transfer is the preferred option, it should increase annually according to a transparent and predictable formula (escalator) that is expected to grow at a rate similar to the anticipated growth rate in national per capita health care costs. Using a Statistics Canada index of aggregate provincial and territorial health care costs is the simplest way to meet this standard. There should be an "escape clause" for the federal government in cases of national financial emergency.

## SUMMARY AND CONCLUSIONS

Our main conclusions are summarized below.

- (1) The primary rationale for government involvement in health care arises from the uncertainty of health care needs for any one individual at any point in time coupled with the uneven incidence of illness and injury. People want to insure against these risks. For some, however, private health insurance is either prohibitively expensive or simply unavailable. This creates a strong social insurance rationale for a public role.
- (2) The rationale for the federal role in health care is related to the idea of Canada as sharing community. There are different conceptions of the Canadian sharing community and each has different implications in terms of the relative roles of the federal and provincial governments in social sharing, including in their provision of health care. The federal role is determined mainly by the extent to which the country as a whole, or the individual province, is seen as the relevant community for insuring against the risks of ill health. Determining what constitutes the appropriate community for social-sharing purposes is a matter of societal values, not scien-

- tific principle. At present, in the case of health care in Canada, we have a dual sharing community. As the relative importance of services not covered by the *Canada Health Act* grows, however, countrywide sharing declines in importance relative to province-based sharing.
- (3) A predominantly Canada-wide vision of sharing would entail ensuring that common health care services, provided according to common standards, were available in all provinces and territories. A predominantly provincial sharing community model does not require that any services be insured on a countrywide basis. It does, however, require that all provinces have adequate fiscal capacity to provide some given basket of health care services on a Canada-wide basis at comparable levels of taxation, if they so choose. A dual sharing community includes elements of both Canada-wide sharing and provincial sharing.
  - (4) While the case for public and federal involvement in health care relates mainly to equity considerations, the manner in which the federal government fulfills its role can contribute to the efficiency of the federation (for example, by removing barriers to mobility). Under the three visions of the sharing community outlined above, there are efficiency advantages in retaining provincial delivery (such as the ability to reflect local conditions and preferences and a greater potential for innovation). These advantages are consistent with the constitutional division of powers.
  - (5) There is a range of instruments through which the federal government can fulfill its role. While the choice of instruments will be affected by the societal consensus on sharing, under all versions of the sharing community there is a strong case for equalization payments. Such instruments include direct federal delivery (which on the whole we consider to be unwise), transfers to individuals (possibly through the tax system), transfers to provinces, revenue sharing, and tax-point transfers. Federal transfers to provinces have been a key instrument in the past and are likely to remain so under dual sharing and Canada-wide sharing models. If Canadians prefer a predominantly provincial model of sharing, revenue sharing is an attractive instrument.
  - (6) The adequacy of the federal financial contribution to Canada-wide health care is a matter of dispute between the two orders of government, as is the broader question of fiscal imbalance. In our judgment, the structure of federal public finances is at present stronger than that of almost all provinces



and territories. This has been the case since the late 1990s. In the preceding couple of decades, the opposite was true. These shifts are integral to the history of Canadian federalism. They occur with changing economic circumstances and the evolving revenue and expenditure policies of both orders of government.

- (7) The prospect of ongoing fiscal dividends at the federal level and ever-rising health care costs at the provincial and territorial level inevitably raises issues of resource allocation. This in turn, however, opens up a much larger debate regarding appropriate debt levels, tax burdens, and other competing claims on the public purse. Improving the federal financial contribution to provincial and territorial health care programs and expanding the coverage of Canada-wide health care services under the *Canada Health Act* are two options that merit careful consideration in this broader public debate.
- (8) There is at present an imbalance between the role the federal government appears to want to play in respect of the Canada-wide dimensions of health care and the magnitude of its financial contribution. The federal government simply contributes insufficient funding to sustain the ability and right to play the role it has historically played. Assuming we are correct about Ottawa's wish to sustain its role, the federal contribution needs to be re-based through a process of federal-provincial/territorial negotiation. We consider a fair federal contribution to be in the order of 20-25 percent of provincial costs based on factors discussed above. Ottawa should also share more fully in the fiscal and political risks associated with the future of the health care system.
- (9) Ottawa's largely unilateral approach to fiscal relations with the provinces since the early 1980s is also inconsistent with the kind of intergovernmental partnership arrangement in health care that the federal government appears to want and that the Canadian public clearly expects. At the same time, a return to a more collaborative approach to fiscal decision-making would require that provinces also engage constructively and realistically in financial negotiations with federal counterparts.
- (10) Further considerations that should guide the fiscal relationship between federal and provincial governments include the following:
  - a) If Canada were to move toward a predominantly provincial sharing community vision, a federal-provincial/territorial revenue-sharing arrange-

- ment would be the preferred option, with a transfer of tax room as second best. In either case, the revenues allocated should be equalized. Under this model, the conditions associated with the *Canada Health Act* should be dropped, except those related to portability and mobility.
- b) Under either alternative models (dual sharing or predominantly Canada-wide sharing), a federal cash transfer should be maintained. The transfer should be visible and understood by all Canadians to be the federal contribution for provincial health care programs. In this case, it would be appropriate to maintain conditions along the lines of those now in the *Canada Health Act* or some modernized version of them.
  - c) The 20-25 percent federal-share contribution should be provided in the form of a separate equal per capita block transfer for health care (CHT), in part because of its equalizing properties. It should not be a formal cost-sharing arrangement.
  - d) Any federal health transfer should grow based on a formula that reflects growth in Canada-wide health care costs. It should be predictable and transparent.
  - e) Consideration should also be given to adjusting the equal per capita transfer on the basis of differences in need among provinces and territories as determined by measurable demographic and geographic factors. While such a needs-related adjustment can be justified in all scenarios, it is strongest in the case of the predominantly Canada-wide sharing model.
- (11) Insured hospital and medical services are declining as a share of total health care expenditures. To the extent that there is interest in broadened public insurance coverage, and given our conclusions in items 6-8 above, it appears that all, or almost all, of the incremental costs of the added coverage would have to be borne by the federal government. Determining the amount of funding involved would require very detailed provincial information on current program costs and a careful assessment of the expected costs of the proposed programs. Assuming it does absorb the incremental costs, Ottawa may wish to be fiscally prudent and finance this initiative through a dedicated tax. Additional features of broadened coverage could include:
- a) As an interim measure, federal funding for the new Canada-wide health care programs should be provided through a separate block fund(s) (separate from the CHT).

- b) The separate fund(s) should have its own escalator reflecting anticipated cost increases in the new programs (based on a Statistics Canada measure of relevant cost increases).
  - c) The funding for new programs should be folded into the CHT when they become mature, with an appropriate adjustment, if necessary, to the CHT escalator.
- (12) The fiscal relations between the two orders of government should be rethought and adjusted to better reflect a partnership relationship. The model of federal-provincial fiscal relations from the 1950-70s era was characterized by tough negotiations but with a determination to reach agreement. Returning to the earlier model, or finding an alternative that provides provinces and territories with a greater say in the outcomes, is highly desirable.
- (13) Consideration should also be given to ways in which the federal government can become the political partner of the provinces and territories with a view to helping them overcome some of the difficult political obstacles they face in moving forward with health care reform.
- (14) In the context of reconstructing the fiscal and political partnership between orders of government, arrangements for handling disputes that cannot be avoided must be considered. The need for improved dispute resolution mechanisms is not as great in the context of a predominantly provincial sharing model as it is under the dual and predominantly Canada-wide models of the sharing community. And to the extent that future policy changes in effect broaden the scope of countrywide health care coverage or make the federal conditions attached to the *Canada Health Act* more onerous for the provinces, there will be a greater need to ensure that dispute resolution mechanisms are seen as authoritative and legitimate by the public and both orders of government. This will require new institutional developments. Under the latter two versions of the Canadian sharing community, dispute resolution provisions should encompass a number of elements. They should:
- > apply to a broad range of disputes, both fiscal and programmatic;
  - > embody the core values guiding health care in Canada;
  - > provide citizens a role in the dispute settlement process;
  - > make provisions for the use of third parties as appropriate for advisory, mediatory, and facilitative functions, in a fashion consistent with the preservation of the democratic accountability of elected officials;

- > encourage the development of shared language and relationships by providing a forum for consultation involving representatives of the two orders of government; and
- > include the public release of fact-finding reports that would inform citizens and apply moral suasion on the parties.

There is no single "right" approach to defining the future role of the federal government in Canadian health care. Finding viable solutions will first require reconciling competing views about the nature of the Canadian sharing community and the Canadian federation through societal debate and consensus. Independent of the outcome of this debate, however, there is clearly a lack of coherence between the vocabulary of partnership that marks Ottawa's policy pronouncements with respect to health care and the way it has used the tools of fiscal federalism and dispute resolution, over the last two decades, to implement its policies.

This lack of coherence needs to be addressed. It is our hope that the framework for renewal proposed in this volume can provide some useful guidelines for improving intergovernmental relations in the field of health care in particular and fiscal relations generally. The federal government in the last few years has taken some steps in regard to both fiscal federalism and dispute resolution that are consistent with the principles we propose. At the same time, our analysis suggests that further steps will be required of all governments if these improvements are to be sustained and the intergovernmental partnership renewed. Reconstructing the partnership is what Canadians want. It is the key to ensuring the quality and sustainability of health care for future generations.

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