

THROUGH THE LOOKING GLASS: FEDERAL AND PROVINCIAL DECISION-MAKING FOR HEALTH POLICY

by
Candace Redden¹
Department of Political Science
Dalhousie University
Halifax, Nova Scotia

INTRODUCTION

The term "rationing" is not popular in Canada's political vernacular. Indeed, it is a pejorative term that conjures-up images of desperate yet deserving people waiting in line during wartime for scarce items such as fuel and foodstuffs. Accordingly, rationing as an approach (taken by the state) to allocating benefits has much more political currency in the United States, where issues of distributional equity are dealt with in a relatively negative way. The "doling-out" of food stamps rather than financial assistance to people in need and the denial of public health insurance to all citizens save for low-income seniors and recipients of social assistance are prime examples of a permanent form of rationing.² Therefore, that rationing is occurring in Canada's health system (despite governments' claims to the contrary) might be an alarming idea.

However, rationing, or allocative decision-making, is becoming an important issue in Canada notwithstanding the fact that it remains removed from public debate. Governments "set priorities" for health care reform without indicating that difficult allocative decisions are being made by citizens, their communities and health care service providers. The claim made by Canadian governments that retrenchment in health care is directly related to the pending fiscal crisis and is therefore a temporary measure that will be lifted in better economic times, is patently wrong. The advancement of medical technology is rapid, the population is aging, and it is unlikely that there will ever be enough (public) money to meet demand. To reiterate in the words of T.H. Marshall: "the target is perpetually moving

forward and the state may never be able to get within range of it."³

There are three main factors that, in combination, provide an explanation for both the increasing importance of rationing and the consequent need for greater transparency in decision-making involving issues of distributional equity in health systems. 1) There is heavy resistance of citizens to increased private sector involvement in health care.⁴ This resistance seriously limits the range of options available to governments to respond to the current financial situation and makes necessary a more transparent rationing process; 2) Most governments in advanced industrialized nations have been guided in recent years (1980s to present) by pressures to exercise fiscal restraint, or pursue the politics of retrenchment. In other words, governments are under pressure to balance budgets and contain costs for programmes that were allowed to escalate in the decades following the Second World War; this means that the health system is particularly vulnerable to cutbacks. And 3) there is a widening gap between the public policy directives for health care reform at both federal and provincial levels and the realities of service provision. In 1994, all of the provinces agreed to structure their health care reform agenda according to the population health model⁵. This means that, to the dismay of many health care practitioners, governments have adopted an approach to health care provision that promotes a broadened focus: social determinants of health, such as socio-economic status, are considered to be of foremost importance within this framework. The problem, as identified by (medical) Dr. T.L. Guidotti, is that "the model provided for the relationship between social and individual factors in health does not distinguish between the individual and the "population," and thus confuses individual "health and function" with population health status."⁶ For medical doctors, who deal with individual patients (with various conditions) on a daily basis, the population health model is an abstraction that fails to recognize the roles and experiences of "front line" service providers. In addition, there is a serious imbalance between federal spending commitments for social

programmes and provincial policy agenda. The policy directives of the social determinants of health framework necessitate strengthened financial and moral commitments to income maintenance spending. This clearly has not been achieved with the Canada Health and Social Transfer, the funding arrangement that seemingly broadened the social policy focus in the country but in reality, has significantly reduced the total amount of the transfer and forced difficult allocation decisions onto provincial governments (provinces must now set priorities among three areas rather than two).

This disjunction between (provincial) policy priorities and (federal) spending commitments is unsurprisingly familiar to students of federalism. As the federal government postures itself to maintain its symbolic role as defender of national standards for health care, it is also reducing its financial commitments in this area. And, as the amount of the federal transfers declines, the provinces attempt to undermine the federal government's symbolic role, and insist that their compliance with federal conditions for payment or national standards can no longer legitimately be enforced. While this predicament might not be new or remarkable in nature, the context in which it is cast draws attention. Given the implications of globalization, fiscal restraint and patterns of retrenchment in the Welfare State, this disjunction has become an urgent political, social and economic matter. How can it be addressed?

Changes can be made at the system level. For example, the public, universal system that currently exists in Canada can be modified so that a second tier of private medicine operates in parallel with the public system, or the entire system could be privatized (the American model). There are two major institutional options for addressing and rectifying this disjunction: 1) the federal role in health care can be strengthened. This would involve strengthening both financial and moral commitments so that there will no longer be an imbalance between spending levels and legitimate moral authority for insisting on compliance with federal standards; or 2) The federal government can withdraw from this policy sector completely (perhaps by converting its current cash transfers into tax points), leaving priority and standard setting to

the provinces.⁷ Hence, it is clear that health care reformers in Canada are contemplating radical structural reform, although it is not clear which institutional option is being pursued or implemented. The federal and provincial governments are in a holding pattern, which is not comfortable or acceptable to any of the parties involved. In fact, the reluctance or inability to resolve the predicament exacerbates the policy disjunction. In this paper I will consider the policy disjunction in the context of the institutional holding pattern, and argue that the federal role in health care ought to be strengthened in order to reverse the momentum that is building toward decentralization and privatization, and renew the state's commitment to health care as social right of citizenship in Canada.

REDISTRIBUTING HEALTH SERVICES

Health care reform in Canada, as a response to the widening gap between citizens' expectations and levels of service, focuses on institutional rather than system change. The universal, single-payer system is not threatened by rational, comprehensive policy redirection (there are no explicit policy initiatives aimed at increasing the role of the private sector in the health system), although it might be threatened indirectly by incremental, institutional changes. However, it has not been determined precisely by governments which institutional changes will be pursued. On the one hand, it seems that governments are maintaining a holding pattern in order to avoid making commitments to a particular direction or vision for Canada's most revered social programme. On the other hand, the nature of the issues involved (distributional, bioethical) precludes prompt and decisive action. Issues of distributional equity are not easily managed by governments in that citizens have come to regard health care as a right and an integral component of Canadian identity; attempts to reduce or limit access to the health system are considered to constitute rights violations.⁸ At the same time, citizens are demanding inclusion and greater transparency in decision-making processes that involve redistribution of health services.⁹ This trend coincides with the current public policy paradigm, which emphasizes preventive medicine and health

promotion, the burden for which increasingly falls on individual citizens and their communities rather than the state.

Despite significant interprovincial differences, there is a certain consistency in the approach to providing health services across Canada. In the turbulent policy field of health care, decision-makers have undertaken implicit (non-transparent) rationing strategies. This means that no clear (or consistent) priorities have been set for determining the answer to the fundamental question of resource allocation as it applies to health care politics: who gets what, when, how?¹⁰ Implicit rationing is defined as

the unacknowledged limitation of care, inevitably occurring where there is no explicit rationing: the volcanic eruptions are the few instances in which implicit rationing becomes an explicit statement that treatment will not be provided.¹¹ Implicit is defined as "implied though not plainly expressed" or "not explicit" where explicit is defined as "precisely and clearly expressed". In terms of rationing this means that where neither the decisions themselves, nor the bases for those decisions, are clearly expressed, rationing is implicit.¹²

Although it is necessary for all governments to exercise fiscal restraint, and the federal government's combining of funding for health, post-secondary education and social assistance into a single transfer requires provincial governments to set priorities among the three areas, many policy makers concerned with the health care restructuring debate in Canada feel that there is really no need to ration health services. Rather, levels of service can be maintained with "increased financial input, or the reduction of waste and the improvement of the present health care system."¹³ It is likely the case that governments avoid making allocative decisions transparently because they believe that their budgetary problems are temporary, and when better economic times return, health services will be fully insured. The good faith and careful political posturing that keep these views afloat are becoming less and less feasible as evidence is mounting to indicate that "there will not be the ability to pay for

increasing amounts of health care in the future, nor for endlessly emerging life-extending technologies, particularly among the ageing population."¹⁴

Further, these misperceptions regarding the temporary nature of rationing health services are the consequence of the fact that most of the debate takes place out of the public's view: participants often include only medical associations and government officials. It is often suggested that in order for health care discourse in Canada to move forward, greater transparency must be achieved in decision-making processes and more participants must be included in the debate. On the one hand, implicit rationing is a closed circuit of decision-makers dealing with intense public issues. Further research needs to be done in order that the important public issues associated with rationing health services become more transparent. The lack of clear and consistent restructuring agenda has many serious implications. The most significant is that many decisions and issues of critical public importance are removed from the fora of public debate and from political control. The scope and scale of decisions that are made behind the scenes are monumental, and often concern, quite literally, matters of life and death. When revealed, these issues that have been removed from polyarchal and political control raise questions of fairness, equality and entitlement. On the other hand, implicit rationing strategies are sometimes considered to be more flexible, more consistent and perhaps more equitable than explicit strategies, but in the literature they are not considered to be models for governments to follow; that less transparency and community involvement in decision-making is preferable seems to contradict the current trend in policy-making. Thus, while it is important for the public to be aware of the changes that are being made in the health system, there seem to be some advantages in leaving the decision-making process as it is; government officials and representatives from medical associations can bargain "behind the scenes" more efficiently than they could if explicit "rationing" agenda were to be established. And while this method might present an affront to the ideals of openness, inclusiveness, discursiveness and democracy, in some cases it might prove to be more flexible, efficient and responsible (in that it does not rely on lay participants to make difficult allocative

choices). Therefore, while some people consider implicit rationing to be "...a silent conspiracy between a dense, obscuring (sic) bureaucracy, intentionally avoiding written policy for macroallocation (rationing), and a publicly unaccountable medical profession privately managing microallocation so as to conceal life and death decisions from patients,"¹⁵ there is evidence to indicate that an incremental process of rationing that operates without public scrutiny has its merits.¹⁶

Current international trends, however, indicate that despite the relative advantages of implicit rationing, the political contexts of most European and North American countries¹⁷ necessitate greater transparency and public consultation in health care rationing. Politically, health care rationing is a volatile and divisive process. Health services cannot be distributed solely according to technical criteria; the decisions to fund certain treatments and not others, to constrain spending on the supply side rather than the demand side of the health care equation, or to allow parallel private service provision, all involve value judgments. In the Oregon Medicaid reform process, for example, rationing decisions were made explicitly and in accordance with community values. Prior to reform (which began in 1989), rationing in the public system was done implicitly; eligibility for Medicaid was limited by lowering the threshold for American Families with Dependent Children (AFDC) eligibility.¹⁸ This implicit form of rationing was discontinued because Medicaid costs continued to expand beyond the capabilities of the state budget and Oregon legislators believed that it was unconscionable to reduce further the AFDC threshold. The "Oregon experiment" relied on extensive public consultation in order to guide the explicit rationing of health services to Medicaid recipients (previously, Medicaid recipients were entitled to a comprehensive set of medical services), and the expansion of eligibility to cover approximately 400 000 Oregonians who had no insurance at all.¹⁹

RESISTANCE TO PRIVATIZATION

The policy disjunction, as identified in the introduction, is not likely to be addressed by the direct and transparent commodification of health

services in Canada. However, the possibility merits some attention because there exists potential for increased indirect commodification, and many Canadians fear what they consider to be signs of "slippage" into an American-style system. The levying of user fees and the practice of extra-billing in the provinces over the last two decades have been met with heavy resistance by the federal government. This has helped to reassure Canadians that the federal government is on moral high ground in the federation and is willing to impose its vision of citizenship on the provinces and enforce it with financial penalties. The degree to which the federal government will be able to defend citizens' social rights against pressures for increased private involvement in health care in the current fiscal context is a matter of steady debate.

Canada's health system is properly considered to contain "private" elements in that physicians and surgeons are not employed by the state, but are in private practice, and bill the government on a fee-for-service basis.²⁰ This is appropriately called a "single payer" system, because the government is the only agency billed for insured medical services. With this established, it is important to identify the range of ideas or initiatives encompassed by the terms "privatization" or "commodification", which indicate a departure from the single payer system. These terms are often used interchangeably in the literature, but "commodification" more accurately defines the processes that are being discussed in the Canadian context. A commodity is an economic good, something of value that can be purchased or traded in the market. The commodification of health care, then, means the offering of health services in the (private) market to be purchased or traded by individuals or insurance companies.

There are many ways in which health services can be commodified, such as through deinsurance. Deinsurance means, quite simply, that a particular service or group of services is removed from a province's list of publicly insured medical services. In 1997 the Nova Scotia government deinsured several medical services. These included: cataract surgery, excision of benign cysts, removal of ear wax, removal of warts, breast reduction and augmentation surgery, circumcision of newborns, artificial/intrauterine insemination, routine vision

care from 10th - 19th birthday, second and subsequent ultrasound examination in uncomplicated pregnancy.²¹ Deinsurance also denotes change in access to a service, such as a procedure that was once performed in a hospital but is now available only in a physician's office or in the community (administered through home care programmes). Deinstitutionalization, the removal of services from hospitals, provides an important reminder that hospital services and medical services are separate insurance programmes. While in hospital patients are not required to pay for certain procedures and medications. However, when they are released, or receive treatment in the community, those same procedures and medications may not be insured by the public plan²². This is a type of de facto deinsurance, which is partially the result of new medical technology -- it is no longer necessary to treat patients in the hospital for many health problems -- and partially a political decision to reduce expenditures in the health field. Deinsurance as a result of deinstitutionalization is particularly problematic for patients who are terminally ill and/or require expensive medication. Finally, services are de facto deinsured if they are not provided. If the hospital in community X does not have ultrasound equipment, for example, and a patient from that community cannot travel to community Y to have an ultrasound examination, then that patient is effectively without coverage for that procedure.

The commonality among all forms of deinsurance is that the impact of the decision to ration is felt at the level of service provision. In other words, although it may have been decided at the governmental level (government officials in consultation with representatives from professional associations) that certain services would no longer be insured by the public plan, or that certain procedures would no longer be performed in hospitals, it is individual medical doctors who must ration the services to their patients. The state has contact with its citizen-patients only through health care service providers. Therefore, it is important for policy-makers to consider whether the public policy paradigm that they have embraced meshes with the experiences and priorities of service providers.

There are no formal mechanisms in place to ensure that policy implications are not disjunctive with the policy community, and few legal safeguards on, or constraints to, "creeping" deinsurance and privatization. In 1982 the federal government implemented the Canada Health Act to clearly establish conditions of payment (of EPF and now CHST transfers) and penalties for failure to comply with the conditions. However, the conditions are quite vaguely stated and have not consistently been enforced. The most controversial language of the Act has been the condition that provincial health insurance plans must be comprehensive, in that they must insure all "medically necessary" services.²³ The Act "neither mentions the quantity of services to be provided nor gives a detailed list of what services will be insured; provincial governments can define these. Thus, the range of insured services may vary among provinces and from one year to the next"²⁴. For example, when the Nova Scotia government removed eye examinations for persons between the ages of twenty and sixty-five from its list of insured services, those persons who were not covered either purchased private insurance to cover the cost of examinations, or were required to pay for the services out of their own pockets. The author of a particularly informative article in *Saturday Night Magazine* explains:

Canada has always had a private health-care sector, separate from the single-payer public system. This sector includes all services not considered medically necessary -- dentists, for instance, or private hospital rooms, drugs, aromatherapy, or chiropractic. Since "medically necessary" is a pretty mushy concept, cash-strapped governments have been shunting an increasing number of minor services into the "not medically necessary" category.

In 1994, Ontario delisted reversal of vasectomies and tubal ligations, most in vitro fertilizations and routine circumcisions, as well as removal of tattoos and spider veins. In Alberta, citizens between the ages of nineteen and sixty-four must now pay for their own eye examinations if they think their vision is deteriorating.²⁵

Commodification of health services could also mean the creation of a private system of health care in parallel with the public system. For instance, if a parallel system were established, those patients who need heart surgery but did not want to wait several months in the public system, could pay to have the same operation performed in the private system. The establishment of private clinics per se does not contravene the *Canada Health Act*; the problems arise with such "hybrid" systems as the Gimbel eye clinic and the MRI clinics in Alberta.

No one would object if all his [Gimbel's] patients paid the full fee for cataract removal as they already do for laser surgery. Clinics that don't bill the provincial health plan don't contravene the Canada Health Act. (At present, few physicians would take the risk of cutting themselves entirely loose from public funding, because of the improbability of attracting enough patients.)²⁶

Hence, the contradiction lies not in the notion of medical services for private consumption, but in the public contribution to private clinics. The legality of the issue, however, is only one (relatively minor) part of the public-private debate. Many observers of the situation in Canada fear increased privatization and movement toward an American-style system. The most recent figures from Health Canada indicate that "public sector health expenditures represented 69.9% of total health expenditures in 1996; with the public share continuing its downward trend from 74.6% in 1991," while "private sector health expenditures represented an estimated 30.1% of total health expenditures in 1996."²⁷ That Canada has now fallen below 70% public contribution to health care is significant because it seems to present a dangerous "slippery slope" to increased commodification of health services; increased private sector involvement in an area of such import (both symbolic and real) is unacceptable to many. Very shortly after the Health Canada document was released, the Canadian Institute for Health Information (CIHI), a government-funded not-for-profit organization that works very closely with Health Canada, produced data that suggest that the "slight" decline in public expenditures noticed in 1996 will be arrested in the following year.²⁸ The

CIHI explained that the more optimistic projections that it has prepared are "more up to date than Health Canada's"²⁹. Seemingly, the CIHI attempted to perform a damage control function for Health Canada, which had revealed figures that were, evidently, alarming for many. However, despite the efforts of CIHI, the potential for creeping privatization in the much revered universal health system seems to have been confirmed.

The province of Alberta has gone much further than any other in experimenting with the commodification of health services. In fact, what is being created in Alberta more rapidly than in any other province, is a two-tiered health system, which offers universal, comprehensive, publicly provided health services for the general population, as well as a parallel system of private provision for those who choose, and can afford, to pay. In 1995, Alberta had thirty-five private clinics in operation, which included "in addition to the Gimbel Eye Centres, two private ultrasound clinics, two abortion clinics, two out-patient prostate-gland surgical suites, several more private ophthalmological clinics, several dental surgery clinics, and at least five out-patient anaesthesia centres, offering plastic surgery, minor orthopaedic operations, and ear, nose and throat procedures,"³⁰ as well as two MRI¹ clinics.³² The private Gimbel Eye Centres have been the source of much controversy. Surgeons bill the Alberta government for the procedures, mainly cataract operations, and the patients are charged an additional facility fee of up to 1 000 dollars. Similarly, at the MRI clinic in Calgary, patients are billed the full cost of their scans, which ranges from \$550 to \$950 per scan. The advantage, for those who can afford the fee, is that they can have emergency service within twenty-four hours of diagnosis; in the public system the same patient has to wait up to four months for an MRI scan. The proponents of private clinics³³ claim that parallel systems of publicly and privately provided services offer both patients and practitioners greater freedom of choice. Critics argue that "private clinics... are the thin edge of a private medicine wedge that could undermine Canada's cherished universal medicare system."³⁴ Thus, tension is created between those who defend freedom and individual rights and those

who defend the principles of universality and accessibility.

Yet in spite of evidence that people are willing to pay for private health care services, recent public opinion research suggests that a majority of Canadians objects to "the prospect of a two-tier system, and most dispute the argument that privatization would not necessarily mean the rich would get better treatment."³⁵ Support for a two-tier system of health care is strongest in Quebec and weakest in Ontario. In Alberta, where private sector involvement in health care is most intrusive, most visible and most controversial, a substantial majority of the provincial population (59%) opposes increased privatization in health care, or a two-tier system.³⁶ It is interesting to note that this information coincides with data that indicate that since Ralph Klein took office as Premier of Alberta in 1993, Albertans have steadily lost confidence in the overall quality of their health system: "by November of 1995... fewer than three-in-ten Albertans now believe the current health care system is above average (8% excellent, 19% very good) and almost one-fifth (19%) feel the system is poor."³⁷ For the moment, the Alberta government has retreated from its commitment to professional and individual liberty with the cancellation of \$53 million in planned health care cuts in the 1996-97 budget.³⁸ However, there is little doubt that plans for increased commodification of health services will move forward at a more politically expedient time.

There seems to be a significant degree of public dissonance regarding health care restructuring in Alberta. Citizens seem to be dissatisfied with the government's performance in this policy area, yet this sentiment does not necessarily translate into dissatisfaction with health service provision in the province. The situation reveals some interesting details of the dynamics within the health policy sector:

These negative perceptions of health care in Alberta were not reflected in evaluations of recent contact with the system. Six-in-ten (61%) Albertans reported they had personally used health care services since the Klein government's restructuring began. When this portion of the population

was asked to rate their most recent experience, the results were overwhelmingly positive. Four-fifths (83%) were satisfied with their last contact with health care in Alberta and nearly one-half (46%) were very positive about the experience. Only six percent stated they were very dissatisfied with their most recent use of Alberta's health care system.³⁹

This apparent contradiction between the level of dissatisfaction with the health care restructuring effort and citizens' evaluations of recent contact with the health system might indicate that citizens are confident in the capabilities of health care providers but at the same time fear that quality of service is being undermined by the public policy agenda.

However, it is not simply the case that citizens resist increased commodification of health services because they are suspicious or critical of the way in which the government is handling health system restructuring. There are other, more specific and tangible reasons for negative public reactions to the prospect of two-tiered health care, which is pushed harder by medical associations than by government officials. Carolyn A. DeCoster (RN, MBA) and Marni D. Brownell (Ph.D.) posit that, using the example of cataract surgery (a procedure that is available in both public and private health care institutions), "the growth in private sector cataract surgery does not appear to be related to cutbacks or rationing, that private access does not necessarily shorten waiting times, and that, contrary to popular belief, it is not only the well-to-do who pay for private surgery in Canada." The main question that the authors seem to be addressing is: can the commitment to treatment based on medical necessity be maintained within the context of private markets? The evidence presented indicates that the answer is no. Growth rates for cataract surgery have increased at the same time that pressures on governments to ration or limit services have become heavier. And in provinces that have private cataract surgery clinics, the growth rate is significantly higher for both privately and publicly funded operations than in provinces with only public hospitals performing these operations. The data show that

from 1990-1991 through 1995-1996, the number of cataract surgery procedures expanded rapidly in both public and private sectors in Manitoba. While cataract surgery in the private sector grew from 284 to 660 procedures (a 132% increase), in the public sector during the same years there was an increase from 3556 to 6211 procedures (a 75% increase).⁴⁰

In addition, it seems that waiting times in the public system are not reduced with parallel public service provision. A recent survey conducted by the Alberta branch of the Consumers' Association of Canada investigated the claim (often made by proponents of two-tiered health care) that private clinics offer faster service. The findings were as follows:

For surgeons who operated only in public hospitals, the prospective "patients" were told that they would have to wait from two to eight weeks for cataract surgery; the average was six weeks. In contrast, the waiting times for surgery at private clinics were from one day to four weeks. However, the waiting times were lengthy -- up to a year -- for surgery performed in public hospitals by surgeons who operated in both public and private sector settings.⁴¹

The conclusion drawn by the authors is that private provision drives-up demand and that parallel public and private service provision can have negative consequences for patients.⁴²

Inarguably, the most obvious problems with the commodification of medicine can be discerned in American experiences with health care business. The health system in the United States is the most expensive among OECD nations (approximately 13% GDP)⁴³, and is the most inequitable. In most states there is a significant number of people with no health insurance at all, and in many cases level of service is declining for those who do have private insurance.⁴⁴ Given this information it is not surprising that among Canadians there is heavy resistance to increased commodification of health services; governments will have to find as much room as possible to restructure the health system within the public sector. In the long term, however, as technology advances and the population ages,

demand will outpace governments' ability to provide service. The temporary, non-transparent face of the Canadian approach to rationing will inevitably be lifted.

THE POLITICS OF RETRENCHMENT

The fiscal crisis (and hence political crisis) of the welfare state has been well documented.⁴⁵ In Canada, unmanageable deficits and debt, lack of economic growth and high rates of unemployment have forced all governments to commit themselves to exercising fiscal restraint and pursuing policies of retrenchment. This has meant significant reductions in funding for health care at both federal and provincial levels at a time when medical technology is advancing rapidly and the population is aging. Approaches to rationing taken by Canadian governments have been non-transparent and temporary because the fiscal crisis is perceived to be temporary and manageable. However, it is unlikely that when governments balance budgets and economic growth resumes, the universal health system will be fully restored. In fact, governments that have successfully balanced their budgets and injected surpluses into the health system (Alberta government, the federal government) have already demonstrated that demands on the health system outpace governments' ability to provide funding. The clocks cannot be turned back for health system reformers.

The fiscal crisis as it pertains to health care can be discerned in federal-provincial fiscal relations. Federal contributions to provincial health programmes were established, at the outset (1966), on a cost-sharing basis, whereby the federal government matched provincial spending in the health field conditionally upon provincial compliance with certain requirements. The arrangements for Medicare established that the federal government would pay 50% "of the national per capita cost of insured services, multiplied by the insured population of the province"⁴⁶ and the provinces were required to operate programmes in accordance with federally determined standards.

With the implementation of Established Programs Financing (EPF) in 1977, the federal

government was able to assume a greater degree of control over spending on health care (under the former cost-sharing arrangements the provinces held the balance of power). The new fiscal arrangements spelled the end of cost matching for health care, and replaced the conditional scheme with a block funding arrangement. There were three components to the EPF arrangements: a block grant, a tax point transfer, and an equalization component. Block funding arrangements are essentially unconditional in nature, which meant that with EPF the provinces were granted a significant degree of autonomy. However, the degree to which this was actually the case is a matter of perception. Some provinces considered the new fiscal arrangements for the established programs to be a victory: there was no longer any requirement that the funds be spent on the designated programmes, and there was no penalty indicated for permitting authorized charges, such as user charges and facility fees.⁴⁷ However, other provinces were suspicious of the arrangements and believed that the federal contribution would not be sufficient to cover escalating costs.

Although the federal government's use of its spending power to direct provincial action has generated great controversy, much of the intergovernmental tension in the field of health is the result of normative and symbolic disputes. For example, one of the most contentious "illusions" of federal-provincial relations is the transfer of tax points provided for in the EPF arrangements. The federal government underestimated the yield of the tax points (13.5% personal income tax and 1% corporate income tax), which meant that the cash component remained a substantial portion of the total contribution much longer than expected. However, the cash component secured federal visibility in this important policy field, which was politically desirable for the federal government. To most Canadians it appeared that in intergovernmental conflict regarding health care, the federal government was on moral high ground; the provinces seemed to be concerned only about the funding arrangements, while the federal government protected the integrity of the system by insisting on provincial compliance with national standards. This, however, was (and is) not quite the case. Thomas Courchene explains that the tax transfer is

"notional" in that "the provinces are assumed to have taken up this vacated federal tax room".⁴⁸ In other words, the revenue yielded by those tax points is provincial revenue, and not a federal contribution, although the federal government indicates otherwise. In the first year of the EPF arrangements the tax point transfer constituted a federal contribution of funds. But, after the initial transfer the tax room created is properly considered to be within the provincial realm of taxing prerogatives. In federal calculations of EPF and CHST transfers, the tax points are included as part of the yearly transfer of funds for social programmes. Hence, it appears in federal accounts that the federal government is transferring much more revenue to the provinces for health services than is actually the case. This practice is what Stefan Dupre considers to be "at the top of my list of the Big Lies of Canadian public finance".⁴⁹

In 1982 the federal government began reducing the EPF escalator, which caused the cash component of the transfer to decline steadily. This also meant that federal visibility and programme conditionality were declining. Because the transfer of tax points is inherently unconditional, and cannot easily be withheld, the federal government devised a new set of financial arrangements to secure the conditional cash portion. It is symbolically important that the federal government maintain the perception that national standards are being upheld. Miriam Smith explains the implications of the declining cash component of EPF: "As the federal cash funding declines as a proportion of total federal expenditure, the federal government's ability to enforce the conditions of the Canada Health Act also declines."⁵⁰ Or, in the words of Thomas Courchene: "Ottawa's version of the 'golden rule' is becoming less and less sustainable: as it stops supplying the gold, it is also losing its moral authority to make the rules"⁵¹.

The federal government addressed these problems with the fiscal arrangements in the 1995 budget. The Canada Health and Social Transfer (CHST) (implemented the following year) collapsed funding for health, post secondary education and social assistance into a single transfer. This allowed the federal government to increase and maintain the cash component, which was expected to run out in

2010 under the EPF arrangements.⁵² The CHST does not make any distinctions among the three areas -- provinces are free (read obligated) to set priorities and allocate funds as they deem appropriate. In fact, the amalgamated transfer represents the first level of downloading of difficult decision-making (from the federal government to the provinces) as well as the first level of rationing scarce resources among the three areas. Under the new arrangements, it seems that health care has fared, and is likely to continue to fare the best of all three programmes. Health care is Canada's success story. In the minds of citizens, Canada's universal health care system is of great practical and symbolic importance. In fact, it is often the health system that Canadians proudly cite as one of the most prominent features that distinguishes the Canadian system of politics and government from the American.⁵³ The country's record in the field of income maintenance, by way of comparison, is very poor. And it is the latter that accounts for relatively low levels of social spending: "It is Canada's relatively niggardly approach to income maintenance (other than unemployment insurance, or UI) that accounts for these relatively low social spending levels."⁵⁴ In other words, Canada's low levels of social spending (relative to other OECD countries) is due not to low levels in all three areas, but generous levels of health care spending and extremely low levels of spending on income maintenance programs.⁵⁵

The implications of these "two worlds" of social policy⁵⁶ will likely be discerned in future restructuring agenda. The population health model, which is an integrated framework that focuses on the determinants of health (socio-economic status, education, for example) was adopted by all Canadian governments in 1994. Like the CHST, the population health framework amalgamates, in theory, all major social programmes so that important connections can be made among them. However, in spite of explicit recognition of the importance of income maintenance spending and policy development in relation to health, it seems that governments have not channeled sufficient resources into these areas. Looking ahead, it does not seem likely that the priorities of social policy will change. Health care will remain the cornerstone of Canadian citizenship, and therefore command the

attention of governments, while income maintenance/ welfare assistance programmes will further diminish as priorities. Governments in New Brunswick and Ontario are already considering "contracting out" welfare services to private firms in order to save money. The use of this (rather sharp) policy instrument hardly represents a commitment to seriously addressing the socio-economic determinants of health.

THE POPULATION HEALTH MODEL

As noted, the CHST was implemented at the same time that there was a public policy paradigm shift in the field of health. The amalgamated transfer collapsed funding for health, post-secondary education and social assistance and, not coincidentally, the population health framework, which recognizes socio-economic status and level of education as determinants of health, was adopted by all Canadian governments.⁵⁷ The population health approach (also referred to as the determinants of health) differs from the traditional medical model in at least two ways:

1. Population health strategies address the entire range of factors that determine health. Traditional health care focuses on risks and clinical factors related to particular diseases.
2. Population health strategies are designed to affect the entire population. Health care deals with individuals one at a time, usually individuals who already have a health problem or are at significant risk of developing one.⁵⁸

The single most important determinant of health, according to the framework document, is income and social status. People of low socio-economic status (SES) have poorer health than those who are further up the social and income hierarchy. At one time it was believed that this difference in health was attributable to higher rates of smoking and alcohol consumption, poor diet and higher levels of stress in the lower strata of the population.⁵⁹ However, research shows that when these factors are controlled in both high and low SES populations, the result is that people in the lower SES groupings

still have poorer health. The data suggest "some underlying general causal process, correlated with hierarchy, which expresses itself through different diseases. But the particular diseases that carry people off may then simply be alternative pathways or mechanisms rather than "causes" of illness and death; the essential factor is something else."⁶⁰ And it is this "something else" on which current public policy agenda are focused (at least in terms of rhetoric; political commitments are very weak in this area).

Public policy has been reoriented to target certain disadvantaged populations in order that the entire Canadian population will become healthier. Essential to this program is recognition of the important linkages between several policy areas: health, education, labour, income assistance, environment, and the economy. This means that the population health strategy cannot be pursued solely within health portfolios; virtually all departments of the state must engage to achieve population health goals.

This integrated approach also includes increased emphasis on health promotion for all citizens. If people exercise more, eat a low-fat diet, smoke less and learn to cope effectively with stress, then the overall demand for medical treatment will be diminished. But clearly, the research suggests that the first component of the strategy (recognizing socio-economic determinants) is the more important. If levels of status and income are positively correlated with health, then governments should be committed to eradicating poverty and increasing the standard of living for all Canadians. However, Canada's record for income maintenance spending and program development for recipients of welfare is quite poor, and is likely not to improve under the current funding arrangements.⁶¹ Therefore, although federal and provincial governments remain firmly committed to the rhetoric of the population health model, it is not clear the extent to which governments are committed to implementing an integrated approach to social policy-making and service provision.

Moreover, there is resistance among health care practitioners to a policy framework that privileges the population over the individual. At the 1997

CMA annual meeting, Dr. Harold Booy explained that "the trouble with the emphasis on the determinants of health . . . is that governments put too much emphasis on overall health for all of society while they ignore what individuals are actually suffering."⁶² To be sure, it is generally accepted by medical professionals that the broad determinants of health do play an important role in the health status of populations as well as individuals. The main concern (as expressed at the annual CMA meeting), was "that the emphasis on determinants of health is used by governments to justify taking money away from health care."⁶³

According to Dr. T.L. Guidotti (writing for the Royal College of Physicians and Surgeons of Canada, the moral faction of the medical profession), the problem is that "the model provided for the relationship between social and individual factors in health does not distinguish between the individual and the "population," and thus confuses individual "health and function" with population health status." This means that for medical doctors, who deal with individual patients on a daily basis, the population health model is an abstraction that fails to recognize the roles and experiences of "front-line" service providers. To the patient who is denied service as a result of systemic rationing, it is not important that the "population" benefits overall. And, within the population health framework, individuals with deteriorating health are weighed against the health of the population. Dr. Guidotti claims that "this analysis is a veiled challenge to the values held by Canadians with respect to social equity. [The omission of the distributive aspects of health] is a concealed political statement. The omission subtly converts an issue of values to an issue of utility."⁶⁴ The utilitarian vision that underlies the new paradigm seems to be completely at odds with the deontological or ends-focused approach that defines the medical profession.⁶⁵ Exemplified by Kant's categorical imperative, "I ought never to act in such a way that I could not also will that my maxim should be a universal law,"⁶⁶ the deontological approach takes into account each individual (patient) as an end in him/herself and would not in theory sacrifice any individual as a means to attain a larger goal such as population health.

In general terms, the pressure on the state to pursue retrenchment policies has translated into a seriously negative environment for health care recipients and providers. Ultimately, in forcing medical doctors and nurses to ration the services that they provide to their patients, the relationship between the citizen and the state is revealed. While policy is made at senior levels in the public service, it is interpreted and re-made at relatively low levels by service providers.⁶⁷ Indeed, most citizens' interactions with the state consist not of consultations with ministers and their deputies, but of daily contact with postal service employees, welfare workers, teachers, police officers, building inspectors and the like. At first glance, it seems that these interactions are of relatively minor importance. However, because of the discretion that "front-line" service providers may exercise, interactions with these representatives of the state have serious impact on the lives of citizens. It is at "street-level" that a person is accorded or denied welfare benefits by a case worker; given a warning or a hefty fine by a police officer; granted or denied permission to renovate their home. Moreover, the attitude, mood or demeanor of the service provider can have a significant effect on the relationship between citizens and the state. In reconsidering the role of the state, it is essential to recognize the importance of the service providers not just because they exercise discretion on behalf of the state, but because they might provide answers to many pressing problems. "In short, they hold the keys to a dimension of citizenship."⁶⁸

SOCIAL CITIZENSHIP IN CANADA

The intergovernmental dimensions of the health care debate in Canada involve discussions about citizenship and the role of the state. As the federal role in health care declines, questions are raised regarding the obligations of the state and the rights and responsibilities of citizens. Constitutional responsibility for health care is accorded to the provinces although the federal government has played an important role in this policy field by virtue of its spending power. In the postwar decades, hospital and medical programmes were implemented on a national scale, which required cost-sharing arrangements. At present, the federal government is

reducing its spending commitments in this policy area, although it is trying to maintain its symbolic role by insisting that the conditions of payment,⁶⁹ as specified in the Canada Health Act, be upheld. The legitimacy of this symbolic role has been the topic of much recent scholarly debate.

The argument for further reduction of the role of the federal government (i.e. decentralization by way of converting existing cash transfers into tax points) is that provinces will have more autonomy and hence flexibility to deviate from national standards. In terms of vertical equity this makes perfect sense; why have national standards if there is no federal financial contribution? Yet when issues of horizontal equity are taken into account, the need for national standards is quite clear.

Thomas J. Courchene has proposed a solution to this apparent impasse with *ACCESS: A Convention on the Canadian Economic and Social Systems*.⁷⁰ Courchene posits that by entering into a formal covenant, provinces can set interprovincial standards independently of the federal government. According to Courchene, the east-west social policy network is disintegrating because it is increasingly incompatible with a north-south trading system. In other words, the existing transfer system does not make sense in a global context. Moreover, within this global context the need for Canada to exercise fiscal restraint leaves few options for political maneuvering in the social policy arena. The bleak conclusion of Courchene's analysis is that: "we have no choice but to forge a federal-provincial partnership and in some cases an interprovincial accord in order to deliver an effective internal union."⁷¹

This "no exit" argument is not entirely convincing for several reasons. First of all, Courchene conceives of provincial partnership being implemented in two stages: the first is a workable interim model whereby Ottawa would continue to play a limited role, which would include maintaining the five CHA conditions. The second stage, or "the full ACCESS model", represents the end-goal of reconfiguring the social union, "a highly decentralized approach to securing the internal common market, with any attendant externalities/spillovers to be sorted out largely via interprovincial

accords rather than federal intervention." Clearly, the second approach (which would be implemented at an indefinite time in the future) is the more radical in terms of redrawing lines of responsibility and potentially, redistributing health services. And it is this full-blown model that draws the majority of criticism. While the interim model reflects the turbulence of the current situation (and is therefore an appropriate response), the full-blown model attempts to predict a future, unknown state of affairs. This contradicts basic theories of budgeting, which explain that budgeting in times of restraint is a much different exercise than budgeting in times of relative abundance. Hence, it is likely that when the context changes from one of restraint to one of relative stability, the dynamics of intergovernmental relations in the area of social policy will also change (perhaps in unpredictable ways).

In addition, by repudiating the federal role in health care it is possible that many positive, complex redundancies will be eliminated. As the days of expanding public revenues fade into the past, governments in North America are left grappling with the complexities of budgeting in an uncertain and unstable environment. In the decades immediately following the Second World War, governments ran budget surpluses, which were spent on a modicum of social programmes. When economic growth declined and fiscal restraint became necessary in the early 1970s, governments were not particularly concerned about balancing budgets (probably because they hoped that the tough economic times were temporary). However, in the 1990s, eliminating deficits and reducing debt have become top priorities. Resources have become scarce, and there is little room to maneuver within the budget to accommodate competing interests. It might be the case (and this demands attention in the context of Courchene's proposal) that the preoccupation with fiscal restraint will result in the reduction of "complex redundancy"⁷² to such an extent that it can no longer "cushion an increasingly uncertain budgeting environment."⁷³ Such redundancy (often criticized as being wasteful) "has been inadequately appreciated" in advanced industrialized countries;⁷⁴ as redundancy is reduced, wide gaps are forming in access to services provided by the state. This is of great significance if the aim

of budgeting is considered to be the "maximization of societal return from public expenditures."⁷⁵

Further, it is not clear how compliance with provincially determined standards will be enforced. It seems to be (and have been) the symbolic nature of intergovernmental tension in the field of health that "guarantees" national standards, or secures important social elements of citizenship in Canada. It is difficult to conceive of some binding political mechanism since there would not be overlapping constituencies of citizens under the new arrangements. Hence, governments would not be able to force one another to maintain or "ratchet-up" their offerings to citizens. On the contrary, the result of provincial autonomy in this policy area would likely mean the impoverishment of social citizenship in Canada in that the degree of social solidarity that is engendered by a universal health care system would be greatly diminished with the decentralization of political responsibility.

Similarly, organized women's groups in Canada have understood their relationship with the Canadian state to include a strong federal presence. Jill Vickers explains that: "the NAC vision... reflects the view widely held among some anglophone and most racial/cultural minority women that the provinces do not represent units which they especially value or seek to preserve."⁷⁶ More specifically, Shelagh Day argues that

Canadian women outside Quebec and the First Nations have had enough experience with provincial governments over the past two decades to "fear, rather than welcome, powers being devolved" to their provinces. She argues that everyone in Canada "disadvantaged by disability, poverty, racism, age and homophobia have a common interest in the federal spending power." Nor does she believe that they will be better off if federal powers are "disentangled" to eliminate duplication. She concludes: "For those who are disadvantaged, even though we feel as though we are running in circles, resort to another level of government or another forum is always useful. This may not be efficient, but it is nevertheless the reality

that women in the rest of Canada cannot depend on any one elected government to hear or address our problems."⁷⁷

This argument is particularly relevant for the debate concerning the federal presence in health care. On one level it exemplifies the problems associated with the elimination of complex redundancies, as mentioned above. Duplicate policy networks offer more points of access for marginalized groups and help to ensure that citizens' diverse needs can be met. And on another level the NAC position acknowledges the moral obligation of the federal government to establish and enforce a national vision of citizenship.

CONCLUSION

The policy disjunction that has been considered in this paper can be alleviated in one of three ways: 1) The system can be changed to accommodate a second, private tier of health care; 2) The federal role in health care can be strengthened; or 3) The federal role can be further diminished. The first option is not being pursued, and is not likely to be directly pursued in the near future. The decision that must be made between institutional options 2 and 3, which Alan Maslove⁷⁸ has summed up as "time to fold or up the ante," is being avoided for political reasons by federal and provincial governments. The holding pattern that results from this avoidance exacerbates the disjunction and focuses attention on intergovernmental disputes over funding and responsibility.

The complexity of bioethical decisions and issues of distributional equity in addition to an aging population and the advancement of medical technology make health care a particularly turbulent policy environment in which citizens' demands and expectations will continue to outpace governments' ability to effectively fund and devise policy responses. In the interim, decentralization with a diminished federal role seems to be a forgone conclusion. But it is hasty, to say the least, to conclude that "full blown" decentralization is inevitable. The federal presence in health care is of continued importance and should be bolstered rather than diminished in order for social elements of Canadian citizenship to be protected and developed.

Further, attention to detail at the administrative level and a strong federal presence are not mutually exclusive goals. It is possible to conceive of a democracy that is both efficient and rich with national vision.

ENDNOTES

1. The Author wishes to thank R. Brian Howe for his insightful comments on an earlier draft of this paper, Tom McIntosh and Harvey Lazar and the anonymous reviewer of the Institute of Intergovernmental Relations Working Paper Series for their comments and suggestions. Special thanks to A.R. Gillis for his constant support and encouragement.
2. The American system is based on the explicit denial of public health insurance to most segments of the population.
3. T.H. Marshall, *Class Citizenship and Social Development*. New York: Doubleday, 1964, p. 115.
4. See Angus Reid Group, "Public policy focus: Canadians' perspectives on their health care system." *The Angus Reid Report*, Jan.- Feb., 1997.
5. The health promotion model requires citizens to take responsibility for their health and the health of their communities, which makes necessary some mechanism for assessing community needs and determinants of health. This means that, on the one hand, citizens must choose to adopt healthier lifestyles in order that their need for medical care is reduced, and on the other hand that because resources are scarce and rationing involves distributing health services according to values, citizens and communities must be consulted in order to determine which values will direct the process.
6. Tee L. Guidotti, "Why are some People Healthy and Others Not"? A critique of the population health model." *Annals RCPSC* (Royal College of Physicians and Surgeons of Canada), vol. 30, no. 4, June 1997, p. 204.

7. This option is particularly appealing to those provinces that were hardest hit by the CHST, namely, Alberta, Ontario and British Columbia
8. For a discussion of social rights see T.H. Marshall, "Citizenship and social class." In T.H. Marshall, *Class, Citizenship and Social Development*. New York: Doubleday, 1964.
9. Canada: National Forum on Health. *Canada Health Action: Building on the Legacy*. Synthesis Reports and Issues Papers, vol. 2, 1997.
10. Harold D. Lasswell. Politics, *Who Gets What, When, How*. New York: Peter Smith, 1950. First Published in 1936.
11. Examples include media coverage of a person who is ill but denied a hospital bed, medical attention, a speedy surgery date or the like.
12. Joanna Coast, Jenny Donovan and Stephen Frankel (eds.). *Priority Setting: The Health Care Debate*. Chichester: John Wiley and Sons, 1996, p.9.
13. Ibid, p. 6.
14. Ibid, p. 7.
15. Crawshaw, quoted in Ibid, p. 11.
16. See Joanna Coast et al eds., *Priority Setting*, Chapter I.
17. See Richard Saltman and Josep Figueras, *European Health Care Reform: Analysis of Current Strategies*. Copenhagen: World Health Organization, 1997; Joanna Coast et al eds., *Priority Setting*.
18. AFDC recipients constitute the largest group of Medicaid eligible persons.
19. Theodore Ganiats and Robert Kaplan. "Priority setting: the Oregon example." In F.W. Schwartz et al (eds.), *Fixing Health Budgets: Experience from Europe and North America*. New York: John Wiley and Sons, 1996, p. 21.
20. Thomas Courchene, *Social Canada in the Millennium, Reform Imperatives and Restructuring Principles*. Toronto: CD Howe Institute, 1994.
21. Nova Scotia Medical Services insurance. *Physicians' Bulletin*. February 7, 1997 and February 21, 1997.
22. Accordingly, many people and groups involved in the reform process believe the establishment of a national pharmacare programme to be of paramount importance.
23. See Cathy Charles, Jonathan Lomas and Mita Giacomini. "Medical necessity in Canadian health policy: Four meanings and... a funeral?" *Milbank Quarterly*, vol. 75, no. 3, September 1997.
24. Odette Madore. *The Canada Health Act: Overview and Options*. Ottawa: Economics Division, Research Branch, Library of Parliament, 1995.
25. "Gimbling with Medicare," *Saturday Night*, March 1996.
26. Ibid.
27. "Private sector health expenditures are sub-divided into three major types of expenditure which reflect the source of funds as well as the source of data: a) expenditures from health insurance firms; b) out-of-pocket expenditures of individuals; c) patient service revenue paid by private insurers or out-of-pocket, such as differential charges for preferred accommodation (private rooms), chronic care co-payments, charges for services to non-residents of Canada and to uninsured residents and charges for services that are not medically necessary; non-patient service revenue received by health care institutions that does not apply to services provided to patients, such as dietetics, investment income, philanthropic donations and ancillary operations (parking and concessions); and expenditures on capital and health research." *Health Canada: National Health Expenditures in Canada 1975-1996*. Policy and Consultation Branch, June 1997.
28. Jane Coutts, "Cutbacks are over, health data suggest." *Globe and Mail*, August 21, 1997.
29. Ibid.
30. "Gimbling with Medicare." *Saturday Night*, March 1996.
31. A Magnetic Resonance Imaging Machine (or MRI) produces images of soft tissue (i.e. it takes pictures of brains, spines, etc.).
32. In British Columbia there are at least two private clinics, and there are five in Manitoba. There are

Kingston: Institute of Intergovernmental Relations,
Queen's University, 1995, p. 147.

77. *Ibid.*, p. 145.

78. Alan Maslove. "Time to fold or up the ante: the
federal role in health care." John F. Graham
Memorial Lecture, Dalhousie University, March 9
1995.