# MONEY, POLITICS AND HEALTH CARE

RECONSTRUCTING THE FEDERAL-PROVINCIAL PARTNERSHIP

EDITED BY HARVEY LAZAR AND FRANCE ST-HILAIRE

THE INSTITUTE FOR RESEARCH ON PUBLIC POLICY
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PROJECT DIRECTORS Harvey Lazar (IIGR)

France St-Hilaire (IRPP)

RESEARCH ASSISTANT Jennifer Love (IRPP)

EDITORIAL ASSISTANT Francesca Worrall (IRPP)

COPY-EDITING AND PROOFREADING Jane McWhinney

DESIGN AND PRODUCTION Schumacher Design

PUBLISHED BY

Institute for Research on Public Policy (IRPP) institut de recherche en politiques publiques 1470 Peel Street, suite 200

Montreal, Quebec H3A 1T1

Tel: 514-985-2461 Fax: 514-985-2559

E-mail: irpp@irpp.org www.irpp.org

AND

The Institute of Intergovernmental Relations L'Institut des relations intergouvernementales

Queen's University Kingston, Ontario K7L 3N6

Tel: 613-533-2080 Fax: 613-533-6868

E-mail: iigr@gsilver.gueensu.ca

www.tigr.ca

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he Commission on the Future of Health Care in Canada undertook a number of in-depth research initiatives and analytical studies to inform its deliberations. One of these initiatives related to the role of federal-provincial relations, and especially fiscal federalism, in the development of publicly insured universal health care. In November 2001 the Commission asked the Institute of Intergovernmental Relations in the School of Policy Studies at Queen's University to undertake this major research activity.

Prior to asking that we undertake this work, the Commission identified the following issues as items needing to be addressed in the proposed project.

- What mechanisms do or should exist for encouraging cooperation and managing conflict between governments (both federal-provincial and interprovincial) in the area of health care financing?
- 2) What are the strengths and weaknesses of the transfer instruments currently employed by the federal government? What alternative transfer instruments are available to the federal government? On what criteria would one evaluate the utility of those current and alternative instruments? How do those different instruments affect the operation of the principles that underlie the medicare pact?
- 3) What are the competing interpretations of the federal government's role in health care and how do those different interpretations conceive of its fiscal role in the financing of the health care system? How has the debate over the federal role in health care changed over time? What other role(s) could the federal government play (other than through transfers) that would be practicable and consistent with the constitutional division of powers and the principles of the medicare pact?
- 4) It is often argued that there is a vertical fiscal imbalance in the federation whereby the federal government has a greater ability to raise revenue, but that provinces have greater obligations for social spending (health care, social services, etc.). To what extent is the relative nature and extent of the apparent vertical fiscal imbalance relevant insofar as there are transfers

- designed to equalize the fiscal capacity of provincial governments with regard to social spending (i.e., the CHST)?
- 5) The ability of individual provinces to raise revenue also varies considerably (what is commonly called a horizontal fiscal imbalance) and is ameliorated by equalization payments from the federal government. To what extent is it necessary to rethink the way in which the federation deals with this horizontal fiscal imbalance?

Over the following several months, the Institute for Intergovernmental Relations provided three background studies to the Commission in response to many, albeit not all, of the above questions. The Institute subsequently also prepared a synthesis report for the Commission, which integrated the key analyses from the three studies. This volume makes available these reports undertaken for the Commission.

We began our work with some assumptions, and it may be useful to high-light key ones here. To start with, we observed that there are a number of competing views within Canada regarding the nature of Canadian federalism and regarding the appropriate role of the state (and thus by inference for markets and the non-profit sector) in society and the economy. A particular focus for us was this divided opinion about the extent to which redistribution is appropriate and the geographic territory over which such redistribution should occur (all of Canada, within provinces only, or some combination of the two). These differences reflect a range of values in regard to the nature and scope of the Canadian sharing community. A discussion of three representative views of the sharing community is set out in chapter 1, and it is carried forward into the subsequent chapters of this volume.

Since there is considerable support for all three views within Canada, and since the question of which view prevails at any point in time is more a matter of societal consensus than of technical analysis, we saw our task as one of advising on the principles that might guide the use of intergovernmental mechanisms under each of the visions or models. The result is that we have not arrived at a single set of recommendations about how intergovernmental relations can be strengthened with a view to facilitating improvements in the quality or sustainability of universal publicly financed health care in Canada. Rather, we have laid out the kinds of principles and policy options that might help to improve medicare under alternative views of the sharing community. Our assessment overall is that there is room for major improvements in the role of intergovernmental relations under each of the alternatives.

In describing its research needs, the Commission drew attention to the issues of vertical and horizontal fiscal balance/imbalance in Canada and was interested in the extent to which they might affect its thinking about the role of the federal government in financing provincial health care programs. We chose to concentrate more heavily on the vertical balance/imbalance issues, since much of the controversy over the financing role of the federal government in health care in recent years has been linked to provincial criticism that Ottawa has more revenues than it needs relative to its expenditure responsibilities, whereas provinces lack comparable fiscal clout. We devote a full chapter here to unpacking the arguments and analysis. In so doing, we hope that we will help Canadians to better understand the positions of both orders of government on this issue and their relevance to questions about the nature and form of Ottawa's financial contribution to health care.

The Commission published its findings and recommendations in November 2002. We believe that there is much in the research and analysis of our preparatory work for the Commisson that is important grist for public policy debate. The question of the appropriate role for the federal and provincial governments in the financing of public health is an issue that is not likely to be resolved overnight. That is the reason that this volume is being published.

The chapters in this volume are not, word for word, the texts we submitted to the Commission but they are close to the originals. In a few places, we have provided updated numbers and clarified meaning. We also have divided one very long paper into two separate chapters in order to make the text easier to digest. The last chapter, which is based on the final synthesis report that was submitted by the research team to the Commission, provides an overview and summary of the main arguments, recommendations, and policy options derived from the analysis in the preceding chapters.

Since the Commission released its report, the first ministers have met and a new First Ministers' Accord on Health Care Renewal has been announced. In a number of respects, we consider this new set of arrangements a step forward when evaluated against the analysis that follows in this volume. But in several ways, it clearly falls far short. Thus, we were not at all surprised to observe the provincial and territorial premiers expressing their dissatisfaction with the new arrangements even as they were being announced. The timing of the First Ministers' meeting, following the release of two major reports (Romanow and Kirby reports) on the future of health care in Canada, had given rise to high

expectations. Indeed, it was hoped that this meeting would mark the beginning of a process of renewal and fundamental reform based on a common vision and solid financial commitment for the long term. Instead, there has been little evidence of a more collaborative stance between Ottawa, who more or less imposed the rules of the game, and the provinces and territories, who begrudgingly took what money was offered fully expecting to be back for more.

Disagreements about money are probably inevitable, and part of the normal jockeying for power in the federation. In and of themselves they are not necessarily a bad thing. In the case of health care, however, these disagreements are symptomatic of an intergovernmental dynamic that is helpful neither to the cause of health care reform nor to the well-being of the federation. As a result, the political will necessary to effectively meet some of the worthy goals laid out in the accord may be lacking (for example on performance indicators). In the last chapter of the volume, we propose a set of principles that might guide the federal-provincial-territorial relationship on health care. In our view, these principles remain as appropriate in the aftermath of the February 2003 Health Accord as they were before it was announced.

The team that undertook this work for the Commission initially included Professors Keith Banting and Robin Boadway of Queen's University, and Professor David Cameron of the University of Toronto as well as the undersigned. Before long, Jean-François Tremblay and Jennifer McCrea-Logie, former students of certain team members, became part of the team.

We were helped in our work by three advisers: Stephen Bornstein of St. John's, Newfoundland; Claude Forget, from Montreal, Quebec; and David Kelly, from Victoria, British Columbia. All three have had rich experience in matters of health policy from a number of different perspectives. They kindly read drafts of the chapters and offered valuable comments that helped us immensely in our work. As is usual in such matters, however, they are in no way responsible for shortcomings in the final product. Tom McIntosh of the Commission staff, and now at the University of Regina, also participated in our team meetings with the advisers. He too helped us with comments and suggestions and ensured that our work was sensitive to the research needs of the Commission.

The publication of this volume is a joint venture of the Institute of Intergovernmental Relations, School of Policy Studies at Queen's University and the Institute for Research on Public Policy (IRPP). In helping us prepare this volume, we want especially to thank Patti Candido of the Queen's Institute for her

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Harvey Lazar
Director
Institute of Intergovernmental Relations
School of Policy Studies
Queen's University

France St-Hilaire Vice-President, Research Institute for Research on Public Policy

### CONTRIBUTORS

Keith Banting is Professor at the School of Policy Studies at Queen's University, and holder of the Queen's Research Chair in Public Policy.

Robin Boadway is Sir Edward Peacock Professor of Economic Theory at Queen's University.

David Cameron is Professor of Political Science at the University of Toronto.

Harvey Lazar is Director of the Institute of Intergovernmental Relations at Queen's University.

Jennifer McCrea-Logie has completed a doctorate in political science with a focus on health policy at the University of Toronto.

France St-Hilaire is Vice-President, Research, at the Institute for Research on Public Policy (IRPP) in Montreal.

Jean-François Tremblay is Professor of Economics at the University of Ottawa.

# DEFINING THE SHARING COMMUNITY: THE FEDERAL ROLE IN HEALTH CARE

KEITH BANTING AND ROBIN BOADWAY

his chapter explores the considerations that underpin the role of the federal government in the provision of health care. Debates over federalism and health care have been intense in Canada. This history of conflict in part reflects different approaches to federalism in this country. For some Canadians, the promise of federalism is that it unites citizens over a vast and fragmented territory and creates a central government that can provide leadership in critical areas of public policy. For others, the promise of federalism is that it can reflect the diversities of our regions and enhance the scope for governance at the provincial level. And for still other Canadians, especially many from Quebec, the promise of federalism is that it can accommodate the distinctiveness of a particular province through asymmetrical relations with the rest of the country.

The history of debate over health care also reflects distinctive features of the health policy. The health sector has witnessed more dramatic clashes between federal and provincial governments than other social programs. Although constitutional politics and energy policy may have strained the political fabric of the country more seriously at different times, health policy has ignited a series of intergovernmental sparks in recent decades. A number of factors accentuate the sensitivity of health policy:

- > The sector itself is very complex, operating as it does through networks of hospitals, medical professions, regional institutions, and community organizations, all of which are capable of vigorous political action.
- > Health insurance also represents Canada's most ambitious social program, which can displace market mechanisms more thoroughly than programs such as public pensions. It is therefore not surprising that

ideological conflict over the role of the state in health care policy often flows through intergovernmental channels.

- > The federal government maintains a stronger role in program definition in health care than in other programs financed by the Canadian Health and Social Transfer (CHST), despite its reduced financial transfers.
- > Health care is very important to the population and has taken on symbolic dimensions well beyond those of a mere public program.

Given the controversy over Canadian federalism and the pressures on health policy, it is perhaps understandable that the role of the federal government in health care has been the subject of recurring and difficult debates.

Our purpose here is to examine the choices that must be made in defining the role of the federal government in health care. A comprehensive interpretation of a role for the federal government in health care inevitably incorporates three distinct dimensions of choice. The first dimension concerns the general role of the state. The second concerns the particular role of the central government in a federal state. And the third concerns the instruments through which the federal government pursues its role. These three dimensions of choice are distinctive: as we shall see, they involve different sets of considerations. However, they are also cumulative. For those opposed to a state role in health care, the second and third choices do not arise. And for those who accept the case for a public role in health care but oppose federal involvement in the sector, the choice of instruments is irrelevant. Accordingly, any comprehensive interpretation of an active role for the federal government in health care inevitably represents all three dimensions.

What types of considerations are inherent in these judgments, and what types of rationales have been advanced for an active federal role? The argument advanced here is that the primary rationale for the extensive public intervention in health care that one sees in OECD countries is one based on arguments of redistributive equity, especially those founded on principles of social insurance. Social insurance refers to the public sharing of the risks of ill health that would otherwise go uninsured in a purely market-based system. Certain inefficiencies of the private provision of health insurance can also reflect market failures. While these inefficiencies point to the need for public intervention, efficiency considerations alone do not justify full public insurance. In the final analysis, the logic of social insurance is its compelling rationale. Given this equity-based argument for public intervention, decisions about the role of the federal government revolve primarily around the extent to which the relevant sharing community for social

insurance purposes is seen to be the country as a whole rather than individual provinces and territories. The extent of the federal role and the mix of preferred instruments depend upon the societal consensus about the sharing community, suitably tempered by efficiency considerations.

In this chapter we develop this argument in distinct steps. First we set the context of the discussion by providing a brief overview of the setting for the debate, focusing on the constitutional framework and the current federal-provincial balance in health care. We go on to examine the general rationale for a public role in the health care sector, emphasizing especially the area of health insurance. Building on this analysis, we consider the role of government in a federal state, and in particular the role of the federal government in health care. After discussing the choice of instruments through which the federal government conducts its role, we pull the threads of the discussion together by examining the ways in which judgments on each of the three dimensions of choice may be combined in the debate over the federal role in health care in Canada.

A word of caution is in order at the outset. Our concern is the role of the federal government in health care, not health policy or the management of the health sector *per se*. This both limits the extent of our inquiry and requires that we take as given certain features of the policy environment, while recognizing that these could change. As a consequence, our discussion of federal policy instruments is presented at a level of generality so as to encompass the possibility of evolving policies.

#### FEDERALISM AND HEALTH CARE: THE CONTEXT

n this section we present a brief survey of the context of federalism and health care in Canada, examining the constitutional division of powers in the field, the evolution of the role of the federal government in health care, the structure of financial transfers to the provinces which have underpinned that role, and the growing controversy that has surrounded federal-provincial relations in recent years.

# The Constitutional Framework

The emergence of the modern social role of the state posed a constitutional dilemma for Canada. The Constitution Act, 1867 was very much a docu-

ment of the nineteenth century, reflecting nineteenth-century conceptions of the appropriate role of government. The health and social needs of Canadians in 1867 were very much a private matter for the individual, the family, the church, and charitable institutions, and the state's role was largely confined to rudimentary forms of relief for the poor administered through local agencies. Not surprisingly, such a minor function of government did not attract a lot of attention either in the debates that preceded Confederation or in the constitution itself, and twentieth-century words such as "health care" or "income security" or "social services" did not appear in the list of jurisdictions allocated to the two senior levels of government. When the social role of the state began to expand in the twentieth century, Canada had to resolve the division of responsibility in new domains of state action. This resolution came slowly through a variety of mechanisms. In part, jurisdiction was inferred from other powers in the constitution; in areas such as unemployment insurance and pensions, the formal division of powers was altered through constitutional amendment. In other areas, more informal means of adjustment were employed.

In the case of health care, the constitution gives important powers to both the federal and provincial governments. As constitutional expert Peter Hogg observes: "Health is not a single matter assigned by the Constitution exclusively to one level of government"; rather, it is "an amorphous topic which is distributed to the federal Párliament or the provincial Legislatures depending on the purpose or effect of the particular health measure in issue" (Hogg 2000, 18.4; Lajoie and Molinari 1978, 579). Section 92 of the Constitution Act, 1867 gave the provinces a central role in the field, and section 92(7) specifically grants to the provinces authority over hospitals. In addition, jurisdiction was inferred from other more general provincial powers, especially section 92(13) dealing with property and civil rights and section 92(16) dealing with matters of a local or private nature. In the early decades of the twentieth century, the courts held that these sections empowered provincial governments to regulate the medical professions and commercial insurance plans. This authority was extended to the new instrument of social insurance during the late 1930s. In striking down the 1935 federal New Deal legislation, the courts determined that social insurance programs financed in whole or in part by premiums paid by or on behalf of the potential beneficiary fall within provincial jurisdiction. The majority of the Supreme Court declared: "Insurance of all sorts, including insurance against unemployment and health insurances, have always been recognized as being exclusively provincial matters under the head 'Property and Civil Rights,'" or under the head 'Matters of a Merely Local or Private Nature in the Province'." And the Judicial Committee of the Privy Council, the final court of appeal at the time, concurred: "In pith and substance this *Act* is an insurance Act affecting the civil rights of employers and employed in each Province, and as such is invalid." Although subsequent amendments to the constitution gave the federal government jurisdiction over unemployment insurance and contributory pensions,¹ no such amendments took place in the case of health insurance. As a result, provinces have control over the medical professions, hospitals, and health insurance; these responsibilities clearly place them at the centre of health services.

The constitution also provides footing for a federal presence in health care. Authority over criminal law gives the federal government a role in the protection of public health through legislation such as the *Food and Drug Act* and the *Tobacco Products Control Act*. In addition, the federal *Narcotics Control Act* has been upheld under the "Peace, Order and Good Government (POGG)" clause.<sup>2</sup> Other sections of the constitution give the federal government responsibility for the welfare – including health care – of specific classes of people, including "Indians," "aliens," inmates in federal prisons, and members of the armed forces. In addition, the federal tax powers are the basis of extensive federal involvement in the financing of health care expenditures through the various tax credits allowed under the personal income tax system and GST exemptions; and the federal role in research gives federal agencies a major role in health research and information.

However, the federal government's primary role in health services for the population as a whole has developed through financial transfers to provincial governments. These transfers find their constitutional footing in section 36 of the *Constitution Act*, 1982 and the doctrine of the federal spending power. Section 36(1) commits the federal and provincial governments to "promoting equal opportunities for the well-being of Canadians," and "providing essential public services of reasonable quality to all Canadians." Section 36(2) then commits both levels of government "to the principle of making equalization payments to ensure that provincial governments have sufficient revenues to provide reasonably comparable levels of public services at reasonably comparable levels of taxation." There is a debate about whether section 36 is simply a statement of principle that is non-justiciable, or whether it constitutes a distinct grant of authority to the federal government, especially in the case of equalization grants. As we shall see,

however, the principle of equalization articulated in this section is fundamental to debates about the role of the federal government in health care.

The doctrine of the federal spending power has also been critical. This doctrine holds that "the federal Parliament may spend or lend its funds to any government or institution or individual it chooses, for any purpose it chooses; and that it may attach to any grant or loan any conditions it chooses, including conditions it could not directly legislate" (Hogg 2000, 6.8a). This power is not specified explicitly in the constitution but is inferred from federal powers to levy taxes, to legislate in relation to public property, and to appropriate federal funds. The idea of a federal spending power is not unique to Canada. In one form or other, other federations also recognize as constitutionally legitimate a federal spending power in areas of state or provincial jurisdiction (Watts 1999). In Canada, however, the use of the spending power has been controversial, and has been challenged both politically and judicially. In the mid-1950s, for example, Quebec's Royal Commission of Inquiry on Constitutional Problems (Tremblay Commission) asked: "What would be the use of a careful description of legislative powers if one of the governments could get around it and, to some extent, annul it by its taxation methods and its fashion of spending?" (Royal Commission on Constitutional Problems 1956, vol. 2, 216). Nevertheless, court decisions on the constitutionality of the spending power have repeatedly sustained the federal position, and federal transfers finding their constitutional footing on this power have played a central role in the evolution of health care in Canada.

# The Evolution of the Federal Role in Health Care Services

The federal government plays a number of critical roles in health policy in Canada. It has a direct presence through a number of important programs that it delivers directly or through wider partnerships. These programs focus on research and evaluation, health promotion and protection, and support for health care information systems and infrastructure. In addition, the federal government is responsible for the direct delivery of the full range of health services to First Nations and the Inuit communities, and for some health services to the RCMP, Correctional Services, the Armed Forces, and veterans. Table 1 indicates the level of federal expenditures under these programs. Table 2 also shows the scope of federal support to health care spending through tax expenditures available to individuals and institutions in Canada.

Table 1
HEALTH CANADA'S SPENDING BY TYPE OF ACTIVITY, 2000/01

	Actual Spending (millions of dollars)	Percentage of Total Spending
Health care policy	112.6	4.8
Health promotion and protection	634.4	27.3
First Nations and Inuit health	1,266.5	54.6
Information and knowledge management Departmental management	126.7	5.5
and administration	180.3	7.8

Source: Health Canada, Departmental performance report (2000/2001), p. 25.

Table 2
PERSONAL INCOME TAX EXPENDITURES AND GST TAX EXPENDITURES RELATED
TO HEALTH, 1996-2001 (millions of dollars)

	1996	1998	2001
Personal income tax expenditures Non-taxation of business-paid	3		
health and dental benefits	1,490	1,650	1,560
Disability tax credit	265	265	385
Medical expense credit	330	405	465
Medical expense supplement			
for earners	-	42	63
Sub-total	2,085	2,362	2,473
GST tax expenditures	r		
Prescription drugs	210	230	270
Medical devices	85	90	105
Health care services	490	545	630
Rebate for hospitals	235	265	325
Sub-total	1,020	1,130	1,330

Source: Department of Finance Canada, Tax expenditures and evaluations, various years (accessed October 10, 2003). www.fin.gc.ca/purl/taxexp-e.html

In addition to its directly delivered programs, however, the federal government has had a pervasive influence on the health services enjoyed by Canadians generally through its financial transfers to provincial governments, and it is this dimension of the federal role that constitutes the primary focus of this study (Standing Senate Committee 2001b). Historically, federal transfers to provinces helped define the basic parameters of the Canadian system of health care. While most of the key innovations emerged first at the provincial level, the federal government played a central role in the process. In the early stages, it played a *transformative* role by extending innovations that emerged in individual provinces across the country as a whole; in more recent decades, it has played a *sustaining* role, maintaining and reinforcing the pan-Canadian model.

In 1945, the federal government set the agenda for the postwar era by proposing a national program of health insurance as part of the policy package it presented to the Dominion-Provincial Conference on Reconstruction. When the larger package collapsed because of the rejection of the associated proposals for federal-provincial fiscal relations by Ontario and Quebec, initiative shifted to the provinces. In 1947 Saskatchewan introduced hospital insurance, and British Columbia and Alberta followed in quick succession. These governments repeatedly pressed for federal support of their programs, but Ottawa was initially reluctant. It introduced National Health Grants in 1948 to assist provinces with hospital construction and public health services, but insisted that it would support provincial health insurance programs only when a majority of the provinces representing a majority of the population was ready to join a nationwide scheme. In the mid-1950s, however, Ontario and Newfoundland joined the list of provinces demanding federal action, and the federal government introduced the Hospital Insurance and Diagnostic Services Act, 1957. The legislation passed unanimously in the House of Commons.

Under the 1957 legislation, the federal government shared the costs of provincial hospital insurance programs that met federal conditions. Provincial plans had to provide universal coverage to all residents of the province on uniform terms and conditions, include specified diagnostic services, and limit co-insurance or "deterrent" charges so as to ensure that an excessive financial burden was not placed on patients. In addition, provincial plans were subject to stringent federal auditing. Despite the federal controls, by 1961 all provinces had signed agreements to join the federal plan. Quebec was the last to join, and did so only with the advent of the new provincial Liberal government led by Jean Lesage. By 1964, however, the Hall Commission found fit to describe the program as a remarkably successful example

of "cooperative federalism" (Royal Commission on Health Services 1964, 413).

Soon, however, negotiations for the introduction of medicare, which covered physicians' services, created more federal-provincial sparks. The medical profession and the insurance industry were strongly opposed, and ideological differences intensified intergovernmental conflict. Once again, Saskatchewan took the lead by introducing a universal model in the early 1960s and pressing for federal support. However, conservative governments in Alberta, British Columbia, and Ontario were committed to the principle of private health insurance for the majority of the population, and they implemented programs that limited the public role to hard-to-insure groups such as the elderly and the poor.3 In 1965 the federal government chose to act and, prompted in part by the report of the Royal Commission on Health Services chaired by Emmett Hall, opted for the universal model pioneered in Saskatchewan. Although the new program started with fewer administrative and reporting controls than in the case of hospital insurance, the Medical Care Act of 1966 did establish four conditions. To qualify for federal support, provincial plans had to provide for: public administration of medical plans; coverage of "all services rendered by medical practitioners that are medically required"; universal coverage of provincial residents on equal terms and conditions; and the portability of benefits. There is some ambiguity about whether "access" was viewed as a co-equal fifth principle or condition at the time. The prime minister's speech to the federal-provincial conference in 1965 had not treated "reasonable access" as a formal principle. The 1966 legislation did require that insured persons not be charged fees that impede or preclude "reasonable access" to insured services; but uncertainty later emerged about whether the legal effect of this provision was simply to preclude provincial government charges for physicians' services or whether it also applied to extra-billing by physicians themselves. Whatever the uncertainties surrounding its origins, however, reasonable access soon evolved to the status of a co-equal principle.

The decision to join the 1966 medicare plan was difficult for the conservative governments in the three provinces that had to undo their recently established programs. The long-serving Alberta health minister resigned in protest, and Premier Robarts of Ontario denounced medicare as "a Machiavellian scheme" that was "one of the greatest frauds that has ever been perpetrated on the people of this country" (Taylor 1987, 375). Nonetheless, all provinces had medicare programs in place by 1971, three years after the implementation of the federal legislation.

With a cross-country health care system in place, the federal role began to shift subtly toward system maintenance. The first phase of this evolution came in 1977 with the transition to Established Program Financing (EPF), which will be discussed more fully below. The second was the passage of the Canada Health Act (CHA) in 1984. This legislation was a response to the growing prevalence in a number of provinces of extra-billing by doctors and the introduction of hospital fees, both of which the federal government opposed as inhibiting equal access to health care. The issues had been discussed in federal-provincial forums for years and examined in several joint studies, but the differences proved unbridgeable. When the Alberta government pressed the issue in 1983 by introducing a hospital fee of \$20 a day, the federal government announced that it would legislate. The CHA introduced several important innovations. It amalgamated the previously separate hospital and medical insurance legislations, and established a fully integrated set of five "principles" that provincial health care plans would be required to meet to qualify for federal support. To the four conditions set out in the 1965 legislation, the CHA added the principle of "reasonable access" in order to prohibit charges at the point of service. To facilitate enforcement, the legislation determined that such charges would lead to dollar-for-dollar deductions in the federal transfer. Although provincial government were angered by the legislation, as we shall see in more detail below they generally moved to compliance over the next few years.

From this review, it is evident that the federal government played a central role in defining the basic policy framework that guided the development of the Canadian health care system in the early postwar decades, and in sustaining that framework on a countrywide basis in the decades that followed.

# Transfers to the Provinces

An appreciation of the structure and evolution of federal fiscal transfers is critical to understanding federal-provincial tensions in the field, and a closer look at these transfers is worthwhile.

The nature of federal transfers has evolved as Ottawa has shifted from a transformative to a sustaining role in health care. In the early stages, when the emphasis was on building a countrywide system of health care, the favoured instrument was the shared-cost program. However, from the outset, federal support for health services differed in important ways from the classic shared-cost program, which is perhaps best typified by the case of social welfare. Prior to

1996 federal transfers for social welfare were based on cost sharing under the Canada Assistance Plan (CAP). For every dollar of eligible provincial expenditures, the federal government contributed one dollar. This system had some important consequences, which ultimately led to its demise. Since costs were shared only for expenditures deemed to be eligible by the federal government, provinces complained that federal conditions constrained their capacity to reform and redefine their programs. But in addition, some critics argued that the 50:50 sharing rule provided an incentive for provinces to expand the generosity of their programs, and the federal government did impose a "cap" on CAP growth for the three wealthiest provinces in 1990.

The approach taken in financing health care had some similarities to social welfare cost sharing. Under the terms of the 1957 Hospital Insurance and Diagnostic Services Act and the 1966 Medical Care Act, financial support was dependent on provincial acceptance of federal conditions, and covered only specified services, creating an incentive for provinces to expand those services at the expense of others (for example, hospital services rather than extended care). But there were also important differences. Under the 1957 legislation, provinces received 25 percent of provincial per capita costs and 25 percent of national per capita costs. Thus, while the federal government covered on average half of the costs, only 25 percent of individual provinces' incremental costs were covered, so the incentive effects on provincial spending were less than under CAP. In the case of the 1966 Medical Care Act, provinces received 50 percent of national average per capita costs, so there was no cost sharing at the margin. As a result, the financial formula in health care was closer to a block grant than a traditional matching one, and subsequent transitions were less dramatic than in the case of social welfare.

The shift in federal emphasis from transforming to sustaining the pan-Canadian model of health care soon left an imprint on the transfer system. By the mid-1970s, the provincial programs could be viewed as "established," and perhaps did not require the same level of federal intervention to encourage the provinces to maintain them. Moreover, the federal government worried that its open-ended commitment to pay half of provincial expenditures in a number of programs, including health care, was eroding its capacity to control its own budget. Provincial governments also had frustrations with the traditional shared-cost model. They sought escape from the onerous negotiations about eligibility issues, such as the need to decide which hospital beds were acute care beds and there-

fore eligible for cost sharing under the health care arrangements, and which hospital beds were long-term care beds that were not.

After extensive federal-provincial negotiations, a compromise emerged in the form of the Established Programs Financing (EPF). The transfers for hospital and medical services, as well as for post-secondary education, were combined in one block grant. The federal government gained greater predictability over increases to its financial commitment, which was no longer based on provincial expenditures but now was to escalate according to a formula based on the rate of growth in the economy as a whole. The provinces gained a further reduction in the specificity of 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.

The EPF transfer was an equal per capita payment to each province, of which half was initially paid as cash and the other half as a tax point transfer, which included 13.5 percentage points of personal income tax room and 1 percentage point of corporate income tax. Since the tax points were ultimately equalized, they too amounted to an equal per capita amount for the provinces receiving equalization. At the time of introduction of the EPF, the federal government adopted two practices in accounting that have been important to the politics of federal-provincial recrimination ever since. First, Ottawa nominally divided the EPF transfer into components for health and post-secondary education, using the proportions that existed at the time EPF was introduced. Second, it calculated its contribution to health care financing to include not only the cash transfer but also the value of the tax-point transfer. There is considerable debate about whether this is a meaningful practice, since for all intents and purposes the tax points, once transferred, became part of provincial own-source revenues. But the federal government has maintained the practice, especially as the share of the EPF transfer consisting of cash has declined gradually, partly because the value of the tax points grew more rapidly than GNP, and partly because the federal government from time to time reduced the rate of growth temporarily for fiscal reasons. Table 3 tracks the resulting shift in the balance between the cash and the tax transfer.

The next significant change in the form of the federal transfers for health services came in 1995 with the introduction of the Canada Health and Social Transfer (CHST), which combined EPF and the previously separate transfer for social welfare into a single block transfer. The impetus for this change was more fiscal than structural. The federal government found itself in an untenable deficit

Table 3
HEALTH PORTION OF FEDERAL TRANSFERS TO PROVINCES
(billions of dollars)

	Cash Transfer	Tax Transfer	Total Transfer.
1977/78	2.8	1.9	4.7
1982/83	5.0	3.6	8.7
1987/88	7.1	5.5	12.6
1992/93	8.2	6.7	14.9
1996/97	6.3	8.3	14.6
2000/01	8.1	10.4	18.5
	•		

Source: Department of Finance Canada, Backgrounder on federal support for health in Canada (March 29, 2000), p. 9.

and debt situation, and embarked on an expenditure-cutting strategy. Transfers to the provinces were cut as part of the exercise, with the severity of the cut depending on how one did the calculation. If one measured the cut in federal transfers using both cash and tax points as the basis (as did the federal government), the cut in transfers was in line with federal expenditure cuts more generally. However, as a proportion of federal cash transfers, the cuts in federal transfers to the provinces were significantly greater than those in other elements of the budget.

Although the impetus was fiscal, several features of the CHST should be mentioned. First, unlike the EPF and CAP systems, growth in the transfer under the CHST is no longer formula-based but is decided at the discretion of the federal government. This discretionary power reinforces concern that the federal government increasingly makes unilateral and unannounced changes to major transfer programs. Second, the CHST maintains the practice established with the EPF of breaking down the amounts, notionally intended for health, post-secondary education, and social welfare. Thus, 43 percent of the CHST cash component is attributed to health. This breakdown is purely nominal, however: there is no mechanism to ensure that provinces actually spend their allocations according to those ratios. Indeed, the funds once received are fully fungible, so it would be impossible to enforce the allocations.

Some lessons from this experience are relevant for subsequent discus-

sions. The first is that federal transfers for health care have always been largely block transfers rather than matching ones. The exception is the 25 percent matching component in the original hospital grants. The 50:50 sharing rule applied more to the overall size of the grant than to its relationship with individual provinces' expenditures. The second is that similar general conditions have been maintained throughout important changes in the underlying structure of transfers. As we have seen, the switch to EPF and the introduction of the CHST did not alter the conditions or principles associated with the health transfer at the time the changes were made. Third, probably the most significant historical shift was the introduction of the EPF, which produced an instantaneous splitting of the transfer into cash and tax point transfer components. This division was to become a slow-acting poison pill in federal-provincial relations, since there was no longer an agreed answer to the question of what proportion of provincial health expenditures was met by the federal government. This poison pill began to take effect as the rate of growth in the transfer declined, and intensified its action when the formula-based rate of growth of block transfers for social programs was abolished with the introduction of the CHST. The fact that the size of the CHST is now at the discretion of the federal government is itself a cause of contention. In addition, the precipitous decline in the cash component has put the controversy over the tax point transfer component more fully in the spotlight.

The cumulative effect of these trends is that the transition from the use of health transfers for transformative to maintenance purposes essentially involved changes in the level of transfers but not necessarily to their basic form. Separate health transfers enabled the federal government to encourage the provinces to introduce public hospital insurance and public medical insurance sequentially. In each case, the transfer was largely a block payment, with the federal government contributing roughly half the *national* share of costs. Once the programs were established, they were amalgamated into a single block transfer along with post-secondary education and, later, welfare, and the size of the transfer was reduced, gradually at some points and more dramatically at others. The basic assumption was that the transformative role required more of a federal presence than the maintenance role. However, the question as to whether the federal financial commitment has fallen below the level needed to support this maintenance role is now a source of considerable intergovernmental tension.

# The Growth of Intergovernmental Tensions

The recent history of federal-provincial relations in health care has been punctuated by dramatic political conflicts, and provinces have increasingly challenged the federal role in health care. In part, the challenge is a long-standing one. The government of Quebec in particular has consistently denied the legitimacy of the federal spending power and its role in health care. This orientation is based on its traditional interpretation of the constitution, and reflects a distinctive political identity and a desire to preserve a greater level of self-determination. In recent years, however, other provinces have also challenged the federal role in health care. In contrast to Quebec, their challenge flows less from constitutional doctrine than from frustration with a long series of federal program changes.

The fundamental issue is the growing gap between the policy role and the financial role of the federal government. On the policy side, the federal government has continued to defend the general parameters of the universal model of health care. Its most forceful step was the introduction of the Canada Health Act in 1984. This Act was opposed by all provincial governments and became a symbol of federal unilateralism. But the legislation was immensely popular with the electorate, and it passed unanimously in the House of Commons. Despite an unprecedented appearance by provincial health ministers before the Senate, approval in that chamber was also unanimous. The federal government proceeded to implement the legislation, withholding a total of \$247 million from provinces that allowed extra-billing or user charges. Although these penalties were to be refunded when provinces came into compliance with the Act, it was the public support for the Canada Health Act that convinced provinces to comply. Provincial authorities often had to face difficult negotiations with the medical profession, which demanded higher fee schedules to compensate for the banning of extra-billing. Ontario had to cope with a twenty-five-day strike by a majority of doctors, and Saskatchewan doctors held a series of rotating one-day strikes. The final settlements with the doctors raised provincial costs in a number of provinces but, given the block nature of the federal transfer, provinces had to absorb the increase themselves (Tuohy 1994b). In the end, all of the federal withholdings were refunded, but the provinces had to cope with the larger financial fallout of federal policy.

In contrast to its forceful policy role, federal financial support for health care has been weakened by a long series of unilateral decisions. In 1986 Ottawa limited the indexation of its transfers to the increase in GDP less 2 percentage points; in 1990 federal transfers were frozen in absolute terms, a freeze that lasted for four years; and in 1995 the combined cash transfer for health, welfare, and post-secondary education under the new CHST was cut by approximately \$6 billion. Although the government reversed this cut by increasing funding during the subsequent election campaign and several times since then, its contribution to health costs has clearly declined over time. How deep the erosion has been depends on how one defines the "real" federal contribution. The federal government insists that its contribution includes both the annual cash transfer and the value of the tax points. Provinces reply that the tax points are part of the general provincial tax base and that the federal contribution is limited to the cash transfer. From the provincial perspective, the key story is a continuous decline in the federal cash transfer as a proportion of provincial health expenditures.

Table 4 illustrates the difference between the federal and provincial views. As these data show, the notional cash contribution of the federal government as a proportion of provincial health expenditures has eroded continuously since the late 1970s, and especially since the advent of the CHST in 1995. At the same time, the proportion accounted for by the tax point transfer has held its own. In the federal view, the total transfer (cash plus tax points) accounted for almost 30 percent of provincial health expenditures in 2000 compared with about 40 percent in 1977, a decline of close to a third. From the provinces' perspective, the federal contribution over the same period fell from about 25 percent to about 13 percent, a decline of about one-half.

The tension between the policy and financial roles of the federal government embittered federal-provincial relations and made enforcement of the conditions of the *Canada Health Act* more politically difficult. The federal government has never penalized provinces for non-compliance with the five basic principles enunciated in the Act, despite concerns raised by the Auditor General of Canada and others about portability, comprehensiveness, and accessibility (Auditor General of Canada 1999). However, Ottawa has penalized provinces for permitting extra-billing and user fees, and its action against facility fees sparked a bitter controversy. The 1990s witnessed the growth of private clinics providing specialized medical services and charging patients a "facility fee," which in some cases was substantial. The federal government argued that such fees created differential access to medical care and thereby violated the *Canada Health Act*. In 1995 Ottawa

Table 4
FEDERAL GOVERNMENT TRANSFERS FOR HEALTH CARE AS A SHARE OF PROVINCIAL GOVERNMENTS' EXPENDITURES ON HEALTH CARE, 1975-2000 (percent)

	1		,
Year	Cash	Tax	Total
1975	41.3		41.3
1976	40.5		40.5
1977	25.2	17.1	42.3
1978	26.1	17.1	44.0
1979	27.0	17.5	44.5
1980	25.3	17.7	43.7
1981	24.1	17.2	41.3
1982	22.7	16.4	39.5
1983	24.1	15.1	39.2
1984	24.0	15.6	39.6
1985	23.8	15.6	39.7
1986	22.9	16.1	39.0
1987	21.6	16.8	38.4
1988	20.4	16.8	37.2
1989	19.1	16.8	36.1
1990	17.9	16.0	33.9
1991	17.1	14.7	31.9
1992 .	17.0	13.9	30.9
1993	16.9	14.2	31.1
1994	16.6	<b>14</b> .7	31.3
1995	16.4	15.8	32.1
1996	12.9	16.9	29.8
1997	10.6	17.9	28.5
1998	10.0	17.9	27.9
1999	12.7	17.4	30.1
2000	12.8	. 16.5	29.3

Source: Calculated using transfer data from the Department of Finance Canada and expenditure data from the Canadian Institute for Health Information (CIHI).

began to compute penalties under the Act for four provinces: Alberta, Manitoba, Newfoundland, and Nova Scotia (see Table 5). The conflict was sharpest with Alberta, where government support for private clinics was strongest. Over several years, however, the provinces largely moved into compliance. Nevertheless, the coincidence of the unilateral introduction of the CHST, a large cut in funding, and the campaign against facility fees generated deep anger in several provinces and a broad-based provincial questioning of the legitimacy of the federal role.

The complexities of these debates are explored in the other chapters of this volume. However, the lesson is clear. It is time to step back from the day-to-day battles, and to reflect once again on fundamental questions about federalism and health care. What is the appropriate role of the state in health care? What are the basic principles and considerations that should inform debates about the federal role in health care? What are the choices, and what is at stake in choosing among them? These questions are taken up in the sections that follow.

# THE GENERAL RATIONALE FOR STATE INTERVENTION IN THE HEALTH ARENA

s noted earlier, the case for federal intervention in the health sector presupposes some general rationale for government intervention in the first place. Moreover, different attitudes about the nature of the general role for government inform the debate over federal and provincial responsibilities.

Health care services are unlike most other goods and services used by persons in the market economy. Resources used in the health sector are not allocated solely, or even primarily, by the price mechanism. Governments are heavily involved in the various stages of their provision, including the training of professionals who deliver health care, the regulation or provision of various forms of health care services and products, the financing of health costs, regulation of health standards in product markets and places of employment, public education, research and development, and the prevention and eradication of various forms of disease.

In this section we outline the arguments for government intervention in health care. Policy analysts often find it useful to disaggregate these arguments into two main sorts – those concerned with efficiency and those concerned with equity. Although in the end the two sorts of arguments are interdependent, the

Table 5
DEDUCTIONS FROM PROVINCIAL TRANSFERS UNDER THE CANADA HEALTH ACT
IN THE 1990S (thousands of dollars)

	Nfld	PEI	NS	NB	Que	Ont	Man	Sask	Aſta	BC	Can	
1992/93 1993/94 1994/95 1995/96 1996/97 1997/98 1998/99 1999/00	46 96 128 53		32 72 57 39 48				269 588 587 612	1.	2,319 1,266	83 1,223 676 43	83 1,223 676 2,709 2,022 772 704 48	

Source: 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: Oueen's Printer for Canada, March 2001), table 2.3, p. 39.

distinction remains a useful one, and we adopt it here. The outcome of this discussion and an evaluation of the legitimacy of the various arguments for state intervention will serve as important considerations for our subsequent discussion of the role of the federal government. We begin with efficiency considerations, since economists typically invoke these as the main source of market failure. However, as will become clear, the primary rationale for government intervention in health care is based on redistributive equity or social insurance grounds. Efficiency considerations are nonetheless important for selecting among policy instruments for achieving these social objectives.

# Efficiency and Market Failure

Markets are efficient mechanisms for allocating resources to the extent that they result in all "gains from trade" being exploited. Well-functioning competitive markets have the feature that the market price reflects both the benefit to the user of the last unit purchased and the cost to the supplier of the last unit produced. At quantities below that, the benefit of an additional unit of product would exceed the cost of providing another unit, so mutually beneficial gains can be obtained by expanding output, and vice versa for quantities above that. A prime facie case for government intervention exists whenever the benefit to users of an additional unit consumed exceeds the resource cost of producing another unit.

Public finance economists have identified a number of situations in

which markets may fail to provide certain types of goods or services efficiently. Some of the more important ones include the following:

- > The free-rider problem: Persons cannot be easily excluded from obtaining the benefits of some goods (for example, public goods) so will not willingly pay a price for them.
- > Externalities: The production or consumption of some products yields benefits or costs to third parties that are not reflected in market prices.
- > *Increasing returns to scale*: Competition cannot be sustained, so the market ends up being served by a small number of firms who are able to restrict output and increase prices above marginal costs.
- > Asymmetric information: One side of the market is better informed than the other side; the better informed party has a form of informational advantage analogous to a monopoly advantage, and is able to manipulate prices in its favour.
- > Coordination problems: In a changing world, supply decisions and demand decisions taken at the same time are not always coordinated, so prices are temporarily out of equilibrium, and the amounts demanded and supplied are not equalized.
- > *Transaction costs*: Trading in the real world can be a complicated matter, and resources must be used up in purely administrative costs (legal fees, advertising, record-keeping, and overhead).

Some or all of these elements are present in the markets for health services and products. In fact, health care consists of a wide variety of types of goods and services, including medical care, hospitals, diagnostic services, pharmaceuticals, prosthetics, immunization, preventive measures, and so on. Different aspects of health care may be subject to different forms of market failure. However, asymmetric information, economies of scale, and externalities in particular, inform debates about the role of government in health care, including especially the choice of policy instruments. We begin with the sources of market failure that have dominated much of the economics debate – moral hazard and adverse selection – before turning to those that might be more important in establishing a role for public provision of health care per se.

#### Asymmetric Information and Moral Hazard

Moral hazard is one consequence of asymmetric information. It occurs when one side of a transaction cannot observe actions or characteristics of the

other side that affect the benefits generated from the transaction. It is especially prone to happen in insurance situations when an insurer cannot observe the behaviour or the state of persons being insured. Moral hazard can take two forms - an ex ante form and ex post form. Ex ante moral hazard occurs when preventive action cannot be observed. The existence of insurance provides an incentive for persons to reduce their level of preventive effort, thereby increasing either the probability of an insurable outcome or its magnitude. Thus, fire insurance may induce persons to be less vigilant, and automobile insurance may induce them to drive less safely. Ex post moral hazard occurs when the severity of insurable outcomes can be mitigated by compensating expenditures. Theft insurance may replace items that are stolen, but these are difficult to verify. In either case, the insurance providers will react by restricting the amount of insurance that can be purchased by devices such as co-payments or deductibles. This is inefficient in the sense that if preventive actions and ex post compensating expenditures could be perfectly monitored, insurance could be made contingent on them and full insurance could be provided.

Health care is prone to both types of moral hazard, especially to the *ex post* form. Once persons become ill, to the extent that health insurance covers the cost of curative expenditures, there will be an incentive to incur inefficiently large amounts of care. Health insurance may also induce lower levels of preventive expenditures. In these circumstances, insurance will again be inefficient, and in private markets this would be reflected in user charges either of the co-payment or the deductible form.

The extent of the inefficiency due to moral hazard depends upon the extent of discretion available to users of health care services. Clearly there are many forms of service over which the insured person has limited discretion. For medical, hospital, and diagnostic services, health care professionals have much more discretion than those being insured. In these cases, moral hazard applies more to the behaviour of these professionals than to the person using the health services. The moral hazard problem then turns into a problem involving incentives facing those who deliver the services. Various forms of payment can be used to mitigate the problem, such as capitation and salary components alongside, or instead of, fees for service.

For our purposes, however, the asymmetric information problems that give rise to moral hazard are not likely to be significantly different for public health insurance than for private health insurance. The implication is that, although moral hazard leads to inefficiency, it does so whether the insurance is provided by the public sector or the market. Market failure due to moral hazard does not imply an efficiency case for public provision. In fact, it does not even imply that public intervention in other ways (subsidization and regulation, for example) is justified. Private market responses to moral hazard using co-insurance or deductible provisions to limit the extent of insurance turn out to be efficient responses, given the information available, and there is no guarantee that public interference with these market mechanisms will improve efficiency.

### Asymmetric Information and Adverse Selection

A second consequence of asymmetric information is adverse selection. Adverse selection occurs when persons face systematically different risks because of different personal characteristics. If insurers could classify persons according to their risk class, they would charge appropriately different insurance premiums to reflect the likelihood of claims. This would be an efficient thing to do. However, if households cannot be so classified, inefficient outcomes will prevail. There are two possibilities. If insurance companies cannot identify the total amount of insurance households buy, the best they can do is offer a uniform insurance contract – a so-called pooling contract – to all persons regardless of risk class. Such insurance will be inefficient because low-risk persons will face excessive premiums given their level of risk, and will therefore underinsure. On the other hand, if insurers can observe the quantity of insurance each person buys, they can make available different quantity/price combinations that induce households to selfselect (referred to as separating contracts). Once again, this is inefficient because the package intended for low-risk persons cannot be generous enough to attract high-risk purchasers. More important, in this case there may be no equilibrium in the insurance industry. Insurers will attempt to cream off the low-risk persons, but in so doing they will force other insurers to make a loss and revise their policies. Notice that this adverse selection argument relies on persons themselves being better informed than insurance companies about their risk class.

Adverse selection problems might plague private markets for health insurance. If insurance companies cannot perfectly observe the risk of ill health for individuals as well as the individuals themselves can, they cannot tailor insurance policies efficiently. Private insurance markets will at best be inefficient, at worst unstable. Whether or not adverse selection is a quantitatively significant problem is an open question. In the case of health care, it is certainly conceivable

that insurance companies can make themselves as well informed as persons seeking insurance. Indeed, this ability may well increase dramatically to the extent that DNA profiling becomes possible.

As in the case of moral hazard, however, it is not obvious that the government can do better than private markets. It is not likely to be better informed than insurance companies. The one possible form of intervention that might improve efficiency is to mandate compulsory insurance coverage. This at least avoids the problem of unstable insurance markets that never reach equilibrium outcomes. However, as in the case of automobile insurance, there is no particular reason why the mandatory insurance provided must be public rather than private.

It should be pointed out that from a pure efficiency point of view, the fact that persons are in different risk classes is itself not relevant. A fully efficient health insurance scheme would be one that charged higher premiums to those who are at greater risk of becoming ill. Indeed, there may be some persons who are virtually uninsurable because of their level of risk. And, those who are more at risk may well have fewer resources with which to purchase insurance.

In fact, it may well be that insurance companies can end up doing too much sorting of households by risk class, the opposite of an adverse selection problem. This might occur to the extent that insurance is for a limited term. Thus, after households incur an illness, it will be in the interests of the insurance company to change the terms of a policy once it comes up for renewal. If insurance policies are not long-lasting, persons who become ill may subsequently be uninsurable. To the extent that this occurs, insurance might be considered inefficient from an ex ante point of view since individuals are unable to insure themselves fully against all future health contingencies (Cutler 2002). One might have thought that markets would take care of this problem by offering very long-term insurance contracts. But insurance companies may be unable to do so because of the uncertainties that exist about future medical technologies and costs. It might be argued that the prevalence of occupational health insurance plans is a partial response to this problem, since they offer more permanent protection to employees who become ill. A full response might involve public provision, which effectively pools all risk types together whether they are privately insurable or not.

In fact, the case for public insurance based on the uninsurability of households that have become ill in the past is basically the same as the social insurance rationale for public insurance discussed below. Whether it is considered an efficiency or an equity rationale is an open question. In our discussion,

we treat it as an equity rationale.

If moral hazard and adverse selection do not point to an efficiency case for public intervention, other considerations do raise relevant concerns.

Asymmetric Information and the Monopoly Power of Health Care Providers

Another form of asymmetric information is more relevant for the health care sector, and that is the imbalance among service providers, clients, and those financing health care. A significant feature of health care is that the providers are typically much better informed than the individuals being served or the institutions doing the insuring. Their skills ensure that they have effective control over the supply of health care. Moreover, in many cases, health professionals have collective control over the supply of their numbers as well as over other aspects of their behaviour (training, discipline, and remuneration). A substantial proportion of the costs of training health care professionals is either directly or indirectly borne by the public sector. These facts suggest that some collectivization of the demand or financing side is called for as a counterweight. In the absence of such collectivization, suppliers of health care would effectively be in a nearmonopoly position, with the result that market prices would be excessive and supply inadequate.

In fact, some of this tendency to monopolization might be countered by the existence of large insurance companies, but that possibility gives rise to a category of problems considered next. The desire to have a collective institution acting as a counterweight to the inevitable existence of monopoly on the supply side of health care constitutes an argument for the single-payer system of financing health care. A single payer serves to ensure that the monopoly power of suppliers is not exploited by excessive prices for health care services and costs of health care professionals, which constitute the bulk of the costs of health care. Moreover, the obvious choice of a single payer is the public sector. The alternative would be to create a private monopoly representing suppliers, and that would have its own disadvantages.

Economies of Scale, Administrative Costs, and Cost Control

Economies of scale constitute another source of monopolistic tendency in addition to the information advantages just discussed. In industries character-

ized by economies of scale, it is hard to maintain the amount of competition required to generate an efficient allocation of resources. In such circumstances, governments might intervene by public ownership or by regulation in an effort to avoid the monopolistic tendencies that would otherwise arise. However, it is hard to maintain that scale is a determining issue in the health sector, since health services are typically delivered to individuals by small units such as doctors' practices and hospitals. The most likely candidates for non-competitive behaviour arising from economies of scale might be insurance companies. These must be large enough to be able to diversify insurance risks, so scale is obviously important to them. But a number of insurance companies offer supplementary health insurance plans at the moment, and entry into the industry is open. Given that the products they provide are reasonably close substitutes, it does not take a large number of firms to ensure competitiveness. Moreover, even if scale were a problem, it is not clear that public provision would be the best policy response.

Administrative costs, however, do represent a more compelling argument for a public role. There is evidence from the United States that the purely administrative costs of using private insurance as the primary means of financing health care are very high as a proportion of health care expenditures. There may be various reasons for this. One is that private insurers might be willing to incur costs of advertising and other measures to diversify their products in a world where products are otherwise very similar. Private insurance might lead to more litigation, with the ensuing costs of settling claims. Administrative costs are imposed on doctors and hospitals who must deal with several insurance companies. There are also costs associated with acquiring the kind of detailed information that is necessarily involved in providing insurance, as well as various legal costs. These considerations suggest that there may be significant economies to be gained from single-payer systems. Given that, there are also advantages in the single payer being the public sector in order to avoid the obvious disadvantages of a monopoly private insurer.

Finally, many analysts contend that a single-payer system provides for more effective cost control in health care for reasons that go beyond administrative costs and countering the potential monopoly power of health providers. It is often argued that, in the context of multiple payers in health services, attempts to contain health spending in one area simply shift the pressures elsewhere in the system, much as when a balloon, squeezed at one end, expands at the other. This tendency for cost containment to be weakened by cost shifting has been discussed extensively in the United States, where efforts to contain costs in public

programs such as Medicare and Medicaid led providers such as hospitals to transfer more of the costs to private insurers. In contrast, a single-payer model provides more powerful levers of cost control. Canadian provinces approximate the single-payer model, and when they sought to limit their costs, especially between 1992 and 1997, service providers were left with nowhere to shift their costs. Presumably, more effective cost containment contributes to efficiency in a wider sense by containing pressures for upward movement in the taxes associated with health care.

#### Externalities and Public Goods

Many forms of health services have an aspect of public good or externality to them. Control of communicable disease is an obvious example. Others include sanitation, health safety regulation, water quality, and air quality. The provision of health-related information constitutes a health service in a broader sense. Examples include information regarding healthy activities and health promotion measures. In all of these cases, private provision would be inefficient because of the free-rider problem. There seems to be little dispute about the rationale for government intervention in these cases, although the form of the intervention may be in dispute (witness the debate over privatization of water provision and regulation).

#### Summarizing the Efficiency Case

In summary, there is an efficiency case for government intervention in the health care field. This case does not depend primarily on moral hazard, adverse selection, or economies of scale. Although moral hazard and adverse selection may well be present in the health sector, the public sector is not likely to be able to overcome the informational problems that give rise to these phenomena. At best, there might be arguments for mandatory health insurance, which might be provided either privately or publicly, to overcome the consequences of adverse selection. Nor are there arguments based on economies of scale. However, there are efficiency arguments for a single-payer system, to avoid what seem to be excessive administrative costs of operating private health insurance, to balance the collective organizations representing health care professionals, and to enhance the capacity for effective cost control. There is also a strong case for public intervention in areas of public health, public safety, and public information.

While the efficiency case for public intervention is important, it is sub-

ject to two qualifications. First, although the failures of the private sector constitute a necessary prerequisite for state intervention, they are not sufficient. There may be shortcomings in public sector solutions as well. We have already referred to the fact that the government may be no better informed than the private sector and therefore may not be able to overcome moral hazard and adverse selection any better. In addition, there may be various sources of failure that temper the case for government intervention. One source of failure is that the public sector may be prone to its own forms of inefficiency. Since it does not have the discipline of competition, it is argued that there are not the same incentives for cost effectiveness that exist in the private sector. This constitutes a caveat that might be set against the advantages of a public single-payer system. However, there are some substitute devices that may be used to enhance public sector efficiency. One that is relevant in federations is decentralization, which may induce forms of political competition conducive to efficiency. A second is the use of the private sector to supply services even where they are being financed publicly. There may also be various ways of enhancing the accountability of public health care, such as the provision of full information to the public and the use of public audits.

Second, while these efficiency arguments are important, they may not seem sufficient, on their own, to justify fully the kinds of state intervention that one observes in almost all OECD countries (with the major exception of the United States), the most apparent of which is the provision of more or less universal coverage of basic medical and hospital services. This is an outcome that goes beyond a single-payer system and the provision of public health. It generates a much different allocation of health services to individuals than the market system would entail. The case for this type of approach must be based on considerations other than economic efficiency, to which we now turn.

# Redistributive Equity, Social Justice, and Sharing

Much of government policy is concerned with redistribution in favour of those who are deemed to be deserving or in need. Modern redistribution theory posits that individuals differ in a variety of characteristics, all of which affect the outcomes they face in the market economy. A distinction is often made between those characteristics for which differences ought to be compensated – the "principle of compensation" – and those for which the individual is deemed responsible – the "principle of responsibility" (Roemer 1998). In the latter category one might

include individual preferences, such as the taste for leisure, the choice of automobiles, smoking, and the like. In the former category, one would include differences in income-earning ability, inherited wealth, and, more relevant for our purposes, differences in health status that are not fully under the control of the individual. Ideally, governments might be willing to compensate fully for differences over which the individual has no control, but not for differences that result from individual decisions, although in practice the two may not be perfectly distinguishable.

Debates about redistribution in the health sector are conditioned by two critical characteristics that set many forms of health care aside from other products and services. First, the need for health care is typically uncertain, or risky: it is only needed in the event of ill health. Second, the risk of ill health is unevenly distributed among the population as a whole. Markets can often be established to pool or share risk among members of the population at large, especially when outcomes are randomly distributed among the population. However, risks of ill health are not always insurable on the same terms among different members of the population. Some persons have a systematically higher risk of illness than others. Private insurance companies would offer appropriately different terms to persons with different levels of insurability, and those with a higher risk of illness could only be insured at much higher costs. Indeed, some may be virtually uninsurable in the sense that the chances of their falling ill are very high. Moreover, one's insurability can change over time as one's risk of illness varies. A person who acquires heart disease is unlikely to be able to purchase health insurance easily after that fact becomes known. Thus, the extent of insurability depends upon the extent to which one's susceptibility to ill health is already known. The extreme case of this change in insurability occurs at birth, since one is typically born with particular health characteristics, making some persons more insurable than others. However, one's insurability at birth is in some sense a matter of luck: some persons are born luckier than others.

The institution of social insurance is used to capture and offset this kind of luck. Social insurance is the term used by economists for schemes that compensate persons for bad luck even if it arises in an uninsurable form, as in the case of differing degrees of illness insurability. The notion that individuals ought to be compensated for their inherent difference in health status is a normative principle which incorporates a value judgment that not all will accept. However, it is a principle that is consistent with the observed tendency of governments to redistribute extensively through the health care system.

It is important to note that the meaning of social insurance as it is used

here in the economic sense differs from that used in some other contexts, including legal ones. The key feature that makes it social rather than private insurance is that payouts are conditioned mainly by need rather than by purely actuarial, or insurance profitability, principles. In a sense, social insurance requires that the relevant risks be pooled across society as a whole, whether its members are insurable or not. Moreover, there is no need for social insurance to be financed by contributions, or if it is, for contributions to bear a close relation to expected benefits. On the contrary, full redistributive equity is better achieved if the system is financed out of general revenues. This differs from the definition of social insurance in constitutional jurisprudence discussed in the last section, which conceived of social insurance more narrowly as insurance delivered by the public sector but having important characteristics normally associated with private insurance. In that context, social insurance refers to public schemes in which there is some relation between contributions and expected benefits, albeit not necessarily fully actuarial (Myles and Pierson 1997). Contributors acquire an entitlement to some level of benefits in the future, as in unemployment insurance or public pensions such as the Canada and Quebec Pension Plans. As we saw, the challenge to the constitutionality of federal programs in these two areas in the 1930s turned in large part on their contributory nature. This is of more than pedantic relevance to the issues at hand. If schemes that are social insurance in the economic sense but are financed out of general revenues are not considered to be social insurance in a legal sense, the federal government might have wider latitude to implement them without running afoul of the constitution.

Even if one accepts the economist's notion of social insurance, its implementation is not straightforward. As with differences in productive ability, differences in health status – and therefore differences in illness insurability – cannot be readily observed by government. If they could be, transfers could be made contingent on health status to compensate different persons for differences in private insurability. These would be sufficient to allow everyone to buy full coverage of basic insurance at actuarial rates. However, with health status unobservable, any compensation scheme must rely on actual usage of the health care system, which points to a larger role for public health insurance.

Several points should be noted about the sort of coverage that would be appropriate under a system motivated by social insurance rather than simply by efficiency:

> Since the idea of social insurance is to compensate persons, regardless of

their means, for differences in health status, basic forms of health care would be available universally to all persons. This would be like a universal pooling insurance scheme available equally to all individuals but also financed out of a common pool of general revenues that is structured with ability to pay (vertical equity) taken into account. This pooling can equivalently be viewed, along with other schemes of redistribution, as a form of *community sharing*. All members of the relevant community are treated uniformly by the social insurance system. What "relevant community" means is important in a federal context, and we shall return to that issue in the next section.

- > The pattern of health expenditures across households would be far different from that found under a private insurance scheme. In particular, there would be a significant redistributive component implicit in the health care system (except in the very unlikely event that there was a perfect negative correlation between higher incomes and good health status). Lower-income households would obtain much higher benefits from the system than they could pay for or would be willing to pay for on the private market, and vice versa for higher-income persons. However, there would also be implicit redistribution among individuals within income groups since some would have better health characteristics than others. The point is that an income tax transfer system could not possibly be relied on to compensate deserving persons, given the inability of governments to target those with a higher risk of illness.<sup>6</sup>
- > This inability in turn implies that the private sector could not be left to itself to provide social insurance. In principle, the public sector could fund the provision of basic health services through its general revenue-raising system and still allow the health services to be provided in a regulated manner by private providers. But, even in this case, there is no real role for private insurers, since the government does the financing out of general revenues. Notice that a social insurance system is effectively a single-payer system, so would capture some of the advantages of such systems noted in the previous discussion.
- > A system of social insurance does not get around incentive problems, which arise precisely because individual health characteristics and behaviour cannot be perfectly monitored. The presence of possibly adverse incentive effects gives rise to an efficiency/equity trade-off that

might be addressed, for example, by user fees. A concern with user fees is that they would be a deterrent to lower-income households, and therefore violate the principle of social insurance unless they were somehow geared to income.

> The logic of social insurance itself does not reject a dual private/public system. As long as a public system is financed out of general revenues and makes health services uniformly available, the co-existence of a private system serving those who wish to opt out is not inconsistent with the principles of social insurance. Arguments to the contrary stem from judgments of political feasibility and the sustainability of a public system in the face of a parallel private one. Studies suggest that increases in private funding are associated with declines, over time, in allocation of public funds to health care (Flood, Stabile, and Tuohy 2002).

While the equity or social justice arguments are based on social insurance or community sharing, other related normative objectives are also relevant in the health context. One is equality of opportunity. In contrast with the standard notion of vertical equity, which concentrates on equalizing ex post market outcomes, equality of opportunity refers to equalizing the ex ante position of persons - equalizing the ability of different households to participate in the economic and social life of society. Good health, like education, contributes to this objective. Another social justice argument is economic security, which refers to offsetting the effects of unanticipated changes in one's economic circumstances. To the extent that ill health affects economic outcomes through lost productivity, health care contributes to economic security. This benefit is obviously of the same class of concerns as social insurance itself. Health care might also be seen as an important dimension of intergenerational equity. To the extent that there are arguments for redistributing from the current working generations to the elderly, the provision of health to the latter may be a particularly attractive means of making the transfer in a way that targets the most needy. Thus, even in the United States, where public health insurance is generally not available, it is available to retirees.

Finally, there is an argument, referred to as the Samaritan's dilemma (Buchanan 1975), which can be used to justify state intervention in insurance-type markets. The argument is that persons who expect to be cared for in the future will have less incentive to take measures to ensure their future well-being. Thus, they may acquire too little insurance, take too little care of themselves, engage in excessively risky activities, save too little for retirement, and undertake

too little training. Government for its part is the Samaritan: it cannot help helping those in need in the future. Economists refer to this as the problem of time inconsistency. It has been used as an argument for state intervention in pensions, automobile insurance, unemployment insurance, and even education (Boadway and Keen 2000). It might also have some contributing relevance to state intervention in health insurance. If individuals do not insure themselves, in anticipation that they will be cared for by society in the event of major illness, the state might improve matters by instituting mandatory health insurance.

In weighing these various considerations of redistributive equity or social justice, however, the one based on social insurance seems to be the most convincing.

# Summarizing the Case for a Public Role in Health Care

The case for a public role in the health sector is thus rooted in both efficiency and equity concerns. Efficiency considerations suggest that single-payer systems can reduce administrative costs, balance the collective organizations representing health care professionals, and strengthen the capacity to restrain the rate of growth in costs. Public action is also important to offset externalities in the field of public health. However, the scope and nature of government intervention in the health sector in most OECD countries, especially in the provision of health insurance, are also based heavily on concerns for equity and sharing. The most powerful rationale for state intervention in health care is based on the notion of social insurance. The core argument is that persons ought in principle to be compensated for differences in their risk of ill health, over which they have no control. This constitutes a form of community sharing, and in the final analysis, the equity argument for a public role depends on a collective sense of responsibility of citizens for each other.

It is worth re-emphasizing that the legitimacy of the social insurance role of government relies on acceptance of the values underlying it. Not surprisingly, therefore, debates over the appropriate role of public health policies are often controversial, and the level of consensus among the population is critical. Lack of unanimous consensus is a typical feature of redistributive policies. This is not just a matter of conflicting individual interests, but more importantly one of conflicting conceptions of the public interest. Some fear that policy will be determined more by special interests than by a broad consensus on the public interest. This problem has no easy remedy, and there will be those who take a

more cynical view of government, and use it to argue against state intervention in health care. In the end, however, one must accept the legitimacy of decisions taken through our democratic institutions.

Recognition of the complex nature of the case for a public role in health care — and of the importance of a commitment to community sharing — is essential when considering the division of responsibilities for health care between federal and provincial governments. It is to this second dimension of choice that we now turn.

## DEFINING THE SHARING COMMUNITY IN A FEDERATION

eciding on the appropriate role for the state in the provision of health care is only the first step in mapping the public sector role in the area. The next dimension of choice concerns how the public role should be divided between different levels of government. Although this step faces all countries, it takes on a special significance in federal states, where constitutional authority is formally divided between federal and provincial or territorial governments.

We have seen in the previous section the part that equity and efficiency considerations play in staking out a role for the state. In a federation, these values take on an additional dimension. Given our earlier conclusion that it is equity — or, equivalently, social insurance and sharing — that supports the sort of comprehensive public health insurance systems found in most OECD countries, we begin with that value. Efficiency considerations, which condition the appropriate type and design of policy instruments, are taken up subsequently. Our aim is to consider the additional issues that arise in applying these values in a federal context, where citizens are simultaneously members of a province or territory and the national community.

## Redistributive Equity and the Sharing Community

As we have seen, a commitment to the principle of social insurance depends on an underlying sense of shared responsibility of individuals for each other. However, this leaves open the question of the precise dimensions of the community within which sharing takes place.

Every country must define for itself the community within which shar-

ing takes place and decisions about the extent of that sharing are made. In a unitary nation, one presumes that a common standard of redistributive equity applies for all citizens across the country, there being no particular reason to discriminate against citizens in one region as opposed to those in another. To use the terminology of economics, both horizontal and vertical equity ought to apply. Persons who are in like circumstances with respect to the characteristics being compensated ought to be treated identically, no matter where they reside. Common standards of sharing apply nationwide, and the broad policy framework is set by the national government.

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 relevant community for sharing purposes can apply along a spectrum that spans two extreme possibilities. At one extreme, the entire country can be viewed as the relevant sharing community. We refer to this as the exclusively countrywide sharing case. In this case, redistributive equity would apply nationwide as in a unitary state, and decisions about the extent of that redistribution would be made by the political representatives of the country as a whole. The objective of redistributive or social insurance policies would be to compensate persons for differences in insurability by the same amount regardless of their province of residence. That is, horizontal equity would apply across the entire country: persons who are otherwise identical but reside in different provinces would receive identical treatment with respect to redistributive policies. In practice, there may be reasons why horizontal equity cannot be fully achieved, such as inequities that might arise if it is much more costly to provide relevant services in, say, distant locations or small centres. But that would not detract from the fact that, in principle, the sharing community is considered to be the country as a whole. The extent of redistribution from the more to the less advantaged, that is, the degree of vertical equity pursued, would depend upon the national political consensus about the amount of compensation for individual circumstances that is appropriate.

At the other extreme, the *exclusively provincial* sharing case, one might think of the province as being the sharing community. According to this view, redistribution occurs mainly among residents in each province. The extent of vertical redistribution and the concept of horizontally equitable treatment would both apply at the provincial level, and each provincial gov-

ernment would define the scope of redistribution separately. It is clear that if this were the case, there would be considerable variation among provinces. Different provinces have very different fiscal capacities for achieving redistributive goals: they have different demographic and geographic make-ups; and their citizens may well reach different consensuses about the appropriate degree of sharing. In this case, unlike that of a countrywide sharing community, horizontal equity would not apply across the country: otherwise identical persons would contribute different amounts or receive different benefits from the public sector (provincial and federal governments taken together). Moreover, the degree of vertical redistribution could vary significantly from province to province.

The exclusively countrywide and the exclusively provincial sharing communities are the two extreme cases of possible sharing communities in a federation. We can virtually rule both cases out as being irrelevant for the Canadian federation. The exclusively countrywide case would be incompatible with any provincial differences in standards of redistribution and therefore seems inconsistent with the constitutional and political realities of Canada. The exclusively provincial case would rule out any role of the federal government in redistributive equity, including that related to its commitment to equalization as well as that achieved by its access to redistributive taxes and transfers. It is necessary, therefore, to consider cases in which the two sharing communities coexist, with some degree of countrywide sharing coexisting with different degrees of sharing within provinces. Indeed, one might argue that this coexistence is the nature of a federation. Countrywide sharing would reflect the idea that citizenship in a country entails some expectation of comparable treatment in redistributive policies. But the federation itself is made up of separate provincial communities, some of which might have greater feelings of provincial solidarity than others. giving rise to asymmetries in redistributive policies.

The envisioned role of the federal government will be affected by what one considers to be the relative importance of the entire country versus the province as the primary sharing community. In this context, it is useful to distinguish three versions of the relevant sharing community along the spectrum of possibilities. In all cases, the fact of countrywide sharing implies that there is interprovincial redistribution. These models differ in the extent to which common interpersonal redistribution policies apply across provinces.

### 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 or social justice in national terms. In this version, all citizens enjoy a form of social citizenship; that is, they enjoy comparable social benefits no matter in which province they reside. As the British sociologist T.H. Marshall noted, the development of a social dimension to citizenship represented a pervasive trend across Western democracies during the twentieth century (Marshall 1950). In previous centuries, citizenship had come to embrace civil rights and political rights such as the right to vote. During the twentieth century, a social dimension was added, by creating social rights and obligations that individuals enjoyed not on the basis of their class, religion, language, or place of residence, but by virtue of their common status as citizens. Stripped to its essentials, social citizenship implies that a sick baby at one end of the country is entitled to medical care on the same terms and conditions as a sick baby at the other end of the country.

This vision of countrywide sharing implies that political representatives from across the country as a whole establish a conception of social benefits. Putting it into place requires both full fiscal redistribution between provinces, and strong, detailed countrywide standards with respect to the kinds of services and redistribution policies that should be available in all provinces. Comparable standards of vertical equity would apply, which implies that horizontal equity would apply nationwide. This version of sharing may well apply to some elements of social policy but not others. That is, there may be a consensus that Canada-wide standards should apply to some social insurance programs like health care and unemployment insurance — because equal compensation for different fortunes in one's health or employment status may be valued for citizens in all provinces — whereas different standards may be tolerated across provinces for, say, income redistribution programs such as welfare and redistributive taxation.

## Predominantly Provincial Sharing

The predominantly provincial version of the sharing community represents the least amount of countrywide sharing among our feasible options. It leaves full scope for provincial governments to chart distinctive approaches to vertical redistribution. Countrywide sharing in this case is limited to redistributing among provinces so that all provinces have the potential to provide comparable overall levels of public services and redistributive equity, if they so

choose. To use the terminology of the economics of fiscal federalism, interprovincial transfers should be such that average net fiscal benefits are equalized across provinces. At the same time, full horizontal equity would not necessarily apply — net fiscal benefits would not be equalized for each and every type of individual residing in different provinces. Some provinces might legislate higher degrees of redistribution than others. However, the system of intergovernmental transfers would ensure that each province has the potential to provide comparable net fiscal benefits to all its residents.

This version of the sharing community corresponds with the principles that underlie the current equalization system. That system involves transfers to provinces with lower revenue-raising capacities so as to enable them to raise some minimum national standard of tax revenues per capita at national average tax rates. More generally, and with health programs in mind, a system of interprovincial equalizing transfers that redistributes among provinces in a way that fully reflects provincial differences in both revenue-raising capacity and need would satisfy this version of the sharing community.

## The Dual Sharing Community

These two versions of the sharing community serve as useful benchmarks, but obviously they do not exhaust the possibilities. One might think of there being a continuum of views along the spectrum from predominantly Canada-wide to predominantly provincial sharing. It is natural to think of the latter version as being the lower limit of the spectrum because the Canadian constitution sets out as a principle the federal government's commitment to equalization, using wording that roughly corresponds with our definition of the predominantly provincial version of the sharing community. For some, however, this position on the spectrum does not leave enough room for Canadians to decide collectively to establish a common approach to social benefits that reflects a sense of social solidarity spanning the country as a whole. For others, the end of the spectrum represented by predominantly Canada-wide sharing seems to require redistribution standards resembling those one might expect in a unitary state, and to give too little scope to the regional diversities that also define Canada. Not surprisingly, much effort has been devoted to finding an intermediate position on the spectrum which balances the community of all citizens and the diversity of regional communities. One such intermediate position would involve a countrywide framework that defines some basic parameters of major

social programs including health care but leaves room for provincial variation in program design and delivery mechanisms that are consistent with the framework. According to this intermediate position, which might be labelled the *dual sharing community* or a modified form of social citizenship, citizens across the country are assured of comparable, as opposed to identical, health care services.

The range of potential options is increased further by the possibility that the balance in the strength of attachment to the countrywide and provincial sharing communities might differ across the country. While much of the country might prefer the dual sharing model, for example, one region might prefer the predominantly Canada-wide sharing and another the predominantly provincial sharing model. The possibility of regional differences in the sense of attachment to community raises the possibility of asymmetrical relationships between the federal and provincial governments in a federation. To make the analysis manageable, this chapter focuses primary on the three primary conceptions of the sharing community: predominantly Canada-wide, dual, and predominantly provincial. Nevertheless, in practice, the possibility of combining different models in different parts of the same federal state is a real one.

In summary, where the federation situates itself along the spectrum will affect the role of the federal government and the design of policy instruments for effecting that role. Such choices ultimately reflect the underlying sense of community in the federation as well as the social context within which individuals feel a shared sense of obligation for each other's well-being.

## Examples of Federal Sharing Communities: A Comparative View

Interestingly, most federations give substantial weight, in practice, to the idea of countrywide sharing in the area of health policy. Almost all federal states choose to engage both the central government and the provincial or state governments in health care (Banting and Corbett 2002). In this sense, multi-level governance in health care is not simply a Canadian pattern: it represents the norm among federal countries generally. However, federal countries tend to organize themselves so as to achieve significant countrywide sharing. Typically, legislation passed by the central government sets a general policy framework that defines key parameters of the health care system for the country as a whole. In many federal countries, the central government also administers important health care programs itself, dealing directly with citizens and service providers.

Moreover, where state or provincial governments manage parts of the system, they typically operate within broad parameters defined for the country as a whole, and normally rely for a substantial portion of their financing on transfers from the central government, transfers which incorporate a significant element of interregional redistribution.

Although the relative balance between levels of government does differ significantly from one federation to another, the central government in most major federations plays a much larger role than in Canada. For example:

- > In Belgium and Germany, the policy parameters are defined in a highly centralized and corporatist process. The federal legislature incorporates the resulting agreements in framework legislation that specifies in detail key features of the system for the country as a whole. Program delivery then proceeds on a decentralized basis through networks of social funds.
- > In Australia, the Commonwealth government plays the dominant role in two ways. First, it takes direct responsibility for major parts of the Medicare system, providing for access to doctors, pharmaceuticals, and nursing homes through programs that are administered by federal agencies operating on similar terms and conditions across the entire country. Second, it provides a special-purpose transfer to state governments to support public hospital care, and attaches highly detailed requirements concerning targets and auditing, with which states must comply. The result is a national health care system that operates on a similar basis across the country as a whole.
- > In the United States, public health programs present a bipolar case. Medicare, which covers elderly and disabled Americans and represents two-thirds of total public health expenditures, is a purely federal program. Congress determines the basic policies, and a federal agency delivers the program across the country as a whole. The federal government also provides significant health services directly to military personnel and veterans. Support for poor Americans, however, demonstrates a sharp contrast. Medicaid and the State Child Health Insurance Program are federal-state programs supported by federal conditional grant programs. Federal conditions are very general, and state programs vary considerably in eligibility, service coverage, utilization limits, provider payment policies, and spending per recipient.

Overall, federal states have tended to approach a countrywide sharing community in health care, such that a sick child in one region receives heath care on comparable terms and conditions as a sick child in another region. The one partial exception among the four major federations surveyed here concerns coverage for poor American families and children. Otherwise, the primary form of territorial variation in health services in federations tends to be urban/rural differences rather regional differences, as is the case in unitary states. That is, differences between urban and rural areas within regions tend to be much greater than differences between regions.

## Defining the Sharing Community in Canada

How do Canadians think of the sharing community in areas such as health care? Canadians live in a set of overlapping sharing communities that are defined by their family and personal relations, their ethnic and religious backgrounds, the languages they speak, and the local, provincial and federal arenas in which they conduct their political life. In thinking about assigning the public role in health care within the federation, we have observed that it is the relative strength of the citizens' attachments to regional and pan-Canadian political communities that is critical. Are citizens more strongly attached to their local and regional communities, and do they seek to manage public programs that matter to them at those levels? Or are they strongly committed to the pan-Canadian community, and do they wish to debate and define core public programs with fellow citizens from coast to coast?

Fortunately, we have evidence on these issues. Surveys of public attitudes and values confirm that Canadians have a sense of attachment or belonging to multiple communities, including both to Canada and to their province, and see no reason to choose definitively among them. Given their allegiances to both political communities, it is perhaps not surprising that Canadians want both levels of government involved in health care. Surveys regularly find that Canadians see health care as a countrywide program and overwhelmingly support the engagement of both levels of government in sustaining it. They endorse an active federal role, a preference that seems to have strengthened over the 1990s, and they expect the federal government to be involved in maintaining the system and ensuring standards. By wide margins, they want the federal and provincial governments to collaborate in the management of

the health care system, and they are uneasy about cuts in federal fiscal transfers to provinces. In addition, public attitudes toward the equalization program suggest reasonably strong support for the idea of pan-Canadian sharing. This commitment to a countrywide conception of health care and the engagement of both federal and provincial levels in defining and sustaining it suggests an underlying pan-Canadian sharing community, and is consistent with what we have termed a dual sharing community and a modified conception of social citizenship in health care.

This vision of a dual sharing community seems also to accord with the realities of social policy as conducted by the federal government and the provinces up to the present time. The provinces are largely responsible for legislating and delivering important public services in the areas of health, education, and welfare. At the same time, the federal government intervenes in a number of ways that lead to the achievement of reasonably comparable pan-Canadian standards of redistributive equity. The equalization program goes a long way toward giving provinces the potential to provide comparable levels of these public services using comparable tax rates. The dominant role of the federal government in the income tax system allows it to achieve reasonably uniform standards of vertical equity in after-tax incomes. This effect is reinforced by the fairly recent federal system of refundable tax credits, which extends national vertical equity standards to those with low levels of income. There is an even greater degree of national sharing for the unemployed and the elderly through the employment insurance system and the system of public pensions. Finally, elements of a countrywide framework in health care have always existed through the broad conditions that have been attached to the original cost-shared grants and more recent block grants for provincial health programs. Thus, there can be little doubt that Canada-wide sharing currently exists alongside the sharing that occurs within provinces through their redistributive programs.

In the specific case of health care, the Canada-wide framework is less elaborate than in other federations. The federal government does not provide health coverage directly to citizens generally; the conditions attached to intergovernmental transfers are less detailed; and the shift to block funding has largely eliminated day-to-day federal scrutiny of specific provincial decisions. In comparative terms, the Canadian health system is clearly more decentralized, and is best thought of as an interlocked series of provincial and territorial health care systems. 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, but interregional variation is greater than in the other federations discussed above.

There is some variation even in core hospital and physician services, which fall within the framework of the CHA. As noted earlier, the Act requires provinces to provide coverage for all medically necessary hospital and physicians' services, as well as all medically necessary surgical-dental services that require a hospital for proper delivery. However, provinces do vary at the margins in the range of services that are deemed medically necessary from one province to the next. Table 6 gives examples of services that are provided in some provinces but not others. There is also variation in the availability of doctors, nurses, and hospital beds provided across the country. It is worth noting, however, that decisions on these services reflect different provincial decisions about the delivery of health care services, rather than differences in the strength of provincial economies. Reading Tables 7 and 8 together illuminates this point. Table 7, which shows provincial per capita expenditures on health for selected years, suggests that the Maritime provinces and Quebec tend to spend less than the national average and

Table 6
UNCOVERED HEALTH SERVICES, BY PROVINCE

### Uncovered Service

Eye refractions

Eye examination (ages 19-64)
Otoplasty (ear plastic-surgery)
Gastroplasty (stomach-stapling)
Reversal of sterilization
Psychoanalysis
Wart and benign skin lesion removal
In-vitro fertilization
Chiropractic services

#### Province

PEI, NS, NB, Que, Man, Sask, Alta Nfld, PEI, NB, Ont, Alta NB, NS PEI, NS, NB, Ont, Man, Sask, Alta, BC Que, Man NS, NB, Ont, Man, Sask, Alta, BC Nfld, NS, Ont, Man Sask Nfld, Sask

Source: Standing Senate Committee on Social Affairs, Science and Technology, The Story So Far. Vol. 1 of The Health of Canadians: The Federal Role. Interim Report (Ottawa: Queen's Printer for Canada, March 2001), table 6.1, p. 99.

Table 7
PROVINCIAL GOVERNMENTS' PER CAPITA HEALTH EXPENDITURES, 1975-2001
(dollars)

		f										
		Nfld	PEI	NS	NB	Que	0nt	Man	Sask	Alta	ВС	Can
	1975	358	353	323	301	400	378	368	329	384	372	376 <sup>-</sup>
	1976	389	383	362	352	465	429	435	391	434	428	432
-	1977	413	419	398	391	508	462	479	435	451	465	468
ĺ	1981	684	679	670	677	805	689	755	727	816	842	752
	1986	1,060	1,026	1.031	1.047	1,150	1.165	1,163	1.189	1.364	1.147	1.169
	1991	1,483	1,454	1.461	1,477	1,585	1,719	1.611	1.653	1.633	1,652	1,645
	1996	1,650	1,563	1,413	1,637	1.590	1,681	1.694	1.605	1,469	1.848	1,652
	2001'	2,420	2,033	2,011	2,153	1,981	2,176	2,359	2,248	2,293	2,457	2,191

<sup>1</sup> Data for 2001 are forecasts.

Source: Canadian Institute for Health Information (CIHI), Statistics by topic - macro-spending, table 10.

Table 8
HEALTH SERVICES IN THE PROVINCES AND TERRITORIES, 1998

		Doctors per 1,000 Population	Registered Nurses per 1,000 Population	Acute-Care Hospital Beds per 1,000 Population
	Newfoundland	1.7	9.8	3.3
	Prince Edward Island	1.3	9.3	3.5 3.5
	Nova Scotia	1.9	9.1	3.5 3.6
	New Brunswick	1.5	9.9	3.6 3.9
	Quebec	2.1	7.7	3.9 3.7
	Ontario	1.8	6.9	3.1 2.2
	Manitoba	1.7	8.9	2.2 3.6
	Saskatchewan	1.5	8.2	3.9
	Alberta	1.6	7.5	3. <del>9</del> 2.2
	British Columbia	1.9	6.9	2.2
	Yukon	1.5	7.8	1.8
ĺ	Northwest Territories	0.9	7.8	3.9
1				

Source: A. Maioni. Health care in the new millenium, in H. Bakvis and G. Skogstad (eds.), Canadian Federalism: Performance, Effectiveness, and Legitimacy, (Oxford University Press, 2002), table 5.3, p. 97.

Table 9
PROPORTION OF THE POPULATION WITH DRUG INSURANCE COVERAGE

	Percent Covered
Newfoundland	65
Prince Edward Island	73
Nova Scotia	76
New Brunswick	67
Quebec	100
Ontario	100
Manitoba	100
Saskatchewan	100
Alberta	. 83
British Columbia	100
Canada	97

Source: Standing Senate Committee on Social Affairs, Science and Technology, Issues and Options. Vol. 4 of The Health of Canadians The Federal Role, Interim Report (Ottawa: Queen's Printer for Canada, September 2001), table 1, p. 75.

the rest of the provinces more. However, differences in the cost of providing services help explain part of this pattern. Table 8 suggests that, although there is considerable variation in the numbers of doctors, registered nurses, and acutecare hospital beds across the country, the differences are not rooted primarily in provincial income levels.

Much more substantial regional differences are evident, however, in services that fall beyond the ambit of the *Canada Health Act*, such as drug therapy outside of hospitals and homecare. Drug insurance differs widely 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. Table 9 shows the proportion of the population in each province that has drug coverage from public and/or private plans. Five provinces ensure 100 percent coverage by establishing programs that provide a minimum level of coverage for all residents. For example, in 1997 the Quebec government introduced a comparatively generous public drug plan that covers everyone who does not have access to private insurance. Alberta has a comparable plan, but participation is not mandatory and a significant minority have chosen not to join and thereby avoid the provincial premium. The Atlantic provinces are at the other extreme; there are no public drug

plans to cover the entire population in this part of the country, and private coverage also tends to be more restricted. In addition to such gaps in coverage, many more Canadians and their families are underinsured, in the sense that they can be placed in financial jeopardy by catastrophic drug costs.

Home care is a second area that varies greatly across the country. Although each province and territory offers some form of home care, there are major differences in eligibility, the proportion of those needing care who are covered, the range of services provided, and the level of user fees. All jurisdictions offer services such as assessment, nursing care, and home support for those they deem eligible. But only some provincial programs provide physiotherapy, speech therapy, and respiratory therapy (Standing Senate Committee 2001b, 81).

The importance of the CHA is highlighted by the greater regional differences in programs outside its scope. Nevertheless, current trends do pose important questions. When the countrywide framework was established in the postwar decades, hospital and physician services represented the core instruments in health care. Currently, however, drug therapies and home care are rapidly growing components of the sector. The fact that they also fall outside the CHA means that the pan-Canadian model of health care is more heavily modified with each passing year.

Canadians have long been committed to sharing, both within their regional communities and across the country as a whole, and they expect both levels of government to respond to important social needs such as health care. During the postwar era, Canada established its own version of a dual sharing community in health care, which took the form of reasonably comparable health services for all Canadians and represented an element of social solidarity across the country as a whole. However, it is important to recognize the limits of the Canadian approach here. In comparison with other federations, the Canadian system of health care is decentralized, and the Canadian model of sharing is more fragmented, especially outside the range of services covered by the CHA. Moreover, these limits are growing. The increasing role of health instruments that fall outside of the Act represents a quiet narrowing of social citizenship in Canada.

Every generation must judge anew the role of community sharing in the life of the country. There is no reason to assume that the postwar model should remain fixed in time. The growing importance of health instruments outside of the CHA raises questions about their possible inclusion, in some form, into a

dual sharing model. In addition, critics of the Act have challenged some of the components of the original model. Some have questioned the role of the principle of public administration. Others seek to revisit the role of financial charges at the point of service. Whether or not Canadians should create more space for private delivery of health services, or introduce fees at the point of delivery, goes beyond the scope of this paper, since these questions turn fundamentally on conceptions of the ideal health care system rather than on approaches to federalism and intergovernmental relations as such. Having said that, the dual community sharing that has animated Canadian health policy over the last half-century suggests that such decisions should be made on a countrywide basis, such that Canadians continue to enjoy access to reasonably comparable health services on similar terms and conditions from coast to coast.

## Efficiency in the Federation

Efficiency considerations also have implications for the federal-provincial/territorial role in health care. Two dimensions of our federal arrangements are particularly relevant here. The first is the balance between centralization and decentralization. As we shall see, efficiency concerns point in different directions on this issue. On the one hand, some efficiency concerns point in favour of decentralization, and many commentators advocate decentralization primarily on this basis. On the other hand, decentralization itself gives rise to potentially adverse efficiency effects that might justify a federal presence in certain programs, including health care. The second dimension of federal arrangements pertains to the nature of relations between the two orders of government. At any particular point on the continuum between centralization and decentralization, the nature of relations between the two levels of government can also raise questions, especially about the quality of accountability of governments to their electorates.

We begin by recounting the efficiency debates about centralization and decentralization, and then turn to the issues posed by the character of intergovernmental relations.

### Centralization/Decentralization

The arguments for decentralization of the provision of public services are well developed in the literature on fiscal federalism. Some of the more prominent ones are as follows:

> Catering to local preferences: Lower-level governments might be better

able to tailor the design of their programs to suit the preferences of local residents. Public programs provided by the national government will tend to be uniform across the country, representing a compromise across a more diverse range of interests and preferences. Provinces, on the other hand, will be able to differentiate their programs to reflect what might be unique provincial political consensuses.

- > Information advantages: Provincial and territorial governments are often seen as being "closer to the people," and therefore better informed about the preferences and needs of their residents. This will be especially important in the case of services delivered to individuals (including health services) that are to be targeted on the basis of need.
- > Administrative advantages: Provinces and territories may be more efficient at administering the delivery of public services to individuals and firms, as well as targeted transfers. These kinds of programs are ultimately delivered by institutions on the ground (welfare agencies and hospitals, for example), and the management of these institutions may be more effective at the provincial rather than the federal level. There will be fewer layers of bureaucracy, and control will be facilitated by management that is closer to the point of delivery. To use the terminology of economics, there will be fewer so-called agency problems involved in controlling these delivery institutions and ensuring that the incentives of program managers are aligned with the objectives of the government rather than with their self-interest.
- > Experimentation and innovation: To the extent that there are thirteen different provincial and territorial programs, the possibility of experimenting with program design and delivery will be enhanced. There will be more opportunities for provinces and territories to discover new ways of designing programs and to introduce completely new types of programs. This response-readiness is especially important in an area like health where new scientific and technical knowledge frequently becomes available, and public programs need to adapt to those changed circumstances. Experimentation at the provincial level also allows for trial and error that can lead to both successes and disappointments. It is more efficient to have disappointments occur on a small scale than at the national level. Successful initiatives can then be adopted across the country through provincial action or federal-provincial collaboration.

> Intergovernmental competition: Governments do not face the discipline of markets, which is the main engine of efficiency in the private sector. Some of the advantages of competition can be achieved through the political competition that is induced by decentralization. Governments implicitly compete with one another for mobile individuals and businesses. As well, citizens are better able to hold their governments to account if they can observe what is going on in neighbouring jurisdictions, a phenomenon that economists refer to as "yardstick competition."

In weighing these advantages of decentralized government, however, it is also important to consider a number of potentially adverse consequences of decentralization for nationwide efficiency. Addressing these negative consequences constitutes the efficiency case both for federal intervention and for a countrywide framework for policies that might be within provincial legislative jurisdiction.

There are three broad sorts of efficiency concerns that must be balanced against the advantages of decentralization. The first relates to efficiency in the "internal economic union." Decentralization can disrupt the internal economic union within a federation. It is generally agreed that economic resources should be allocated efficiently across a national economy, or what is often called the internal economic union. Efficient allocation is fostered by the free and undistorted flow of goods, services, capital, and labour across provincial borders. Unconstrained decentralized decision making can lead to distortions in these flows if provinces implement policies that favour their own residents over residents of other provinces (preferential procurement and hiring policies, fiscal measures that favour local firms or individuals, differential access to provincial public services, and discriminatory licensing policies, for example). Even if provincial policies are not intentionally discriminatory, the fact that provinces are designing their policies to suit their own needs may well give rise to distortions in the internal economic union. Provincial tax systems might differ, as may the structures of provincial public services. These problems are analogous to those that occur with respect to trade between countries, although they take on special importance in a federation that espouses the freedom of persons to take up residence and pursue a livelihood in any province.

The primary way in which the internal economic union is relevant to health care programs pertains to the mobility of individuals. The main requirement in regard to mobility is that health benefits be portable across provinces so that interprovincial movements of persons are not discouraged. There are various

ways in which this concern may be addressed. In some federations, constitutional provisions do not allow provinces to distort cross-border flows or discriminate against non-residents. The Canadian constitution, however, gives relatively little guidance in this regard. A second mechanism for ensuring portability might be negotiated intergovernmental agreements. The Agreement on Internal Trade is a wide-ranging document that is intended to serve this purpose, but it has relatively weak dispute settlement provisions. The third means of tackling the issue is for the federal government to act as the guarantor of efficiency in the internal economic union. Given the structure of the Canadian constitution, the use of conditional transfers (the spending power) is the only realistic instrument that the federal government can bend to this purpose. It has been used to induce mobility provisions in provincial social programs, including the portability provisions of the Canada Health Act.

A second source of inefficiency in a decentralized federation arises because decisions taken in one province result in spillover benefits or costs to other provinces and their residents. These can take many forms. Changes in tax rates can induce interprovincial migration of tax bases, with the result that provinces compete by lowering tax rates and possibly also degrees of progressivity to attract high-income residents and businesses. By the same token, transfers to the less well-off and other social programs may be eroded as provinces engage in a "race to the bottom." More generally, in some cases, some of the benefits of provincial programs might accrue to residents in other provinces. This scenario constitutes the classical argument for conditional grants as a means of inducing provinces to take account of the full benefits of their programs when deciding on levels of expenditure.

The potentially adverse effects of tax competition are difficult to avoid. They are often used in the fiscal federalism literature as an argument for restricting the amount of revenue-raising responsibility assigned to provinces, especially for mobile tax bases. The fact that virtually all federations are characterized by sizable vertical fiscal gaps can be attributed to the predicted consequences of tax competition.

On the expenditure side, fiscal competition has both beneficial and detrimental effects. As we have seen, some amount of fiscal competition can be useful as a means of inducing provincial governments and their bureaucracies to be more efficient. On the down side, vigorous fiscal competition can reduce the size of programs and detract from the amount of sharing through social programs that might otherwise exist. A case can be made for using the spending power to

prevent the worst effects of fiscal competition on the quality of social programs, including those in the provincial health sector, from occurring.

The third broad source of inefficiency results from "fiscally induced migration." As noted earlier, fiscal decentralization generally gives rise to differences in the ability of provinces to provide comparable levels of public services to their citizens. Provinces will have differing revenue-raising abilities, and will have different needs for public service expenditures because of the different demographic mixes of their populations. In a unitary state, the national government will typically provide common levels of public services across the nation and will finance them through a common tax structure. As a result, persons of like circumstances who are residing in like communities in different regions will have access to comparable public services and will pay comparable taxes; that is, they will receive similar net fiscal benefits (NFBs) from the national government.

This will no longer be the case in a federation in which major services are decentralized to the provincial level. Residents in provinces with high revenue-raising capacities or lower needs will typically obtain systematically higher NFBs. The consequences of systematic differences in NFBs across provinces are well known. On the one hand, they provide a purely fiscal incentive for persons and businesses to migrate to provinces with higher NFBs. This fiscally induced migration will lead to a situation in which too many resources settle in provinces with high NFBs. At the same time, to the extent that people are not mobile, otherwise identical persons living in two different provinces will obtain different NFBs from their provincial governments, leading to a violation of horizontal equity, as discussed above.

The health sector seems particularly susceptible to fiscally induced migration. Access to quality health care is a powerful motivator for people, especially those with serious illnesses. In a regionally varied health care system, people with a serious illness for which they lacked adequate coverage where they lived would have a real incentive to move to a province that provided much fuller coverage for their problem. A similar calculus would presumably also affect retirement decisions.

These efficiency problems would be avoided or muted by federal interventions that were consistent with either the predominantly Canada-wide or the predominantly provincial version of the sharing community. The former approach, which defines a common set of social benefits and obligations for citizens across the country as a whole, avoids the problem fully. In the case

of the predominantly provincial sharing community the problem can be addressed by an appropriate system of intergovernmental equalization transfers. By undoing the source of NFB differentials, these transfers will enable different provinces to have the ability to provide "reasonably comparable levels of public services at reasonably comparable levels of taxation," to use the constitutional phraseology. Almost all federations (with the notable exception of the United States) have in place a system of equalization payments for this very purpose.<sup>10</sup>

Health programs are clearly of the sort that might give rise to NFB differentials across provinces. They are financed mainly out of provincial general revenues, and their benefits are intended to be available without distinction of income level. In the absence of intergovernmental equalizing transfers (including both equalization and the CHST), provinces with lower revenue-raising capacities would not be able to provide the same level of health services without substantially higher tax rates. Both the equalization system and the CHST serve to make it possible for all provinces to raise some minimum standard of revenues at given tax rates. At the same time, no program takes into account the differences in needs among provinces. In the case of health programs, provinces with more aged populations will have higher needs for health expenditures simply because health care costs rise with age. In principle, it is possible to incorporate needs into federal-provincial transfer systems, as can be seen in federations elsewhere (for example, Australia and South Africa).

In contrast to the predominantly Canada-wide version of the sharing community, NFB differentials will not be eliminated entirely by a system of equalizing transfers. At best, an equalization system can provide provinces with the potential for eliminating NFB differentials. If provinces have the opportunity to design their public services according to their own preferences, they may well choose programs with very different features. Such differences would pose a challenge to Canada-wide sharing, and the challenge would be exacerbated to the extent that fiscal competition itself reduces the extent of provincial sharing. But the level of interprovincial differences that would likely emerge under the predominantly provincial version of the sharing community is unlikely to pose a serious problem. The differences in NFBs that might arise from differences in provincial program structure are unlikely to be sufficient to generate substantial migration responses.

## Intergovernmental Relations and Efficiency

In addition to establishing a balance between centralization and decentralization, federal states must also define the character of relationships between the two levels of government. The nature of intergovernmental relations can also have important implications for the efficiency of public policies. Observers have long argued that federal-provincial relations can generate inefficient incentive structures, constrain flexibility in program adjustment, undermine transparency and openness of governmental decision making, and weaken the accountability of governments to their electorates.

Critics tend to argue that efficient incentives, flexibility, and accountability are best preserved in a classical model of federalism, in which each level of government operates independently within its own jurisdiction, making its own policy decisions and raising its own revenues. In this arrangement, voters have a clearer view of who is responsible for government decisions, and have a better opportunity to hold governments accountable at the polls. By comparison with these relatively clean lines of accountability, stronger forms of intergovernmental collaboration and partnership in the management of public programs pose greater challenges.

Considerable attention has been devoted to the issue of whether some specific forms of federal-provincial fiscal arrangements can induce inefficient responses by provincial governments. For example, shared-cost programs might lead provinces to overspend or to skew their spending priorities. They may preclude the provinces from adopting innovative approaches to program design or financing. More generally, complex decision rules that require substantial consensus among federal and provincial governments may reduce program flexibility and impede the process of adjustment to changing conditions, a phenomenon that has been labelled the "joint decision trap" (Scharpf 1988).

In a similar fashion, the Canadian version of executive federalism, in which policy issues are resolved through negotiations between the two levels of government, is often held to weaken accountability to the electorate. Critics argue that the system accentuates the closed and secretive nature of policy making. Legislative debate plays a more limited role; participation by affected groups is more difficult; and intergovernmental secrecy can mean that public debate is less informed by the open clash of contending ideas. Moreover, given the intergovernmental parentage of important decisions, it is often difficult for citizens to understand which level of government should be held accountable

on a continuing basis. Only very knowledgeable citizens can understand the complex interplay of governments that shape social programs, including health care, and even they have difficulty in deciding whom to hold accountable for policy failures.

Such tensions are not unique to Canadian federalism. The potential exists in all systems of multi-level governance. For example, considerable attention has been devoted to a "democratic deficit" in the context of the European Union as well. However, it is important not to overstate the impact. By its very nature, parliamentary democracy concentrates power, and decisions made by Canadian governments in their own jurisdiction are hardly models of open, participatory decision making.<sup>11</sup> Indeed, executive federalism is prominent in our system of governance because power is concentrated in the hands of cabinets and first ministers. Undoubtedly, the dynamics of intergovernmental negotiations accentuate the tendency toward secret and closed decision making in Canada. But they are not the sole reason for it.

Deciding what weight to accord these tensions when defining the role of the federal government in health care involves complex judgments in two ways. First, whatever attractions the classical model may have had in an era of smaller government, it is difficult to fully disentangle federal and provincial governments today. Second, whatever their reservations about executive federalism, Canadians still express a powerful preference for federal and provincial collaboration in the management of contemporary pressures in the health care system, as we have seen. These factors suggest that the critical challenge is not so much to disentangle governments in the health sector as to manage the interdependence of the federal and provincial governments in more open and transparent ways.

## Efficiency and the Federal Role in Health Care

As in the case of the general role of the state in health care, efficiency concerns about the design of federal institutions do not point unambiguously in a single direction. As we attempt to define the balance between centralization and decentralization, we discern advantages on both sides. Decentralization promises a closer fit with local preferences, as well as informational and administrative advantages, greater scope for experimentation and innovation, and stronger intergovernmental competition. On the other hand, decentralization can disrupt the internal economic union, generate fiscal competition and spillovers, and lead

to fiscally induced migration, all of which point to advantages inherent in a cross-country framework on key policy parameters. Similarly, the debate over the form of intergovernmental relations does not point unambiguously to a simple conclusion. The advantages of classical federalism in terms of incentive structures, flexibility, and accountability to the electorate need to be counterbalanced by the seeming intractability of intergovernmental interdependence in the contemporary era and the clear preference of Canadians for intergovernmental collaboration in health care.

# The Federal Role in the Sharing Community: A Summary

As we have seen, the general rationale for a federal role in health care reflects both equity and efficiency concerns. Most important, the federal role depends on the conception of the sharing community that prevails in the federation. The key issue is the extent to which the sharing community is seen as the community of all citizens rather than communities defined by provincial or territorial boundaries. Further, if the pan-Canadian community is seen as an important sharing community, the role of the federal government, and the choice of instruments through which it should implement that role, will depend on whether a predominantly Canada-wide or predominantly provincial conception of that community is chosen. Is the goal to establish health care as a component of "social citizenship" such that all Canadians receive the same health services no matter where they live? Or is the goal simply to ensure that all provinces have the potential to establish comparable health services if they wish? Or is the goal to be found somewhere between these two poles, reflecting a dual sharing model that promises Canadians comparable but not identical health services across the country as a whole? Put differently, should standards of redistributive equity and social insurance be defined primarily for the country as a whole or province by province? If it is the latter, there will be no guarantee that individuals of a given type will receive comparable health services if they reside in different provinces.

Considerations of efficiency are also important in defining the federal role. As we have seen, decentralization can have a number of important efficiency advantages. However, decentralization can also generate efficiency concerns related to portability of benefits, fiscal competition among provinces, and fiscally induced migration. Similarly, concerns about the form of intergovernmental relationships do not seem strong enough to resolve issues of institutional design

definitively. As a result, efficiency concerns do not point unambiguously in a single direction. Much depends, for example, on the balance one strikes among the various strengths and weaknesses of centralization and decentralization.

Redistributive equity and efficiency considerations cannot be acted on in isolation. In contemplating a federal role based primarily on values of pan-Canadian sharing, it is important that the instruments used for achieving that role not abrogate the important advantages of decentralized provision. In particular, the ability of the provinces to design and manage their own health systems, to experiment, to innovate, and to undertake new reform initiatives should not be compromised unduly by federal measures designed to achieve countrywide sharing and efficiency in the internal economic union. Put another way, the case for federal intervention is based on sharing considerations, not on the advisability of a federal role in reforming the health care system. This will be a primary consideration in our discussion of instruments in the following section, especially with respect to the use of federal instruments for a transformative role. For example, on grounds of community sharing, a stronger case can be made for the federal government using its influence to extend social citizenship to pharmacare and home care programs than to induce provinces to undertake reform of the way in which they deliver primary care.

The balances that should be struck among these various dimensions of sharing can only be determined through our democratic processes. To date, the preferences of Canadians and the federal-provincial balances that our elected leaders have crafted seem consistent with what we have called the dual sharing model. This model sees health care as a pan-Canadian enterprise, and reflects a commitment to a pan-Canadian sharing community. The model assumes that provinces are also sharing communities, and that different regions may choose to vary the mix of services and the modes of delivery in innovative ways. This blend seems consistent with current evidence on Canadian preferences. In this area, Canadians see no reason to choose between levels of government. They express a powerful preference for both the federal and provincial governments to collaborate in the maintenance and enhancement of our health services. Such collaboration does not require that health services be defined in identical fashion and delivered in identical ways across the country. But it does seem to suggest a model in which Canadians have access to quality health care services on comparable terms and conditions across the country as a whole, regardless of the province or territory in which they live.

Admittedly, the dual sharing approach to health care is more heavily

weighted in favour of the provinces than in most federations, and is being narrowed steadily by changes in medical technology that enhance the importance of instruments falling beyond the CHA, such as pharmacare and home care. The current generation of Canadians will therefore have to decide anew about the range of health services that should be available to Canadians across the country on broadly comparable terms and conditions. Given the evolution of both medical technology and the demography of Canadian society, the key question for the future may be whether elderly Canadians are to have access to health services of particular relevance to them on broadly similar terms from one end of the country to the other.

An important conclusion flowing from this discussion is that it is misleading to pose the debate about the federal role in terms of an inevitable tradeoff between equity and efficiency. The federal role is essentially determined by the extent to which the country as a whole rather than the province is deemed the appropriate community within which social insurance against ill health is provided, the one in which 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. The efficiency advantages of decentralization of health care can be best achieved by following the constitutional norms concerning the provinces' role in health care. Unless one adopts the exclusively countrywide sharing model, the federal government's efficiency objectives can be achieved without the need to violate provincial delivery. Predominantly provincial sharing can be achieved by a carefully designed equalization system that attends to both the revenue-raising abilities and the needs of the provinces. Such a program would enhance efficiency in the federation by undoing NFB differentials that would otherwise result from fiscal decentralization. The intermediate version of pan-Canadian sharing implicit in the dual sharing model can be achieved by setting pan-Canadian norms that can be embodied 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 and efficient provincial delivery of health care. Moreover, the norms themselves might address efficiency issues such as the portability of health services across provincial borders. Thus, it is quite conceivable that both equity and efficiency can be enhanced by a suitably designed set of federal policies.

That is not to say that tensions between the two levels of government

will dissolve. The federal government and some provinces may disagree both with the social insurance arguments for state intervention in the health sector in the first place and with the appropriate level of community sharing in the second place. To the extent that the federal government interprets the pan-Canadian consensus to be in favour of a greater degree of countrywide sharing than the provinces do, the types of standards that it will wish to see in place will appear to the provinces to be excessively intrusive. But this disagreement will be more a conflict over values than over the efficiency of federal intervention. There may also be conflicts about the processes for making decisions on these critical issues, and whether the level of financial contributions from the different levels of government are appropriate. But these issues lie more in the third dimension of choice, the instruments of federal action, to which we now turn.

### THE CHOICE OF FEDERAL INSTRUMENTS

e have suggested that a comprehensive interpretation of the federal role in health care combines choices on three key dimensions: the general role of the state in health care; the particular responsibilities of the federal government in the sector; and the instruments through which the federal role is implemented. In our discussion of the first two dimensions, we have referred from time to time to the kinds of instruments that could help achieve equity and efficiency in health care. We extend the discussion of this third dimension of choice in this section

As we have seen, the federal role in health care is sustained by considerations of both equity and efficiency. However, it is primarily equity, or more precisely social insurance considerations, that lead most OECD countries to provide health insurance through the public sector more or less universally regardless of private insurability, and to fund it largely out of general government revenues. Federal states are confronted with the additional question of whether the country or the province is the primary sharing community. In practice, sharing can coexist at both levels, and there is a spectrum along which the relevant sharing roles of the federal and provincial governments might locate.

What are the implications of this analysis for the choice of federal instruments? According to the predominantly provincial version of community sharing, which we have taken to be the end of the feasible spectrum involving the least countrywide sharing, the main role of the federal government should simply be to ensure that all provinces have the resources to provide comparable public services at comparable levels of taxation. Provinces would then be free to define the degree of sharing or redistribution within their jurisdictions as they see fit. If this view were applied to the full range of social programs, the federal redistributive effort would mainly involve transfers to provinces rather then to individuals. Of course, in financing those transfers and other federal expenditure programs, it would be necessary to take a stand on how redistributive the federal tax system should be, so some element of countrywide sharing would be inevitable. But provinces would themselves be able to choose their own tax systems to reflect their preferred degrees of redistribution.

The main policy instrument for implementing the predominantly provincial notion of community sharing would be the system of equalizing transfers to the provinces. It is important to emphasize that this currently includes not just the equalization program but also the CHST, and that these schemes focus on revenue equalization. The equalization system is designed explicitly to ensure that all provinces have the ability to raise some minimum standard level of revenues (currently the five-province standard) at national average tax rates. The CHST can be thought of as a purer, more complete, form of revenue equalization. It effectively obtains funds from a common national average tax system (federally defined) and disburses it in equal per capita terms among all provinces. It is a perfect net revenue equalization system.

At the same time, full net revenue equalization does not satisfy the predominantly provincial version of community sharing if the latter is taken to imply the literal satisfaction of the principle of equalization set out in section 36(2) of the constitution. This would require that provinces be able to provide reasonably comparable levels of public services at reasonably comparable levels of taxation. Revenue equalization only goes part way toward that objective. Provinces may also face different "needs" for public services in the sense that they differ in the composition of populations for whom the major public services are targeted. In the case of health care, there is a systematic difference in the costs of providing services to persons of different age and other characteristics. It can be argued that the predominantly provincial version of community sharing as applied to health requires that needs ought to be taken into account in allocating funds to provinces through the CHST block transfer. There are a number of examples of federations and other nations with decentralized delivery of health

services that do precisely that: and provincial funding of regional health authorities is normally based on some indicator of need. The allocations could be determined using the same representative approach as is taken in the revenue equalization system. That is, needs equalization could be based on the cost of a national standard level of care for different demographic groups, in which the costs could represent some average of actual provincial costs. As with revenue equalization, the idea is to base the entitlement to needs equalization on objective measures that are outside the direct control of the recipient provinces.

The setting of norms for calculating needs-based transfers for health. although conceptually straightforward, would have complex measurement problems not unlike those found in the revenue equalization system. As well, difficult decisions would need to be made concerning the kinds of services that should be included in the standard, given that provincial health insurance coverage varies from province to province. However, they do not present an insuperable problem. Moreover, there might be ancillary advantages to basing CHST allocations on indices of need. For one, measures of need would inform the public about the magnitude of costs faced by the provinces, and might serve as a basis for informing public debates about the share that might be borne by the federal and the provincial governments. An index of need might also form the basis for allowing citizens to judge the adequacy of their own province's health care system. More generally, an index of need that was jointly agreed to by the federal government and the provinces and used as a basis for allocating federal transfers might serve to operationalize the principles set out in section 36(1) of the constitution. As we saw earlier, this section jointly commits the federal government and the provinces to "providing essential public services of reasonable quality to all Canadians" and "promoting equal opportunities for the well-being of Canadians." Both of these commitments could be interpreted as having relevance for health care.

Under the predominantly provincial form of community sharing, interprovincial equalization would be sufficient. There would be no need for pan-Canadian parameters to structure provincial programs, and each province could design its own program. Ideally, it would be a net equalization scheme, based on national average standards of revenue-raising capacity and needs. To achieve this net outcome, it may well be necessary for there to be enough of a vertical fiscal gap that the net outcome can be achieved without requiring that any provinces receive "negative" transfers. Revenue-raising capacity could be measured using a

representative tax system approach as in the current equalization system, or it could be based on more aggregative measures, such as the so-called macro formulas that use a single macro measure of a province's fiscal capacity. As discussed above, needs would primarily reflect different demographic features of the provinces that are relevant for estimating the costs of providing public services to target populations. Of course, if the provinces chose quite different program and tax mixes, the design of an appropriate equalization system would become problematic. The transfers would be unconditional and would evolve as provincial fiscal programs evolved; and they would be formula-driven both in terms of their aggregate level and their interprovincial allocation.

Notions of community sharing that give more weight to countrywide sharing, including the dual sharing model, would require a wider set of instruments. A system of equalizing transfers would still be a prerequisite. But there would also be a need for mechanisms to define a common framework for health insurance across the country as a whole. Logically, there would seem to be a number of instruments available in a federal state that might be employed to this end:

- > Direct federal delivery of health insurance programs;
- > Direct financial transfers to citizens to support the purchase of health insurance:
- > Federal fiscal transfers to provincial governments associated with a common set of policy parameters, expressed as standards or principles;
- > An interprovincial compact to establish a common framework for provincial health insurance programs.

The same set of instruments is relevant in responding to the efficiency arguments for federal intervention. As we have seen, a case can be made for full equalization on grounds of efficiency as well as equity. Efficiency considerations might justify federal action to protect the functioning of the internal economic union (by avoiding barriers to economically efficient migration and inducement to migration driven purely by differential access to health services), or where fiscal competition is so strong as to jeopardize the extent of provincial sharing desired by the population. For instance, provincial sharing might be compromised by a race to the bottom in redistributive programs, tax competition that causes too little revenues to be raised to finance provincial social programs, and beggar-thy-neighbour fiscal policies.

Responding to these problems would require choosing from the same

set of instruments. For instance, intergovernmental agreements might preclude provinces from engaging in discriminatory policies or destructive competition in programs. Given that social programs are involved, this would go beyond the kinds of provisions one finds in the Agreement on Internal Trade. Conditional federal transfers represent an alternative instrument, even where the relevant sharing community is the province. Conditions could be imposed on transfers to protect the portability and mobility provisions of special programs and individuals' access to them. If interprovincial competition seemed to be eroding the levels of health services desired by provincial electorates, minimal programs standards could be sustained on the basis of federal transfers.

Choices among such instruments tend to be highly sensitive to constitutional provisions and the distinctive traditions governing federal arrangements prevailing in each country. As a result, there is no single "best practice" in instrument choice. Moreover, each of these instruments permits many variations and, as in many policy domains, the real impact is determined by the implementation details. Nevertheless, each general approach does present strengths and weaknesses, and each one deserves more detailed attention.

## Direct Federal Delivery

As we have seen, direct federal delivery of health insurance is a feature in many federations, including Australia and the United States; and one former provincial premier has recently suggested the transfer of direct responsibility for pharmacare to the federal level. The main feature of direct federal provision of health insurance is that it would effect full sharing countrywide, since presumably the same program would apply in all provinces. In addition, the single-payer principle would apply Canada-wide rather than at the provincial level. The case for direct federal provision thus relies on the country as a whole being the exclusive sharing community for health care (even though it is not for many other social programs).

This approach would represent a major departure in Canada. It would certainly raise interesting constitutional controversies. 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 certainly challenge deeply held political conventions about the division of powers in the sector and would require a significant degree of integration with existing provincial pharmacare programs.

However, this discussion does not exhaust the possibilities of direct federal action. Another option is an expansion of direct transfers to citizens through the tax transfer system.

## Direct Federal Transfers to Citizens

Table 2 above demonstrated that the federal government already makes sizable implicit transfers for health care in the form of tax expenditures in the personal income tax and sales tax systems. However, these are mainly for health expenditures incurred by persons over and above what is provided in provincial health care systems. The question is whether this approach might appropriately be used as a basis for financing basic health insurance coverage.

In principle, Canada-wide sharing objectives in social programs might be achieved by a system of direct federal transfers to citizens. By being national in scope, this system would ensure that common standards of sharing would apply countrywide. Moreover, different degrees of Canada-wide versus provincial sharing could be accomplished by co-provision of transfers by both levels of government. Such an approach has proven to be successful in other areas of social policy. The federal program of refundable tax credits, for example, represents a nationally defined system of redistribution toward the poor and toward poor children, which supplements similar benefits offered through provincial social assistance programs. The question is whether this approach could be adapted to the case of health insurance.

The key feature of health insurance is the contingent nature of its assistance: payments are required only if health expenditures are incurred. Moreover, to the extent that health insurance fulfils a social insurance role, the extent of reimbursement should be independent of the recipient's means. One rather trivial way that a public health insurance program could be implemented using direct transfers to individuals is for the transfers to simply mimic payments that would otherwise be made directly to health providers; that is, health providers would bill individuals, and individuals in turn would claim the relevant amount from the government. This method might have some salutary value in terms of informing citizens of their cost of usage. But, otherwise it would simply increase administrative costs and would clearly require the cooperation of the provincial governments. Moreover, liquidity problems might be imposed on individuals if they were required to pay up-front and receive reimbursement later on.

An alternative way of achieving similar results, in theory, would be to

make transfers directly to citizens and allow them to purchase their own insurance on private markets. For such a system to mimic social insurance, the transfers to each citizen would have to be differentiated according to risk so that all citizens could in fact purchase full insurance. It would obviously be very difficult to operate such a system on an ongoing basis. Moreover, by relying on the private insurance market, it would involve giving up the advantages of a single-payer system.

Programs of direct transfer to citizens might instead be viewed as ways of introducing some incentives into the use of health services by citizens. One way this might be done would be to offer only partial reimbursement of expenses incurred, which would simply be an indirect way of introducing user fees at the federal level. It might have an advantage over charging user fees directly, in that by being operated as a government program, reimbursement might be tied to ability to pay. This type of program might be a way for the federal government to actually implement a countrywide income-contingent system of user fees, 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. A variant of this plan has recently been proposed by Aba, Goodman, and Mintz (2002). They propose that a proportion of the cost of health care services used by each individual (40 percent in their proposal) be assessed as a charge through the income tax system. However, the maximum that a family would pay would be restricted to 3 percent of income in excess of \$10,000. This proposal would both exclude low-income families and ensure that the payment increases in relation to income. Since both the federal government and the provinces administer income taxes, the proposal could in principle be applied at either level of government. However, for the federal government to be involved, provinces would have to agree to set up the required administrative machinery to both bill taxpayers correctly and receive the federally collected contribution as co-payment for health costs incurred in the province. Canada-wide sharing principles would apply to the extent that the same co-payment schedule was used in all provinces. Of course, since the scheme would be intended solely as a means of addressing incentive concerns, it would have limited value as a social insurance device.

Another proposal for injecting individual incentives into health insurance that has gained some currency is the use of so-called Medical Savings Accounts (MSAs) (Ramsay 1998). The use of MSAs originated in the United States, where

they are used in conjunction with private health insurance plans, typically as part of an employer-provided package. The basic idea in the American context is that the private health plan has a high deductible amount and so only covers serious or more catastrophic expenditures. Lower-cost, more routine expenditures would be covered from the MSA. The employer (or other provider) would have an amount corresponding to the size of the deductible deposited into the MSA in the individuals name. The individual would then be responsible for covering his or her own health expenses up to the deductible amount. The MSA could be used for this purpose until it is exhausted. Health expenditures above the amount of the MSA would have to be paid by the individual (though there could be some tax incentives to help defray the cost). Unused MSA funds could be carried forward for use within a specified number of future years, and eventually could accrue to the individual as part of the incentive to save on health expenditures.

The MSA could in principle be used as part of a public health insurance system. This would involve introducing a deductible provision into the system, and at the same time creating an account for each individual in the jurisdiction. This could be simply an accounting device that individuals could draw on to meet health expenditures below the deductible amount. As with private MSAs, individuals would be responsible for such expenditures once their MSA had been exhausted, and would be able to claim unspent funds as their own income.

The case for MSAs, as with the proposal of Aba, Goodman, and Mintz, is based on incentive arguments. In particular, it represents a response to concerns about moral hazard, which, as we saw, refers to the built-in incentive for individuals to overuse the health system if the costs of such use are fully paid by insurers. With a system of MSAs, individuals would implicitly bear the opportunity cost of small health expenditures. The effectiveness of the MSAs would then be judged on the basis of how much discretion individuals have in their demand for health expenditures, and how great a problem the resultant moral hazard might be. Another benefit is that they may provide a base of funds for all individuals who have no other means of financing their own health expenditure requirements. They also can be designed to retain the advantages of a single-payer system.

The disadvantage of MSAs is that they effectively undo the insurance function of the public health insurance system. Basically they require individuals to self-insure out of their own accounts, so all the pooling advantages of ordinary insurance are lost. This loss is mitigated to the extent that individuals can self-insure over time by carrying unused MSA funds forward. Nonetheless, the system remains one of

self-insurance, which may be a steep price to pay to address the moral hazard issue. As well, MSAs do not fulfill the social insurance role except to the extent that the size of individual funds is somehow related to health risks. As we have mentioned, insuring against risk requires information that governments are unlikely to have.

There would be no constitutional barrier to the federal government establishing a system of MSAs. As long as benefits were financed from general government revenues, as opposed to being tied directly to contributions, such a system would represent a valid use of the spending power. From the viewpoint of federalism, however, it is not obvious that MSAs have any attraction as a federal, as opposed to a provincial, policy device. To the extent that one views the federal role as being essentially motivated by countrywide social insurance or sharing considerations, MSAs have little to recommend them as a federal policy instrument. In fact, MSAs represent an abrogation of what we have called the social insurance rationale for government intervention in health insurance.

# Federal Transfers to Provincial Governments

Transfers to provincial governments have been the primary instruments in the definition of a pan-Canadian sharing community in health care. Moreover, as we have learned, the basic structure of these transfers needs to differ only incrementally between the transformative phase, when the countrywide framework is being created, and the subsequent phase, when the emphasis shifts to sustaining that framework over time. As we learned from the medicare case, a transfer with quite general conditions is sufficient to initiate a program that contains a reasonably high degree of sharing countrywide while at the same time allowing the provinces discretion to design and deliver health care systems that suit the needs and preferences of their residents and satisfy their own norms of province-wide sharing. Full traditional cost-sharing grants, such as the CAP, are not absolutely necessary. The basic structure of federal-provincial block health transfers also sustains the dual sharing conception of the federal role. A block transfer with general conditions is flexible enough to allow for the maintenance of countrywide standards, while at the same time allowing provinces the discretion to deliver their citizens' own preferred modes and levels of province sharing.

If Canadians wish to maintain some form of dual sharing communities in health care, transfers to provinces are likely to remain a central instrument. To be effective, this approach would ideally require a clear definition of relevant standards; sufficient levels and predictability of federal funding to ensure that federal policy parameters are credible and effective; and some suitable procedure for resolving disputes between the federal government and the provinces and territories. However, Canada has never fully achieved this ideal, and has fallen further from some aspects of it recently. The result has been an increasingly active debate about the future of transfer programs.

On one side are commentators who seek to reinforce the legitimacy of the federal role through a stronger, more predictable, and more visible financial commitment. For example, some have proposed a return to a global cost-sharing approach, perhaps at the level of 25 percent of aggregate provincial health expenditures. Others have suggested the reinstatement of an automatic escalator for the CHST. In this context, it is useful to distinguish between the level and the 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 federal standards, the greater the level of federal support presumably needed. It is difficult to be precise about the minimum level of federal support required. In the final analysis, the considerations are political rather than economic. What is the level of support required to preserve the legitimacy of the federal policy framework in the eyes of both provincial governments and Canadians in general? Recent challenges from provincial governments suggest that the federal government has fallen below the essential level. Whether a return to cost sharing is the best way forward, however, is less clear. Given past practice, presumably cost sharing would apply to aggregate provincial expenditures rather than to the expenditures of individual provinces. Even in the latter case, however, cost sharing would require measuring eligible provincial expenditures, and would 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 unclear.

The predictability of federal support, however, remains critical. 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 unannounced changes to the transfer system, the case for an automatic escalator that bases changes in the CHST on a formula rather than on federal discretion is strong. Various formulas for the rate of growth of such transfers are possible. Basing a formula on the rate of growth of actual provincial health

expenditures would have the advantage of maintaining the federal share of funding (and therefore authority to enforce the general conditions) over time. However, it would imply the administrative and measurement costs mentioned above. At the other end of the spectrum, the escalator could be the rate of growth of GDP or GNP as was the case under the EPF. An intermediate approach that might more accurately reflect affordability would be to base the transfer on the rate of growth of federal tax bases. These latter two options have the advantage that they put the transfer on a formula basis, thereby removing discretion from the federal government. But they are based on economic aggregates that are themselves variable and unpredictable over time. The lack of predictability could be avoided to some extent by using a rolling average of the relevant economic aggregate to smoothe out changes over time. Alternatively, to avoid fluctuations altogether, one could simply adopt a constant escalator of some arbitrary percentage. This growth rate could be applied either to aggregate transfers or to per capita transfers. This formula could be a more flexible option if the percentage was periodically subject to change.

Other proposals focus primarily on making the federal contribution more visible by separating the block transfer for health from those for welfare and post-secondary education. The main argument in favour of this reform - and it is certainly a substantial one - is that a separate transfer would enhance the transparency and visibility of the federal role in health care, thereby enhancing the ability of citizens to hold governments to account. On the other side of the ledger, however, there would be difficulties in deciding on the precise allocation of transfers to such a fund. At the moment the federal government pays some lip service to the separate components of the CHST by attributing a share to each program. But until recently the attribution of share was based largely on historical data, and probably had little relationship with provincial expenditure patterns. More recently there has been an attempt to base the shares on more relevant estimates of federal support for provincial spending in health. This issue is discussed more fully in chapter 4 by Lazar, St-Hilaire, and Tremblay. Moreover, the impact of a separate transfer on provincial decisions would be marginal, since the transfers would remain fully fungible in the hands of the provinces. Finally, in the absence of increased federal commitment, a separate health transfer would necessarily be smaller than the current CHST, and would therefore dilute further the ability of the federal government to sustain federal policies.

These proposals all come from commentators committed to sustaining a pan-Canadian conception of health care. At the other extreme are proposals

that would reduce the commitment to national sharing. Some have suggested converting the CHST into a straight tax point transfer to the provinces. Such a plan would result in a significant reduction in the level of national sharing in two ways. First, it would spell the end of dual community sharing in health care. It might be argued that the equivalent could be achieved by national standards negotiated among the provinces, but for reasons discussed below, that seems not to be feasible. Second, under a tax-point transfer it would be difficult to maintain even the minimal level of national sharing, which relies solely on effective equalization. Replacing CHST with tax points would make this difficult for four reasons: a) the net equalization property of the CHST would be lost, and would be unlikely to be replaced under Equalization proper; b) decentralization of more tax room would itself place much more pressure on the Equalization system and make it difficult to sustain politically; c) it would be more difficult to take account of needs, which we have argued is important for the predominantly provincial sharing model; and d) decentralizing the tax system would make it more difficult to maintain common redistributive standards through the taxtransfer system. Proponents of this option often point to the advantages of accountability. This argument, which is generally taken as self-evident, is actually quite unclear. It is not obvious how accountability for provincial health spending is compromised by the fact that some of the provinces' revenues come as fungible block grants from the federal government.

Whatever view one takes of the appropriate extent of countrywide versus provincial sharing, equalization is bound to be a key component. It is worth digressing for a moment on the principles of the design of an equalization system that would suit a decentralized federation. On the basis of both economic and constitutional principles, a strong case can be made for basing equalization in the broadest sense on both revenue-raising ability and needs. In the current fiscal arrangements, the Equalization system is specifically designed to equalize the ability of the have-not provinces to raise revenues comparable to the five standard provinces using national average tax rates. There is no doubt that the revenue-equalization system could be fine-tuned and improved in various ways, many of which are documented in the 2002 Report on Equalization by the Standing Senate Committee on National Finance. At the same time, the CHST system can partly be interpreted as a very crude needs-based equalization system, where the measurement of need is based on equal per capita spending requirements. To incorporate needs more carefully into the fiscal arrangements system, the per capita transfer of

the CHST could be adjusted by adopting the same representative provincial method as is used to equalize for tax capacity. The procedure would work in the case of health as follows. A national average cost of providing medical and hospital services to identifiable groups of persons could be calculated. These groups could include age groups, genders, geographical descriptors such as urban or rural, and perhaps ethnic groups in the population whose health care needs vary substantially from others, such as Aboriginal peoples. For each group, a national average per capita cost of providing a standard package of medical and hospital services would be calculated. For each province, these could be aggregated up to determine the average per capita cost of providing medical and hospital services to the population as a whole. Each province's per capita health transfer could then be adjusted to account for differences in needs across provinces.

Such a scheme would have a number of features. First, the needs-based equalization could be carried out as part of the CHST transfer system, and, unlike with the Equalization system, it could be a net scheme (provided the size of the CHST were large enough). Second, the needs adjustment would be appropriate for all points along the relevant community-sharing spectrum. It would be compatible with varying sizes of vertical transfers. Third, because the system would be based on countrywide average per capita costs, there would be no incentive for provinces to vary their own spending patterns. Moreover, the incentive to attract more desirable demographic types to the province would be blunted. Fourth, there would be considerable discretion to decide how finely to divide the population into different segments. That would be partially driven by the extent to which different identifiable groups incur different health costs. Finally, as with the Equalization system, there would be unavoidable measurement and design problems, the more so, the more the fiscal system was decentralized. Since different provinces choose different definitions of insurable services, some compromise would be required in choosing the national average standard of services on which to base the needs calculation. In fact, incorporating needs into equalization systems is quite feasible, as examples from other federations have shown. Even a new multi-level government like that of South Africa has a reasonably sophisticated system of needs equalization along the lines described above.

The preceding discussion focused primarily on the sustaining role of the federal government. Advocates of a more transformative federal role, one that provides greater leadership in responding to new challenges in health care, probably must look to other instruments. Take, for example, pharmacare and home care. It would be difficult to incorporate these increasingly important areas into the dual sharing model by simply increasing transfers flowing through the CHST. Rather, transformative action would require repeating the precedent established for hospital and medical services. At the outset, this would involve new transfer programs, with a stronger shared-cost component. When established, these programs might then be incorporated into the general block fund transfer mechanism.

Two particular observations about the use of federal-provincial transfers for transformative purposes are in order. First, in the case of pharmacare and home care, the transformation to fully public programs would not be starting from scratch. Unlike in the earlier cases of hospital and medical insurance, a substantial proportion of the population of most provinces is already covered by either public or private health insurance programs. Turning these into fully funded public insurance schemes would not be anywhere near as financially ambitious as instituting such programs where none previously existed (although the actual transformation might be no less contentious). Logically, this might suggest that the extent of federal support needed to engineer the transition would be correspondingly lower. However, the political reality is that provinces are under considerable pressure from cost increases in the traditional core health services, and encouraging them to extend coverage in newer areas might well require a greater federal contribution.

Second, as mentioned earlier, the main rationale for federal involvement turns on the social insurance argument, and especially the notion that the umbrella for social insurance should cover Canada as a whole. The case for federal involvement in the actual design and reform of health services has not been made. On the contrary, the presumption is that the provinces are better suited to legislate and deliver health programs, a presumption that is also reflected in the constitution. The implication is that a case has not been made for using federal grants as a medium for the reform of health care. Thus, one does not contemplate the transformative role as including the use of federal transfers to induce the provinces into, say, adopting a particular model for primary health care or affecting the balance of in-patient and outpatient services. The reason that pharmacare might be viewed as a suitable candidate for the transformative role rests on the argument that it is an element of social insurance, not on the idea of encouraging the use of pharmaceuticals per se.

# Interprovincial Compact on Health Services

During the 1990s the weakening of traditional instruments of federal influence triggered a search for alternative mechanisms for sustaining a Canadawide approach to social programs. In that context, some analysts argued that programs do not have to be federal to be national, and that a compact negotiated by provincial governments among themselves could sustain a common approach to programs such as health care. <sup>12</sup> In the most extreme version of this approach, the CHST would be replaced by a transfer of tax points, and provincial governments would take up the burden of national leadership by developing a compact on core principles of social policy.

As critics of such suggestions have emphasized, this approach faces significant problems in regard to collective action (Kennett 1998). Provincial governments are elected by provincial electorates to respond to provincial concerns and interests. The key question is: why would provincial governments voluntarily agree to constrain their policy-making autonomy in the area of health policy? In the current context, provincial governments do so in return for federal financial support. Absent such support, they have limited incentive to plan their programs with the interests or preferences of residents of other jurisdictions in mind. To the extent that there is a countrywide consensus about the kind of sharing that ought to be reflected in provincial health programs, it might be argued that provinces ought to be able to negotiate an agreement on a set of pan-Canadian principles to govern their own programs. But consensus would not guarantee that an effective interprovincial response would actually emerge. The problems of achieving collective agreements when all participants must agree are well known: each participant has enormous bargaining power when unanimity is required. Moreover, given the mobility of individuals including medical professionals - and businesses, there would be incentives for some government to "free-ride" or to engage in social dumping despite such an agreement. In the absence of a decision rule enabling a majority of provinces to impose a collective outcome on dissenting provinces and an effective binding dispute settlement mechanism, outcomes would be governed by consensus decision making. As a result, there would be strong pressure to reach a lowest-commondenominator outcome. It seems highly unlikely that a strong Canada-wide policy framework could emerge from such a system. The example of the relatively toothless Agreement on Internal Trade, which in principle should lead to collective gains for all provinces, is instructive in this regard.

These difficulties on the policy side reappear on the financial side. The fullest version of the interprovincial approach, which replaces the CHST with a transfer of tax points, would lead to all of the problems of sustaining a strong system of interregional transfers discussed above. It seems unlikely that an effective system of interregional sharing could be negotiated among provincial governments. The current Equalization program is a federal program, financed through federal tax revenues and established by federal legislation. Although provincial premiers often articulate views about the program, their assent is not formally required. An interprovincial sharing mechanism would require wealthier provinces to agree to a sharing formula and send cheques to some pooling mechanism. The probability that this process would generate as strong a system of interprovincial transfers as the current system seems low. At a minimum, it would be a high-risk strategy for have-not provinces.

In the words of one commentator, the strategy of relying on an interprovincial compact to sustain a Canada-wide sharing community rests on "heroic" assumptions about the role of provincial governments (Kennett 1998). While it is true that programs do not have to be exclusively federal to be national, there seems to be no escape from the world of federal-provincial collaboration.

# Asymmetrical Approaches

Other commentators have suggested that it would be possible to develop an asymmetrical approach to health care, one that would allow individual provinces greater flexibility in the definition of health care services. This proposal is most often advanced in relation to the province of Quebec.

Such proposals are usually premised on the distinctive nature of political identity and community in Quebec compared to other provinces. The essential proposition is that Quebec represents a distinct society within Canada, and that a different conception of the relative importance of the Canadian and provincial sharing communities prevails there. Surveys of public attitudes do suggest that political identities and the sense of attachment to Canada are qualitatively different in Quebec than other provinces.

The precedent of the Canada and Quebec Pension Plans points to possible ways in which such an asymmetrical relation could be established in practice. The difficulty with this approach, however, is its acceptability to other provinces. In the decades since the establishment of the Canada and Quebec Pension Plans, much greater emphasis has been placed on the norm of the

equality of the provinces, especially in western Canada. It is not at all clear that the asymmetrical arrangements that were negotiated in the mid-1960s could be established today, even in the case of contributory pensions. In the case of health care, other provinces would probably also insist on any additional flexibility that was made available to Quebec, and the distinction between an asymmetrical model and a simple decentralization would narrow substantially. As a result, it would be difficult to preserve a pan-Canadian approach to health care even in Canada outside of Quebec. In theory, asymmetrical federalism seems like an attractive mechanism for accommodating the distinctive role of Quebec in Canada. In practice, however, it seems likely to trigger a wider set of provincial opt-outs that would erode the broader proposition that Canadians value a shared vision of their social future.

In summary, the federal government has a limited set of instruments available to pursue its transformative and sustaining roles in the Canadian health care system: direct delivery, direct transfers to citizens, and transfers to provinces. In addition, an interprovincial compact remains an instrument with some potential for limited purposes. Adapting the mix of instruments to changing realities remains a continuing challenge in federal states.

The combination of constitutional provisions and traditional federal-provincial practice places most of the burden on one instrument, transfers to the provinces. Hence an important dilemma remains. The basic legitimacy of the primary instrument available to sustain a countrywide sharing community in health care has increasingly been challenged within the processes of federal-provincial relations in Canada. Yet no other instrument seems capable of filling the void. A key question, therefore, is whether it is possible to reinforce the legitimacy of the federal spending power. This would seem to require re-establishing a consensus on appropriate fiscal shares, federal-provincial decision processes, and dispute resolution. These issues are taken up in more detail in the following chapters.

#### SUMMARY

comprehensive interpretation of the federal role in health care incorporates judgments on three separate dimensions of choice: the general role of the state in health care; the particular role of the federal government in health care; and the instruments through which the federal government carries

out its role. These dimensions of choice are distinctive, in that each raises a different range of considerations, but they are also cumulative. For those who oppose a general role for the state in health care, the second and third dimensions are not relevant. For those who support a role for the state in health care but oppose federal intervention in the sector, the choice of federal instruments is moot.

We have argued that the general role of the state in health care is sustained by considerations of both equity and efficiency. The primary rationale for the extent of government intervention common in most OECD countries is to be found in considerations of equity and social insurance. The central proposition is that, in a humane society, persons ought to be compensated for differences in their risk of ill health over which they have no control. Some people are unlucky, often from birth, in having a systematically higher risk of illness than others. We cannot know for sure about these differences in health status and illness insurability in advance, but they are real. Governments have therefore established social insurance programs to offset such differences in luck and insurability by, in effect, creating a universal pooling insurance scheme. This equity case for public health insurance is reinforced by efficiency considerations, since single-payer systems can have important advantages in reducing administrative costs, balancing the collective organizations representing health care professionals, and strengthening cost controls, all of which are important. Public action is also critical in overcoming externalities in the field of public health. Yet, when all is said and done, the core of the case for the comprehensive role that governments have assumed in health care is rooted in the logic of social insurance. It represents a form of sharing and redistribution that depends in the final analysis on a collective sense of responsibility among individuals for other members of their community.

Federal states such as Canada confront a second dimension of choice as they decide on the boundaries of the community within which this sharing takes place. Are our commitments to each other bounded by the pan-Canadian community of all citizens, the community of people living in our own province, or a mix of both? Or to pose the questions in other words: Is the goal to establish health care as an element of "social citizenship" such that all citizens receive health services on the same terms and conditions irrespective of where they live? Is the goal simply to ensure that all regions have the potential to establish the same level of health services if they wish? Or is the goal somewhere between these poles, reflecting a dual sharing community approach that promises comparable but not identical health insurance programs across the country as a whole?

The preferences of Canadians as revealed in public opinion surveys, and the federal-provincial balances that their elected governments have established in the past are consistent with this intermediate model, which we have called the dual sharing community model. This model sees health care as a pan-Canadian enterprise and reflects a commitment to a pan-Canadian sharing community. The model also assumes that provinces are sharing communities as well, and that different regions may choose to vary many important features of health services and the modes of their delivery in innovative ways. Health services, as a result, will not be, and need not be, identical across the country. But a broad pan-Canadian framework remains important in this model. It holds that Canadians should have access to quality health care services on comparable terms and conditions across the country as a whole. The bedrock of this approach is the conviction that that a sick baby in British Columbia should be entitled to health services on broadly comparable terms as a sick baby in Atlantic Canada.

Although the role of the federal government is rooted primarily in a commitment to a pan-Canadian definition of the sharing community, efficiency considerations are also important in defining the balance between federal and provincial governments. Decentralization has undoubted advantages that point to the desirability of local delivery of complex programs such as health services. However, decentralization can also generate important efficiency problems regarding the portability of benefits, fiscal competition among provinces, and fiscally induced migration. In addition to basic equity concerns, it is simply inefficient to have people with serious illnesses moving from one part of the country to another to qualify for adequate health coverage. Thus the debate about the federal role in health care does not simply pit equity against efficiency considerations. Capturing the benefits of both involves a judicious balancing in the federal-provincial division of labour.

The third dimension of choice, the selection of federal instruments, is also dependent on which conception of the pan-Canadian sharing community is selected. The predominantly provincial conception points primarily to equalization of the fiscal capacity of provincial governments through instruments such as the formal Equalization program – perhaps augmented to reflect different needs for provincial health expenditures – and the CHST. Conceptions of the sharing community that put more weight on Canada as the relevant community, including the dual sharing community model, require a broad policy framework for the country as a whole, and therefore point to a wider range of instruments. In the

Canadian case, the primary instrument remains federal transfers to provinces that are conditional on provincial acceptance of common principles or standards. Ideally, such an instrument would be sustained by a broad federal-provincial consensus on the ways in which the common policy framework would be determined, the appropriate financial responsibilities of the two levels of government, and a mechanism for resolving particular disputes, issues that will be addressed in the following chapters.

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#### NOTES

- In the case of unemployment insurance, the transfer was complete; in the case of contributory pensions, the constitutional amendments retained provincial paramountcy, such that provinces can choose to establish contributory pension schemes if they wish. Only Quebec has exercised this option.
- 2 This usage of the POGG power has been criticized by Hogg (2000, 17.3b), who holds that the legislation is better seen as criminal law. It is worth noting as well that section 91(11) gives the federal government responsibility for "Quarantine and the Establishment and Maintenance of Marine Hospitals."
- 3 The mechanism of coverage of the poor and hard-to-insure varied among these governments. Alberta offered public subsidies to the poor and hard-to-insure with which to purchase private coverage; British Columbia and Ontario created government agencies to insure those who could not obtain private coverage (Taylor 1987, 338-41).
- 4 See Alberta 1995. The differential size of the sector can be seen in the monthly penalties calculated by the federal government: Alberta \$422,000; Newfoundland \$11,000; Manitoba
- \$68,000; and Nova Scotia \$4,500.

  The actual role of the state in implementing these interpersonal transfers-cuminsurance could vary. The state could simply make the transfers and rely on the
  - private market to provide insurance. Or, the government itself could provide the insurance. In a world with full information available both to the government and the insurance industry, the two would be equivalent.

    Nonetheless, some observers have advo-
- 6 Nonetheless, some observers have advocated funding the non-catastrophic part of health expenditures through assessments based on users' taxable income (Aba, Goodman, and Mintz 2002).

As we stress below, identical treatment of like persons will have to be tempered even in a unitary nation if there are different costs associated with providing services to different persons. For example, it may well be the case that the level of services available in rural areas is different from that in urban areas. This reflects a standard equity/efficiency trade-off. Our concern is really with dif-

ferences across provinces with respect to

services provided to given types of per-

- sons in comparable circumstances.

  Net fiscal benefits refer to the difference between the value of public services that an individual enjoys and their tax payments. For a discussion of the concept and its application in fiscal federalism see Boadway (2000).
- The next two paragraphs draw on the survey of data on public attitudes in Mendelsohn (2001).
   Equalization systems fulfill at the same

time another efficiency purpose. They

- provide a sort of regional insurance to provinces against idiosyncratic fiscal shocks that they might be faced with. Thus, equalization-receiving provinces that suffer an unexpected decline in their tax bases will be sheltered from the full effects of that decline by an increase in equalization payments. In a unitary state, this kind of insurance is implicit in the nationally defined system of taxation and public services. In the absence of equalization, part of that regional insurance would be lost.
- A long-standing critique of decision making within the federal government as concentrated, closed, and secretive can be traced from Smith (1977) to Savoie (1999).
- 12 This case was developed most fully by Courchene (1996). For a variety of assessments of this proposal, see Cameron (1997).

CHAPTER 2

# COOPERATION AND DISPUTE RESOLUTION IN CANADIAN HEALTH CARE

DAVID CAMERON AND JENNIFER MCCREA-LOGIE

ooperation and conflict, consensus and dissonance, collaboration and competition – these are features of all federations, as they are of most if not all forms of human association.¹ In Canada, as in other federal systems, the political forces of conflict and cooperation are mediated through the particular institutions and processes of the federation. Our interest in this study lies in exploring these forces as they are expressed in intergovernmental relations, particularly in the health care field; specifically, we plan to look at the origins and nature of intergovernmental cooperation and conflict, and the arrangements that have been employed, or might be employed, to foster beneficial cooperation and resolve destructive conflict.

Before we proceed to the theoretical and comparative discussion of dispute resolution mechanisms, an overview of the intergovernmental disputes in the health care field will be helpful. 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 protest that Ottawa does not transfer sufficient resources to them to give it the moral and political authority it needs to encourage them to uphold the principles of the Canada Health Act (CHA) over the long term. Thus, they resent the hierarchy and paternalism implicit in the unilateral federal control over health care funding, and over enforcement of the conditions of the CHA, as Ottawa disregards the constitutional, financial, policy, and administrative dominance of the provinces in the field itself. Health disputes intensify periodically when Ottawa intervenes to prevent the provinces from contravening the principles of the CHA, an example being the case of Alberta's and other provinces' approval of private

clinics charging user fees. We make the case that reforms to institutionalize joint federal-provincial decision making through the establishment of a formal dispute resolution mechanism could ease tensions in the health and fiscal systems.

#### CONCEPTS AND ISSUES

# Dispute Resolution Mechanisms

hile acknowledging the dynamism and fluidity of the processes of cooperation and conflict in federations, it is nevertheless possible to identify several different approaches to conflict management in such states as these.<sup>2</sup>

#### Dispute Avoidance

One approach entails undertaking policies or initiatives designed to avoid the dispute in the first place; an example of this might be the transfer of tax points from Ottawa to the provinces so as to reduce or eliminate the conflicts that are sure to flare up about the level of ongoing federal transfers. It should be recognized that some initiatives can have the unintended effect of simply shifting the location of the conflict elsewhere. In this case, for example, the transfer of tax points would place extra weight on the equalization system and raise questions about whether the federal government had done enough in its horizontal redistribution programs to ensure that weaker provinces were compensated for the differential impact of a more decentralized taxation system. Integrating institutions, such as the party system or the second chamber, serve both to avoid or minimize conflict in federal systems, and to offer useful channels for its resolution when it breaks out. Dispute avoidance is most likely to be an attractive option when the parties involved have shared policy goals and are engaged in a relationship where there is a high level of trust and ongoing dialogue and negotiation.

#### Formal Dispute Resolution

Another approach is to tackle the resolution of disputes formally, by establishing official institutions and mechanisms, often based on constitutional provisions. These dispute mechanisms may seek to create the incentives for the parties directly concerned to sort things out among themselves. For example, the South African Constitution explicitly states that it is the responsibility of govern-

ments to avoid third-party, or judicial intervention. Consider section 41(1)(h) of the South African Constitution:

All spheres of government and all organs of the state within each sphere must:

- (h) co-operate with one another in mutual trust and good faith by
  - (i) fostering friendly relations;
  - (ii) assisting and supporting one another;
  - (iii) informing one another of, and consulting one another on, matters of common interest:
  - (iv) co-ordinating their actions and legislation with one another,
  - (v) adhering to agreed procedures; and
  - (vi) avoiding legal proceedings against one another.

This is a constitutional code of conduct, imposing a legal obligation on the participants to approach intergovernmental relations in a spirit of partnership rather than opposition. Since the provision is only six years old, it is perhaps too soon to say how compelling this constitutional injunction will prove to be.

The German Constitutional Court has elaborated the principle of "federal comity," which enjoins the Bund and Länder governments to behave in a fashion that is "friendly to the idea of federation." This principle is credited by some with limiting the growth of German federal legislative power. The Canadian Supreme Court's identification of "federalism" as a basic principle of the constitutional order not only helped to clarify the proper character of any secession process in the country, but has also imposed a clearer obligation on the federal actors to conduct themselves in a manner consistent with this fundamental reality.<sup>3</sup>

Dispute settlement mechanisms may invoke third parties to become involved in fact-finding, mediation, arbitration, or formal resolution by a court or tribunal. In a federation the judiciary has as one of its central functions the authoritative settlement of jurisdictional and other disputes among the constituent members. Beyond the normal judicial processes, such as were followed in the dispute concerning the cap on the Canada Assistance Plan (CAP) in 1990, the ability of the actors in the Canadian constitutional system to make a reference to the courts to test the constitutionality of their own initiatives or the initiatives of another federal actor is a fairly definitive legal procedure for seeking to settle entrenched disagreements.

## Informal Dispute Resolution

Informal dispute resolution approaches are quite diverse. Meetings of officials, ministers, and first ministers, are the classic devices in Canadas system of executive federalism for settling conflict and reaching agreement on matters involving both orders of government. Recently, as we have seen, Canada has taken a leaf out of the book of international trade dispute settlement practices, applying, with modest success, a broadly similar approach to the domestic Agreement on Internal Trade (AIT). The Social Union Framework Agreement (SUFA) contemplates the elaboration of an explicit dispute settlement process to cope with conflict in the social policy field, and, in fact, in response to considerable provincial pressure, the federal health minister, Anne McLellan, has recently addressed this matter (Cotter 2002; Mahoney and Laghi 2002). We will take a look at her proposal toward the end of this chapter.

# Cooperation and Conflict

It would be a mistake to assume that cooperation is always good and conflict bad; both, as we have said, are inevitably facts of life in federal systems, and their respective consequences can be noxious or beneficial depending on the circumstances. This being so, a capacity to challenge non-beneficial cooperation, to accommodate useful conflict, and to resolve disputes that impede the effective functioning of the system is an indicator of a mature form of government.

Drawing on our reading of the work of Peter Kellett and Diana Dalton (2001), we would suggest that useful intergovernmental conflict normally occurs in the following circumstances: when there is an authoritative voice whose pronouncements are definitive and legitimate; when the dispute management process generates energy and motivation; when substantive policy concerns take precedence over considerations of turf, status, credit-claiming, and blame avoidance; when the short-term outcome is a resolution of the matter under dispute, possibly with a new modus operandi. Alternatively, the short-term outcome could be non-confrontation, involving avoidance behaviour, where the disputing parties redirect their attention from the contentious matter to cooperative initiatives as new issues arise on the policy agenda. The long-term outcome of constructive conflict is the commitment of governments to participate in ongoing dialogue and negotiation.

In contrast, destructive intergovernmental conflict is typically characterized: by the absence of an authoritative voice whose pronouncements are

definitive and legitimate; by a dispute management process that follows rigid, predictable patterns; by quibbles over turf that overshadow substantive policy concerns; by the creation of a worse situation in the short term where there is a failure to deal with the hard issues, gravitation to lowest-common-denominator solutions, a blurring of issues, and a freezing-out of the public in decision making, and by a long-term tendency for intergovernmental relations to deteriorate into stonewalling and escalating tensions, and a unilateral decision by one of the disputing parties to resort to silence and withdrawal.

# Horizontal and Vertical Relationships

In a multi-governance system, such as that of the Canadian federation, patterns of cooperation and conflict express themselves in a complex variety of ways; horizontally, which is to say, between and among provinces; and vertically, between the provinces and the federal government. Joanne Bay Brzinski notes: "In the process of representing interests, elected leaders in a federal system have to decide which interests and which set of constituents (regional or federal) they will serve. Citizens seeking representation must likewise select the government (regional or federal) to which to appeal for response" (1999, 46). Consequently, the policies that arise in a federal system represent the diverse national and local needs of citizens and privilege some interests over others. Inevitably, policy differences arise but they do not necessarily imply conflict; nor does intergovernmental harmony necessarily require "harmonization" of all policies.

Sometimes cooperation between governments becomes a resource to assist in pursuing a conflict with another government or governments. In the early 1980s, the Government of Ontario, under Premier Bill Davis, cooperated with and supported Ottawa on two highly controversial policies – the National Energy Program (NEP) and constitutional patriation – both of which precipitated a bitter dispute between Ottawa and several other provinces. In the late 1990s, the provinces and territories, minus Quebec, leagued together in opposition to the Government of Canada's fiscal transfer and social policies.

In the health care field, the most important lines of tension flow vertically between Ottawa and the provinces rather than among the provinces themselves. While there are interprovincial difficulties that arise from time to time (for example, the dispute between Ontario and Quebec about Gatineau residents seeking medical services in Ottawa hospitals), by far the most problematic intergovernmental relationship in the health care field is federal-provincial. That is the focus of this chapter.

#### Institutions and Events

One can draw a useful analytical distinction between an ongoing process and a particular episode, or between a system and the events that occur within the system. Do the institutional arrangements in a political system tend to foster productive cooperation and minimize destructive conflict, or do they do the reverse? That is a system question, clearly distinguishable from a question about specific occurrences within the system. Are governments in conflict over a particular matter, and, if so, how is it being resolved? That, in contrast, is a question about a specific dispute, not a question about the system within which it occurs.

Having made the analytical distinction, one needs at once to qualify it, by recognizing that, in practical and operational reality, it can be blurred. What is a system, after all, but an almost infinite series of individual events? Forces of conflict and cooperation play themselves out over time. It is rarely the case, for example, that there is an isolated dispute whose resolution will have no longer-term implications for the parties to the conflict. A disagreement is embedded in an ongoing political process, and its resolution will in turn shape the subsequent evolution of the political relationships of which it is a part. Working together and working against one another – these elemental forces both shape the political culture and institutions of the particular society in which they are set and are in turn shaped by their specific context.

Having said that, however, an examination of the political landscape from either an institutional or an episodic perspective raises different issues and points to a distinct set of concerns. If one looks at the Canadian federation from an institutional or systems point of view, several structural elements present themselves to the eye of someone interested in forms of cooperation and conflict:

- > The first-past-the-post electoral system plus parliamentary government makes for very powerful executives at both the national and the subnational levels, and creates a pattern of executive-driven intergovernmental relations. The role of the legislatures and Parliament in the functioning of the federation is minimal to non-existent.
- > The fragmented nature of the political-party system in Canada, together with the reality of very weak political parties, means that party processes cannot perform as integrating institutions in the federation.
- > The absence of a constitutionally rooted intergovernmental body, like the *Bundesrat* in the Federal Republic of Germany, deprives the Canadian federal system of another potentially significant institution for

linking governments and jurisdictions together.

- > The absence in Canada of an integrated public service supporting both federal and provincial governments, together with the relatively low level of mobility between federal and provincial bureaucracies, sharply limits the integrating potential of Canada's public administration.
- > The way in which crown authority and responsible government are structured in Canada means that governments cannot contractually bind each other. This constitutional reality contributes to the unenforceability of intergovernmental agreements and accords.

These structural characteristics of Canadian federalism mean that the country is weakly endowed with the multi-dimensional institutional glue that helps to hold many other federations together. Executive relations between federal and provincial governments must carry the lion's share of the burden of integration and perform the central role in reconciling the federal and provincial business of the country. The Supreme Court of Canada, itself an Ottawa-appointed rather than a "federal" institution, stands as the ultimate backstop in regulating intergovernmental relationships that have become dysfunctional, but, by their nature, the courts are institutions to be resorted to only in extremis.

This means that, barring the courts, there is no effective monitor of the vertical intergovernmental relationship. While Ottawa is able, at least to some extent, to perform as the monitor of horizontal relationships and disputes among the provinces, <sup>10</sup> there is no equivalent institution that can perform this function with respect to the vertical relationship between Ottawa itself and the provincial governments. Federal relations are shaped decisively by the actions and behaviour of federal and provincial executives, but, when these relations fall into disrepair, or when there is acute conflict, there is no agency other than the actors themselves that is capable of intervening to set things aright.

What Canada has, then, is this: a system in which the critical relations among the federal units are narrow and focused, rather than multiple and dispersed; these relations rely almost exclusively on governments, not on political parties, on legislatures, or on an effective federal upper chamber. It is a system in which intergovernmental relations are weakly institutionalized, with intermittent meetings of first ministers awaiting the call of the Prime Minister – no decision-making rules, and no settled processes for tackling the resolution of disputes. The European Union, an association of sovereign states which is not yet a federation, is by comparison vastly better equipped than Canada in this respect, with

a set of powerful common institutions to conduct, oversee, and regulate the public business of Europe.

In these circumstances, the chief instrument that Canada employs to shape the common business of the federation is Ottawa's autonomous capacity to define its own role in the federation, which is normally expressed in fiscal terms. We will discuss this in a moment. When specific disputes arise in this context, they are typically resolved via a political process in which the federal government is ultimately both the prosecutor and the judge. There is effectively no nonjudicial third-party capacity to oversee the federal-provincial relationship, as there is in some other federations (for example, Australia with the Commonwealth Grants Commission and South Africa with the Financial and Fiscal Commission). It seems plausible to contend that the absence of a dispute settlement process, in which both or all parties to the dispute can have confidence, has pushed the Canadian intergovernmental system toward the negative rather than the productive side of the conflictual ledger.

It is possible that the double-barrelled prosecutor-and-judge role of the federal government with respect to vertical competition may not simply be a problem in itself but may compromise Ottawa's capacity to exercise its horizontal monitoring functions as well. The most significant field for the expression of intergovernmental vertical competition is unquestionably the fiscal transfer system, particularly insofar as it is focused on the provision of federal support for provincial programs rather than (as in the case of equalization) on fiscal redistribution among the provinces. 12 Federal transfers in support of health, education, and social assistance have been in existence long enough to be understood as a structural feature of the federation, yet the system lies entirely within the hands of the federal government.<sup>13</sup> The provincial search during the Charlottetown negotiations for a mechanism to make intergovernmental agreements binding was an attempt to correct what many regarded as a design flaw in our system of intergovernmental relations. The Government of Canada's prosecutor-and-judge function with respect to monitoring its own actions vis-à-vis the provinces means that it is not acceptable to the provinces as an impartial monitor of interprovincial competition; provincial suspicion of federal intentions in the regulation of securities seems to be an indication of this (Coleman 2002).

Canada would benefit from an effective dispute settlement process in the health care field that would respect federal principles (that is, the two levels of government would agree to a political process for resolving conflicts). Ideally, a third party, whose pronouncements were definitive and legitimate, would oversee the federal-provincial relationship, offering recommendations to address the destructive intergovernmental 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, be accessible to all those who have a legitimate interest in the outcomes, and facilitate clear, efficacious, and timely settlement of disputes.

# THE CANADIAN EXPERIENCE

It would be a mistake to assume that the Canadian federal system is mostly about conflict simply because it is the disagreements and the federal-provincial battles that receive the greatest public attention. By far the largest proportion of intergovernmental relations in Canada is marked by informal, effective, sustained cooperative relations between and among Canada's governments. The country could not function on any other basis. Federal and provincial public servants work productively together, out of the limelight, year in and year out, sharing information, solving problems, and reconciling programs and administrative responsibilities. In the line departments, where most of the day-to-day business of government is carried on, officials from both orders of government work in an atmosphere of mutual respect, sharing values, recognizing one another's specialized expertise, and acknowledging shared codes of professional conduct.

The conflict that attracts public notice is, almost by definition, political in character. If it is sufficiently persistent and acute, this type of conflict, which characteristically marks public and political debates, can penetrate the ranks of the bureaucracy; in these circumstances the ongoing business of the federation risks being compromised by division and destructive conflict. This state of affairs has existed at several points in our postwar political experience and has exacerbated regional tensions. Intergovernmental conflicts have developed quite often between Ottawa and sovereigntist governments in Quebec; between Alberta and Ottawa during the NEP period (Milne 1986, 87-95); among several governments during the constitutional patriation exercise; and between Queen's Park and Ottawa during the Harris years. Yet these cases are in the minority compared to the vast range of common endeavours on which federal and provincial officials cooperate.<sup>14</sup>

# Intergovernmental Relations since the Second World War

The roots of our present system for the provision of health care to Canadians go back to the early postwar years. The federal government's spending power was the critical Canadian instrument fostering the expansion and consolidation of the system, but a singular focus on the federal role tells only a part of the story. One might locate the origins of public health care in Canada in a dialectical relationship that prevailed between the provincial governments and Ottawa. A Canada-wide public health insurance scheme was first seriously proposed by the federal government at a Dominion-Provincial First Ministers' Conference at the end of the Second World War, but was dropped for lack of support (Cohn 1996, 169). Public hospital care was actually introduced first in Saskatchewan in 1947, with British Columbia and Alberta<sup>15</sup> following suit in 1948 and 1950 respectively - all of this before the federal government became directly in involved in 1957. The federal government's role was to pick up on an important social-policy initiative begun by several provinces, and, through moral suasion and money, convince the other provinces to come on board. Saskatchewan again was the first jurisdiction to initiate public support for medicare in 1962, followed in due course by Ottawa, which in 1966 fostered the establishment of a Canada-wide medicare program. The acknowledged dominance of federal fiscal transfers in shaping and supporting provincial provision of health services has obscured the significant role of the provinces as incubators of social reform and managers of social policy, a feature of the Canadian system that has continued in various ways to this day.

The Canadian health care system is the most impressive product of a complex set of cooperative and conflictual relations between governments over an extended period of time, each side endowed with significant political resources, and neither side finally capable of dominating the other. In looking back, one can see that a good deal of the friction in the system has served a beneficial purpose.

The first chapter in this volume speaks of the constitutional foundations upon which government roles in health care rest, describes the nature and use of the federal spending power, and briefly charts the evolution of intergovernmental relations in respect of health care. Chapter 3 provides a general account of the history of federal and provincial public finance since the end of the Second World War, while chapter 4 depicts the evolution of the federal transfer system in respect of health and other social programs.

From 1945 to the early 1970s there was a dramatic increase in the size of the public sector, especially at the provincial level, as central elements of the Canadian welfare state were introduced. The creation of major new programs, for example, in the areas of health, social assistance, and post-secondary education, and the provision of federal transfers and some taxation room to the provinces were key elements in this story. Between the early 1970s and the beginning of the 1990s, social programs were consolidated, as both federal and provincial governments sought greater fiscal predictability and policy autonomy. In the service of these objectives, there was a move away from federal-provincial shared-cost programs to block-funded fiscal transfers. 16 The shift suited Ottawa, because it did not wish to see its expenditure patterns in the area determined by the provinces' spending on health care and education; it suited the provinces, because they did not wish to have their priorities distorted by the existence of "50-cent dollars" and because they found the accounting requirements that cost sharing required burdensome. Less satisfactorily from the point of view of Ottawa, the federal government lost its leverage over provincial social programs, which it sought to recover through the passage in 1984 of the Canada Health Act (to be discussed below).

In the early 1990s governments across the country made fighting the deficit their top priority, and sought to contain or reduce their financial commitments to the major social programs. During this period (1992-96) the rate of growth in per capita health expenditures in Canada flattened out before beginning to rise again in 1997. In the late 1990s most Canadian governments entered a new era of budgetary health, with Alberta and Ottawa in particular experiencing significant surpluses, but health care continued to be without question the biggest item driving up provincial costs, as it is today.

Students of federalism have used a number of terms to describe the style and operation of the federal process in these various phases of Canada's historical development. The Some of the phrases that have been used are: "cooperative federalism," administrative federalism, executive federalism, summit federalism, and "competitive federalism," and "collaborative federalism. These are not scientific terms. While both the periodization and the characterization of the several styles of federalism and intergovernmental relations vary from author to author, the important thing to realize from the point of view of our story, is that — whatever the periodization and characterization — a central element of the account has to do with the balance and the relationship between cooperative and conflictual practices.

Program-specific relations among relatively decentralized governments and bureaucracies, for example, distinguished cooperative federalism in the 1950s and 1960s. Ottawa was widely acknowledged to be the senior government (the major exception to this view being Quebec); practical arrangements were typically worked out among officials in line departments, and the level of tension was low.

What some authors have called competitive federalism emerged in the late 1960s and existed throughout the 1970s and early 1980s, marked by a higher level of intergovernmental tension. Central agencies took over files and linked them together to fashion corporate intergovernmental strategies; first ministers became more directly involved; the status of politicians and their governments became more directly implicated in the conduct of the business of the federation; and issues were increasingly framed in zero-sum terms, making them awkward candidates for artful compromise.

Some writers have argued that a discernibly different form of intergovernmental relations, dubbed collaborative federalism, emerged in the course of the 1990s. In part a response to federal fiscal retreat, collaborative federalism refers to the growing practice of provinces and territories, working together, to initiate serious discussion of national policy questions. Sometimes Ottawa is involved; sometimes not. Perhaps the distinguishing features of this style of intergovernmental relations are an assumption of equality among all participating governments and a belief that provinces and territories, acting on their own, are capable of fashioning programs and initiatives in the national interest. One example of a product of collaborative federalism is the Ottawa-led negotiation of the Agreement on Internal Trade, signed in 1994 and implemented in 1995. Another, this time initiated and carried forward by the provinces and territories, is the Social Union Framework Agreement, agreed to by all governments except Quebec in February 1999.

A review of Canada's postwar experience with federalism permits some observations about the sources and levels of conflict in federal-provincial relations (Cameron and Simeon 2000, 71-73). They will be greater:

> When differing ideologies exist. If there is tacit agreement among governments and citizens about the nature of politics, the role of government, the central problem confronting the public sector, the extent to which radical change is necessary, and so forth, this will reduce the likelihood that intergovernmental relations will be poisonous. In the case of health

care, if the provinces and federal government are in agreement about the value of national health insurance, the principles of the *Canada Health Act*, and the role of the private sector, the likelihood of conflict over the fed-

- eral government's enforcement of the Act is diminished.

  > When the status, recognition, and identity of regions, communities, and governments are seen to be at stake in intergovernmental negotiations. Using shared perspectives and expertise to solve practical problems encourages compromise; challenging a player's status or identity is almost certain to create conflict. Symbolic issues are much more difficult to resolve than practical problems. Increasingly, from the 1960s, intergovernmental relations came to embody "identity politics." The "facility fee" confrontation is an example of a highly charged symbolic issue. Premier Ralph Klein has allowed user fees for private clinics to proliferate in Alberta since the 1990s as part of his drive to broaden the role of the private sector in the health care system and to uphold the province's autonomy, even though his critics have argued that these fees contravene the Canada Health Act (Boase 2001).
- > When issues play out differentially along regional or linguistic lines. The NEP set the west, particularly Alberta, against central Canada. Phrases such as "Let the Eastern bastards freeze in the dark" and the "blue-eyed sheiks" are coarse reminders of the interregional animosity that existed at that time. The CF-18 incident envenomed French-English relations and was one of the chief regional grievances behind the formation of the Reform Party. The federal cap on CAP drove a wedge between the wealthy provinces (Alberta, British Columbia, and Ontario) and all the others; it was the impulse behind the push for constitutionally binding intergovernmental agreements during the Charlottetown negotiations.
- > When neither government is prepared to defer to the other. In the immediate postwar period, there was considerable agreement among both citizens and governments that Ottawa was the "senior" partner equipped with political and financial strength and a self-confident bureaucracy. By the 1970s Quebec had come to see itself as the primary political expression of the Quebec people, and western provinces had come to see themselves as defenders of a regional interest that was not represented in Ottawa, with its weak senate and its governing parties that had to pay attention to the more populous Central Canada. Neither their politi-

cians nor their increasingly professional bureaucracies were prepared to defer to Ottawa.

> When the primary concerns of governments become blame avoidance, the winning of credit, and the enhancement of their own political status relative to other governments. While these are obviously virtually universal phenomena, the factors listed above affect whether such concerns are in the foreground or background during intergovernmental negotiations. The framework for cooperation and conflict is shaped by a number of practical factors: the nature of the issue involved (high politics, involving symbolically freighted issues or specific program-based matters); the site at which the issue is being addressed (at the level of first ministers, for example, as distinct from the level of senior officials, or line department civil servants); and the substantive content of the issue (money, for example, as opposed to jurisdiction).

Let us turn now to several examples of the way in which conflict has been dealt with in the Canadian federal system outside the field of health care. We will reserve our discussion of the *Canada Health Act* and the Social Union Framework Agreement to the final section of this report, where we examine various models of dispute resolution in the health care field.

# Dealing with Conflict in the Canadian Federation: Some Examples

In our examination of Canadian experience, we will pay particular attention to several characteristics of dispute settlement mechanisms: their authoritativeness, compatibility with federal principles, formality, scope, accessibility, transparency, frequency of use, and enforceability. The authoritativeness of dispute mechanisms is bolstered when a third party whose pronouncements are definitive and legitimate offers recommendations to the conflicting parties for resolving their disputes. The authoritativeness of decisions and rulings is based on the legitimacy of the process in the eyes of the parties to the conflict. Is the process open and fair? Is the decision-making authority impartial and balanced in its judgments? A mechanism could be considered compatible with federal values if it recognizes that both levels of government are on an equal footing and have their own competences and policy-making capacities. Both levels of government 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 destructive conflicts. The formality of

dispute mechanisms turns chiefly on whether they have a constitutional or legal foundation. Some dispute resolution mechanisms contain provisions that encourage the conflicting parties to engage in dispute avoidance and informal dispute resolution processes such as mediation before resorting to more formal ones such as resolution by a court or tribunal. Dispute mechanisms range in scope from narrow (focusing exclusively on CHA interpretation, for example) to broad (including for instance, CHA interpretation, fiscal transfers, mobility, and future joint initiatives, as envisioned in the Social Union Framework Agreement). Accessibility depends on the number of people who are party to the agreement and can use the mechanism. Is the mechanism only open to government actors or are interest groups and private citizens also potential participants in the dispute resolution process? Transparency refers to the ease with which the public can access the process, including viewing the documents that are submitted by the conflicting parties and the reports that are produced by the dispute settlement body. The frequency of use depends on the cost, length of deliberations, and the accessibility of the mechanism. The frequency with which a mechanism is resorted to is also related to the perceived likelihood of its leading to a settled resolution of the conflict, which will allow the parties to move on. Enforceability of the dispute mechanism has to do with the binding or non-binding nature of the recommendations, the existence of an appeals process, and the severity of the penalties for non-compliance.

#### The Charlottetown Accord

The Charlottetown Accord (1992) aimed at addressing some of the enduring problems of federal-provincial power sharing by clarifying the roles and responsibilities of the two levels of government in several different policy sectors. It represented the Mulroney government's second attempt to bring about constitutional reform acceptable to Quebecers, and included changes in Aboriginal self-government and senate reform. What is relevant for our purposes is that it made provisions for conferring legal status on intergovernmental agreements and for creating dispute mechanisms to resolve issues concerning the common market and self-government, although the details were very sketchy. Had the Charlottetown Accord been enacted, the first ministers would have been responsible for determining the role, mandate, and composition of the common market dispute mechanism. The mechanism for resolving self-government disputes would have involved mediation and arbitration and would have been set out in a political accord.

In 1992 Canadians rejected the Charlottetown Accord in a referendum. Thus, a wide-ranging constitutional package did not prove to be a useful vehicle for introducing a dispute settlement mechanism. Incremental agreements between the provinces and territories and the federal government are more promising vehicles for creating dispute mechanisms. They can more easily be implemented than constitutional reforms because they do not require as many individuals to give them their stamp of approval and the issues under consideration can more easily be disaggregated.

## Environmental Policy: 1987-1990

In the environmental policy field, as in health care, there have been vigorous debates over the appropriate role of the national government in a federal system since there is some overlap of jurisdictional responsibility in both areas. We will examine federal-provincial relations in environmental policy during two time periods: 1987 to 1990, and 1991 to the present. The former period illustrates an informal federal leadership approach to dispute resolution where harmonious intergovernmental relations were put to the test, whereas the latter illustrates a more collaborative approach. The environmental example will show that collaboration between federal and provincial governments does not necessarily produce better policy outcomes than when the federal government takes a leadership role.

During the late 1980s the federal government sought to renew its regulatory activity in the area of environmental assessment through the *Canadian Environmental Protection Act* (1988) even though the provincial governments, particularly Quebec and Alberta, strongly objected to its "interference" in provincial resource-management decisions. <sup>24</sup> In a sense, the federal government had its leadership role thrust upon it. It was motivated to take a stronger leadership role than it had traditionally claimed by a federal court decision in 1989, which ruled that the government "had to adhere to the terms of its own Environmental Assessment and Review Process (EARP) and conduct environmental assessments on two dams on the Rafferty and Alameda rivers" (Conrad 1999, 40). Pressure from environmentalists and the court's verdict made it impossible for the federal government to "restore intergovernmental harmony simply by retreating from the field," <sup>25</sup> as it had tried to do in the past.

A number of different mechanisms were in use between 1986 and 1990, including informal (for example, meetings between provincial and federal offi-

cials at advisory meetings) and formal dispute mechanisms such as the federal court. The authoritativeness of the federal government's unilateral initiatives (including the 1988 Canadian Environmental Protection Act, the Canadian Environmental Assessment Act, and the 1990 Green Plan) was bolstered by the court decision and public opinion, which has "consistently supported a stronger federal role in the protection of the environment" (Winfield 2002, 124). Federal relations were strained during this time period, but there is little evidence that the governments' adherence to the principle of federalism suffered. One of the advantages of competitive federalism was that there was very little overlap and duplication between the federal and provincial programs (Winfield 2002, 127). The scope of federal environmental policy expanded because there was an increase in international pressures on Ottawa to enact more sustainable policies, and citizens became more determined that the environmental ramifications of economic development should be considered (see Skogstad and Kopas 1992). Accessibility grew as environmental groups learned to use the courts to encourage government to take a more proactive stance in enforcing regulatory standards. Governments needed to at least appear to be more responsive to the public. They invited industry representatives and environmental groups to comment on regulatory changes in key forums such as the Canadian Council of Ministers of the Environment. Meetings of provincial and federal officials became more frequent. Policy innovation and enforcement of environmental regulations became a priority.

In the 1990s the federal government shifted from using a leadership model to a more traditional cooperative one. Mark Winfield attributes the shift to "national unity concerns and neo-liberal ideas" and regrets that they "have intruded into and overridden environmental protection goals" (2002, 124).

# Environmental Policy: 1991 to the Present

Part of the impetus behind the harmonization initiative in the 1990s was to illustrate the federal government's flexibility and the potential for non-constitutional policy reform with respect to one of the leading irritants in intergovernmental relations (Winfield 2002, 127). A collaborative approach in the area of environmental policy is clearly illustrated by the Canada-wide Accord on Environmental Harmonization (1998) and its three sub-agreements on inspections, national standard setting, and environmental assessment. The Accord was signed by all provinces that were represented in the Canadian Council of

Ministers of the Environment, except Quebec. Conrad (1999) notes that in signing the Accord the federal and provincial governments "agreed to move toward a radical reallocation of environmental responsibility, shifting away from the bilateral arrangements or less formal multilateral arrangements, to ... multilateral coordination and joint action" (43). The governments agreed to cooperate in conducting a single environmental assessment and review process for cross-jurisdictional issues. This cooperation was intended to make it easier for them to share information and expertise on environmental problems.

The government that is "best situated," using criteria such as physical proximity and capacity to address client and local needs, which appear to favour the provinces in most cases, is to deliver the services under the "one-window" mechanism (Winfield 2002, 129). The Accord and the sub-agreements can be altered only with the unanimous consent of the signatories, although a government can withdraw from the arrangements on six months' notice. If there is an intergovernmental disagreement within the inspections sub-agreement, six months of consultations are required, after which, if the concerned government is still not satisfied, it has the option of withdrawing from the sub-agreement after the sixmonth notice period. Disagreements with respect to the implementation of national standards call for an effort on the part of the concerned governments to develop an "alternative plan," but there is no provision for the dissatisfied level of government to act where it judges the other government has failed to acquit its obligations satisfactorily (Winfield 2002, 129-30).

Winfield argues that the collaborative approach to environmental issues has greatly reduced the level of intergovernmental tensions in the field, but notes that, with the race to the bottom among the provinces continuing, it is apparent that good intergovernmental relations do not necessarily equal good substantive policy outcomes. He argues that the earlier, conflictual era of competitive federalism "seemed to produce far better results for the protection of the environment" (2002, 131-32). The federal government will be hard pressed to regain the leadership authority it needs to respond to domestic and international developments related to environmental matters.

## Canada's Agreement on Internal Trade

The Agreement on Internal Trade, <sup>26</sup> signed in 1994 by all Canadian governments, provides an example of a quasi-formal dispute settlement mechanism in a collaborative setting. It is not as formal as a legal document, since

it is a political accord, and is not justiciable. Nevertheless, the creation by all governments of the Internal Trade Secretariat in Winnipeg indicated a determination to institutionalize the arrangements, and the Agreement certainly requires governments to engage in a greater level of consultation or "process" when introducing measures affecting internal trade than was the case before it was enacted (Certified General Accountants 2001, 5). The Agreement is aimed at reducing barriers to the free movement of goods, services, investments, and members of the workforce across Canada. As in the health care case, harmonization was a contentious concept in the negotiation of the AIT, with the federal government wanting to assert national standards and the provinces resisting them (Doern and MacDonald 1999, 136).

The dispute settlement mechanism, described in chapter 17 of the Agreement on Internal Trade, is designed to facilitate the resolution of disputes between governments, and between governments and businesses. If disputes are not settled through cooperation (consultation, mediation, and conciliation) they can be referred to a panel for arbitration. Individuals, companies, and governments can use the mechanism. An individual or a business can access the process in one of two ways:

- > An individual or a business may request that their government pursue the government-to-government dispute resolution process. This process may lead to a request for the assistance of the Committee on Internal Trade and a dispute resolution panel of experts.
- > If the government chooses not to step in, an individual or business may proceed under the private party-to-government dispute resolution process and request consultations. At this stage the complaint will be assessed by an independent screener who will determine the merit of the request. If a complaint has merit, a panel is formed (see MacDonald 2002, 146).

The transparency provisions of the AIT are limited. Consultations are confidential. Although all proceedings before a panel are public, all documents filed are accessible only to the parties (see Doern and MacDonald 1999, 139).

The panel process is time-consuming (there is a 545-day wait for the submission and implementation of a panel report, and a further 365 days for meetings to discuss non-compliance). The panel can make its findings public and offer recommendations (Alberta 1997). The two government-to-government disputes that have been subject to the panel process have both led to provincial

compliance with the panel findings (MacDonald 2002, 146). The decision from the first person-to-government dispute resolution panel under the Agreement on Internal Trade was made public in December 2001, sixty days after its issuance, to put pressure on the party complained against (Ontario) to comply with the recommendations in the panel report (Internal Trade Secretariat 2001).

Critics point out that "aspects of the mechanism make the AIT more complex and cumbersome than it should be (for example, limited private-party access, lack of a right to appeal, and dubious enforceability measures, not to mention multiple procedures for different industries)" (Clendenning 1997, 47). Its detractors regret that the scope of the institution is somewhat limited since, if Ottawa is unhappy with the functioning of the AIT, it has the option of bypassing the mechanism entirely and introducing legislation to remove barriers, using its constitutional trade and commerce powers (Howse 1996, 13-14). For example, Bryan Schwartz argues:

Given its limited scope of application and many exceptions, the AIT is a smallish and rather mild-mannered tiger. When it becomes clear that the terms of the agreement are offended, the guilty party is expected, as a matter of honour, to mend its ways. If it does not do so, the agreement may be cited to bring public attention to the offender's shameful conduct. If the offender is still unrepentant, the agreement can provide no further relief except that the victimized party is authorized to retaliate. (1995, 212-13)

Defenders of the AIT dispute mechanism, however, praise it as "a first step" in a longer process of improving intergovernmental trade relations. Furthermore, they argue that in circumstances such as those in Canada, in which the probability of repeated trade is very high, the incentive on the part of the actors to play by the rules of the game may be very high, making a political process, rather than a binding legal one, effective. Indeed, as time passes, and the AIT becomes more deeply institutionalized, "the politically based dispute resolution mechanism may be all that is necessary to maintain the AIT" (MacDonald 2002, 147).

A number of lessons can be drawn from the AIT example which may have relevance for the health care case, such as the importance of including incentives for conflicting parties to settle their disputes through blame avoidance, and the need to use informal dispute resolution processes before using formal ones. The AIT experience also suggests that a dispute mechanism does not need to be

legally binding to be effective, but that there must be sufficient political and economic incentives to encourage individuals, companies, and governments to use it.

# Labour Market Policy

The labour market has also been the topic of sustained discussions among academics and policymakers over the appropriate role of the national government. The Charlottetown Accord envisioned making labour policy the exclusive jurisdiction of the provinces in order to relieve some of the intergovernmental tension relating to this matter. That proposed change, along with the introduction of a dispute mechanism for the common market and the other provisions in the Charlottetown Accord, was rejected in 1992. The bilateral Labour Market Development Agreements, signed in 1996 and 1997 by Ottawa and eleven of the twelve provinces and territories, are of interest because they embody an attempt by the Government of Canada to reach concord in a controversial intergovernmental file by a process of differential decentralization. In 1996 Ottawa offered to transfer all of its labour market programs plus the associated funding and staff to the provinces, provided certain basic conditions were met. The Labour Market Development Agreements that were signed between the federal government and the provinces and territories have been classified into several types: the "co-management model" (Newfoundland and Labrador, British Columbia, Prince Edward Island, and Yukon Territory); "full-transfer agreements" (New Brunswick, Quebec, Manitoba, Saskatchewan, Alberta, Northwest Territories, and Nunavut); and a "strategic partnership" (Nova Scotia). Only Ontario has yet to sign an agreement. Thomas Klassen observes that:

Under the co-management model, there is no transfer of resources (either dollars or staff) to the provinces, but a joint management of program design and implementation ... The full-transfer model, on the other hand, involves provinces assuming responsibility for labour market policy and program delivery within the federal funding and client eligibility constraints. The federal government retains responsibility for the delivery of EI benefits and pan-Canadian initiatives such as national labour market information and exchange, as well as responding to economic emergencies ... The only requirement of the [strategic partnership] agreement is that a joint-management committee be established to examine the areas of joint cooperation and collaboration. (2000, 177)

The advantage of this new regime is that it allowed the provinces to "negotiate and tailor their particular agreements to meet their specific needs and wishes" (Hanson 1999, 132-33). However, the Agreements offer few opportunities for citizen engagement, have weak accountability mechanisms, and do not as yet include Ontario. Moreover, as Klassen comments, the danger of the new regime for the provinces is that "they provide services but ultimately the federal government, along with macroeconomic conditions, determine the size of the caseload" (2000, 194).

What has been the effect of this initiative? Herman Bakvis (2000) contends that it was an intergovernmental success, in the sense that it effectively resolved some long-standing issues in the intergovernmental arena. On the other hand, he acknowledges that, at the federal political level, there is some disenchantment with the loss of visibility and the minimal credit Ottawa has won for its initiative; that, in Quebec, checkerboard federalism – asymmetry for all – does not directly address that community's desire for distinct recognition; and that, in terms of good public policy, devolution inevitably undermines the country's capacity to formulate national labour market strategies (215-16). The labour market case illustrates that the federal and the provincial and territorial governments can design innovative and workable asymmetrical solutions to long-standing intergovernmental problems, but that these may imply increasing inequities across the nation.

## SOME RELEVANT COMPARABLE EXPERIENCE

ere we examine a number of approaches to conflict management that have been employed elsewhere in the world. We begin by reporting on arrangements (ranging from most advanced to least advanced) designed to resolve disputes among international actors. In the second section we explore relevant experience in other countries that are in some ways similar to the Canadian federation. Here, as in our discussion of the Canadian experience, the criteria for comparing the dispute mechanisms include: their authoritativeness, compatibility with federal principles, formality, scope, accessibility, transparency, frequency of use, and enforceability record. It is important to examine their design closely because provisions of existing national and international dispute mechanisms that have proven to be effective can be borrowed for the creation of new mechanisms in other sectors and countries.

# International Organizations

The European Union has been described as more advanced than the other examples of international mechanisms that follow. Clendenning, for example, considers the European Union to be the most highly developed on several counts:

It provides direct access for both private and public parties through national courts and the European Court of Justice. In addition, it provides for the direct effect of secondary legislation and allows Commission directives to supersede national legislation in the establishment of the economic union. Indeed, the EU has made continuing strides in expanding the scope of the economic union through amendments to the Treaty of Rome, the adoption of Commission directives and compliance precedents established by Court of Justice rulings. (1997, 45)

We will describe the dispute mechanisms of the European Union in more detail before examining two other international mechanisms, the World Trade Organization and the North American Free Trade Agreement, and national mechanisms in two federal countries, Belgium and Australia.

#### The European Union

The European Union (EU) has a highly rules-based, confederal structure that some observers have suggested has relevance for dispute resolution in the Canadian social union (Biggs 1996, 22). In order to participate in the EU, governments must consent to share a measure of their sovereignty with a network of supranational institutions. Informal processes (for example, meetings in advance of official conciliations) smooth the interaction between institutions responsible for the adoption of European Union legislation (Garman and Hilditch 1998, 283), including the European Commission, the Council, the Parliament and the Court of Justice (ECJ). The Union is supported by a group of officials dedicated to making the whole system work.

The commissioners have the authority to oversee and implement treaties between member states without being directly accountable to their own governments. The Council of Ministers is the main legislative body with the mandate to define the EU's general policy guidelines. Regarding the matter of transparency, Steven McGiffen critically observes that: "In common with the other major decision-making bodies of the European Union – with the exception

of the European Parliament – the European Council shrouds itself in a Kremlin-like secrecy which seems to many quite out of keeping with what might be expected from a community of democratic nations" (2001, 15). The Parliament, which derives its authority directly from the voters of the member states, considers the Commission's proposals and shares budgetary powers with the Council. Depending on the type of policy instrument emanating from the Council of Ministers, enforceability varies. Regulations are automatically binding in member states without any action on the part of their government; directives give each member state the opportunity to decide how to achieve the objective prescribed by the European Union; decisions target a particular member state, company, or individual; and recommendations are completely non-binding.

The Court of Justice is the most formal body for conflict resolution. The ECJ mechanism is used frequently and its scope is very broad, encompassing all of the legal issues that arise in the member states. The Court's decisions are highly credible since "the Commission, its member states, business firms and individuals can all take action directly to enforce EU provisions with the certainty that Union law will supersede any national law" (Clendenning 1997, 6).

Critics have suggested that the European Union suffers from a "democratic deficit" because the supranational institutions like the Council of Ministers and the European Court of Justice meet in secret and are not directly elected, yet they have the power to direct national legislatures. Other observers, like Moravcsik (1993, 515), contend that the "'democratic deficit' may be a fundamental source of its success" (Biggs 1996, 23). Governments can bargain and reach consensus with relatively little constraint from citizens and interest groups on issues related to all sectors and types of barriers. At the same time, business firms and individuals do have access to the EU dispute settlement mechanisms, which is one of the reasons that they have been used frequently. The EU example shows the importance of informal processes for resolving disputes even when a highly formal structure like the ECJ is in place.

#### The World Trade Organization

The World Trade Organization (WTO), which came into being in 1994 after the Uruguay Round of trade negotiations, is based on the principle of formal equality among actors. The dispute mechanism of the World Trade Organization is highly developed, especially compared with that of its precursor, the General Agreement on Tarriffs and Trade (GATT). It was set up in order to

prevent the competitive raising of trade barriers and to ensure that major players did not shirk their GATT responsibilities at the expense of poorer countries.

The World Trade Organization is a forum for resolving disputes among countries through consultation or, failing that, a procedure that includes the possibility of a panel and an appeal. Any interested member states can participate in the process as "third parties." The panel may consult experts, upon agreement from the disputing members, in order to determine whether or not a member has violated its WTO obligations.

Decisions of WTO panels may be appealed to the standing WTO Appellate Body, where seven members with experience in law and international trade re-examine the case. The WTO's Appellate Body has the authority to reject the expert panel's interpretation of the agreements and overturn its ruling. The final step in the WTO's dispute mechanism process is as follows: the decision of the panel or Appellate Body is "presented to all WTO Members for adoption at a meeting of the Dispute Settlement Body (DSB). Panel and Appellate Body decisions are adopted by so-called 'negative consensus': they are adopted unless there is a consensus of all DSB Members not to do so. Once adopted by the Members, the report becomes a 'WTO ruling' " (Department of Foreign Affairs and International Trade 2001).

The dispute mechanism is available only for contracting parties to the Agreement; hence its frequency of use is limited. If individuals or firms have grievances that they want resolved through this mechanism, they have to persuade their own governments to take up their cause (Clendenning 1997, 9), in which case panels composed of three members seek a resolution. The decisions and rulings that are made by the panel are highly credible, since measures are taken to prevent the panel from becoming vulnerable to political influence. For example, the members on the panel do not come from countries that are party to the dispute. Although the deliberations and written submissions of the panels are confidential, the disputing parties have the option, which Canada uses, of disclosing their own positions to the public. Parties have some incentive to comply with the recommendations, since compensation is theoretically "available in the event that the recommendations and rulings of a panel of the Appellate Body are not implemented within a reasonable period of time" (Epps 2001, 71). However, enforcement of compensation is difficult. The primary remedy is to bring the offending measures into conformity with the relevant agreement.

Critics contend that the WTO does not provide adequate protection for

smaller countries that are not economically able to retaliate effectively against stronger economies (Zekos 1999; Bhagwati 2001). As well, William Davey (2000, 167-70) suggests that the WTO dispute settlement system is weakened by the absence of permanent panellists and sufficient staff support. Nevertheless, the WTO has attracted positive commentary for its success in opening markets, increasing predictability in trade relations among states, and improving on the impressive dispute settlement record that existed under GATT (Grané 2001). Whereas 300 disputes were dealt with through GATT between 1947 and 1994, 167 cases were dealt with by the WTO between 1995 and March 1999 (WTO 1999, 5). The number of cases indicates the members' confidence in the WTO dispute resolution process. Observers have also stressed the importance of the Appellate Body as an innovative feature that bolsters the WTO's "impartiality, integrity and independence" (Clendenning 1997, 54) and could be incorporated into other dispute resolution mechanisms.

#### The North American Free Trade Agreement

The North American Free Trade Agreement (NAFTA) is the successor to the Canada-US Free Trade Agreement (FTA) (Rosa 1993, 255) and is designed to eliminate barriers to trade in goods and services between Canada, the United States, and Mexico. Like the FTA, it has formal dispute mechanisms that involve consultation, arbitration, and mediation (although mediation is used infrequently). Thapter 20 provisions of NAFTA (under chapter 18 of the FTA) involve government-to-government proceedings. Chapter 19 provisions govern the settlement of anti-dumping and countervailing duty cases and allow individuals and companies to bring cases against governments even without the consent of their home government (Appleton 1999, 94). NAFTA created a binational panel process to review trade determinations by domestic agencies and apply the law of the importing country (Hoberg and Howe 1999, 4). Parties are required to resolve the dispute by agreement in accordance with an arbitral panel's findings within thirty days of the release of the report (Crommelin 2001, 142).

Canadian critics argue that the credibility of NAFTA decisions may be compromised for several reasons: (1) The proceedings lack transparency. All panel hearings and submissions are treated as confidential, and only the final report is released fifteen days after it is submitted to the Commission; (2) There is no opportunity for non-parties such as interested members of the public to participate, although expert testimony may be permitted if both parties

approve; (3) There is an inherent bias favouring the nation with the majority of panellists; (4) The arbitrators "may not have any familiarity with Canadian law or health policy objectives and little real sense of Canadian values"; (5) "Arbitral panels are not required to follow the decisions of previous panels. This means that there is uncertainty whenever a dispute comes before such a panel"; (6) "There is no right of appeal or judicial review from the decision of an arbitral panel" (Epps 2001, 103-4). An expert challenge panel can address allegations of gross misconduct but, unlike the WTO's Appellate Body, it cannot confront the issue of interpretation.

The strengths of the FTA and NAFTA dispute settlement mechanisms are that they provide: "(1) a specific forum in the Commission for consultation and mediation; (2) a defined timetable set for stages of dispute-settlement procedure; (3) an option to retaliate with 'equivalent effects' if either party is not satisfied by the Commission decision; (4) a more rapid process than that of the GATT; and (5) the development of a body of 'jurisprudence' on Canadian-US [and Mexican in the case of NAFTA] trade within the Commission' (Campbell and Pal 1991, 220).

In general, the FTA and NAFTA dispute settlement mechanisms have created a more predictable trading environment, but observers have made compelling recommendations to strengthen them. Some of the lessons that could be drawn for the health care case are that the credibility of a dispute mechanism can be improved by making it more transparent, allowing interested members of the public to participate, requiring panels to follow earlier decisions, and making provisions for an appellate body with panellists appointed for specific terms to review rulings.

# Dispute Resolution Bodies in Other Countries

Belgium's Conseil d'État

Belgium's Conseil d'État (supreme administrative court) and Comité de Concertation are of interest because they are authoritative institutions in a complex, decentralized environment, and their pronouncements for resolving intergovernmental disputes are widely viewed as legitimate (Commission on Fiscal Imbalance 2001b, 33). Subnational governments in Belgium (as in Canada) play a significant role in central decision making, just as member states do at the supranational level in the EU. The Conseil d'État is an example of a formal dispute mechanism with a

broad mandate. It reviews draft legislation prior to implementation, including all constitutional amendments, to ensure that each order of government does not overstep its jurisdiction. In some cases, its assistance in reviewing legislation is compulsory, in other instances it is optional. Its decisions are credible since it is composed of experts in various fields who have a reputation for providing uniform, consistent interpretations of legislation. Its decisions are enforceable. It can annul administrative acts and regulations that are incompatible with existing legal opinions, or suspend their execution. The Conseil d'État has the power to refer draft legislation to the Comité de concertation if the legislation risks sparking jurisdictional conflict. The committee, which is composed of representatives of all governments, then reaches a consensus on the contentious matter. If legislation is developed that may exceed the competence of the level of government, governmental actors or interested individuals can refer the matter to the Court of Arbitrage, which acts as an independent arbitrator among the federal state, the communities, and the regions, and protects the rights of citizens. The Court has the authority to cancel the offending legislation within six months of its publication and to rule on preliminary questions.

These dispute resolution mechanisms allow intergovernmental issues to be treated in technical and legal ways and minimize the political considerations that would otherwise surround disputes.

#### Australia's Council of Australian Governments

The Council of Australian Governments (COAG), which was established in 1992, is a collaborative forum where disputes between the federal, state, and territorial governments can be resolved through negotiation. It evolved out of traditional premiers conferences as a way of making Australian intergovernmental relations more cooperative and productive. Margaret Biggs identifies the features that distinguish COAG from premiers conferences: "What distinguishes COAG from the Ministerial Council system is that it addresses areas of national significance and has a central agency, 'whole of government' perspective. COAG is a forum for spearheading reform, challenging existing processes and thinking, and making the cross-sectoral linkages and trade-offs that are often essential to a 'national' solution' (1996, 26).

The scope of COAG is very broad. Within this intergovernmental body, political actors tackle such difficult issues as competition, Aboriginal policy, and taxation policy. Representatives of the two levels of government have used the

forum to initiate "major policy reforms across a wide range of sectors, in relatively short periods of time" (Biggs 1996, 28). There is a lot of pressure on parties to reach an agreement in the latter stages of the negotiation because COAG operates under a unanimity rule. If a consensus is not reached, the parties have few options for settlement other than handing over outstanding issues to other intergovernmental bodies. COAG decisions are not enforceable and its existence is tenuous. Since it was created by agreement, it could simply be dissolved if the parties no longer supported it.

The credibility of COAG is diminished by the fact that the public is not privy to the negotiations but is only informed of the results through communiqués at the end of the meetings. Some critics are concerned that COAG has the potential to undermine parliamentary accountability (Painter 1996). Nevertheless, the forum attracts a lot of popular support and praise from policy experts for creating more cooperative intergovernmental relations by facilitating the development of shared language and relationships (Painter 2001).

# COPING WITH CONFLICT AND DISPUTES IN THE HEALTH CARE FIELD

fter setting out some of the factors that will frame our analysis of dispute resolution approaches, we will examine the Canada Health Act (CHA), both because it is central to the Canadian health care system and because it offers a useful base-case scenario for considering alternative ways of tackling the resolution of conflict in the health care field in the Canadian federation. This analysis will lead to a framework for understanding the nature of conflict in the health field, which we will then use as the foundation for an evaluation of a number of alternative approaches to the resolution of conflicts between the federal and provincial governments in the field of health. Our focus, as we have said, is on disputes among governments, not on conflicts in the private sector or conflicts between citizens and the state. We do not include any discussion of possibilities that would require constitutional change, as these lie beyond the range of practical politics.

In a federal state, the pattern of conflict is established to a substantial degree by the distribution of jurisdictional authority between and among the federated governments. These conflicts may be rooted in the aspirations and con-

victions of the populations in the various parts of the country, or they may be more restricted to the political ambitions of political leaders and other actors.

Some conflicts are so deeply rooted in the cleavages and fault lines of the country that they are better regarded as eternal facts of political life than as disagreements that may, in principle, be resolved. For example, the nationalist conflict concerning Quebec's status within or outside of Canada is of this character. Efforts at conflict resolution have involved the entire Canadian state, its political parties, its legislative and judicial institutions, and its people. This is not the sort of conflict we are speaking of in this paper, although it is eminently capable of spawning the second- and third-order conflicts that *are* the subject of our study. Indeed, Quebec's constitutional views and its position on health care jurisdiction set it decidedly apart from all the other provinces — so much so that much of the discussion of alternatives in this paper, which presupposes normal participation of the government actors in the system, does not really apply at all to Quebec, whose involvement in national health care discussions is greatly limited and deeply ambivalent.

While a conflict will almost always be framed in the vocabulary of justice and fairness, a dispute may have its origins in one or more of a fairly wide range of differences: ideological or policy disagreements; a quarrel over money and resources; the drive for status or reputation; the desire for political credit or public reputation; the ambition to control and direct; and differences of view about programs and program implementation. For the purposes of our discussion here, we will focus chiefly on money and policy authority as the two main matters around which disputes tend to form in the health care field. This is not to say that the quest for political credit, political ideology, and jockeying for reputation and position have no role to play, but simply to say that such factors tend to be implicit or unacknowledged in the dispute and are mediated through the formal, public discourse, which normally focuses on money and policy authority. The federal-provincial fiscal transfer system and the provisions of the *Canada Health Act* are emblematic of this twofold reality.

Given the realities of politics, the needs of politicians and the differing orientations of widely dispersed communities in the Canadian federation, recurrent conflict should be taken as a given. The point is not to get rid of it, but to try to ensure that there are productive channels for its expression and for its resolution when the time is right. Conflict can arise at the level of officials, ministers, or first ministers. As we said earlier, the record of collaboration and quiet, effec-

tive conflict management is very good in Canada at the level of officials and line departments; the great majority of the public business of Canada is carried on efficiently beyond the hurly-burly of political debate. It is when intergovernmental conflict breaks out at the political level of ministers – and, especially, first ministers – that the concern for dispute resolution processes arises. This is the level at which our investigation proceeds.

#### The Canada Health Act

The main instruments for regulating governmental behaviour in the health field are the *Canada Health Act* and the ten provincial health acts. The *Canada Health Act* is a case of one of the actors, heavily implicated in a complex system, announcing rules for the conduct of the other actors, and determining for itself whether the rules have been flouted, and whether a penalty should be imposed.<sup>29</sup>

Because of its central importance to the Canadian health care system, we will examine how the *Canada Health Act* has operated over time. What is of particular interest is the role that formal sanctions have played in shaping behaviour and in exacerbating or diminishing conflict between Ottawa and the provincial governments. Underlying the CHA are several assumptions: that there is a national interest in maintaining a public health insurance system in the country; that Canadians, wherever they live, are entitled to broadly comparable services; and that the federal government has a responsibility to enforce provincial compliance with respect to key elements of the health insurance system.

What has been the impact of the CHA on federal-provincial cooperation and conflict? What are the options for using the Act as a dispute mechanism in the future? These are the questions that are central to our discussion. In order to set the context, let us review the terms of the Act, the processes and arrangements for enforcing compliance, the cases in which a penalty was imposed or was contemplated but was not imposed, and the strengths and weaknesses of the current system.

The Canada Health Act, which was enacted in 1984, re-established the four principles that have been in place since medicare was introduced, and added the principle of accessibility. The five criteria with which provincial health insurance plans must comply before they qualify for a cash contribution from the federal government are public administration, comprehensiveness, universality, portability, and accessibility.<sup>30</sup> The Act also bans extra-billing and

user charges. If provinces contravene these two conditions, there is an automatic dollar-for-dollar penalty. As the Canada Health Act Overview explains, an automatic penalty means that "if it has been determined that a province has allowed \$500,000 in extra-billing by physicians, the federal transfer payment to that province would be reduced by that amount" (Health Canada 2002). Through orders-in-council, financial penalties can legally be imposed for not complying with the five criteria and two conditions of the Act. However, no discretionary penalties have ever been applied for contravening the conditions of universality, comprehensiveness, and accessibility. The Canada Health Act Overview indicates that if the penalty is discretionary, "the amount of any deduction is based on the gravity of the default." The Canada Health Act Division, part of the Intergovernmental Affairs Directorate, Health Policy and Communications Branch, Health Canada, is responsible for administering the CHA. It advises the Minister of Health on whether to make deductions. The Minister then communicates the amount of any deductions to Finance officials after informing the province of the problem, obtaining its explanations, drafting a report on its concerns, and sometimes holding a meeting with the province to discuss the issue.31

Federal government enforcement of the Act has been sporadic, a fact that reflects the deeply politicized nature of the process. The federal government imposed around \$245 million in cash penalties against seven provinces for extrabilling in the first three years after the Act was introduced. After the violations ended, the money was reimbursed. The *Canada Health Act Overview* notes that "the second period of deductions related to extra-billing in British Columbia during the period 1992-1995" (Health Canada 2002). British Columbia lost \$2,025,000 in Established Program Financing (EPF) transfer payments because some doctors extra-billed. Then, in the second half of the 1990s, \$6 million was withheld from the provinces, specifically Newfoundland and Labrador, Nova Scotia, Manitoba, and Alberta, where patients had been charged a facility fee for medically necessary services at private clinics. Since 1999 Nova Scotia has lost \$57,360 in transfer payments for contravening the Act concerning the federal policy on private clinics. <sup>32</sup>

There have been many instances in which a penalty was contemplated but was not imposed. For instance, the provincial governments have contravened the spirit of the CHA by providing uneven access to abortion services (there are no services in Prince Edward Island, and only in 1996 did Alberta shift from no coverage to full coverage at clinics) and by denying medical services to British Columbians if they did not pay fees to be enrolled in health insurance. In fact, the discretionary penalty provisions of the Act have never been applied.<sup>33</sup>

The Auditor General has been critical of the federal government because it has never required the provinces to give the detailed information required in section 23 of the Act (the provinces are expected to indicate the degree of their compliance with the Act in general and the extent to which they have satisfied the five criteria and two conditions); nor has Health Canada provided this information to Parliament.<sup>34</sup> The federal government's lack of political will to systematically enforce the CHA may be traced to its reluctance to get involved in an intergovernmental dispute in an area of provincial jurisdiction unless it is obviously in the short-term interest of the federal political leadership.<sup>35</sup> Enforcement is not subject to the initiative of non-governmental actors: citizens and non-governmental organizations do not currently enjoy the right of launching actions under the CHA – only the Government of Canada can do that.<sup>36</sup> So, although the CHA is highly popular with Canadians, citizens have been effectively locked out of its processes.

It is important to consider the effect of the CHA on federal-provincial cooperation and conflict, since the only formal dispute resolution mechanism associated with an intergovernmental impasse in the federal-provincial/territorial health conference system pertains to the principles and conditions identified in the Act (O'Reilly 2001, 119). The federal government's style of enforcement of the CHA contributes to federal-provincial cooperation only insofar as some of the provincial leaders may secretly be relieved that national principles like the portability of services exist. But it has been argued that Ottawa's approach to enforcement does much more to exacerbate intergovernmental tension than to relieve it. As Joan Boase has observed, the intergovernmental negotiations to resolve conflict relating to CHA interpretation and enforcement have tended to be "highly politicized, confrontational, and competitive. This has resulted in residual feelings of intergovernmental resentment, suspicion, and frustration well beyond the health arena" (Boase 2001, 194). At the same time, Health Canada (2002) implies that it is important not to overstate the degree of conflict in this area. It emphasizes that almost all CHArelated disputes have been resolved through informal consultation with the offending governments without resorting to penalties. It is undeniable that the existence of this federal legislation has helped to preserve the basic architecture

of the Canadian health care system, at least insofar as it rests on the five principles specified in the statute. While we cannot know for certain how health care in Canada would have evolved in the absence of the CHA, it seems clear that, without it, respect for the basic principles that have shaped its operation would have been attenuated over time.

All these factors make the *Canada Health Act* a very interesting case in point in the dispute resolution field. It is federal legislation, passed by the Parliament of Canada alone. Using federal fiscal transfers as leverage, it provides for the imposition of fiscal penalties on provinces that do not comply with its five principles and two conditions. The principles are vague and undefined. The administration of the Act is highly political, in that the federal government chooses not to apply its provisions impartially and systematically, but circumstantially and politically. The regulatory process is not accepted as legitimate by the provinces. Yet it seems certain that its existence has had a good deal to do with the preservation of the basic national architecture of the health care system in this country. Altogether, it leads to a surprising conclusion: that a highly political, selectively applied, unilaterally interpreted federal Act, intervening in a field of undoubted provincial jurisdiction, can have beneficial public policy results.

Having said that, we must recognize that the capacity of the Government of Canada to influence provincial behaviour in the health care field has not relied solely on a piece of legislation, but on the fact that the legislation is paired with a significant federal fiscal presence in the system. As Tom Kent (1997) and others have pointed out, this fiscal presence has been allowed to fade in recent years, leading perilously close to a situation in which Ottawa claims a voice without substantive participation. Beyond the instability that this introduces into the system, the disjunction between voice and presence risks, over time, depriving the federal government of the public legitimacy that has buttressed its role vis-à-vis the provinces in the past.

# The Anatomy of Conflict in the Canadian Health Care Field

Federal-provincial conflict in the field of health is the product of two structural forces: one has to do with policy, and the other with money.

With respect to policy, the provincial health care programs are embedded in a broadly accepted national policy framework expressed by the five prin-

ciples of accessibility, portability, public administration, universality, and comprehensiveness. Extra-billing by doctors and user fees for medical services are widely viewed as being incompatible with the public insurance philosophy that underlies the Canadian health system. The Canada Health Act, and the more recent Social Union Framework Agreement (SUFA), offer the authoritative enunciation of the policy framework within which Canadian health services are to be provided. As an intergovernmental agreement, SUFA confirms the general acknowledgment on the part of Canada's governments that the five principles are structural features of the Canadian system. While the Government of Quebec refused to sign SUFA, it was not on grounds of disagreement with the principles.

As for the question of money, fiscal transfers from the federal government have supported provincial health programs for even longer than the policy framework described above has been in existence. Almost half a century's continuous experience with federal fiscal transfers to the provinces in support of health entitles the impartial observer to conclude that this too is a structural feature of Canada's health care system.

It is, then, not surprisingly, chiefly with respect to money and policy that intergovernmental disputes arise. When they do, an intergovernmental imbalance appears in the processes by which conflicts are addressed.

While there is a good deal of intergovernmental discussion about the nature and level of federal transfers in support of provincial health programs, the technical instrument employed to effect transfers is parliamentary legislation. In other words, with respect to this crucial element of the federal-provincial relationship, it is ultimately Ottawa, and Ottawa alone, that makes the final determination as to the nature, level, growth, and duration of the fiscal transfer. Ottawa's sovereignty in this matter has been confirmed in the courts. There is no formal or informal dispute resolution mechanism relating to this structural feature of the Canadian intergovernmental health support system. There is federal-provincial discussion, negotiation, and contestation, but at the end of the day the Government of Canada unilaterally decides on the terms and conditions of the transfers and submits legislation to Parliament to that effect.

As for the policy side of the intergovernmental relationship, the determining instrument is again a piece of federal legislation, the *Canada Health Act*, which provides for the imposition of financial penalties on provincial governments that fail to abide by its terms – terms, be it noted, that relate to matters falling clearly within provincial jurisdiction. While there is a process of exchange

and discussion with the given province prior to federal action, the decision whether to impose a penalty and, if so, how much, rests with the Government of Canada alone. Again, then, disputes are ultimately resolved by the federal government acting on its own.

We spoke above of several features of dispute settlement mechanisms: their formality, scope, frequency of use, enforceability, and credibility. Canada's mechanisms for dealing with intergovernmental conflict in the health field are informal or non-existent, narrow in scope, and intermittent and unpredictable in their application. They are, broadly speaking, enforceable – that is to say, the federal government's decisions, once made, are usually complied with: in the fiscal domain, the provinces have no choice; in the policy field, the financial penalty, or perhaps public opprobrium, is normally enough to bring provincial governments into line. However, the process and the decisions arising from the process are not typically regarded as legitimate by the provinces, although they would normally be positively viewed among much of the population in English-speaking Canada.

In reflecting on existing arrangements for dispute resolution in this field, there are two dimensions to which we must pay particular attention. The first is the character of the mechanism itself: is there a mechanism, and, if so, what does it provide? In particular, does it meet what one might call the "authority test"? An authoritative voice is critical to an enduring dispute settlement process. When one is dealing with autonomous, democratically elected actors in a federal system, a voice of authority implies two things: that its pronouncements are definitive, and that they are legitimate. Are decisions reached via the given dispute settlement mechanism definitive? — that is, do they authoritatively resolve the conflict? And are they legitimate — that is, do they derive from a procedure that both sides acknowledge as fair and impartial? The second dimension is the scope of the mechanism: to what issues does the mechanism apply? How broad is its sweep? Does it apply to the main elements in the relationship or to only a portion of them?

When approaching it from this perspective, what one discovers in Canada is a system tilted radically in favour of the federal government. To the extent that a dispute settlement mechanism exists, it applies only to the policy dimension of the relationship, not to the fiscal aspect. Within the policy dimension, disputes under CHA are ultimately decided by the federal government – one of the parties to the dispute. With respect to the fiscal transfer system, there

is effectively no mechanism at all, and disagreements are simply left unresolved, with Ottawa finally determining what it is and is not prepared to do. Provincial governments in both domains are subject to the will of the Government of Canada.

This one-sidedness seems dysfunctional, given that the paternalistic position of the central government at the time of Confederation has long since been superseded in most areas by the operating principle of federal-provincial equality; and anomalous, given that health is an area of provincial jurisdiction. Health is the largest expenditure item modern governments face. Current arrangements for coping with intergovernmental relations in the health field suggest a costly institutional immaturity in the Canadian federation that is unlikely to serve the interests and needs of citizens very well. They foster a recurrent and. in some respects, intentionally obfuscatory debate between governments, in which it is impossible to agree even on the most basic numbers. How much does Ottawa really contribute to the provinces in support of health care? Governments cannot agree, and it is almost as if they have been complicit in designing a system in which it is not possible to agree, and in which each side can therefore evade responsibility by shifting blame to the other. This avoidance does not build confidence among Canadian citizens that their welfare is at the centre of the debate.

The actor for whom the current system works best is the federal government. As we have seen, it holds most of the cards; it is viewed by many citizens in English-speaking Canada as the monitor of provincial health care behaviour; and it chooses, with a fairly high degree of autonomy, when and how it will involve itself in the policy field. The grinding, day-to-day management of the system is left to the provincial governments, for whom the often mercurial participation of the federal government is yet another element of uncertainty. Claude Forget has employed an arresting image to describe the conduct of the Government of Canada vis-à-vis the provincial health care systems. He says that the federal government invests in provincial health care like a bondholder but wishes to behave like an equity shareholder; it seeks voice without risk and influence without responsibility. Forget argues that the provinces assume a wide range of risks in performing their health care responsibilities - medical, financial, management, and demographic. In the federal government, they confront not a partner who is prepared to share the risks and burdens of the enterprise, but a creditor who maintains an arm's-length relationship from the provinces and seeks

to exercise control from a distance.38

Using the framework of analysis outlined above, we will block out several alternative dispute settlement models, using the CHA and the existing fiscal transfer regime as the base-case example. In each case, we pay particular attention to the character and scope of the mechanism and relate the model to one of the three notions of the sharing community elaborated by Keith Banting and Robin Boadway in chapter 1.

## DISPUTE SETTLEMENT MODELS

# The Three Notions of the Sharing Community

he idea of the "sharing community" that Banting and Boadway develop refers to the breadth of the community over which health insurance programs are designed to apply. It does not refer to the decision-making process (which is our focus here), but to the extent of the community in Canada over which redistribution, common policy structures, and assumptions of mutual citizen obligation are understood to prevail.<sup>39</sup> The authors describe, but set aside, two extreme versions: exclusive Canada-wide sharing (as in a unitary state), whereby all citizens of a given category receive identical treatment no matter where in the country they reside; and the exclusive provincial sharing community, which effectively assumes no country-wide sharing whatsoever.

Between these extremes, Banting and Boadway identify and discuss three relevant or imaginable alternative conceptions of the sharing community:

- > The predominantly Canada-wide sharing community: This conception would have strong, detailed national standards and strong interregional transfers. It might have a considerable direct federal delivery role.
- > The dual sharing community: This conception would have a full equalization system as well as broad, common program principles applying to health care, as in the current regime. It might be supported by fiscal transfers from the central government to the regional governments.
- > The predominantly provincial sharing community: With this conception, sharing would occur primarily via an un-earmarked equalization transfer, possibly via federal income taxation with selected programs, like

pensions and unemployment insurance, delivered by Ottawa. There would be no conditions associated with an instrument like the CHST, and no equivalent to the *Canada Health Act*.

Since these are alternative conceptions of sharing not decision-making models, it would theoretically be possible to have, let us say, a predominantly Canada-wide sharing community, supported, not by an active federal government exercising oversight and control, but by a powerful intergovernmental compact laying out obligations and responsibilities for all public-sector actors. In reality, however, a predominantly Canada-wide sharing community would likely assign a significant role to the federal government; a predominantly provincial sharing community would likely assign a relatively minor role to the federal government and a correspondingly large role to the provinces; and a dual sharing community would likely assign a balanced role to each order of government.

The relationship between the different conceptions of the sharing community and potential forms of dispute resolution is complex and relies on a number of factors that need to be specified. As a starting proposition, one might argue that the more intense and mutually dependent the relationship among governments is, the greater will be the need for a well-developed dispute settlement arrangement; if there is little or no connection among governments, there will be few disputes and minimal need for conflict resolution processes. The nature of the dispute settlement process may vary, not only by virtue of the relationship's intensity but also by virtue of the nature of the actors that are in relationship with one another. The nature of disputes and the consequent character of the settlement mechanism are likely to differ according to whether it is a question of the federal government playing a preponderant role or a group of provinces working within the framework of a powerful intergovernmental compact.

But there is more to it. One needs to make a distinction between logic and need, on the one hand, and the practical reality of the situation, derived from politics and circumstance, on the other. It may be that the long-standing structural relationship that exists between Ottawa and the provinces in the health care field logically calls for a well-developed dispute settlement mechanism, but the reality is rather different, as we have seen. Why is Canada so weakly endowed with institutions and processes in this area? There appear to be two chief reasons.

The first is the jurisdictional reality of the Canadian federation. Health care is a primary provincial responsibility; Ottawa chooses to contribute to its support, but, in principle, it might not. This discretionary role

creates very different circumstantial pressures and unequal leverage of one actor over the other, while Ottawa, at least at the level of theory, has the option of withdrawing from the intergovernmental relationship and terminating its commitment to the support of health care, there is no way in which the provinces could exercise an option to cease to involve themselves in health care provision and simply vacate the field. Thus there is a power imbalance; Ottawa has the upper hand.

The second reason why Canada's dispute settlement system is not what one might theoretically expect it to be is what might be called the "pay for say" principle. The federal government has substantial freedom of action to determine the conditions under which it will offer financial support to provincial governments. It can therefore structure the framework of the intergovernmental relationship within which it is prepared to participate. It has never wanted an impartial, equitable dispute settlement mechanism to govern its relationship with the provinces, and it has had the power to avoid it.

Considerations of power and circumstance, then, should be very much borne in mind as one reflects on hypothetical alternative dispute settlement regimes. The models we outline below are organized from the least to the most highly developed. This structure makes analytical sense, but the question of how any one of these relates to any given practical reality is a matter for detailed consideration in the circumstances that exist, not a matter of mechanical application.

### Alternative Models

Model 1. Federal Withdrawal

A designation of intergovernmental roles and relationships consistent with the notion of predominantly provincial sharing communities might involve the following type of arrangements. Ottawa might transfer tax points to the provinces to allow them to fulfill their health care responsibilities as they see fit, and reduce the cash transfers to little or nothing. It might place greater emphasis on the equalization system to redistribute resources in a way that would permit the fiscally weaker provinces to acquit their health care responsibilities to their residents, but the amount to be spent on health care and the way in which it is to be spent would be left to provincial governments. Ottawa would abrogate the *Canada Health Act*, and leave it to the provinces to manage the health care system in a fashion that meets the aspirations of their regional communities.

Governments might agree that the principle of interprovincial mobility would be respected, or, as Lazar, St-Hilaire and Tremblay suggest in Chapter 4, Ottawa might retain sufficient cash leverage to enforce that principle. Ottawa would effectively withdraw from the field, perhaps restricting itself to specific, limited activities, such as public health promotion and the regulation of pharmaceuticals, where the logic of a Canada-wide approach is self-evident. This is the model closest to the preferences of Quebec.

This model, involving substantial federal withdrawal, would address the problem of federal-provincial disputes by diminishing the degree to which the two orders of government are in relationship with one another. The absence of an explicit federal-provincial dispute settlement mechanism would not be felt as a significant institutional lack in such circumstances. The regulation of any common national standards would be maintained by the provinces, through an interprovincial dispute settlement mechanism.

Given the politics of health and the contemporary Canadian system, this model would clearly be a radical change of approach. Nevertheless, one has only to look at the way in which Canadians manage their education systems to see how an arrangement that is in fact very similar works in practice. With the significant exception of federal support for research, Canada's provincial governments run their systems of primary, secondary, and higher education in virtually complete autonomy, with what is effectively no national intervention, not even with respect to mobility; yet it is probably fair to say that these provincial educational regimes, collectively, operate according to shared principles and display common characteristics to the same extent that provincial health care systems do. There is no "Canada Education Act" to parallel the CHA, and the provincial governments have successfully fended off Ottawa's intermittent desire to intervene in this field, but the schools and universities of the country resemble one another to a remarkable degree, and the constraints on interprovincial educational mobility are, all in all, quite limited in their scope. This reality reminds us that public policy and government action are not the only means by which communities preserve themselves and the values they cherish; the notion of "established programs," as in the Established Programs Financing Arrangements legislation of 1977 may in fact refer implicitly to the degree to which certain public programs and policies are embedded in the preferences and expectations of the citizens themselves. A country is more than its publicadministration architecture.

#### Model 2. The Base-Case Model

This system, with which Canadians are familiar, provides for no explicit conflict resolution regime that applies to both the fiscal and policy dimensions of the intergovernmental relationship. Thus the scope is narrow. The federal government sees itself as the dominant player in the field, despite the management and administrative primacy of the provinces, and has structured its central policy instruments to reflect that view. This is apparent in both the fiscal and the policy authority dimensions of the health care field.

Federal fiscal arrangements, despite their considerable structural variety over the years, have always been grounded in federal statute and subject to amendment by the Parliament of Canada. Provinces have been invited to express their views and they have sought to influence federal decisions about the kind and levels of support on offer, but there has never been any question that the final word in the matter rests with Ottawa. There is no authoritative procedure by which provinces can hold the Government of Canada to account for the fulfillment of its fiscal commitments to the provinces. The federal government is free to do what it wishes with respect to the level of transfers it promises and can change its undertakings at any time as circumstances dictate.<sup>40</sup>

At times, the Government of Canada designed the fiscal transfer system itself to achieve certain policy goals. Examples of this strategy can be found in the era of conditional grants, and in the provisions of the Canada Assistance Plan until its disappearance, announced in the 1995 federal budget (Cohn 1996). But even in the era of block grants under the Established Programs Financing arrangements, the federal government felt entitled to assert its policy oversight of Canadian health care. The passage of the CHA in 1984 introduced policy and program compliance requirements for the provinces that laid out the federal government's conditions for giving the block transfer, and discouraged certain forms of provincial behaviour.

The procedures under the CHA for determining provincial non-compliance and consequent penalties described earlier in the paper are perfectly consistent with the assumption of a federal oversight and control function. *Prima facie* cases of non-compliance are identified and investigated by the federal government. Provinces have an opportunity to submit whatever evidence they wish, to counter Ottawa's concern, but a finding of non-compliance is made by the federal government on its own, as is the imposition of any penalty. Should the province contest the finding and the penalty, there is no appeal process, except

the political one of going back to the same federal authority that made the determination in the first place.

The processes under the CHA, which apply to the policy side, clearly favour the federal government. Ottawa designed the procedures, passed the legislation, decides when to trigger the process, and determines whether penalties will be imposed and what they will be. By most standards of conflict resolution, this design would be judged deficient on several grounds: the relationship between the actors is paternalistic rather than egalitarian; only one party has recourse to the instrument; one of the parties acts both as prosecutor and judge; 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

The Social Union Framework Agreement (SUFA) emerged in the late 1990s as the provinces and territories struggled to cope with the sharp reduction in federal support for social programs. They were looking for ways to express and protect the common interest in provincial social programs in the absence of a vigorous federal-government presence, to put pressure on Ottawa to re-engage in the field, and to fashion a more productive, less unilateral style of intergovernmental relations

SUFA can be understood in part as an attempt to address the absence of an autonomous monitor to manage competition and conflict between the provinces and the federal government. This absence should not be understood simply as the lack of a dispute settlement mechanism to regulate particular conflicts between Ottawa and a province or provinces relating to a specific matter, although that was clearly part of the provincial and territorial concern. The design of the framework as a whole reflects an effort to establish a system in which the various relationships between the federal and provincial governments in the social policy field are rendered more stable, more predictable, and more balanced as between the two orders of government.

While a number of observers associate this initiative with the emergence in recent years of a model of collaborative federalism, it should not for that reason be assumed that SUFA contemplates nothing but collaboration among Canada's federal partners. As William Forward, then Assistant Deputy Minister of Ontario's Ministry of Intergovernmental Affairs, observed, SUFA is an example of "governments' agreeing on a workplan for co-operation and a rulebook for com-

petition" (Bakvis and Skogstad 2002, 11). It assumes that both are an ongoing, inevitable reality in intergovernmental relations, and seeks to place conflictual and cooperative behaviour in an orderly frame of reference, and to expose both forms of conduct to the fuller scrutiny of the public.

Perhaps the major innovation, from the point of view of our story, is the effort to redefine the federal-provincial interface on a broader and more synthetic basis, as "the social union," and to subject that complex set of relations and joint activities to the disciplines of collaborative federalism. Thus, section 6 of the Agreement, "Dispute Avoidance and Resolution," is clearly intended to apply to the broad range of intergovernmental social policy matters, and not just to a particular program. Indeed, SUFA makes this breadth explicit by stating that "dispute avoidance and resolution will apply to commitments on mobility, intergovernmental transfers, interpretation of the *Canada Health Act* principles, and, as appropriate, on any new joint initiative." The scope is considerably broadened and explicitly includes federal fiscal transfers. In this way it seeks to deal with one of the deficiencies in the current arrangements.

With respect to the other deficiency, namely, federal dominance of the dispute settlement mechanism itself, it is silent. The provisions are at a very general level, referring to dispute avoidance, fact-finding, mediation, third-party involvement, and public reporting, but the Agreement does not develop any of the ideas in detail. Clearly, that was as far as the federal-provincial negotiations were capable of going at that stage, and, as we will see below, the federal government is not yet prepared to abdicate its privileged position in the intergovernmental process.

Were the federal government prepared to do so, however, the Social Union Framework Agreement might be creatively used as the basis for developing a more balanced and impartial dispute resolution regime. In its present form, the Agreement has clearly broadened the scope or ambit of any such regime; consistent with its central philosophy, it could be employed to construct a dispute settlement process of fuller legitimacy. This might be done even with the continued existence of the CHA, if the Government of Canada declared that it was prepared to have the fiscal transfer arrangements subjected to the provisions of the regime, and if it and the provincial and territorial governments indicated that they would be bound by the determinations made by a dispute settlement process to which they had all agreed. Presumably, the provisions of the CHA would need to be clarified through federal-provincial negotiation, so that con-

duct in compliance or in contravention could be specified with greater certainty. This approach would be perfectly consistent with the collaborative, partnership philosophy that informs the document as a whole.

#### Model 4. The McLellan Dispute Settlement Process

The Social Union Framework Agreement was in part a provincial attempt to balance the forces between the two orders of government in the social policy field. On the money and resources front, there is an attempt to broaden the scope and impose a kind of code of conduct on the federal government's use of the spending power, with notice provisions and the like. As we have seen, the last section of the Agreement asserts the need to develop a formal federal-provincial dispute settlement mechanism that would offer all participants a more settled and orderly process for addressing both fiscal and policy disputes. This provision is of particular importance to the provinces, and, until recently, had been strongly resisted by the federal government. The idea is to subject the federal government to disciplines and accountabilities parallel to those Ottawa has sought to impose, with some success, on the provinces.

In a letter dated 2 April 2002 to her counterpart in Alberta, Federal Minister of Health Anne McLellan proposed a dispute settlement process that appears to respond to the concerns of at least some of the provinces, although it does not fundamentally alter the play of intergovernmental forces and is restricted in its ambit to the CHA, not applying to mobility, intergovernmental transfers, or any other joint initiative, as is contemplated by SUFA.

The letter begins with a discussion of dispute avoidance, arguing that governments need to continue to participate actively in the ad hoc federal/provincial-territorial committees on CHA issues and to exchange information on issues as they arise. The Minister commits Health Canada to providing advance assessments of specific issues upon request to any province or territory.

If dispute avoidance fails, either the federal or the provincial minister of health could initiate the dispute resolution process by following required procedures that would apparently look something like this. A disputes panel would have to be struck and report before any steps were taken by the federal government to enforce the provisions of the CHA. Governments in conflict over the meaning and applicability of the CHA to a particular case would have to agree to collect and share relevant information, prepare a fact-finding report, and make an honest effort to negotiate an end to the dispute. If the issue remained unresolved, either minis-

ter of health could initiate the dispute panel process by writing to his or her counterpart. Within thirty days a panel would be set up, composed of a federal appointee, a provincial appointee, and a third-party chairperson agreeable to both sides. The panel would have sixty days to hand down a report, based on its assessment of the issue in dispute in the light of the provisions of the CHA. The report would be made public.

The federal minister could accept or ignore the report; McLellan's letter states that "the Minister of Health for Canada has the final authority to interpret and enforce the Canada Health Act." As the Globe and Mail says, it is "a new, non-binding dispute-settlement mechanism that would give the provinces the right to a hearing before they face fines for breaching the Canada Health Act." The federal minister is quoted as saying: "I take that [the panel report] into consideration in deciding, which is my right and my right alone, whether I will enforce the Canada Health Act" (Mahoney and Laghi, 2002). This is a step away from unadorned unilateral federal action, since it provides for a federal-provincial process of fact-finding and reporting, but the ultimate authority to determine the outcome remains unequivocally in federal hands. In that sense, then, the Government of Canada remains both prosecutor and judge, although the other actors in a system of federal dominance possess limited tools to challenge federal action that were not available to them before. The procedure remains definitive, and its legitimacy has been increased, although it is still compromised by the dominant role of Ottawa. Furthermore, it is not a procedure that applies to federal fiscal transfers.

#### Model 5. Interlocking Legislation

If there were an intergovernmental will to introduce a substantial degree of formality and certainty into the relationship between Ottawa and the provinces in the health care field, an approach mooted by Richard Zuker is the notion of interlocking legislation; that is to say, interrelated legislation that would be passed through Parliament and the legislatures of the provinces establishing a pattern of reciprocal obligations in the area of health care. Once established, these arrangements would endow the system with significant stability and predictability, because of the mutual obligations created. We will quote directly from the discussion paper Zuker presented at a recent Manitoba conference:<sup>41</sup>

The parties would agree to a funding formula for a period of time with required review provisions ... The federal legislation would

include a provision that the funding formula could not be changed without the approval of a certain number of provinces (and territories?) representing a certain percentage of the population. (For the CPP, it's 7 provinces and 50% of the population.)

In exchange, all provincial and territorial governments would pass the equivalent of the *Canada Health Act*, with the provision that the legislation could not be amended without federal government approval. The federal government legislation would state that some or all of the funding to a provincial or territorial government that amended its CHA-equivalent legislation without federal government approval could be suspended, perhaps with a schedule of fines. In turn, the provincial and territorial government legislation would automatically become null and void, if the federal government modified the funding arrangement without the requisite provincial and territorial government approvals. It is high stakes poker, but that is the general idea.

This approach effectively ties together the policy and fiscal components of the intergovernmental health care regime and imposes equivalent obligations on all the actors in the system. Clearly, to introduce an initiative of this kind would call on a degree of cooperative behaviour and intergovernmental concord that the country has not witnessed for some time. Equally clearly, since both orders of government would be subjecting themselves to an interlocking set of obligations, it would reflect the underlying philosophy of dual sharing communities in which governmental representatives of both communities find the means to work together on the basis of equality.

# Model 6. Bringing the Public In

Canadian governments have been decidedly reluctant to open up their intergovernmental decision-making processes to the active participation of the public, yet giving the public a voice in the proceedings is a potentially powerful tool for aiding the resolution of disputes in a manner that advances the public interest and not simply the interests of the participating governments.

Model 6, developed by Richard Simeon after reading a draft of this chapter, develops one possible approach and is grounded in a recognition of the following realities:

> Ottawa is not going to transfer to a provincially dominated body its

right to make its own fiscal decisions, nor is it likely to forgo its ultimate capacity to determine contraventions of the principles of the *Canada Health Act*.

> Provinces are not going to agree to any mechanism which provides for significant unilateral federal intervention in the operation of their provincial health care systems, nor will they assent to a mechanism that entrenches the hierarchical federal position Ottawa has long enjoyed.

Hence, there is unlikely to be agreement on any purely intergovernmental mechanism that embodies these constraints.

In these circumstances, a promising way to get beyond the impasse and establish a new mechanism is to inject third parties and the public into the process. As governments, understandably, will not cede authoritative decision-making power on finance or policy to any such third party, it should be seen as an advisory and facilitative body. Contrary to the views of many, such a role would not necessarily make a body of this kind powerless; indeed, to the extent that it was open, transparent, demonstrably fair, and solely committed to the central values guiding health care in Canada, the recommendations of this body could have considerable legitimacy and persuasive power.

The governments of Canada, then, might agree to create a jointly appointed and funded "Canadian Health Care Commission." No significant federal action with respect to funding or enforcement under the CHA could go into effect until the commission had considered the matter and issued its recommendations. Thus, if the Government of Canada believed that a province had violated the Act, it could not withhold funds before the commission had examined the issue. Similarly, no provincial health care legislation with significant implications for other provinces or for the national system as a whole (a very important qualification) could go into effect before it had been assessed by the commission.

The commission would report to the governments and legislatures of all provincial jurisdictions. It would be mandated to hold public hearings where appropriate, and its deliberations and recommendations would be open to public scrutiny. Governments, provider groups, and concerned citizens could seek standing before the commission. One of its initial tasks would be to draw up a specification and codification of the principles of the *Canada Health Act.* <sup>42</sup> It would attempt to spell out how these principles would be operationalized, and what they mean, in the current health care context. While the CHA would remain in place as a piece of national legislation, a more fleshed out and mod-

ernized statement of principles, accepted by governments, would make it clear that the Canadian health care system is a concern and responsibility of all Canadian governments and their citizens. This document, once developed, could be submitted to governments and then ratified by them in a new intergovernmental accord.

An initiative of this kind could bring the public much more fully into the health care debate and give citizens a voice in the major decisions their governments are confronting, but it would do so while preserving the autonomy of both orders of government. On the evidence, it is not an undertaking that Canada's governments would find easy to accept; the role assigned to the public in SUFA, for example, is quite carefully confined, and the governments themselves determine the processes of public involvement. The Canada Health Care Commission, once established, would almost certainly be difficult for governments to control - which, after all, is just the point; the voices of the citizens would be freely expressed, and heard. Governments would not be obliged to accede to those views, but they would have a powerful moral incentive to explain their decisions in reference to them, thereby elevating the quality and expanding the scope of public debate. Such an arrangement might prove to be an instrument for focusing more attention on what citizens need in their health care systems, and less on what governments seek to protect in their intergovernmental relations

## TOWARD A MATURE PARTNERSHIP

e will conclude this chapter with a series of points that summarize our main findings in our exploration of potential avenues to resolve conflict and foster cooperation in the Canadian federal system, particularly in the health care arena.

> Before there can be a concern with conflict — or with cooperation for that matter — there first needs to be a significant relationship. A close relationship means that more connections, patterns of exchange, points of concord and friction exist than would be the case with a shallow or superficial relationship. The actors are more engaged in the relationship, it matters more, and it is, inevitably, composed of elements of disagreement as well as consensus and agreement.

- > The idea of the sharing community speaks to conceptions of collective identity and redistribution, not, as such, to the agencies and instruments that give effect to that sharing. Thus, one could in theory have a predominantly Canada-wide sharing community in which there was no role for the federal government; the principles reflecting collective identity and redistribution would be operationalized by interprovincial compact; and disputes (which would in this scenario be among the provinces) would be addressed by interprovincial processes to which all provinces have agreed. A given conception of the sharing community may receive expression through a variety of institutional arrangements.
- > The federal and provincial governments have been jointly involved in the provision of health care to Canadians for generations. The relationship between the two orders of government is structural, both with respect to fiscal support of the system and with respect to its policy design.
- > History, constitutional law, and the preferences of Canadians have combined to produce a rough equality among federal and provincial governments and a dual notion of sharing communities in the health domain.
- > The dispute settlement arrangements currently in place do not reflect this. To the extent that they exist, they are clearly biased in favour of one of the parties to the relationship. This can be understood as a kind of institutional immaturity that has negative effects on political responsibility and public debate.
- > An appropriate relationship needs to be established between the conception of the sharing community and the institutional arrangements designed to support it. In the Canadian federal system, the more the emphasis is placed on the notion of the Canada-wide sharing community, the more intense the relations among governments become. The more intense they become, the more disputes there will be, and the more necessary a mature system for managing conflict becomes. It is difficult to imagine that provinces would agree to stronger versions of Canada-wide sharing in the health care field in the absence of muscular, balanced, and impartial procedures for managing the inevitable conflicts between and among federal, provincial, and territorial governments.

Our findings imply a major shift in the federal government's conception of its role. It currently views its role chiefly as an external monitor of provincial behaviour and as a beneficent donor of federal largesse, rather than as an actor deeply implicated in the workings of a highly complex system and deeply responsible for its success or failure. The question is whether Ottawa is prepared to transform that role, become a partner with the provinces in supporting the health care system in Canada and accept the disciplines, burdens, sharing of responsibilities, and satisfactions that go along with working in a partnership.

A more mature system also implies a shift in the way in which the provinces conceive their relationship with the federal government. If Ottawa wants maximum political credit for maintaining the Canadian health care system with minimum involvement, the provinces for their part appear to want more federal money for health care, but with no strings attached. Provincial governments have often found it expedient to exploit the existence of an irresponsible external actor in the health field, attacking the arbitrary reduction by the federal government of its fiscal contributions, rather than acknowledging their own management problems; if Ottawa contributed what it should, all would be well. Clearly, a shift to a notion of federal-provincial partnership would require the cessation of this blame-avoidance behaviour, and the assumption, with the federal government, of joint responsibility for the functioning of the system.

Finally, a bolder and more sweeping commitment to genuine public participation in making the nation's health care choices could assist in greatly altering the way in which Canada's single most important social program is shaped. Governments are currently mutually complicit in keeping the public at arm's length, and in limiting the role of the country's legislators. The timidity of one affects the behaviour of all; no premier or health minister is prepared to risk the disapprobation of colleagues by pushing the issue too hard. Yet giving back a measure of political power to citizens – allowing them to be actors, rather than simply reactors – would be a potent means of suppressing the dysfunctional elements of intergovernmental relations in Canada today, and of increasing the likelihood that the health care decisions taken on behalf of Canadians will actually serve them well.

#### NOTES

- Kellett and Dalton (2001, 9) review some of the literature on the positive and constructive aspects of conflict. Heisey (1991) explains that humanking is both individualistic and communal, we are similar and different, and the tension between these complementary but opposing forces results in conflict, Further, Rapoport (1992) illustrates that conflict and cooperation are essential to each other's existence. They are complementary as a "union of opposites" (87). Each, Rapoport argues, is a "cardinal principle of life" (81). They stimulate each other, and at the same time, justify themselves by the existence of the other (81). Conflict can be. therefore, both natural and beneficial. The key, according to Arnett (1986), is to allow these natural oppositions to exist in creative tension such that they generate ideas and new possibilities. Thus, conflict should not necessarily be viewed as a negative or dysfunctional form of communication (Cahn 1997).
- 2 See Michael Crommelin (2001), whose discussion was helpful here.
- 3 Crommelin (2001, 139-40), cites these examples.
- 4 Deutsch (1991, 49-50) describes the types of skills that third parties need to help conflicting parties constructively resolve their conflicts.
- 5 The Agreement on Internal Trade provisions include dispute avoidance and formal and informal dispute resolution processes. See Doern and MacDonald (1999, 137-39).
- 6 Walton (1987) identifies three possible general benefits of conflict. First, conflict can generate a certain level of energy and motivation. Second, in bringing out varying viewpoints, conflict can increase levels of creativity and innovation. Third, people can gain a deeper understanding of their situation and themselves from engaging in conflicts.

- 7 For a discussion of deliberate "gaps of unsettlement" in the Canadian Constitution, see Thomas (1993).
- 8 Scharpf distinguishes between three types of arrangements (networks, regimes and joint decision systems) that evolve to facilitate multi-level joint action between both state and non-state actors. "Networks facilitate trust and information sharing, reducing transaction costs and creating opportunity structures for probtem solving ... Regimes are characterised by ongoing rule structures that may be imposed from above, or be mutually agreed on, imposing obligations and increasing the costs of certain kinds of damaging unilateral action. Joint decision systems, finally, are 'constellations in which parties are either physically or legally unable to reach their purposes through unilateral action and in which joint action depends on the nearly unanimous agreement of all parties involved" (Scharpf 1997, 143). Scharpf argues that federations that place too much emphasis on securing intergovernmental agreement can suffer from delay, deadlock, and other drawbacks associated with the "joint decision trap." Similarly, Breton (1985) defends the virtues of competitive over collaborative federalism.
- 9 Albert Breton uses this notion in his Supplementary Statement to the Royal Commission on Canada's Economic Development Prospects. He suggests that the role of the Supreme Court "is likely to be considerably larger than it should be unless the Senate is reformed in a way that introduces an effective provincial dimension in the federal Parliament" (1985, 520).
- 10 As an example of horizontal monitoring, the equalization program is based on federal legislation and is managed by the federal government. While there are federal-provincial discussions prior to any significant change in the system, the ultimate shot is called by Ottawa. Breton mentions the old Borden line for energy

distribution, as well as federal regional economic-development policies as other examples of this horizontal monitoring function. The Agreement on Internal Trade, which is meant to reduce economic barriers among provinces, is another example of horizontal monitoring; it was initiated by the federal government, as was the attempt to insert a strong economic union provision into the Charlottetown Accord. The federal government has, however, been incapable of performing its horizontal monitoring function in relation to the "nationalization" of provincial responsibilities for securities regulation, which seems a classic case in which provincial jurisdictional jealousies block a reform that is almost universally regarded as a long-overdue adjustment to the framework of the

It is important to note, as Watts does, however, that the federal government imposes fewer conditions on its federal transfers than any other federation. In the United States, 100 percent of federal grants to the states are conditional; less than 5 percent are conditional in Canada, if the EPF and CHST transfers are treated as unconditional (1999b, 49).
 It is ironic that horizontal redistribution.

Canadian economy.

- which after all involves the transfer of funds from wealthier to poorer parts of the country, should be far less controversial than vertical fiscal transfers.
- This point was made perfectly clear by the court case launched by British Columbia, and, as government intervenors, the Attorney Generals for Ontario, Manitoba, Alberta, and Saskatchewan, which contested the federal government's decision to impose a cap on the growth of the Canada Assistance Plan transfers for Ontario, Alberta, and British Columbia. <a href="http://www.lexum.umontreal.ca/csc\_scc/e">http://www.lexum.umontreal.ca/csc\_scc/e</a> n/pub/1991/vol2/html/1991scr2\_0525.htm
- 14 The Canadian Intergovernmental

  Conference Secretariat lists twenty-five
  high-level intergovernmental conferences

between January and April 2002. <a href="http://www.scics.gc.ca/confer02\_e.html">http://www.scics.gc.ca/confer02\_e.html</a> (3 June 2002).

- 15 Alberta's scheme covered only a part of the provincial population.
- 16 The Canada Assistance Program, which covered 50 percent of provincial expenditures for social assistance, continued essentially unchanged until 1990, when the Mulroney government capped the transfers going to Ontario, Alberta, and British Columbia. It disappeared entirely
- with the creation of the CHST in 1995.

  17 David Milne (1986, 12-13) uses the terms
  "quasi-federalism," "classical federalism,"
  "emergency federalism," "cooperative
  federalism," and "double-image federalism" to classify the evolution of Canadian
  federalism.
- 18 Kenneth Kernaghan and David Siegel observe: "It is difficult to pinpoint the precise date when *cooperative federalism* emerged, but Donald Smiley noted in the early 1960s that the development of Canadian federalism since 1945 had been 'a process of continuous and piecemeal adjustment between the two levels of government', and that these adjustments

had overwhelmingly been through 'inter-

action between federal and provincial

- executives' rather than through formal constitutional amendment of judicial interpretation" (1995, 453).

  Administrative federalism, also referred
- to as bureaucratic federalism, implies that bureaucratic executives are at least as dominant as political executives in the practice of Canadian federalism (Van Loon and Whittington 1987, 522-4).
- 20 Jackson et al. note that "executive federalism, represents an attenuation of federal power [over cooperative federalism]. The clearest sign of the change from cooperative to executive federalism was the movement of intergovernmental talks from among public servants behind closed doors to among politicians in the

full glare of publicity" (Jackson, Jackson,

and Baxter-Moore 1986, 222).

- 21 Summit federalism refers to the tendency for intergovernmental relations in Canada to be carried out in committees, usually at the level of first ministers.
- 22 Albert Breton (1985, 498) argues that competitive federalism is superior to cooperative federalism on the grounds that a system that makes greater use of checks and balances for impeding the passage of legislation stimulates discussion and is more efficient in the long run.
- 23 Judith Maxwell describes collaborative federalism as a model that "involves joint management and joint decision-making." For a more detailed description of collaborative federalism, see Simeon and Cameron (2002, 279-81).
- 24 Johns 2001. For an explanation of the federal government's unilateral approach in this field from 1987-1990, see Conrad (1999, 40).
- 25 Kathryn Harrison (1996, 116) made this observation.
- 26 For analyses of the Agreement on Internal Trade, see Certified General Accountants (2001) and Leeson (2000).
- 27 Steven K. Andersen (2000) identifies the barriers to mediation that currently exist with the participating NAFTA countries as: "cultural differences, language barriers, and legal traditions."
- 28 For a discussion of public health reforms initiated by the Council of Australian Governments, see Lin and King (2000, 251).
- 29 Choudhry (1996, 476) emphasizes that the current political reality where the CHA "is commonly described as imposing obligations on provincial governments who wish to receive federal monies for Medicare" is quite distinct from the legal situation. He says "Federal statutes in areas of provincial jurisdiction (such as health insurance) cannot, by themselves, impose legal obligations on provincial governments. As a matter of law, the CHA imposes obligations on the federal government. It defines the conditions that must be met by the provinces for federal

- payments to be legal. If a provincial plan falls short of these conditions, the federal government is obliged to take certain enforcement measures, which, in the extreme, can include withholding all contributions to the offending province."
- 30 For a copy of the CHA text, history, and annual reports, see the Government of Canada Web site <a href="http://www.hc-sc.gc.ca/medicare/home.htm">http://www.hc-sc.gc.ca/medicare/home.htm</a> (20 May 2002).
- 31 See Auditor General of Canada (1999, 29-12). See also Madore (2000).
- 32 For a list of the deductions by province or territory since the passage of the CHA, see Health Canada (2001, 14-15).
- 33 For a list of non-compliance issues that the Auditor General considered unresolved in 1999, see Auditor General of Canada (1999, 29-15 and 29-16). The Auditor General attributes the federal government's approach of not speedily resolving compliance issues to national unity concerns.
- 34 Auditor General of Canada (1999, 29-17).
- 35 For example, see Canadian Press Newswire 14 November 2000. Klein shoots back at Chrétien over threats of fines for private clinics.
- 36 Choudhry (1996, 501) identifies three cases in which the CHA argument was unsuccessfully raised: Lexogest, B.C. Civil Liberties, and Morgentaler v. P.E.I. Substantial legal hurdles would discourage most potential claimants from launching a suit that examined the compliance of a provincial plan with the CHA criteria. For example, an applicant would need to demonstrate that the agreement was legally enforceable. However, the case law on intergovernmental agreements to date does not point in this direction, "A claimant must obtain third-party standing to challenge this agreement; however, this issue is unresolved under existing case law." The Medical Post describes a recent case where a lawsuit arguing that a provincial plan was in conflict with the Canada Health Act failed to

receive certification. In June 2001 a B.C. doctor tried unsuccessfully to launch a class action against the provincial Medical Services Plan, which he alleged to have "violated federal law by failing to reimburse doctors who provided medical services to patients not insured under the plan." The B.C. judge, Justice Baker, refused to certify the class action on the grounds that his "Canada Health Act argument was 'bound to fail,' given that previous court cases have ruled the statute is principally a funding mechanism, and doesn't create a right for all

37 Quebec accepts the validity of the principles, but not the federal government's role in defining and enforcing them.

services" (Fitz-James 2001).

residents generally to obtain health-care

- 38 Claude Forget, at a meeting to discuss drafts of these chapters, Montreal, 19 April 2002.
- 39 Raymond Breton once remarked that a country is a territory over which redistribution occurs.
- 40 The court case on the selective imposition of a cap on the Canada Assistance Plan confirmed the legality of this reality.
- 41 Zuker (2002).
- 42 A body such as this might assume responsibility for the panels on medical services suggested by Richard Zuker in his discussion paper: "Perhaps, we could have a national body - national, not federal - that would be charged with establishing guidelines for what services should be insured. The outcomes need not be black or white only - there could be 'gray' services, too. that would be recommended for partial coverage. There would likely need to be several panels for various areas of medical services. These panels could have members drawn from doctors, nurses, other health professionals, user groups, etc. Perhaps, these panels could go even further and recommend services levels, such a waiting times, and perhaps even procedures, based on up-to-date research findings. Regardless

of the extent of the mandate, provincial

governments would still be free to make their own choices. This type of body could increase the probability ... for babies in Victoria, St John's and rural Saskatchewan to obtain similar services. Moreover it could provide a firmer basis for Canadians to assess their health care systems, both absolutely and comparatively" (2002).

CHAPTER 3

# VERTICAL FISCAL IMBALANCE: MYTH OR REALITY?

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

he issue of vertical fiscal imbalance has been a principal irritant in Canadian intergovernmental relations since the mid-1990s. Indeed, the political controversy surrounding that issue permeates much of the ongoing debate on the funding and policy role of the federal government in determining the future of public health care.

Federal and provincial/territorial governments share the cost of financing health care. How the burden is and should be shared, however, has become a matter of dispute between the orders of government, particularly as program costs continue to escalate and the provinces and territories find that their slice of health care spending continues to grow. The provinces and territories argue that they are saddled with an unfair structural situation whereby the amount of revenue they raise is insufficient relative to their expenditure responsibilities, whereas the federal government collects more revenue than it needs relative to its spending obligations. They point to Ottawa's large budgetary surpluses since 1997 as evidence of this. According to the provinces, there is a fiscal imbalance (VFI) between the federal and provincial/territorial governments, and this imbalance needs to be corrected. They have therefore called for a redesign of federal fiscal arrangements – including the division of revenues – in order for them to have the resources

and management flexibility required to cope with their rapidly rising costs. The federal government, for its part, disputes the idea that there is a vertical fiscal imbalance, particularly since the provinces have no formal constraint on their ability to raise revenue. It further argues that considerable increases in its cash transfers to the provinces in recent years do not seem to have significantly improved the health care system.

This sort of controversy over the question of fiscal imbalance is not unprecedented in Canada. Similar disputes have taken place in different forms at different times in the past. For instance in the early 1980s, it was the federal government that was claiming the existence of a fiscal imbalance favouring the provinces. However, after the introduction of the Canada Health and Social Transfer (CHST) in 1996, the provinces argued that they were the ones that were disadvantaged by a vertical fiscal imbalance since, in their view, they had unfairly been made major, involuntary contributors to the balancing of the federal government's budget. Given the difficulty in explaining this rather obscure concept to the public, the provinces intertwined it with the health care issue in their bid to obtain increased and stable funding from the federal government over the long term.

Observers are divided over whether a vertical fiscal imbalance exists and, if it does, whether it should be interpreted as an enduring feature of the division of taxing and spending powers in the Canadian federation or whether it reflects a policy choice (Norrie 2002, 23-4). In the second section of this chapter we describe some of the events and arguments at play in the ongoing federal-provincial dispute over the VFI issue. In the third we examine the concept of vertical fiscal imbalance (and the related concept of vertical fiscal gap) and outline the difficulties involved in applying this concept in a Canadian context. After analysing and comparing three recent Canadian studies that present estimates of vertical fiscal imbalance, we examine the relative state of public finances of each order of government since the postwar years and the changes in federal-provincial fiscal relations that have taken place over time, in an effort to bring some historical context to the current VFI debate. The conclusions and options on federal health care funding that we offer in the last two chapters of this volume are not ultimately predicated on the existence or extent of vertical fiscal imbalance. Nonetheless, we believe that this question needs to be analysed, so that the reader understands the important issues it raises and the way it factors into the debate on health care financing in Canada.

# THE DEBATE ON FISCAL IMBALANCE AND FEDERAL HEALTH CARE FUNDING

## The Origins of the Current VFI Debate

he current federal-provincial dispute on vertical fiscal imbalance was triggered by the 1995 federal budget, which was the centrepiece of Ottawa's strategy for restoring federal public finances. At that time, the federal minister of finance announced that two of the largest federal transfers to provinces - Established Programs Financing (EPF) and the Canada Assistance Plan (CAP) - would be rolled into a single federal block transfer, the CHST. The transfer would be conditional on provinces' upholding the principles of the Canada Health Act and continuing to provide social assistance without minimum residency requirements. As initially presented in the 1995 budget, the cash component of the CHST was to be reduced from approximately \$17 billion in 1994/95 to \$12.8 billion in 1996/97 and to \$10.3 billion in 1997/98.1 The federal finance minister, in his House of Commons budget speech, observed that the cash portion of major transfers represented 21 percent of Ottawa's total program spending and therefore could not remain untouched, given the broad goals of the budget. He presented the reductions, however, as cuts from a base that included both tax points and cash, and thus did not lay out explicitly the magnitude of the cash reductions (Department of Finance 1995a, 17-19).

The fiscal measures announced in the 1995 federal budget contributed significantly to the large and swift improvements in federal public finances that have since occurred. What is in dispute, however, is whether the measures adopted to improve federal finances were harder on provincial governments than on other federal programs. Did the federal government cut transfers to the provinces more significantly than it cut its own expenditures? Provinces have argued this position vigorously, and their point of view is part and parcel of the fiscal imbalance debate. As for the federal government, it has denied this charge. In essence, since 1995 both orders of government have been arguing the fairness of the federal government's fiscal stance and the related the issue of vertical fiscal imbalance.

Let's begin with a summary of how Ottawa defended its position. It argued that provinces were still enjoying the full benefits of the tax room that had been transferred to them in 1977 when it moved from cost-sharing grants for health and post-secondary education to block funding under EPF. In addition, Equalization payments had not been reduced in either the 1994 or 1995 federal

budgets. Taken together, the major fiscal transfers to the provinces – made up of EPF, CAP, and Equalization, and including EPF tax points whose value increases in line with income tax revenues – had not been cut in percentage terms more than other federal programs. The 1995 budget documents thus declared that cuts in transfers for major social programs "are less than cuts to other federal program spending." In the budget speech itself, Minister Martin declared: "As a matter of fairness and balance, we believe that the provinces should not be expected to bear more of the fiscal burden than we are prepared to impose on ourselves. This budget meets that test" (Department of Finance 1995a, 18).

At the regularly scheduled Annual Premiers' Conference (APC) in August 1995 in St John's, premiers expressed their anger in somewhat muted terms. They observed: "It is unacceptable for the federal government to, on the one hand reduce federal transfers to provinces and territories, and on the other prescribe the structure and standards of provincial and territorial social programs." The premiers agreed to establish the Provincial/Territorial (P/T) Ministerial Council on Social Policy Reform and Renewal "to consult on federal reform initiatives and discuss common policy positions." In the following year, at the APC of August 1996, the premiers (except the premier of Quebec) directed their finance ministers to "work with their federal counterparts to ensure that an agenda for the redesign of financial arrangements proceeds and is coordinated with social policy renewal." In so doing, they began to take a series of steps to support their view that the federal position on the financing of national social programs was politically untenable.

In 1997, P/T finance ministers submitted a background paper to premiers that has served as a fundamental underpinning of their position on the issue of fiscal imbalance. Among other things, the paper declared the following:

- > The tax points that were transferred from Ottawa to the provinces twenty years earlier are "not an ongoing federal transfer to provinces, any more than the provincial tax room shifted under the Wartime Tax Agreements constitutes an ongoing provincial transfer to the federal government."
- > The federal cuts in cash transfers to the provinces in respect of health, post-secondary education, and social assistance and services between 1994/95 and 1998/99 were 33 percent, whereas reductions for other (i.e., direct) federal programs were only one percent.<sup>7</sup>
- > "There is a fiscal imbalance between the federal government and the provinces, even after the federal transfer system is taken into account," and

this imbalance is "likely to widen."

> "Finding the right distribution of fiscal resources between the federal government and the provinces means dealing with both the existing imbalance and the need for new financial arrangements to reflect any coming rebalancing of federal-provincial roles."

The report also sets out three options for addressing the fiscal imbalance, including enhanced cash transfers, a reallocation of equalized tax points, and realignment of tax fields.

These conclusions were endorsed publicly by the APC in August 1997 at St. Andrews-by-the-Sea. The premiers also declared: "Coordinating the redesign of financial arrangements with social policy renewal will require addressing provincial/territorial differences in the ability to raise revenues and ensure that individuals are treated as fairly as possible no matter where they reside in Canada." In effect, they were affirming that the need to correct the vertical fiscal imbalance was not inconsistent with ongoing efforts to reduce horizontal fiscal imbalances.

By this time, provinces and territories were following a three-pronged approach in their efforts to undo the damage associated with the CHST transfer cuts. First, they were attempting to persuade the federal government to enter into a new framework agreement on the development and management of social policy in Canada. Their objectives in pursuing this initiative were to secure some limits on the use of the federal spending power and to obtain formal procedures for dispute resolution. Second, they were undertaking detailed studies on vertical fiscal imbalance that they hoped would enable them to persuade the federal government (and the public) of the validity of their financial claims. Third, they were also developing proposals to improve Equalization.

At the December 1997 First Ministers' Meeting, all first ministers, with the exception of the premier of Quebec, agreed to initiate talks on a new framework for Canada's social union. The joint communiqué from the meetings set out objectives for the negotiations that were to ensue. There was no reference, however, to fiscal imbalance as an item of discussion. The premiers wanted to have these issues addressed as a package, but Ottawa apparently preferred to have them handled independently of one another.

Over the following year negotiations took place on what would eventually become the Social Union Framework Agreement (SUFA). While these negotiations were proceeding, P/T leaders continued to demand that the cuts to CHST

cash transfers be restored. Their strategy, however, had undergone a significant change. By this time, public concern about the future of Canada's health care system had grown considerably, and provinces were also concerned that Ottawa, with its recent and anticipated budgetary surpluses, might attempt to launch a new Canada-wide shared-cost health program such as pharmacare or home care. Thus, the news release emanating from the 1998 Saskatoon meeting of the APC declared: "As their first priority for new federal spending, Premiers emphasized that the federal government must restore its funding to health care through the existing CHST arrangements. Premiers also agreed that funding for core health services, once restored, must be stable and adequate, before new health care programs are established." "11

While in substantive terms, the P/T position had not changed, the focus on health, rather than more broadly on CHST-related social programs (i.e., health, post-secondary education, and social services) marked a departure in their public communications strategy. Health care was by then at the top of the public agenda. Therefore provinces judged that it might be easier for them to secure incremental funds from the federal government if they committed to spend any additional transfers on health care only.

The federal and provincial/territorial governments signed the Social Union Framework Agreement in February 1999 in the run-up to the federal budget. By this time the federal government's fiscal position had improved quite significantly. Thus, a deal on SUFA with terms that Ottawa could accept turned out to be the *quid pro quo* for an improvement in the federal government's CHST cash payment.

Even as the provinces were mounting their critique of the CHST and beginning their campaign on fiscal imbalance, the federal government had already begun to improve the cash component of the CHST. In its 1996 budget Ottawa had announced a five-year arrangement that included a new cash floor provision of \$11 billion to limit the impact of reductions announced in 1995. In the 1998 federal budget, the cash floor was raised to \$12.5 billion. The 1999 federal budget went much further, however, with a one-time CHST supplement for health care of \$3.5 billion and a \$2.5-billion increase in the CHST cash base to \$15 billion for a three-year period. The 2000 federal budget provided an additional one-time CHST health supplement of \$2.5 billion.

At the Winnipeg APC in August 2000, premiers drew attention to the fact that the federal government's surpluses were projected to rise quickly as a result of greater than expected growth in revenues and reduced expenditure

commitments. In contrast, the provinces and territories would "be hard pressed to keep their budgets in balance over this same period." To lend substance to their views, premiers released a report entitled *Understanding Canada's Health Care Costs*, which documented in detail the growing cost pressures on provincial health care systems. The premiers again called for the "immediate and full restoration of the CHST to 1994/95 levels, together with an escalator," claiming that these measures would still leave Ottawa with "substantial surpluses."

Meanwhile, the provincial and federal governments were in the process of negotiating a new agreement on health. The federal government was willing to further increase it cash commitment to CHST if and only if it was part of a substantial, commonly agreed upon commitment to health care reform by all governments. In September 2000 first ministers met in Ottawa and released a detailed and broad-ranging "Communiqué on Health," setting out a vision and set of principles for the future of health care and an action plan for health system renewal (First Ministers 2000a). In conjunction with this Health Accord, the federal government announced a further investment of \$23.4 billion over five years. Of this, \$21.1 billion would be expended through the CHST (with \$18.9 billion earmarked for health care and \$2.2 billion for early childhood development), thus providing the provinces and territories with "stable, predictable, and growing funding through to 2005/06."<sup>13</sup>

# He Said/She Said: The VFI Debate Following the 2000 Health Accord

Despite the large increases in CHST announced prior to and as part of the 2000 Health Accord, provincial and territorial governments continued to maintain that the federal cash contribution for health, education, and social assistance and services is not adequate or equitable. They insist that there is still a large and growing fiscal imbalance between the two orders of government, that the cash associated with the CHST is too limited, given ongoing cost pressures, and that other aspects of the CHST are inappropriate. They point in particular to the lack of a solid federal commitment to provincial social programs beyond the CHST cash floor and the absence of formal provisions for growth (escalator). In addition to producing their own series of reports on VFI, the provinces have also commissioned independent studies to support the validity of their case against the federal government. Each public statement on the issue by the provinces has, of course, been met with equally vigorous federal counter-arguments.

In essence, the provinces argue that the federal government has revenue-raising abilities that considerably exceed the cost of fulfilling its program responsibilities, while they lack the revenue-raising capacity to meet their constitutional obligations, especially in the areas of health, education, and social services, which are recognized as key public priorities. They further argue that the costs of delivering these large and important programs are rising more rapidly than federal program costs, while their revenues are growing at a significantly slower pace than federal revenues. <sup>14</sup> The following excerpts from the 2001 and 2002 reports of the provincial and territorial finance ministers on fiscal imbalance capture the provinces' position:

- > To accomplish their crucial programming goals, provinces and territories must have access to adequate funding, both from their own-source revenues and from federal government transfers. This adequacy has not been achieved with respect to federal transfers.
- > Past cuts to federal support for provincial social programs, especially those that accompanied the CHST have widened the fiscal imbalance. Between 1994/95 and 1998/99, annual federal transfers under the CHST were cut by one-third \$6.2 billion. Despite a partial restoration in 2000/01, federal CHST payments were still \$3.2 billion lower than in 1994/95. In contrast, annual provincial and territorial spending on health care, education, and social services was an estimated \$18.8 billion higher than in 1994/95.
- > Even with the increased payments announced at the September 2000 First Ministers' Meeting, future CHST growth ... will be less than that of the cost of the main programs it helps fund. As a result, the federal contribution, expressed as a percentage of provincial and territorial social program expenditures, will once again decline.
- > It is clear that the changes to the CHST announced by the federal government in September 2000 represent neither an adequate nor a durable solution to the problems of fiscal imbalance and funding of major social programs.<sup>15</sup>

The P/T documents also quote extensively from the work of Professor G.C. Ruggeri, which indicates that the federal surplus is likely to continue to grow over the next two decades, while the provinces' fiscal situation is deemed "precarious." We examine Professor Ruggeri's research in the next section.

The issue of vertical fiscal imbalance has received considerable attention in Quebec in particular. In 2001 the Government of Quebec appointed the

Commission on Fiscal Imbalance headed by Yves Séguin. Its report, entitled A New Division of Canada's Financial Resources, was released in March 2002. It also concludes that there is a structural imbalance in revenues and spending between Ottawa and the Quebec government. Moreover, the Commission considers the system of intergovernmental transfers to be inadequate and points to the federal spending power as part of the problem. The report states:

- > The CHST "is the most problematic transfer program" because it "applies to fields of jurisdiction attributed to the provinces, and its attendant conditions, as well as its defining terms, clearly limit the provinces' decision-making and budgetary autonomy in these fields of jurisdiction." Federal budgetary cuts compound these difficulties. As for Equalization, it "fails to eliminate major differences in the fiscal capacities of the provinces" due to several deficiencies in program design.
- > The federal spending power exacerbates these difficulties. The use of this power distorts provincial budgetary choices, from one perspective, and has a destabilizing impact, from another (when Ottawa withdraws from joint programs or reduces transfers). It is only because of the fiscal imbalance that Ottawa has the money to use the spending power. Doing away with the imbalance would thus improve autonomy and reduce distortions.

The Commission's main recommendation to restore fiscal balance was to abolish the CHST and have the federal government transfer the GST as an own-revenue source to the provinces. <sup>16</sup> With the release of its report, the Commission also made public a study undertaken on its behalf by the Conference Board of Canada (2002a) on the long-term fiscal outlook for the federal and Quebec governments supporting its conclusions.

While the provinces and territories were building their case for improved intergovernmental fiscal arrangements, the federal government responded in two ways. It implicitly acknowledged that there was some validity in the provincial/territorial position to the extent that it did increase (quite substantially) the size of the CHST transfer in the late 1990s and early 2000s. At the same time, it has been steadfast in contesting the existence of a vertical fiscal imbalance.

In an effort to counter provincial claims, the federal government also produced a number of reports laying out its arguments.<sup>17</sup> In particular, it points out that both orders have access to the same major revenue bases and are able to set their own rates. Moreover, provincial revenues (including federal transfers)

have exceeded federal revenues for more than two decades, and provinces have exclusive access to certain revenue bases such as royalties, which are growing rapidly. On the expenditure side, Ottawa argues that provincial health spending has been rising sharply, but not if it is measured as a share of the economy. It also points to its own spending pressures in areas such as elderly benefits, Aboriginals, skills and learning, and national security.

The 2002 document produced by the Department of Finance lays out further arguments:

- > As a result of the \$100 billion five-year tax reduction plan announced in 2000 and the recent economic slowdown, federal revenues are expected to grow by an average annual rate of only 1.9 percent between 2000/01 and 2005/06.
- > In contrast, federal cash transfers to the provinces are expected to grow at an average annual rate of 6.1 percent over the same period (more than three times faster than revenues).
- > Federal surpluses are recent and "quite small compared with the large deficits that preceded them." Provinces' deficits have been much smaller. The federal debt burden is twice that of the provinces (federal debt charges totalled \$42 billion in 2001/02 relative to \$22 billion for the provinces). This reduces the federal government's fiscal room to manoeuvre and makes it more vulnerable to volatility in global interest rates.
- > The fact that virtually all provinces have chosen to reduce taxes in recent years implies that they believe that they have sufficient revenues to manage their spending pressures. Indeed, provincial tax cuts enacted since 1995 will reduce revenues by about \$20 billion this year. 18

Thus, while the Commission on the Future of Health Care in Canada deliberated about ways of improving the sustainability of public health insurance in Canada, federal and provincial governments were engaged in a "he said, she said" debate about whether or not there is an imbalance in Canada's fiscal arrangements. Provinces clearly believe that there is an imbalance, while Ottawa insists that "the 'fiscal imbalance' is a myth." Provinces also argue that not enough is being done by Ottawa to deal with horizontal fiscal imbalances. The federal government displays various charts and graphs that suggest the opposite. Central to this dispute is a disagreement on the adequacy of federal funding for provincial health care programs.