SOCIAL UNION SERIES

Federalism, Democracy and Health Policy in Canada

EDITED BY DUANE ADAMS

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The future of health policy is centre stage in Canadian politics today with declining public confidence in the quality and timeliness of available health services. Fixing the situation is high on governments' agendas. Since both federal and provincial governments play a role in the health-care system, part of addressing these issues requires that the different orders of government learn to work more effectively with one another.

The focus of this volume is on how federal and provincial governments relate to one another, and to citizens and stakeholder groups, in the development and implementation of health policy. The chapters include an assessment of the political landscape surrounding health policy and a careful and systematic analysis of intergovernmental relations in the following areas: Canada-wide goals and objectives for the health system, cost containment, the interpretation and enforcement of the *Canada Health Act*, the system for health surveillance, and the regionalization of provincial health systems. The authors focus on the tensions and trade-offs associated with advancing health policy goals in each of these areas in ways that are consistent with federalism principles and democratic accountability.

The case studies speak to the way the Canadian social union is functioning at the very time when the 1999 Federal-Provincial Social Union Framework Agreement is up for review. In a context where health policy is an overriding concern, this volume sheds new light on governance in the health sector and on ways it can be improved to better serve the health needs of Canadians and of the Canadian federation.

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SOCIAL UNION STUDY OF THE CANADIAN HEALTH SYSTEM: INTRODUCTION AND OVERVIEW

Duane Adams

Canada's health system is an outstanding intergovernmental achievement. It provides a high quality, comprehensive acute care and physician insured health service for all Canadians without regard to their individual ability to pay. Health-cost escalation has been tolerable by international standards. The health system serves Canadians remarkably well, and Canadians are passionate about preserving it.

But to preserve the essence of the Canadian health system means to modernize it, perhaps to change some features of it. To assure the system is financially sustainable in the longer term and can provide high quality service in future years, preservation of our national health system means it must now be led through the difficult process of developing, accepting, and applying contemporary models and standards of medical, management, and governance practices. Given that the birth of the Canadian health system was the product of intergovernmental insemination, so too will intergovernmental action be needed to preserve it.

For the past decade the Canadian health-care system has endured massive onslaughts of reform and adjustment, as well as intergovernmental contention about financing obligations, to the point where public confidence in the future of the system is now seriously challenged. The public is not clear about which order of government (federal, provincial/territorial, regional or

local) is accountable for the performance of the system or its financing. Nor does it appear the public much cares so long as its concerns about health services are quickly addressed. This presents a challenge for federal/provincial/territorial governments because the public is not interested in the processes of settlement, the intricacies of the constitutional division of powers or the complex intergovernmental arrangements necessary to reach acceptable health service solutions. Navigating the turbulent currents of federalism affecting the Canadian health system is seen as a responsibility of governments. The performance of governments in dealing with this challenge will be judged by the public as it affects direct health service delivery to them, collectively and individually. In short, if something is wrong with the Canadian health system, "Governments, fix it!"

Although the public may be uninterested in the niceties of Canadian federalism, the reality is that the difficulties and challenges of the Canadian health-care system(s) are influenced by the intergovernmental structures and processes within which they function. The flow of causality, however, is not one way. What happens in the health-care system also has an impact on the workings of the federation, creating tensions as well as opportunities. And, of course, the health-care and federal systems interact as well with the country's democratic values and institutions.

This volume reports on a more than three-year project which has focused on the role of intergovernmental regimes and their effects on Canadian health policy, federalism, and democracy. Our objective was to shed light on the role and impact of intergovernmental processes (and in some cases the absence of such processes) on the public interest as reflected in the quality of health policy and the well-being of our democratic values and federal structure. Our approach involved six case studies, the purpose of which was not only to assess the impact of the intergovernmental regimes that we have in the health sector but also the advantages and disadvantages of alternative regimes. There is no attempt through the case studies to examine provincial or site-specific operational policies in the health system.

We were, of course, aware that attempting to isolate the impact of intergovernmental regimes on issues of health policy, democracy, and federalism entailed complications. One was that it would be analytically difficult to separate the influence of the intergovernmental regime from other influences, like fiscal restraint. The second was that it would not always be possible to gain a complete sense of what was happening between governments since so much happens in private.

Since there is no way of overcoming these complexities fully, we simply worked within those realities understanding that our results would be based on incomplete empirical evidence. We thought this was worth the effort, however, for two reasons. Intergovernmental relations in the health sector have a major impact on both the health sector and the polity. Second, these relations have not, to the best of my knowledge, previously been examined closely. And given the current priority of the health system in Canada, this work seemed particularly timely.

The purpose of this introductory and overview chapter is to explain the methodology guiding the case studies and to summarize the main lessons learned from the six case studies about the intergovernmental regimes and processes. The final chapter in this volume synthesizes all the case study information and offers some options for advancing federalism, democracy, and national health governance in Canada.

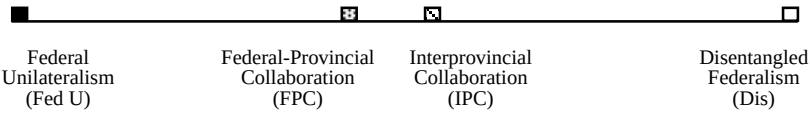
METHODOLOGY OF THE CASE STUDIES

The methodology for undertaking these case studies (and for those in other volumes in this series dealing with Canadian policy) was developed by Harvey Lazar and Tom McIntosh. McIntosh reported on the methodology last year in his introductory chapter to the volume in this series on Canadian labour market policy.[1] His excellent methodological explanation is equally applicable to the health sector and is extensively quoted here.

> [The methodological] criteria were outlined in a working document … which was meant to provide both background and methodological guidance to the authors.[2] In short, the authors were asked to assess the nature of the current intergovernmental regime within the specific policy area under consideration and to speculate on possible alternative regimes that might better maximize federalism principles, policy goals, and democratic practice.
>
> Lazar and McIntosh's methodological framework begins by constructing a typology of intergovernmental regimes on the basis of two characteristics fundamental to any federal system: the degree of independence or interdependence between the two orders of government and the extent to which the intergovernmental relationship is hierarchical or non-hierarchical. Using these characteristics, they identify four types of intergovernmental regimes which can then be placed on the continuum illustrated in Figure 1. The four "regime types" are as follows:

- *Federal Unilateralism:* characterized by the use of federal powers in areas of provincial jurisdiction — an interdependent, hierarchical relationship.
- *Disentangled Federalism:* characterized by each government acting solely in its own areas of jurisdiction — an independent, non-hierarchical relationship.
- *Federal-Provincial Collaboration:* characterized by federal-provincial co-operation — an interdependent, non-hierarchical relationship.
- *Interprovincial Collaboration:* characterized by provinces acting jointly in the absence of the federal government — a mutually interdependent, non-hierarchical relationship.

FIGURE 1
The Continuum of Intergovernmental Regimes



This continuum is used by Lazar and McIntosh for two different purposes. The first is to identify the essential characteristics of the way in which "policy frameworks" are developed among governments. The second is to identify the way in which governments relate, or do not relate, to one another in terms of "policy implementation" (everything from the details about policy design to administration, evaluation and audit). The "map" in Figure 2 captures the intersection of both aspects of policy-making and the different intergovernmental regimes. It should become possible, then, to place specific policy areas on this map and to ascertain the implications of moving around the map.

Lazar and McIntosh then make explicit the specific criteria for assessing the different intergovernmental regimes in each of the policy areas covered in the case studies. As argued above, this is an attempt to evaluate the intergovernmental regime in a policy area with reference to how it reflects on:

Policy Goals and Outcomes

- redistributive equity
- efficiency
- human development
- mobility
- social equity (equality of access and of opportunity)

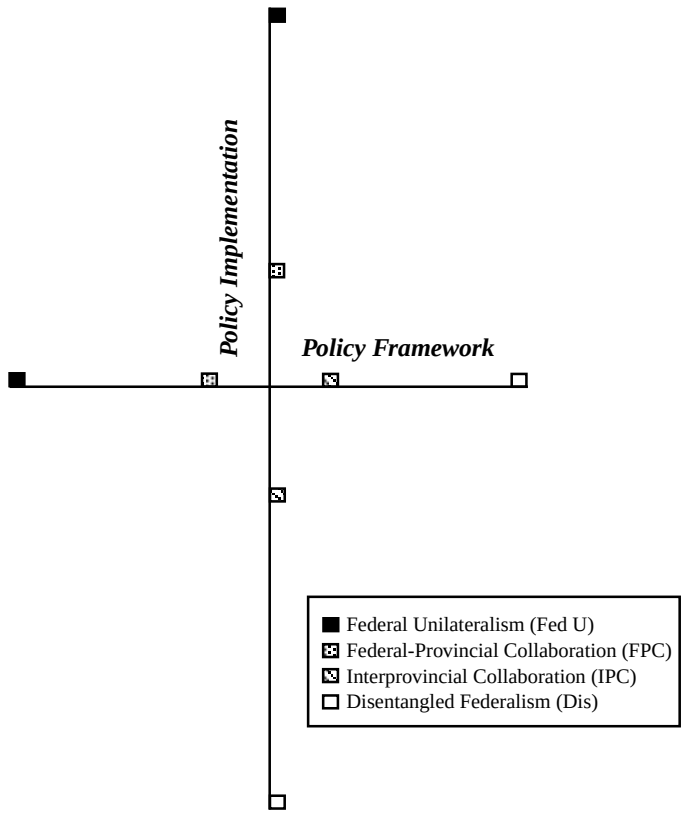
Democratic Values and Goals

- promoting the rights of majorities and minorities
- effective role for legislatures in decision-making
- citizen consultation and involvement
- transparency and accountability

Federalism Principles

- respect for the formal (legal) division of powers contained in the constitution
- respect for the (political) sovereignty of both orders of government
- commitment to legal and political processes to resolve conflicts and disputes and to improve outcomes[3]

FIGURE 2
Mapping Regimes and Policy Areas



In bringing these three sets of principles together, there are a number of important considerations which must be kept in mind. First, there are tensions within each set of principles (e.g., majorities versus minorities). Second, there are tensions between the sets of principles (e.g., transparency versus intergovernmentalism to resolve disputes). Third, these principles interact with each other in a complex manner. Fourth, promoting one set of principles can affect the promotion of other principles both positively and negatively. And, finally, how these sets of principles interact with each other may well be specific to the nature of each policy sector and may vary within each sector.

The authors of the three case studies that follow, therefore, were given the unenviable task of assessing the trade-offs involved in moving toward any different kind of governance regime.[4] In other words, is what would be gained in a new regime worth the risk in light of what might be lost? For example, what might be good policy might not be good federalism (dependent on the definition of each). Or, similarly, what might be good federalism might have the effect of cutting the public out of the social policy-making loop, and thus contributing to what is now commonly called a "democratic deficit."

This necessarily leads the authors into making difficult choices between elements that are each crucial to the reconstruction of the Canadian social union, namely a respect for Canada's federal nature, the desire for effective and attainable policy goals and democratic oversight of the policy-making process. It is all too easy to say that "good policy" is all that matters and all the public wants. Whatever truth there may be to this, the reality of Canada's politics is such that this cannot (and never has been) the only consideration in social policy development. If what "works" in policy terms creates untenable intergovernmental tensions that spill over into other relationships or clearly violates the constitutional division of power or marginalizes the oversight role of legislators and citizens, then the very ability of social policy to weave and strengthen the ties that bind Canadians to each other is compromised. The social union is and will be about balancing all these elements and about keeping all these balls in the air at the same time.

In the final analysis, what becomes apparent is that not only are different sectors of the Canadian social union governed differently, but that there are different intergovernmental regimes at work within each sector.... There is no "one size fits all" governance regime, but there are some important lessons that can still be derived, not only for each of the policy areas but for the sector as a whole.[5]

LESSONS LEARNED FROM THE CASE STUDIES

This volume begins with the chapter, "The Canadian Health System Landscape," by Patricia O'Reilly. In broad terms, O'Reilly sketches the main features of the Canadian health system and places the system in its intergovernmental context within the federation and its political context within society. She describes some of the major pressures on the system which were prominent during the 1990s, including "privatization," and she visits several of the key health-reform issues of the decade, notably with respect to hospitals, physicians, and nurses. O'Reilly also examines the key professional challenges of other main groups of health-service providers. An overview of the growing demand for more democracy in the health system and some of its emerging features is provided. O'Reilly concludes that the Canadian health landscape is being remodeled with some difficulty for all the players and a great deal of tension for governments, institutions, interest groups, and stakeholders.

"Canadian Federalism and the Development of National Health Goals and Objectives" by Duane Adams analyzes the successful and failed attempts to establish Canada-wide goals and objectives in the health system, and considers the intergovernmental regime and conditions that would support an effort to achieve modernized health goals and objectives for the entire country. He argues that modernizing Canada's national goals and objectives is essential to providing the overall health system with a sense of direction and purpose, potentially improving health-care service, efficiency, and effectiveness. Modernizing goals and objectives would possibly alleviate public worries about the sustainability and future concerns of the system. The principles of the *Canada Health Act* remain relevant, but they do not address all the current interests of the public. Adams notes that the present governance model of the Canadian health system has been unable to update or modernize national health goals and objectives since 1984, although the September 2000 first ministers' agreement on health may eventually prove to be a contemporary start on the renewal of goals.

This case study concludes that:

1. in the past, the greatest successes in building a Canada-wide health system have been based on negotiated collaborative policy initiatives between federal/provincial/territorial (F/P/T) governments and that significant federal fiscal contributions to the national program have been indispensable to this type of F/P/T agreement;

2. although successful intergovernmental cooperation is desirable to establish the policy framework of a national health program, such collaboration is not necessarily required to implement the scheme. Under the constitution, the Canadian health system is basically a disentangled regime that seems to offer benefits of certain cost efficiencies (such as different provincially negotiated union contracts and provincially sensitive physician reimbursement rates), program sensitivity to regional clients' needs and provincial circumstances and encouragement of innovation;
3. health-system innovation at either level of government cannot advance in a vacuum. It is inevitably linked to broader issues of finance, jurisdictional concern and political needs, and priorities of both orders of government. At a minimum, national health-system innovation and new solutions will necessarily involve finance and intergovernmental ministries, sometimes Social or Human Services, Aboriginal Affairs or Technology ministries, and occasionally first ministers;
4. the current problems faced in the national health system require Canada-wide reforms to take place in medical practice and in health-system governance and management. To advance these issues, and to re-establish public confidence in the health system, both the federal government and the provincial/territorial governments possess elements of jurisdiction and capacity to contribute to solutions. No one order of government can solve the problems alone. An important federal contribution is its fiscal capacity to finance a transition in the national health system. Therefore, an intergovernmental approach for advancing solutions is needed, the most historically successful regime being a collaborative one. The Social Union Framework Agreement accepts a collaborative regime as being a preferred intergovernmental approach as does the September 2000 first ministers' health agreement;
5. external-to-government expert committees, as well as internal bureaucratic committees have not been successful in overcoming intergovernmental impasse when dealing with the most important framework policies and public concerns about health programs. Certain of these committees, though, have contributed useful ideas to the health policy planning process; and
6. the Canadian public does not trust either the federal government, or the provincial/territorial governments alone, to govern the national health system.

"The Federal/Provincial/Territorial Health Conference System," by Patricia O'Reilly examines the F/P/T intergovernmental advisory and decision-making mechanism to assess its capacity to deal with Canada-wide health issues. She identifies the major Canada-wide health issues of the 1990s and compares these to the issues treated intergovernmentally by the F/P/T health conference system. She assesses the outcomes of these governmental policy activities and the performance of the health conference system.

O'Reilly concludes that:

- the established health intergovernmental machinery, while being an amicable network of bureaucratic and professional colleagues, has delivered very little new health policy to the country in the past decade with the exception of some new technical and system support programs and institutions (such as the Canadian Institute for Health Information), a few collaborative activities to deal with some specific high-cost matters such as the assessment of new technology and new drugs, and a few topics of intergovernmental political importance (like the Canadian Blood system and hepatitis C issues). New national policy with respect to most of the major public issues and Canada-wide policy issues are either ignored because of jurisdictional sensitivities or are deadlocked because of financial, political, and other F/P/T policy considerations;
- the present health intergovernmental machinery is rather secretive, allowing only a few select professional individuals and relatively little public or external-to-government professional expertise into policy development or decision-making processes;
- this process permits governmental interests and tensions to prevail over health system or public interests; and,
- some external-to-government public body is desirable to add a public dimension to health debates and provide checks and balances on the executive federalism process of the health conference system.

"Cost Containment in Health Care: The Federalism Context," by Katherine Fierlbeck is an assessment of the implications of the governmental health-cost containment strategies of the 1990s and their impacts on Canadian federalism and health programs. Fierlbeck examines the experience of three provinces in dealing with federal and provincial health-cost containment in her chapter: Ontario, for its political clout vis-à-vis Ottawa; Alberta, for its efforts to obtain more autonomy in health governance; and Nova Scotia, for its dependency on Ottawa. Although in different aspects and to varying degrees,

provinces have adopted similar approaches to reform by restraining rising health costs, restructuring, and integrating health services.

Fierlbeck concludes that:

- poor fiscal planning by Ottawa regarding the consequences of its health fiscal policies on provinces/territories has led to major intergovernmental tensions. These tensions have had serious consequences for federalism. As well, the unpredictability of federal fiscal policy concerning health and social transfer payments has had serious consequences for provincial fiscal frameworks; some would say intolerable consequences. Most damaging, asserts Fierlbeck, were the effects of the Canada Health and Social Transfer (CHST) payment reductions on provincial programs other than health services as well as on intergovernmental relations;
- at the time of the reduction in transfer payments for social programs through the introduction of the CHST in 1996, health programs could no longer absorb further cost reductions. Provincial/territorial governments therefore absorbed much of the cuts in federal transfer payments by reducing their expenditures in other program fields. This can be demonstrated by the fact that P/T health expenditures did not decline by anywhere near the amount of the federal reductions, and in some provinces health expenditures continued to rise. As well, health spending provincially increased across the entire country relative to other provincial government expenditures;
- the reductions in the rate of increase in health spending by provincial governments began in 1992. Throughout the decade, with minor exceptions, the current dollars of provincial government health spending actually increased marginally from 1992 to 1996, but the constant dollar and per capita dollar equivalent of this investment fell marginally as well, indicating that the value of provincial government spending in the health system was not keeping pace with price and volume increases; and,
- Ottawa's default on such a large proportion of its financial responsibility for health care (since 1982 and more recently the CHST in 1996) has led to a serious erosion of federal influence over national health policy as well as provincial/territorial health policy.

"Federalism and the Health Facility Fees Challenge," by Joan Price Boase is an assessment of the health "facility fees" challenge as an illustration of the F/P/T dispute resolution process in the Canadian health system. Facility fees,

a form of health user fees, were applied in some private clinics in certain provinces, most prominently in Alberta, during the early 1990s. At that time, provinces were facing burgeoning health budgets and beginning to implement reforms in an attempt to regain some control over the system's finances. Some provinces shifted certain services into the private system in order to cut public costs. In these instances, facility fees were in clear violation of the *Canada Health Act* (CHA) and therefore the federal government in 1995 imposed penalties under the Act on provinces that permitted these facility fees to be charged by clinics.

Contributing to the intergovernmental animosity which the facility fees issue provoked was the federal government's introduction of the Canada Health and Social Transfer in 1995. With this action, the federal government reduced substantially its cash payments to the provinces, even while insisting that provinces continue to respect fully the principles of the CHA. The result was to inflame intergovernmental relationships. Provinces argued that not only was Ottawa without the jurisdictional right to interfere in health care, but its level of funding was too low to justify its claim to a "trusteeship" role in protecting the Canadian health system at the expense of the provinces.

In the absence of an adequate intergovernmental mechanism for dispute avoidance and resolution, Price Boase argues that minor disagreements fester into serious disputes and ill-will between the provinces and Ottawa which affect other major aspects of the federalism relationships.

Price Boase concludes that:

- the present Canada-wide health governance regime has permitted the realization of redistributive equity, efficiency, human development, and mobility within the health system to the benefit of Canadians;
- confidence in democratic government is shaken when health policy becomes a publicly divisive and contentious political issue that focuses more on the disputes than on strengthening the health system for Canadians;
- an ultimate governmental authority is required to rule on CHA interpretation disputes and that in the absence of an alternative power in the democracy, this must be the federal government. If provinces were permitted joint interpretation authority with Ottawa over the CHA, medicare's public nature, universal coverage, and equitable access would be undermined;
- more democratic participation to assist the federal government to interpret and explain the scope of the CHA and any challenges to it is desirable

if the health-care system is to be supported as a "national" program in years to come; nevertheless, in a dispute where all collaborative and facilitation processes for resolution have been exhausted, without the federal government's ultimate authority to enforce the CHA unilaterally, the principles of the Canadian national health system cannot be sustained;

- F/P/T disputes, notably under the CHA, are frequently politically raised to federal/provincial ideological challenges that submerge the facts of the particular issue in dispute. For the public, this kind of debate inhibits its understanding of the specific issue and perhaps its influence on the eventual settlement. Price Boase suggests that a newly created Canadian Health Council, empowered to investigate, arbitrate, and publicize its findings before a final decision is taken by the federal government might be an option to contribute to the resolution of intergovernmental complaints; and,
- adequate and stable federal funding is required to sustain reasonably comparable health services Canada-wide, to permit reasonably comparable health funding obligations for provinces/territories (given their different fiscal potential), and to sustain the foundation principles of the CHA.

"The Role of Federalism in Health Surveillance: A Case Study of the National Health Surveillance 'Infostructure,'" by Kumanan Wilson is an illustration of collaborative federalism and the health perils for Canadians of ambiguous intergovernmental health jurisdiction. Wilson notes that the current disentangled surveillance system is burdened with inefficiencies, duplication and, of most concern, important program gaps. The present inefficiencies and inadequacies in the health surveillance system pose a serious public health risk to Canadians. The potential consequences of this are noted by drawing a parallel to the health catastrophe in the Canadian blood system documented by the Krever Commission report.

Developing a system that greatly improves coordination of surveillance activities between orders of government is a critical yet daunting challenge within present constitutional and intergovernmental relationships. This case study demonstrates the inefficiencies that can develop when a disentangled regime exists in an area in which constitutional roles and responsibilities are not clearly defined. It describes how some of these problems can be overcome by using a more collaborative regime as well as identifying some of the issues that will remain difficult to solve.

Wilson concludes that:

- disentangled governmental performance in a health sector field with unclear or shared constitutional responsibilities can produce a health program with serious systemic problems that can lead to unacceptable public health risks for Canadians. The public risks are aggravated where the programs do not have a high public profile and little or no public input or oversight;
- collaborative program planning and development appears to be well suited for a policy initiative where there is a recognition of need for Canada-wide development among all F/P/T partners, where jurisdiction is shared and jurisdictional sovereignty issues are a major concern;
- a collaborative planning process appears to be complemented by a voluntary "pilot" or demonstration system of implementation. This approach may mitigate governmental concerns over jurisdiction. As well, this might allow greater involvement of non-government stakeholders in the developmental process. This pilot process, however, can result in slower, more incremental policy implementation than if one used a disentangled governmental regime where new policy can be imposed quickly, if so desired; and,
- the collaborative regime, at least in the area of health surveillance, has still not resolved intergovernmentally issues of shared F/P/T funding, the creation and enforcement of national standards regarding data-sharing and its quality.

"Regionalization and Collaborative Government: A New Direction for Health System Governance," by Ken Rasmussen is an examination of the provincial health governance concept known as "regionalization" and an exploration of its potential lessons for federalism. Rasmussen argues that the evolving relationship between the federal and provincial/territorial governments is mirrored by the process of regionalization at the provincial level.

Regionalization has three main objectives (similar to those in the Social Union Framework Agreement): greater citizen engagement, improved efficiency, and enhanced accountability. These objectives are to be met through local governance of service delivery. If they are to be achieved, these objectives present new challenges to the provincial governance of the health system, not entirely dissimilar from the issues found on the national scene. Moreover, the development and adherence to provincewide standards may become a problem if Regional Health Authorities (RHAs) exercise their right to set their own

regional priorities. It is also possible that regional priorities might also challenge the five principles in the CHA.

Rasmussen notes that the amount of funding for health programs, and how this money is allocated, will always be a point of intergovernmental contention at the provincial level, as it is now between F/P/T governments. He observes that the federal role in health care has been weakened as provinces and Ottawa publicly dispute the interpretation and enforcement procedures of the CHA as well as the federal funding contribution to the health system. This type of dispute is also not substantially different from provincial/regional disputes about funding levels and regional deficits. In both cases, public confidence in the health system has continued to plummet as the public disputes persevere.

One difference is that with respect to programs and standards, provinces and regions are supposedly working under contractual service agreements where the expectations are defined and refined annually. He notes that this definition of contractual responsibility is, to date, not well achieved in the regionalization schemes across Canada. However, repairing this ambiguity in expectations is less difficult to resolve under a contractual relationship than under a constitutional division of powers arrangement.

Rasmussen concludes that:

- regionalization requires more collaborative policy and program planning between the RHA and the provinces;
- roles and responsibilities of the provincial government on the one hand, and the RHAs on the other, need to be clearly defined and understood and respected by both orders of government, and shared widely with the public;
- provincial standards of health service need to be developed so that appropriate provincial public accountability can be applied to the RHAs; and that these standards ought to be developed collaboratively with the RHAs in order that they will be meaningful, useful, achievable and measurable;
- some provincial/RHAs dispute resolution mechanism will likely need to be developed; and,
- some Canada-wide organization or the federal government ought to be charged with hearing and evaluating the experiences of the Canadian RHAs, and disseminating their best-practice experiences to the Canadian public and all governments. (One possibility is the Canada Health Services Research Foundation.)

When one integrates the findings of the six cases involved in this study, there are some additional lessons learned.

Public confidence in the health system, and perhaps also in the performance of governments, has been eroded by the intergovernmental disputes surrounding the health system, particularly its future direction and funding, both at the F/P/T level and the provincial/RHA level. The lack of governmental response to the advancement and future security of Canadian health programs should politically command governmental attention.

Both the positive and negative features of the health system today are a reflection of the outcomes of using a mix of intergovernmental regimes to address policy issues over time. No single regime has been found best to deal with all emerging policy problems. Furthermore, the case studies have concluded that given all the political constraints, there is presently not much scope for re-allocating powers between orders of government to strengthen disentangled regimes. There is scope, however, for interpreting and clarifying the roles of governments in areas of shared jurisdiction, and thereafter negotiating responsibility for the programming gaps in order to facilitate Canada-wide program implementation and rationality.

The absence of public involvement in health planning and/or decision-making in the national health system may be contributing to policy stalemates among governments whose negotiations are permitted to coalesce around intergovernmental interests, not necessarily Canadian public or health system interests.

A Canada-wide organization which can acquire high public credibility and confidence is needed as part of the governance mechanism of the Canadian health system, to provide objective and meaningful information and explanation to the public about the health system's performance, about the issues in contention within it and about future directions needed in the system.

When all the financing facts and argumentation are taken into account, it remains that federal money is essential to support provincial health reforms through their current transition and thereafter to assist the health system to continue in a fiscally sustainable state.

NOTES

[1]Tom McIntosh, "Governing Labour Market Policy: Canadian Federalism, the Social Union and a Changing Economy," in *Federalism, Democracy and Labour Market Policy in Canada*, ed. Tom McIntosh, Social Union Series (Kingston: School of Policy Studies, Queen's University and McGill-Queen's University Press, 2000), pp. 1-28.

[2]Harvey Lazar and Tom McIntosh, *Federalism, Democracy and Social Policy: Towards a Sectoral Analysis of the Social Union* (Kingston: Institute of Intergovernmental Relations, Queen's University, 1998).

[3]These terms are, of course, subject to multiple definitions and different emphases. A clarification of some of the issues surrounding these terms can be found in Tom McIntosh, *Governance Aspects of the Social Union: Operationalizing Key Concepts* (Kingston: Institute of Intergovernmental Relations, 1998).

[4]The reference to three case studies here is a reference to the case studies in the McIntosh volume on labour markets. In this volume on health, there are six case studies.

[5]McIntosh, "Governing Labour Market Policy," pp. 3-7.

2

THE CANADIAN HEALTH SYSTEM LANDSCAPE

Patricia O'Reilly

The Canadian health-care landscape is predominantly composed of and influenced by: federal and provincial/territorial governments, health-care institutions and programs, health practitioners, the public, private business interests, and particularly in today's restructuring climate, the media and policy designers and analysts.[1] The relative influence of each depends on the context of the issue; or as one involved actor put it, "It is impossible to generalize."[2] Despite relative stability in the Canadian health-care sector,[3] our present economic policy of fiscal restraint is providing a strong impetus for fundamental change, causing our "landscape" to be in transition.

GOVERNMENTS

In Canada,

> it is generally accepted ... the primary constitutional responsibility for health care rests with the provinces under provincial authority over hospitals, property and civil rights, and local or private matters ... the federal government's ability to legislate in respect to health care ... derives [predominantly] from ... its spending power (which includes the power to collect indirect as well as direct taxes). Through a combination of transfer payments and legislation, the federal government has come to play a very significant role in health care, in particular, by imposing national standards on provincial medical insurance and hospital programs.[4]

The provinces and territories operate and administer their insurance funds "on a non-profit basis by public authority."[5] For certain groups of the population, such as the elderly and some chronically disabled people, certain disadvantaged children, and recipients of public assistance, provinces provide supplementary insurance coverage for certain health services that remain outside the national health insurance framework for the general population. In addition there are general provincial health programs such as public health and mental health services available to all, as well as other programs which are targeted to benefit low-income families or people requiring very expensive health products (such as drug programs, oxygen, etc.), or classes of disease or disability (such as addiction treatment programs).

Since the provinces and territories are responsible for the actual delivery of public health care, they control the distribution of funds within the sector. However, as we shall see in our discussion of health institutions and practitioners, the day-to-day operations of health service or delivery also affords a certain measure of control to the practitioners and institutions that provide this care directly to the public.

Federal political parties attempted to keep a low profile on health-care issues during the early to mid-1990s. If it had not been for the considerable efforts of health-care coalitions to place health care on the 1993 federal election agenda, there would have been a concerted silence on the issue.[6] During the 1997 federal election, there was "virtually no debate of ... health care."[7] Banting points to little difference between the Conservative and Liberal federal agenda in recent years regarding social policy programs. While the Conservatives are less sympathetic to universal social programs (preferring group-targeted programs) and are generally more concerned with welfare fraud or abuse of the system, the federal Liberal government, from 1993 on, "did not change the overall direction of social policy established by the Conservatives [of the previous decade]."[8] Today, however, the federal governing party has been forced to enter the public debate for the same reason as the provincial parties have become increasingly publicly engaged with health-care issues: the effects of reducing or withholding services and/or funds from public programs has resulted in dramatic media coverage of the adverse side-effects of downsizing. As opposition party in the federal legislature, the Reform/Alliance Party has been keeping health-care issues — such as the fight for compensation for hepatitis C victims — alive. They also dominated the 2000 federal election.

Provincial political parties have been drawn into the public health-care debate in both their legislatures and the media mainly because of the dramatic

cuts to health-care services and ensuing disaffection of the public and the health practitioners with the changes. After a series of hospital closures and critical media coverage of emergency and rural medical services, a party policy advisor claims, "No government can get elected in Canada without dealing with health care."[9] Just what "dealing with" consists of is not clear. For example, in Alberta, "even after [Klein] initiated massive cuts in government services ... his popularity held up remarkably."[10] Likewise, both Harris and Romanow returned to office after considerable "downsizing" in the health sector.

Ministers of health, for their part, are under pressure to reduce or flatten costs, reinvest in hospital/long-term/community health care, ensure quality, ensure accountability, ensure system coordination and cooperation, pacify various stakeholder groups, and enhance public participation, at the same time as they move toward redesigning the system itself without irrevocably damaging their chances of re-election. This is a rather tall order. Even with such pressures, it appears that the overall influence of legislative and bureaucratic bodies has been exerted mostly through budget-related committees.[11] Extraordinary bodies, such as joint-management committees (e.g., between government and medical associations) and arm's-length assessment and advisory committees have developed on an ad hoc basis in the sector, but their influence has been minimal; their roles have remained advisory and their recommendations voluntary.[12] Public influence on the politicians appears to be more influenced by media attention and public opinion in the health sector.

Intergovernmental relations have focused on funding and regulation. Under the Canada Health and Social Transfer (CHST), federal contributions and payments come in the form of a block fund intended by the federal government to be used for health care, postsecondary education, and social assistance.[13] It is provided in the form of both (conditional) cash transfers and (unconditional) tax-points transfers. Cash transfers (under this and previous arrangements) were sharply reduced in 1995. The provinces won a guaranteed floor of $12.5 billion in 1998, rising to $14.5 billion in 1999-2000 as a result of a supplement of $2 billion targeted to health programs. Then in mid-2000 the provinces succeeded in negotiating a five-year, $23.4 billion health-funding deal with the federal government — most of which had no conditions attached. Of course, no one can be certain any longer, what proportion of this total CHST transfer is intended for health programs or actually allocated by provinces to health programs because there is no "notional" targeting of the transfer to specific programs.

Throughout this period of financial adjustment federal-provincial relations were tense. Provincial and territorial governments claimed, "federal

reductions in transfer payments have created a critical revenue shortfall for the provinces and territories which has accelerated the need for system adjustments and has seriously challenged the ability of provinces and territories to maintain services. Federal funding reductions forced the acceleration of change beyond the system's ability to absorb and sustain adjustments."[14] The provinces and territories had been "particularly concerned that some previous federal interventions have raised public expectations without sustaining federal commitment."[15] Regardless of blame, provincial and territorial governments across Canada have continued to engage in a program of downsizing and restructuring. In that process, some provinces are also doing to their municipal governments what is being done to them, that is, pulling funds out of (local, public) health services while still expecting to "call the shots."[16] Tensions between all levels of government are high.

The intergovernmental focus on regulation has centred on the struggle to define or re-define the guiding principles of the *Canada Health Act* (CHA). As it stands, this Act upholds the principles of "universality, portability, accessibility, comprehensiveness, and public administration"[17] for the whole system. Equity is defined in rather narrow terms as the removal of financial barriers to accessing health services.[18] However, these principles were designed in better economic times (in the mid-1960s), and as provincial governments struggle with reduced budgets and the "downsizing" this entails, they are finding it difficult to uphold the federal interpretation of these principles. In the mid-1980s the federal government fought for the maintenance of the medicare principles, especially that of universality, and has since remained committed to them.[19] According to Health Canada today,

> Governments, health providers and Canadians alike agree that all efforts to preserve and enhance Canada's health system have to build upon the five fundamental principles of the Canada Health Act that guide the design and operation of our national health insurance system. Canadians regard health care as a basic right and they value their health system highly. They identify strongly with their health system because it exemplifies many of the shared values of our society, such as equity, fairness, compassion, and respect for the fundamental dignity of all. Adherence to the principles of the Canada Health Act will remain an important characteristic of Canada's health system as it continues to evolve to respond to the needs of Canadians.[20]

The federally sponsored (and intergovernmentally contentious) National Forum on Health noted that "throughout its public consultations, Canadians

expressed commitment for medicare based on the values and principles embodied in the Canada Health Act, and supported by strong government partnerships."[21] This claim is backed up by public opinion polls. In 1996 "Canadians expressed a desire for involvement of both senior levels of government" in health care, and despite a lack of general confidence in federal spending priorities in 1997, 56 percent of Canadians (everywhere but in Quebec) agreed then that "Ottawa should set national standards for [social] programs."[22]

For their part, provincial and territorial ministers of health

> support the five principles of the Canada Health Act (CHA) ... and are committed to protecting and renewing the network of public services, programs and policies which are beyond the CHA ... Ministers of Health believe that the three primary goals of the future health system for Canadians must be:
>
> 1. to preserve, protect and improve the health of Canadians,
>
> 2. to ensure that Canadians have reasonable access to an appropriate and effective range of health benefits anywhere in Canada, based on their needs, not their ability to pay, and
>
> 3. to ensure the long term sustainability of the health system.[23]

Here we see the provincial/territorial authorities expressing a need for a balance between the federal stance on the CHA principles and provincial/territorial needs. As we saw earlier, this concern is at times expressed somewhat more forcefully. As Canada's western premiers pointed out in mid-1997, "the federal government has made the largest cuts to health care ever and provinces are being forced to shoulder the blame."[24]

Both the federal and the provincial/territorial governments were associated with grand vision statements during the second half of the 1990s. Each order of government took both "the high road" and a pragmatic political stance at the same time. A Health Canada statement, for example, called for "a renewed national health system that is based on a health determinants approach to population health, that manages risks to the health of Canadians, and that ensures universal access to appropriate and cost-effective health care."[25] The "vision document" of the provincial/territorial Ministerial Council on Social Policy[26] called for

> partnership between ... (federal/provincial/territorial/local) governments, stakeholders, service providers, care givers, researchers, suppliers, communities and individuals ... with each partner having a clear understanding of its

> roles and responsibilities/accountabilities ... And with the federal government providing its fair share of resources in the form of adequate, predictable, and stable, cash transfers at levels high enough to protect and preserve the national health system (pp. 3 and 8); a system that integrates a full range of health services to better meet the needs of the patients ... with improved quality, access, efficiency and accountability (p. 4); evidence-based decision-making, and sound management: evidence-based decision-making is based on "good information, research and evaluation ... to improve services, increase benefits, and improve system management" (p. 10); and a conciliation or arbitration body ... to make recommendations on disputes and issues referred by either the federal government or the provinces / territories on: interpretation ... application ... and adherence to the principles of the CHA, related financing, and emerging trends (p. 9).[27]

Again we see a broadening of the "vision" by the provinces and territories, plus the interesting suggestion of an arbitration body to settle what they obviously see as intractable differences.[28]

Overall, intergovernmental relations remain tense. It is unlikely this tension will diminish much while the implementers of the medicare system are struggling with restructuring the system to fit both a new budgetary reality and a set of standards premised on the old reality. It is also unlikely that the federal government will back off from its commitment to the five principles of the CHA; it has little to lose by standing behind its earlier design. Having said this, however, it is important to keep in mind that while the controversial rhetoric will likely continue to fly in the political arena, the everyday workings of the intergovernmental governance system for the national health system continue to function reasonably normally. As one federal inside observer put it, "We would not have the system we have today, if there had not been a history of collaboration ... There are many nuts-and-bolts areas in the health sector where relations have been very good."[29]

INSTITUTIONS AND PROGRAMS

Given their considerable cost, hospitals have been prime targets for restructuring. Over 95 percent of Canadian hospitals are operated as public non-profit corporations run by community boards of trustees, voluntary organizations, or municipalities. The for-profit institutional sector comprises mostly long-term care facilities or specialized services such as addiction centres.[30] Hospitals and

other health-care institutions have control of day-to-day allocation of resources provided they stay within the operating budgets established by the regional or provincial health authorities. As greater cost control has been required in the health sector, all of the provinces have moved, or attempted to move, from global budgets to more specifically targeted budgeting. Global budgets for both medical and hospital services have been replaced by more detailed case-based funding formulas[31] with considerable discussion on how best to develop more finely-tuned mechanisms of cost control.

Hospitals are primarily accountable to the communities they serve, not to the provincial bureaucracies (except for their financing and any provincial regulatory or contractual requirements). However, political/bureaucratic concern for overall cost and coordination of services, coupled with a long history of turf protection in the hospital sector, has led to independent reviews by bodies such as the Health Services Restructuring Commission in Ontario, which have been granted considerable power to reconfigure the delivery of hospital services in communities.[32] In response to pressures to "downsize," "restructure," and "coordinate," the hospital sector throughout Canada has seen hospital closures or hospital conversions to health centres (e.g., 52 rural hospitals in Saskatchewan),[33] closed wards, reduced beds, clinical specialization with institutional forfeiture of some types of care,[34] and the consolidation or coordination of hospitals (e.g., via shared services and increased private contracting out of services).[35] Critics argue that the assumption of efficiency supporting these moves is debatable.[36] One hospital representative predicts "hospitals won't exist in ten to twenty years. [In their place will be] health care centres [providing] virtual health care [via the new information technologies]"; they will be either specialized centres, such as a cardiac centre for the whole province, or integrated health systems which can do everything."[37] However, it should be noted that despite what appears to be considerable change to the hospital sector, some analysts see in reality little fundamental change to the sector as yet. Tuohy points out that the new "organizational configurations" have not shifted the "weight of hierarchy in the system," for example, "the monitoring of medical behaviour in hospitals remains firmly lodged with hospital medical staffs."[38]

Hospital restructuring has been generally supported by policy analysts familiar with the lack of coordination and duplication of services in the sector, particularly between denominational hospitals often located blocks from other hospitals. Public reaction, however, has been less than supportive: triggered

by media stories of backed-up or absent services, public anxiety has been growing, as has the anger of health professionals and other health workers from the hospital system.

Policy designers and analysts are busy. New models of health delivery are being developed and studied for long-term and community-based care as well as the subsystems within them, especially that of primary care (i.e., the point of first entry of the patient). New "integrated health systems" models which emphasize the needs of patients are being designed, at the same time as national designs for "home care" and "pharmacare" are being debated, and international experiences are being scrutinized (such as the British "Integrated Care" primary and community care reforms).[39]

What these models all have in common is a search for a more integrated, cooperative system of health care and promotion that can provide a better balance between quality and efficiency. That balance, however, is more than an intellectual construct. It is an everyday terrain rife with stakeholder and interest group turf wars. Regarding intergovernmental interests, for example, despite early signs of "optimism" on the part of the federal minister of health for a national home care system,[40] proposals have been met with familiar concerns over jurisdictional control, or as an *Alberta Report* writer put it, "Home Care Marks another Foray onto Provincial Turf."[41] Provincial ministers were quoted during debates on Ottawa's budget surplus as saying they did not want the federal government launching any new "boutique programs" like "pharmacare and home care," but the federal minister of health continues to want them discussed whenever increased federal transfer funds for health are being requested by the provinces.[42] Regarding institutional interests, the proposed integrated health-care systems, for example, raise questions of institutional jurisdiction. As one health analyst noted, there is likely to be a move on the part of the dominant provider institutions of the past, especially hospitals, to attempt to move into a position of influence within the proposed models of primary or community-based care were they to become a reality. One significant instrument for gaining and maintaining influence in a restructured system is the control of information access. Hospital managers are likely to attempt to retain as much control as possible over the collection of patient data,[43] and everyone is likely to want to gain some measure of control over this important instrument.

The new relationships being called for between the old institutions such as hospitals and the new community-based organizations will also be hindered

by cultural differences. The large institutions and their health practitioners have long been organized along hierarchical lines, while the emphasis on community involvement in health care is based on egalitarian principles. The public/patient voice was the voice of the little guy challenging the big elite institution. It still is. Although some health policy analysts see good management as capable of making this difficult transition,[44] those of us who have been analyzing political cultures for some time have noticed how very difficult the coordination of two opposing and deeply embedded cultures can be. The results of years of cultural differences produces a myriad of institutional practices and assumptions which are so common place within the workings of an institution as to have become almost invisible to its participants. Even finding the language to talk across two "worlds" is often difficult and fraught with anger and resentment. As one noted hospital CEO in favour of even more fundamental change to the hospital sector (including "partnership with the community") put it, "It is incredibly complex to talk to a community."[45] Whether or not "sound management" is up to the difficult task of coordinating the parts and the people of the hospital and community institutions and programs remains to be seen.

Sound management is considered by the provincial and territorial ministers of health to be one of two "essential means to securing the health system of the future" (the other being evidence-based decision-making). They say that, "[i]mproved management will require enhanced partnerships among policy makers, service providers and users of the system through more collaborative planning, priority setting, public policy development, and implementation." It will also include practices that are "open, effective, efficient, and accountable."[46] The Canadian College of Health Services Executives (CCHSE) has predicted that despite the present upheaval in the health sector, "the role of the clinical manager will continue to take on a greater scope of responsibilities and accountabilities at both the senior management and clinical programmatic level."[47] It also predicted that the new decentralized organizations will not operate on the command-and-control model of management/leadership, rather, "an adaptive and flexible managerial style ... of coaching, mentoring and facilitating will be key for future leaders of health care organizations."[48]

One aspect of health restructuring which is likely to test good management skills is that of the relations between the institutions and their professional and non-professional health practitioners, and the relations amongst those same practitioners.

HEALTH PRACTITIONERS

Physicians

Prior to the contemporary climate of fiscal reduction and restructuring, the prime determinant in Canadian health policy as a whole has been, as Tuohy has demonstrated, "the logic of an accommodation between the medical profession and the state" whereby the state as "single-payer" negotiated the allocation of resources with "the monopoly providers of services, ... particularly, the medical profession."[49] Tuohy demonstrates the strength and continuity of this "collegial accommodation" and its institutional "collegial mechanisms" which have resulted in "relative structural and institutional stability" in the Canadian health-care system.[50] The Canadian health-care design has long contained a high degree of medical autonomy based on the provision of exclusive scientific expertise and a trust-based system of professional self-governance. This autonomy has stood up well; only now, with an ever-increasing emphasis on efficiency and coordination, is it threatened.

Attempts to enhance control of today's physicians have targeted what Tuohy refers to as both their "entrepreneurial discretion" and their "clinical discretion."[51] Originally, under medicare, individual physicians gave up some of their entrepreneurial discretion over broad public funding levels (which were to be collectively negotiated between their professional associations and the state) for the maintenance of more specific entrepreneurial freedoms, such as location, labour, and volume and mix of services, as well as the maintenance of individual clinical discretion. Gradually, however, the state has moved to limit more of the physician's individual entrepreneurial discretion and may well be poised to limit some of the physician's clinical discretion, as well. Beginning with the 1984 (CHA) limitations on "extra-billing" by physicians and up to the present time, increasing attempts have been made by state actors to contain the escalating costs of the system by reaching down into the finer mechanisms of previously designated fields of physician discretion.

This move by the state has not, of course, been well received by Canadian physicians; nor has it been, as of yet, very successful. Tuohy documents the strain on the relationship of collegial accommodation between the medical profession and state political and bureaucratic actors during the course of the latter's attempts to gain some control over physician supply, scope of coverage, payment mechanisms, and clinical protocols. Others, such as Lomas *et al*., have looked at the problems of instituting these finer mechanisms of control over physicians.[52] Attempts to control physician supply have mostly targeted

physician location with an emphasis on incentives to recently-graduated physicians to locate in rural and remote areas, coupled with disincentives to locate in over-serviced areas. The more heavy-handed attempts have not been very successful, nor will they likely be in the near future given a recent Supreme Court decision in favour of physicians' mobility rights. Likewise, control over the scope of nationally insured medical practices, by "de-listing" services (i.e., leaving them to the private sector), has been slight. Those services that have been successfully delisted have been mostly in specialized cosmetic and reproductive techniques.

Physician payment mechanisms have been the subject of considerable debate in recent years. Physicians are generally paid on a fee-for-service basis and submit their service claims directly to the provincial health insurance plan for payment. They may also be paid by salary or contract, or remunerated through an alternative payment scheme. Where physicians receive reimbursement from the state, they cannot charge deductibles, co-payments or place dollar limits on coverage for insured services. One of the means of controlling the fine-tuned entrepreneurial discretion contained in the physician's control over the mix and volume of services is to place a cap on the amount that can be billed by a physician. Early capitation-based funding projects, such as those in Quebec and Ontario, covered only small population bases, and were targeted at physicians' services (which could be salaried); more recent models of capitation are being advocated and tested in pilot projects as part of a larger organization of primary care, community-based health delivery. For example, as part of their proposed Integrated Health Delivery System model, the Metro Toronto District Health Council (MTDHC) argues,

> the current funding incentives for health providers does not support integrated systems. There is a need to look at alternative methods of funding that will encourage services to be delivered by the right provider, in the right setting, and at the right time. There is growing acknowledgment that capitation funding offers considerable advantages over current methods ... Usually under capitation schemes, consumers choose to roster with an organization.[53]

Under their design "the [central organizing/service delivery body] would receive a capitation payment from the Ministry of Health for each person on the roster." Not surprisingly, some physician's groups have argued against any move away from the fee-for-service type of physician payment, although others have been willing to discuss possible combinations of alternative physician payments, such as salary-plus-bonus, or a combination of fee-for-service with capitation.[54] One medical group suggests "different funding mechanisms" ought

to be tested for family practitioners in primary care: arguing the system "needs a whole menu of payment options that work for different [rural, urban, suburban] areas."[55] It is interesting to note the federal National Forum on Health (1997) called for "funding the care rather than the provider or site."[56]

Another area of influence over the cost of physician's services is that associated with their clinical practices.[57] It is only at the level of the actual practices and procedures of all health practitioners that the specific costs of their services can be assessed and perhaps adjusted, that is, deemed unnecessary, overutilized, inconsistent with that of peers, and even potentially shifted to less expensive practitioners. Needless to say, those profiting from these practices and procedures have a vested interest in keeping outside scrutiny at a minimum. Today, however, that scrutiny is inevitable. There are increasing signs of interest in "evidence-based" research and "utilization" review. It remains to be seen whether or not any new evidence, if found, will be used to diminish the clinical control of the health practitioners.

These attempts at control, targeted at physician's services, have weakened the historical relationship of "collegial accommodation" between the medical profession and the state.[58] The power of the medical profession in the sector is based on its control of a highly valued expertise, backed by a history of virtual regulatory monopoly over that expertise. Despite some internal divisions, and complaints they had lost their "voice" in health-care decision-making forums,[59] the medical lobby is not likely to be greatly diminished in the near future. It has considerable monopoly power (particularly when it threatens strike action). While the public might not like the monopoly, it continues to give physicians strong support. There is some indication, however, that even our more conservative policy commentators are moving beyond the old relationship of support for the medical profession in their recommendations for change.[60] The present move to utilize and legitimize nurse practitioners and midwives within the established institutions of health care,[61] may represent an incremental strategy to reduce the strength of the dominant practitioners within the sector. It will at least open the door for reconsideration of the overutilization of physicians, as well as the underutilization of other practitioners throughout the system.

Nurses

One of the main targets for cost reduction in the hospital sector has been nonphysician personnel. Nurses have been put under tremendous pressure in the current climate of restructuring and downsizing. Many hospital nurses have

lost their jobs and many more are working under difficult conditions.[62] Concern is being expressed over the loss of nurses from Canada — nurses who will be needed for the proposed community-based care should it be developed as called for.[63] Under many of the proposed reforms, nurses would play a key role. For example, Rachlis and Kushner predict: "as in other modern organizations, hospitals will have new incentives to flatten the hierarchy and promote real collaborative teamwork ... Doctors who want to work like nurses and social workers will probably be out a job."[64] For their part, nurses are advocating the importance of their role in "providing cost-effective health care ... primary health care ... and health promotion."[65] This appears to be backed by public opinion.[66]

As institutions move to reduce costs, particularly nursing costs, lesser trained workers are being given some of the former nurse's tasks. This utilization of the "Lowest Cost Care Provider" (LCCP) has led to concerns from professionals and academics regarding the treatment of health practitioners, the possible trade-off of quality for cost; the lack of practitioner preparedness for ethical choices/actions; and for equity issues.[67] On the latter, for example, cultural diversity in the workplace is being threatened by employment lay-offs guided by the "last-hired, first-fired" policy of most labour unions. Since much of the cultural equity gain in employment has occurred in the recent past, this employment policy makes it increasingly difficult to provide services that reflect and respect the cultural diversity of patient populations.

Unions are lobbying for changes that will include increased staffing levels and give health-care providers ongoing input into long-term health-care policies and programs. A study conducted by the Canadian Union of Public Employees (CUPE) and the Service Employees International Union (SEIU) found "greater numbers of patients are entering homes for the aged where staff is required to provide higher levels of care with the same or fewer staff and resources. Under-staffing and workload increases have resulted in errors, accidents, injuries to patients and lapses in infection control."[68] Labour adjustment strategies are developing to help deal with the effects of restructuring on labour.

Labour Issues

As Adams points out with regard to health sector labour issues dealt with recently in Saskatchewan,

> Working through the difficulties for labour, both organized and unorganized, and the individual job adjustments that had to be made for some health workers

> was an especially complicated problem, one that was seriously underestimated at first ... Diversity amongst [worker] contracts for the same type of work ... stirred stormy debate amongst employees and employers ... There were two essential aspects of the labour challenge. The first was how to restructure organized labour in order to improve the situation for individual workers in a reformed health system while simplifying the historic complexities of conflicting contracts and union governance. The second was how to explain and communicate regularly and accurately with workers so that they were not unduly frightened of change, and could be positive contributors to reform initiatives while at the same time not offending contractual relationships with the unions.[69]

Prior to restructuring, the Saskatchewan health system contained approximately 30,000 employees (excluding physicians and other privately employed health professionals) represented by 382 local unions in 538 bargaining units with 25 collective agreements. The misalignments this diversity created, in wage and benefit packages, for example, "created major impediments for the District Health Boards with regard to program planning, moving and transferring staff, the flexible use of health providers, and minimizing the costs of collective bargaining." When the unions failed to come to an agreement among themselves with regard to outstanding issues, at the request of the unions an independent commission was set up by the government to give advice on an appropriate settlement. This resulted in an amalgamation of bargaining units and therefore a simplified collective agreement process. "The resulting labour legislation and readjustment has contributed to the enhancement of mobility and flexibility of labour, and consequently to a more cost effective and efficient delivery of health services."[70]

While labour reform in the Saskatchewan health industry was achieved under stressful circumstances, it was accomplished on the basis of collaboration and consultation. The health workers, the Health District Corporations and the health unions have benefited in the end because it has simplified collective bargaining, has protected the job security and seniority of workers in the same district, and has reduced the anxiety of labour force adjustment. What has not yet occurred to any large degree is the increased participation of labour in health system decision-making which is the root of their decade-end discontent.

Other Health-Care Practitioners

All Canadian health practitioners are regulated in one way or another, either directly through licensure and/or registration and/or certification of their

profession or semi-profession, or indirectly through the licensure or legal control of the health practices they engage in or are barred from engaging in. Within these regulatory controls, further hierarchies of prescription, supervision, and delegation have been embedded into the institutions and programs of the system. Relationships amongst these practitioners range from friendly and supportive to antagonistic and conflict-ridden. Directly regulated health practitioners have a governing body (college or board) that, at least theoretically, is supposed to act as an agent of the state. Some provinces have recently moved to ensure a much higher degree of accountability from these governing bodies.[71] Practitioner associations act as union-like bodies for both the professional and non-professional health practitioner groups they represent.

Today's health system's designers are all calling for a more integrated health-care system, making "cooperation and coordination" key words for interest groups and stakeholders.[72] For the health practitioners, it is as if old rivalries are expected to be dismissed.[73] Given the long history of turf wars amongst regulated and unregulated health practitioners, however, this transition to cooperation may be more difficult than its many proponents realize.

One of the main "border disputes" of the health practitioners hinges on the question of "primary contact" (Who should see the patient first?) and its link to the practitioner's capability to "diagnose" diseases, disorders, or dysfunctions. Medical practitioners have long claimed to be the only health profession capable of this "whole body" function, and therefore, rightly, the gatekeepers of health-care's points-of-patient-entry.[74] These are rather expensive gate-keepers, however; so the question arises as to whether or not other practitioners might also be capable of primary contact or diagnosis. Ontario has recently moved to allow other practitioners (optometrists, chiropractors, and psychologists in 1991, and more recently, midwives and nurse practitioners) the "diagnosis" function (and therefore the point of entry) in their particular sphere of care. Alternative practitioners, such as naturopaths, osteopaths, and homeopaths (who also claim to be whole-body practitioners capable of primary contact with their health-care recipients) were unable to convince the Ontario Ministry of Health of their need to be given legislative sanction for this role in the institutionalized health-care system. Physicians continue to fight to maintain their exclusive gate-keeping role in the system, arguing against the fragmentation of a system with too many independent practitioners.

Merchant-service specialists, such as pharmacists, dentists, denturists, audiologists, chiropodists, and optometrists have long struggled with the contradiction between the merchant role and the professional role. There has never

been a comfortable fit between the two and this might portend difficulties for the new designs aimed at increasing the weight of market forces in health care. Pharmacists and audiologists, for example, continue to struggle for greater control over their profession by emphasizing their "professional service" role as an indication of their professional status. In general, many of the practitioners cross into or would like to cross into the sale of merchandise related to their scope of practice. Battles have waged for years over the "dispensing" of pharmaceutical, dental, ophthalmic, auditory, orthotic, prosthetic, and dietetic merchandise, especially if this merchandise and accompanying services fall under state benefits.[75] Lines were redrawn in the Ontario *Regulated Health Professions Act* of 1991, but there, as elsewhere, further disputes will inevitably arise in a climate of deregulation and open markets.

Technique specialists (independent practitioners of non-merchant, non-medical techniques, such as chiropractic, psychology, midwifery, speech-language pathology, and occupational therapy, as well as their professionally-dependent counterparts in physiotherapy, massage therapy, psychometry, dietetics, dental hygiene, nursing, and so on) have long fought for both state support (via funding and legitimacy) and further independence or expanded "scope of practice" or licensed procedures. These border disputes have resulted in years of political lobbying and practitioner tension. Many of them have been left unsettled, but they could come to play a very important role in the health practice "utilization" reviews now gaining popularity amongst decisionmakers. The bottom line of the reviews is that they raise the issue of unnecessary monopoly of services in the sector. Which practitioners can competently and appropriately perform which functions or services?

Technology groups (medical, radiological, respiratory, dental, etc.) and assistant groups (medical, dental, and nursing), like all other health practitioner groups, would like to better their position within the sector. These groups also raise interesting questions about requisite knowledge for both technological and basic (easily performed) practices in health care. Both bring forth questions of how to design adaptive policies and legislate scopes of practice which will have room to grow. Here the Ontario *Regulated Health Professions Act* (used as a model for later practitioner legislation in British Columbia) provides a useful experiment, since it sought to do this by licensing not the practitioners themselves, but the practices of health care, thereby leaving room for various practitioners to adapt to changing health-care practices and technologies. How well this works in Ontario over the next decade or so, particularly

during a period of restructuring throughout the whole sector, will tell us whether or not our practitioner legislation has caught up with the times.

Another sign of the times is the proliferation of alternative and/or complementary (non-professional) health practitioners. Alternative practitioners, such as naturopaths, osteopaths, homeopaths, Chinese medicine healers, Shiatsu therapists, and Botanic healers, are attracting consumers and, therefore, have the potential to affect change in a system which has long relegated them to the fringes. There is increased pressure on the traditional health-care system to fund, accommodate, and study their practices. They are also attracting attention from politicians, state officials, and the medical profession.[76] The road to legitimacy will not likely be an easy one, however. The British Columbia Naturopathic Association comments that

> [d]uring the (last) federal election both the Reform Party and the NDP formally endorsed a moratorium on the government's ... restrictive actions limiting patient access to natural medicines. Under the public pressure on the campaign trail the Liberals set up a complementary medicine committee reporting to the Ministry of Health. The Liberals promised an open and transparent process. However, they have since [moved] the committee ... to the Health Protections Branch–the source of all the problems, narrowed the agenda from complementary medicine to herbal remedies, made the meetings in-camera, and have only one naturopathic physician on the committee.[77]

As one federal official put it "there is an increasing acknowledgment of the alternative practitioner's role" but we still "have a middle-of-the-road group of civil servants talking with middle-of-the-road type practitioners."[78]

Overall, as health-care restructuring continues, further questions will arise about both the underutilization and overutilization of the whole range of health practitioners, especially those who can present a reasonable case for their cost-effectiveness (accompanied by evidence of quality of care). During the comprehensive 1980s Ontario review of health practitioners, general medical practitioners were challenged by the psychologists, optometrists, audiologists, speech-language pathologists, podiatrists, chiropractors, and midwives for practising techniques for which they have little training. The dentists were challenged by the denturists and dental hygienists for the same lack of comparative training. Pharmacists were challenged by prosthetic and orthotic practitioners, as well as the hearing-aid dispensers. The latter also challenged the audiologists. Even at the technical and assistant levels, the less-educated

practitioners, such as the technicians, lab assistants and assistant nurses, argued they were often better able to do particular tasks than their supervisors.[79] These claims have yet to be investigated, partly because this is a very complex and understudied area, but the "evidence-based decision-making" being called for today in the sector may well instigate investigation into these challenges.

It is not clear whether either level of government, or both, will be able to overcome the power of science and professionalism embedded into the organization of the health practitioners. It is the complex science-based expertise and the professional trust-based autonomy of governance deeply embedded into the health sector, which are going to be the hardest to reach for the change-makers. Already we are seeing some indication of the latter with recent recommendations for accountability,[80] but I am as yet unconvinced the *political* will exists to go even further than the mechanisms of good governance, that is, into the rarified and hitherto protected territory of scientific expertise.

INTEREST GROUP COALITIONS

In an effort to carry more weight in the sector, coalitions have formed amongst health-care interest groups. One influential national coalition, the Health Action Lobby (HEAL), contains the key health-care associations: Canadian Medical Association, Canadian Nurses Association, Canadian Hospital Association, Canadian Public Health Association, Canadian Long-Term Care Association, Canadian Psychological Association, and the Consumer Association of Canada. It has now been joined by 20 other national organizations. One key official referred to this group as health-care's "most important coalition." According to the coalition, in 1995-96 they conducted a "comprehensive lobbying campaign around the Canada Health and Social Transfer (CHST).... When Finance Minister Paul Martin presented his 1996 budget he announced a number of measures that addressed key elements of the HEAL lobby position... [par ticularly] that the government halt the decline in cash transfers and introduce a stable funding environment."[81] Another coalition group, the Canadian Health Coalition (CHC), also takes credit for influencing this important decision.[82]

The difference between these two large lobby coalitions rests in the fact that HEAL is predominantly composed of professionals and targets "mostly financial issues," while the CHC is predominantly labour and consumer oriented ("including [34 national organizations], such as labour organizations [including the Canadian Labour Congress and nursing associations], women's groups, anti-poverty organizations, churches, seniors, students"). The CHC

targets changes in medicare or health-care delivery, as well as engages in "political activism and mobilization on issues like the *Canada Health Act* ... patent amendments, extra billing ... the impact of trade agreements and health care privatization — the emerging issues."[83] While HEAL keeps a narrow financial agenda which fits the "varying issues and interests" of its disparate and sometimes opposing member groups, the CHC is able to develop a more specific policy agenda which fits the broad labour and consumer orientation of its member groups. Both appear to have some influence with government. HEAL has "regular meetings with the people in finance and health ministries, and meets with the [finance] minister before the budget is released, and the deputy minister [of finance] at other times." When asked about the relative power of their group in the sector, the HEAL representative responded positively:

> Before HEAL, all the national health care groups had to compete to be listened to, now united we have more of a voice ... There are lots of special interests, like non-smoking rights and the Hep C groups, but HEAL and the CHC are the main ones. It is not likely we are competing ... we have a shared common interest to see the improvement of Canada's health care system.[84]

When questioned further about who had the most influence with the federal government, the response was, "the provincial politicians and bureaucrats ... and the community as a whole including health care groups ... and the public through opinion polls."

The Canadian Health Coalition representative, when similarly questioned, agreed their group has some "voice" in the sector, but she also commented that this is offset by other interests, particularly those of private industry and the physicians, as well as by "the political direction within government policy arenas." The CHC, like many other actors involved in health-care restructuring, is quite conscious of the limitations to their influence imposed by the fiscal agendas of politicians at both the federal and provincial levels.

THE PUBLIC

There is considerable talk about the importance of the public's involvement in health care. The 1997 National Forum on Health emphasized the role of the public in its recommended changes to the sector. A 1992 intergovernmental health policy statement called for the pursuit of "quality, through greater

consumer involvement."[85] Rachlis and Kushner argue "politicians committed to structural change will need the informed support ... of a consumer coalition for health reform." They recommend "no strings financial assistance ... and participatory forums for public debate."[86] Decter points to "three important dimensions to greater consumer involvement: 1. Total Quality Management (TQM) or Continuous Quality Improvement (CQI), 2. informed consumer choice, and 3. re-balancing governance and advisory structures to include more consumers and fewer providers."[87] Rachlis and Kusher also see considerable consumer influence in the future. They argue "consumer choice will drive publicly financed competition in primary care"; provinces will have to publish performance reports on various delivery sites and outcomes; advertising restrictions will have to be lifted; and routine consumer surveys will need to investigate satisfaction levels. New "population needs-based" delivery systems designs, for example, the Community Health Services Organizations (CHSO) recommended by the Metro Toronto District Health Council as the "front line delivery component of the new integrated system [serving a population of two to three hundred thousand] ... envision a system of health care ... that encourages the people and communities of Metropolitan Toronto to be active partners in their health, and gives them the information, education and support they need to enable them to make appropriate choices."[88]

The general emphasis on community care in all of the restructuring models assumes input from the public stakeholders of the communities, emphasizing the importance of democratic principles of public participation, representation, and accountability. And we are now seeing signs of more consultation; better representation on decision-making bodies such as regional boards and professional governing bodies; and, most recently, reciprocal calls for patient/consumer responsibility and accountability.[89] But there are also serious concerns about the overall ramifications of the "shift to the community," particularly the community and family burdens which might accompany the "empowerment." The "downloading" of services to the community, lacking as those services have been in coordination and funding, may not represent much of a prize.[90] Previous attempts at deinstitutionalization of mental health care, for example, resulted in high rates of homelessness amongst this patient body — especially schizophrenics. These new expectations for, and pressures on, the community also come at a time when fund-raising efforts for health-care related projects are increasingly experiencing competition from other philanthropic organizations for a limited, and probably diminishing, money supply.

Another element causing concern is community care's utilization of volunteers. New health-care models are calling for more "volunteer and informal family and community support" mechanisms,[91] but economic conditions, such as the increase in lower paid part-time work, have reduced the number of available volunteers at the same time as the community is expected to accommodate more and more people in need. Families, particularly the female members, are experiencing difficulty coping with the extra burden deinstitutionalization and shortened hospital stays are placing on them.[92] Critics also point to the fact that community organizations are not always more democratic, participatory, innovative, and caring than large institutional organizations (as tends to be assumed by its advocates).[93]

These recommendations and changes, however, mostly came originally from academic and political interpretations of "the public," rather than from direct public pressure on the system. Much of this interpretation represents genuine attempts to bring in the voice and interests of the public, but a democratic government and its bureaucracy can also use the *idea of the public* or "the public interest" as a more instrumental means to direct policy outcomes or strategies, for example, for offsetting the requests of the more powerful interest groups that do not fit the government's agenda, with a "public interest" that does.[94] As state actors struggle for more control over their expensive health-care experts, institutions, and practices, they are more and more voicing the democratic call to the "public interest" as a means of redefining their historic relationship within the sector.

Public stakeholders tend to represent disparate and sometimes conflicting interests, and they are not easily mobilized, so their effectiveness as an interest group per se has always been limited. They generally lack the cohesion of the health practitioner interest groups, although as we have seen, public "consumers" have allied themselves with the two dominant coalition groups of the sector (HEAL and CHC). Seniors' groups (forming their own coalition groups) have been the exception to the disparate and generally uninfluential public interest groups. Ontario seniors' groups, for example, formed a coalition (amongst themselves and with the Consumer's Association of Canada, Ontario) called the Senior Citizen's Consumer Alliance for Long-Term Care Reform in the early 1990s and successfully moulded, and continue to mould, policy designs and decisions in that area of health care.[95] National seniors' groups are lobbying the federal government to reduce protection for brand-name companies, allowing more room for the use of generic drugs.[96] Seniors

may also influence the current debates over alternative or complementary medicine, as they become "more and more interested in alternative medicine."[97]

Aside from the seniors, however, interest group representatives of the public (and parent coalition groups such as the Canadian Health Coalition) say there is a general lack of patient or consumer influence in today's policy decisions.[98] The Consumer Association of Canada (CAC) joined HEAL (to benefit from its "power and money,") because of its own "lack of comparative resources" (particularly industry and the professional resources), and although they note the Health Protection Branch of Health Canada has been asking for "dialogue with consumers," they also point to signs of diminished consumer voice in the structures of the federal bureaucracy.[99] The CAC focuses its attention on "consumer rights in general," and more specifically in the last ten years, on "perceived threats to the Canada Health Act," with their biggest issues being

> a) drugs (costly patent drug controls, labeling and explicit directions — including herbal remedies — and banning of public advertising of drugs), and
> b) the regulation of medical devices.[100]

Although the CAC claims to represent consumers in general, the overriding influence of seniors in this body is apparent by the list of concerns.

Other public interest groups carry specific orientations, such as "victims' rights" and "choice" in health care: the latter including concerned consumers of "natural" or herbal products, as well as concerned consumers of private health-care services.[101] The victims' rights organization is interesting in that it seems to represent a switch, at least in Ontario, from a more general ethics-based, patient-rights lobby group led by philosophers, to a "victim"-oriented group attempting to produce "evidence of abuse," particularly by the dominant professional group of the sector, the medical profession.[102] That this victim orientation is important to health politics today is evident in the current provincial and intergovernmental "crises" over victim compensation and government responsibility for abuse of health patients, both past and present. From the Alberta case of past sterilization of patients diagnosed as mentally disabled, or the cross-provincial accusations of state support (or acquiescence) of institutional abuse of native children, to the hepatitis C intergovernmental debates in process, legal, and moral questions of the relationship between the state and the public with regard to abusive actions are on the forefront of policymakers' minds. Attention to public concern is thought to be one method of avoiding similar political nightmares in the future.

But while the formal interest groups representing various segments of the public, such as labour, the professions, consumers, or victims of abuse, are being heard in the sector, it is not clear just how large or small a role the ubiquitous and amorphous "general public" is now playing in the sector. One method of obtaining (and therefore at least potentially reacting to) the voice of the public, is through public opinion polls.

PUBLIC OPINION

Public opinion appears to play a role in the contemporary politics of the health sector in Canada. Perlin finds "strong levels of [public] commitment to the social programs of the welfare state in both [Canada and the US] that have persisted over many years, despite some short-term fluctuations."[103] The federal government, in particular, has made much of the public's dedication to the preservation of the "universal" medicare system, but whether or not Canadians now hold an unshakable commitment to universal medicare,[104] or are just reluctant to lose any long-held benefits is not clear. Ekos linked public support of the health-care system to Canadian identity and optimism[105] in 1995 and 1996, but the conclusions on identity seem rather weak.[106] While 61 percent of Canadians expressed "satisfaction with the overall system of health care" in 1995,[107] by 1997 "six out of ten of the 1,525 Canadians polled in March said they believed government spending cuts to have had a negative impact on the quality of health care in their communities."[108] Angus Reid polls "showed that health care worried Canadians more than the debt and deficit" in 1997,[109] but when presented with government triage choices in 1997 and 1998, those Canadians polled "continued to prioritize reducing the accumulated debt (45 percent) over cutting taxes (29 percent) and spending more money on government programs (23 percent)."[110] 1998 polls indicated rising concern for health-care issues at both the provincial and federal levels, and in a triage choice in early 2000 the Canadian population named health care as their lead concern (55 percent) over education (23 percent) and taxes (19 percent).[111] Ambiguity continued in 2000 when 78 percent of Canadians agreed that the health-care system in their province was in crisis but 71 percent said they were confident that if they had a serious medical problem they would get the health-care services they needed.[112]

Public opinion is a slippery concept. The public is not always either informed or consistent. As the Ekos researchers say, "Current public judgements are not based on high fluency about the 'facts.'"[113] Nor is it clear that

those who have financial responsibility for the public health-care system can count on the public to understand the difficulty of their cost constraints. When asked in 1995, for example, "Which of the following aspects of health care is of greatest importance to you?" only 8 percent of the respondents prioritized "cost of health care system to country" over "equal access" (53 percent), "quality of health care services (31 percent), and health of the Canadian population" (9 percent).[114] Nor is causality between public opinion and policy change at all clear. As Tuohy points out (in light of Canadian, British, and US comparisons), "public opinion may be a factor contributing to the opening of windows of opportunity for major policy change, but it is neither necessary nor sufficient to explain the timing of their opening or the policy changes that occur as a result."[115] Likewise, Leblanc finds Canadians supporting both universal and targeted social programs — as long as the latter are targeted at "deserving" recipients.[116] And Banting expects to see "more targeting of expenditures."[117]

We also know public opinion can be shaped or socially constructed. The media plays an important role in the generation of public opinion, particularly in public concern over health-care cuts. News articles with headings such as, "5-year-old Dies after Emergency Care Delay"[118] fuel public concern. Interested parties such as physicians, nurses, and hospital managers, can use this type of emotion-targeted reporting as a means to getting the public on their side. It is more difficult for governments to do the same,[119] but politicians have long been in the business of shaping both public opinion and group interests. They may take the advice offered by Rachlis and Kushner.

> To succeed with major reforms, politicians need public support ... [They need to] move public opinion as much as they can, then change the rules of the game, creating new interests to carry the reforms forward with new momentum.[120]

PRIVATIZATION AND BUSINESS INTERESTS

Another important set of actors and ideas within the health sector in the current climate of fiscal restraint is that associated with the public-private mix of health services. Public sector funding represents about 70 percent of total health expenditures. The remaining 30 percent is financed privately through supplementary insurance, employer-sponsored benefits, or directly out-of-pocket.[121] Although the provinces and territories do provide some additional benefits, supplementary health services are largely privately financed and Canadians must pay privately for these non-insured health benefits. The individual's

out-of-pocket expenses may be dependent on income or ability to pay. Individuals and families may acquire private insurance, or benefit from an employment-based group insurance plan, to offset some portion of the expenses of supplementary health services. Under most provincial laws, private insurers are restricted from offering coverage that duplicates that of the governmental programs, but they can compete in the supplementary benefits market.

Since there is little indication that we are about to abandon public health care, privatization arguments are mostly being applied to the margins of health services. One argument is the potential alleviation of economic stress on the system by increasing the degree of privatization in physician or facility services via the user fees or facility fees discussed earlier. User fees or facility fees (charged to the patient) are not allowable under the terms of the *Canada Health Act*.[122] Some physicians warn of "passive privatization" with services such as physiotherapy being made more readily available to patients "based on their ability to pay."[123] Health analysts have also questioned the assumption that privatization of health services actually reduces cost. Shapiro quotes US reports that would indicate otherwise.[124] Nevertheless, the private sector of health services and delivery is increasing, and analysts predict "private companies [will begin] to take a more active role in analyzing and interacting with the health care industry, as employer supplementary health insurance coverage rates continue to grow."[125]

The private health-remedy industry is also growing. According to Health Canada, over 50 percent of Canadians now consume natural health products.[126] The federal government has set up an Office of Natural Health Products to evaluate and regulate natural health products.[127] The pharmaceutical companies are, of course, interested in any outcome of this scrutiny. They are also quite interested in the current debate over the possible *de-privatization* of drug insurance plans, via a publicly funded system of "pharmacare."[128]

One contentious and far-reaching issue with regard to the privatization/non-privatization debate relates to potential American-style adaptations to our present system, in areas such as high-demand services or situations where anxious patients might wish to "jump the queue." This type of free market orientation threatens the present public-private balance in Canadian health care in a far more fundamental way than does the highly political debate over user fees or facility fees. But it is unlikely we will see any serious move in this direction under our present Liberal leadership which is strongly associated with, and appears to be strongly committed to, the public-private divisions of the *Canada Health Act*, particularly while public opinion polls generally indi-

cate public rejection of "two-tier health care."[129] Strong federal opposition to a recent bill introduced by the Alberta government demonstrates the federal commitment to the public system. Klein's *Health Care Protection Act* would allow for an expansion of the role of the private clinic in providing surgical procedures to the public, and despite a dispute as to whether Klein's proposed legislation would contravene the *Canada Health Act*, it has been met with considerable opposition from those opposed to the privatization of Canadian health care.[130]

Two economic goals, which both fit our present conservative economic climate and are much less contentious than the issue of privatization, are economic efficiency and enhanced competition. The introduction of regionalization (in all but Ontario), for example, is expected to result in increased rationalization of resources with concomitant increased gains in economies of scale.[131] This restructuring is also meant to allow for mechanisms of closer scrutiny of the less-than-efficient activities common to the health sector institutions and practices. The British Columbia Regionalization Assessment Team, whose mandate included "a review of the cost-effectiveness of regionalization," recommended (among other things): eliminating the co-existence of regional health boards and community health councils; "clear strategies for reducing unnecessary health expenditures"; and the establishment of a "mechanism to audit and report on the performance of providers."[132] However, it must be kept in mind that recommendations are just that. Chrichton *et al.* point out, "it is far from clear whether provincial governments are ready to devolve much of their power to these new authorities (except in Saskatchewan where the provinces were forced to take some action because of impending bankruptcy)."[133]

Likewise, the restructuring trend toward consolidation of a number of types of health care (acute, outpatient, long-term, primary, home, etc.) under one management and governance system, or "vertically integrated delivery system," is expected to "significantly alter internal market competition between health care providers, institutions and agencies." The Canadian College of Health Services Executives expect competition within and between the various institutions and stakeholders to increase as resources diminish and restructuring continues. For example, competition will increase: between institutions, physicians, and possibly regions, if rostering is put in place, since the funds follow the patient; between institutions with similar case-mix groupings if provincial funding is calculated based on case-mix or adjusted case mix; and in the private sector industry to insure and provide de-listed health

services (i.e., formerly under government insurance plans). They also argue that increased public-private sector partnerships will enhance competition between vendors as they "compete to establish long-term relationships with health care providers, institutions and regions ... This will likely result in a consolidation and concentration of vendors, similar to the current consolidations facing health care providers."[134] In 1994, Rachlis and Kushner recommended "fostering competition between different publicly funded primary care centres based on quality of care and service."[135] Others have contributed to this argument. Health Canada argues "Medicare [itself] provides a variety of economic benefits, which arise from efficiency and cost-savings associated with public financing, as well as the competitive advantages it provides to Canadian business.[136] Critics of the idea that health care would benefit from more competition between provider groups, institutions, and service industries dispute the assumptions of the free market model when applied to the health sector.[137] This is backed by findings such as that of the recent White Paper on the British National Health Service which refers to that system's previous "internal market" health system which "wasted resources administering competition between hospitals."[138]

Lastly, many people express concern for the overall orientation of business in the sector. It is not clear that the business definition of efficiency and profit presents a model we might wish to emulate in a sector premised on humanitarianism and care. Perhaps health-care efficiency, which not many dispute as necessary, is not exactly comparable to business efficiency. We may wish to find a better balance.

RESEARCH

At the federal level, research funding has been provided through, for example, the Medical Research Council, the National Health Research and Development Program, the Networks of Centres of Excellence Program, the Canadian Foundation for Innovation, the Health Transition Fund, the Canadian Health Services Research Foundation, Canadian Institutes of Health Research, the SociaI Sciences and Humanities Research Council, the Canadian Institute for Health Information, and more specifically, target projects such as the Community Action Program for Children and the Canada Prenatal Nutrition Program.[139] Provincial governments also provide funds for research into health policy issues and health-care research.

The common themes attached to this research funding are "renewal, restructuring ... and modernization," "health determinants," "health evidence ... and evidence-based decision making," "knowledge and information ... networks," "research uptake and application of findings," "home care," "primary care," "pharmacare," and so on. They show a commitment to developing a better understanding of the determinants of health as well as the efficiency of health-care programs and procedures. They also show a commitment to new designs. New research money is being marginally shifted from bio-medical research to the health system's research. There does appear to be commitment to, at least, the idea or possibility of, planned change.

CONCLUSION

The Canadian health-care landscape is being remodeled; some would say bulldozed, and others would say only groomed. As the economic ideas in good repute push up against the sector, the ensuing restructuring threatens to realign old positions and relationships. Governments at all levels are struggling to interpret their new positions vis-à-vis each other, the sector's interest groups, and the public. Those interests, in turn, are struggling to adapt to rapid adjustments to their everyday functions at the same time as they are being asked to envision a restructuring of their long-embedded roles and relationships. Institutional actors, health practitioners, and private sector actors are trying to maximize their benefits and minimize their burdens in a future not yet understood. The support of the "public," already disadvantaged by an historic lack of identity, form, and information is being sought to assist and adjust to radical changes in the health system. Given the anticipated change, competition, anger, and power struggles are expected. And, hopefully, cooperation and progress will be obtained.

One participant of the process predicts there will be more incremental and even haphazard reform in the sector, with the strongest measures taken by the smaller provinces who, unlike the larger wealthier provinces, will not be able to "subsidize inefficiency." Therefore, the less wealthy provinces may also be the most interesting provinces to watch for innovation. There will be no "big bang" because of the power held by the threat of service withdrawal. There will be re-investments to reassure the public, and a shift in resources to home care, with the necessary restructuring this will entail for primary care and pharmacy-based care. Some of the new designs for integrated health systems will reach the pilot stage, and perhaps even implementation, but some will not. And

lastly, there will be tension: intergovernmental tension, institutional tension, and interest group and stakeholder tension.[140] Nothing will come easily.

NOTES

[1]In order to provide the background piece for this collected works, this chapter was completed in July 1998. It has been updated where changes necessitated, but remains otherwise intact.

[2]Interview with senior federal civil servant, 29 January 1998. Many of the lobby groups interviewed expressed the same opinion.

[3]Tuohy has compared Canadian stability in the health sector with the relative dynamic of the British and United States health sector. Carolyn Hughes Tuohy, *Accidental Logics: the Dynamics of Change in the Health Care Arena in Britain, the United States, and Canada* (New York: Oxford Press, 1999). During the course of interviews conducted for this chapter, other health actors, such as the Canadian Health Coalition (CHC) said the present "restructuring" was best described as "cut-backs" rather than "reform." Interview with K. Conners, executive director of the CHC, 18 July 1998.

[4]Erin Nelson, "What's It All About? The Canada Health Act" *LawNow* (December 1997/January 1998):29-30. Federal constitutional responsibility under the *Constitution Act 1867* "extends to the provision and regulation of health care for residents of the two territories, First Nations Canadians, military and RCMP personnel and, in some instances, immigrants and refugees" (ibid, p. 30).

[5]<http://www.hc-sc.gc.ca/datapcb/datahesa/hlthsys/Ehlthsys/htm> "This public authority is appointed or designated by the government of the province ... and its accounts and financial transactions are subject to audit." J.J. Morris, *Law for Health Care Administrators* (Toronto: Butterworths, 1996), p.25 (citing the CHA, s.2). For details of service provision for each province, see the provincial icons in <http://www.hc-sc.gc.ca/medicare/index-e.htm>.

[6]Both the Canadian Health Coalition (CHC) and the Health Action Lobby (HEAL) pressured the federal government to offset some of the negative effects of its actions regarding the CHST (more below).

[7]Robert J. Jackson and Doreen Jackson, *Politics in Canada: Culture Institutions, Behaviour and Public Policy*, 4th ed. (Scarborough: Prentice Hall Allyn and Bacon Canada Inc., 1998), p. 461.

[8]Keith Banting, "The Social Policy Divide: The Welfare State in Canada and the United States," in *Degrees of Freedom: Canada and the United States in a Changing World*, ed. K. Banting, G. Holberg and R. Simeon (Montreal and Kingston: McGill-Queen's University Press, 1997), p. 307.

[9]Hugh Segal (former Conservative Policy Advisor), Health Care Panel, *"Studio Two" TV Ontario*, 6 February 1998.

[10]Perry Rand Dyck, *Provincial Politics in Canada: Towards the Turn of the Century* (Scarborough: Prentice Hall Canada Inc., 1996), p. 517.

[11]It might be argued that the 1984 House of Commons Standing Committee on Health, Welfare and Social Affairs, set up to consult and debate the issues of Bill C-3 (which was to become the 1984 *Canada Health Act*) had considerable input into the health policy arena, but I would point out, despite considerable interest group debate, especially over the principle of universality, not only was the original government's agenda met, but the highly controversial terms of the "new" Act repeated those of its precursor, the *Medical Care Act* of 1966.

[12]Rachlis and Kushner refer to health care's joint management committees as a "disaster," and Tuohy can point to few cases where such committees had any major impact on the sector. Michael Rachlis and Carol Kushner, *Strong Medicine: How to Save Canada's Health Care Reform* (Toronto: HarperCollins, 1994), pp. 244 and 310. Tuohy singles out the 1988 Ontario Task Force on the Use and Provision of Medical Services, and the 1992 Saskatchewan Health Services Utilization and Research Commission; the former was "derailed by budget reductions and caps in the mid-90s"; the latter was successful in winning some voluntary compliance from the health practitioners in targeted research. Tuohy, *Accidental Logics*, pp. 248-50.

[13]The federal government defines this as "a block fund designed to give provinces enhanced flexibility while maintaining the criteria and conditions in the *Canada Health Act* and the condition that there be no period of minimum residence with respect to social assistance." <http://www.fin.gc.ca/FEDPROVE/chse.html> (Finance Canada), taken 14-11-97. For a good explanation of these arrangements, see Tuohy, *Accidental Logics*, ch. 3, section on Canada.

The most important condition for the provinces and territories related to health is compliance with the *Canada Health Act*.

[14]Provincial/territorial Ministers of Health, *A Renewed Vision for Canada's Health System*, 29 January 1997, p.7.

[15]Ibid, p.8.

[16]For example, under the *Ontario Services Improvement Act*, January 1998, the Harris government has transferred "100 per cent funding responsibility for public health programs" to the municipalities (with the exception of disease surveillance, provision of vaccines, general advice to local health boards, and certain programs for children) <http://www.gov.on.ca/health/english/news/release/pubhl.html>. For concerns over adverse effects, see <http://www.cpso.on.ca/articles.asp?>.

[17]The CHA "aims to ensure that all residents of Canada have access to necessary health care on a prepaid basis by establishing criteria and conditions for the provinces and territories to satisfy in order to qualify for their full share of the federal transfers for health care services. The CHA criteria are: 1.Uni versality: requires that all residents of the province be entitled to public health insurance coverage. 2.Accessibility: requires reasonable access unimpeded by financial or other barriers to medically necessary hospital and physician services for residents, and reasonable com-

pensation for both physicians and hospitals. 3. Comprehensiveness: requires that all medically necessary services provided by hospitals and doctors be insured. 4.P ortability: requires that coverage be maintained when a resident moves or travels within Canada or travels outside the country (coverage outside Canada is restricted to the coverage the resident has in his/her own province). 5. Public Administration: requires that the administration of the insurance plan of a province be carried out on a non-profit basis by a public authority." <http://www.hc-sc.gc.ca/medicare>.

[18]Susan Silver, "The Struggle for National Standards: Lessons from the Federal Role in Health Care," in *Remaking Canadian Social Policy: Staking Claims and Forging Change*, ed. Jane Pulkingham and Gordon Ternowetsky (Halifax: Fernwood Press, 1996).

[19]This battle is well documented in Monique Begin, *Medicare: Canada's Right to Health* (Ottawa: Optimum Publishing International, 1988).

[20]See <http://www.hc-sc.gc.ca/datapcb/datahesa/hlthsys/Ehlthsys.htm> (27/11/97), p.7. Health Canada also sa ys, "Our Operating Principle: A commitment to excellence in an environment characterized by teamwork, innovation, trust, and cooperation; and fairness, dignity and respect in our treatment of each other."<http://www.hc-sc.gc.ca/links/healthcan/abthc_e/htm> (27/11/97), p. 1.

[21]Interestingly, one reporter commented, "the National Forum on Health report goes in the opposite direction of most Canadian governments." <http://www.newsworld.cbc.ca/archive/html/1997/01/31/health.html>.

[22]Ekos Research Associates Inc., *Rethinking Government 1995: The Final Report* (Ottawa: Ekos, 1996), p.40. CTV / National Angus Reid Poll, December 1997. <http://www.GlobeandMail.CA/docs/news/19971208/GlobeFront/UPOLLN.html>.

[23]Provincial/territorial Ministers of Health, *A Renewed Vision*.

[24]See <http://www.newsworld.cbc.ca/archive/html/1997/05/30/western.html>. "Western Premiers Support Health Care" (reporter's quote).

[25]See <http://www.hc-sc.gc.ca/links/healthcan/abthc_e/htm>.

[26]Provincial/territorial premiers created a Ministerial Council on Social Policy (after a 1995 annual Premiers' Meeting) to focus discussion on social policy renewal. <http://www.gov.nf.ca/releases/1997/health/0129n03.htm> 29 January 1997.

[27]Provincial/territorial Ministers of Health, *A Renewed Vision*.

[28]In light of a balanced 1998 federal budget, premiers put forth a "demand for the federal government to spend any future federal budget surpluses on restoring funding cutbacks to provincial social programs." <http://www.newsworld.cbc.ca/archive/html/1998/02/13/finance980213b.html>. "Premiers offer advice on Ottawa's Surplus" (reporter's quote).

[29]Interview with senior federal civil servant, 29 January 1998.

[30]See <http://www.hc-sc.gc.ca/datapcb/datahesa/hlthsys/Ehlthsys/htm>.

[31]Tuohy discusses the details of this and the following attempts at controlling the costs of physician services, in a clear and cogent manner in ch. 7 of *Accidental Logics*.

[32]There is a lot of discussion on provincial hospital restructuring. See for example, <http://www.newswire.ca/cgi-bin/view.cgi?OKEY=OR-87525> or <http://www.oha.com/MEDIA.NSF>.

[33]*Maclean's* noted there were "nearly 10 percent fewer hospital and residential care beds in Canada by 1996 than in 1987," *Maclean's Magazine*, "The Health Report," 15 June 1998, p. 21.

[34]See <http.www.dhc.toronto.on.ca/action7.htm> (MTDHC) 25/11/97, p. 6.

[35]For example, the Urban Shared Services Corporation in Manitoba institutions.

[36]Pat Armstrong and Hugh Armstrong, *Wasting Away: The Undermining of Canadian Health Care* (Toronto: Oxford University Press, 1996), pp. 82-83.

[37]Interview with Mr. Hy Eliasoph, Director of Hospital Relations and Policy, Ontario Hospital Association, 10 July 1998.

[38]Tuohy, *Accidental Logics*, pp. 39 and 108.

[39]For a developing model of integrated health systems see, for example, the "Needs Impact Based Planning Model" of the Metro Toronto District Health Council. Among the key issues of health planning for the decade are: health promotion, long-term care, mental health, midwifery, women's health, diabetes, Aboriginal health, substance abuse, tobacco, and AIDS. <http://www.dhc.toronto.on.ca/update.htm> posted October1997. Both home care and pharmacare were recommended for study by the National Forum on Health report, but both have been resisted by the provinces. Tuohy's *Accidental Logics* provides an excellent review of the British health-care system and its comparisons to the Canadian and American health-care systems.

[40]He says, "First, I think there's a broad and growing perception that it is needed. Second, many of the provinces have already started down that road. Third, acting in a coordinated fashion will give us an opportunity to make it a standard approach across the country. Fourth, there is the prospect of federal help in financing the plan. Finally, I think the provinces also acknowledge that with a properly developed home-care system they can save money in other parts of the health-care system." "Pushing Home Care," *Maclean's Magazine*, 9 March 1998, p. 54.

[41]Brian Mulawaka, "Just Trying to Help: Home Care Marks Another Foray onto Provincial Turf," *Alberta Report / Western Report* (13/3/98) 25:14, p. 6. The author notes that, "what did raise concerns was the [federal] minister's insistence that Ottawa should assume the administration of home care."

[42]See <http://www.newsworld.cbc.ca/archive/html/1997/12/09/finance971209b.html> "Health Ministers Urge PM to Break Deadlock," *CBC News*, Webposted 31 March 2000.

[43]Interview with Metro Toronto District Health Council member, 20 January 1998.

[44]Rachlis and Kushner predict that CEOs experienced in Total Quality Management (TQM) and Continuous Quality Improvement (CQI) will "know how to flatten and democratize the traditional hierarchical culture of the hospital." Rachlis and Kushner, *Strong Medicine*, p. 320.

[45]Marilyn Bruner (president and CEO of St. Joseph's Health Centre, Toronto), "Leadership and Health Care Restructuring," seminar given at Ryerson Polytechnic University, 16 January 1998.

[46]Provincial/territorial Ministers of Health, *A Renewed Vision*.

[47]They note that "senior administrators, especially CEOs, are experiencing increased turnover of positions, and middle-management continues to shrink, while self-directed provider teams rise. They also express concern that displaced or dissatisfied managers … are migrating to other industries and/or other countries." Canadian College of Health Services Executives (CCHSE), *Health Reform Update*, 4th ed. (Ottawa: CCHSE, 1996/97), p. 7.

[48]CCHSE, *Health Reform Update*, p. 8. They go on to say, "From a managerial perspective, the idea will be not to think in terms of either/or (decentralization versus centralization; community based versus institutional based; public system versus private system, and so on) but rather to imagine the endless number of potential combinations of solutions between these extremes. Or to put it in slightly different terminology, it is hoped that as stakeholders in the future health-care system, "we are offering not an alternative perspective, but an enlarged one" (p. 3).

[49]Tuohy, *Accidental Logics*, manuscript p. 229.

[50]Ibid, p. 279.

[51]Tuohy first documented this in the mid-1970s and has continued throughout her body of work to demonstrate its importance. Carolyn J. Tuohy "The Political Attitudes of Ontario Physicians: A Skill Group Perspective," PhD dissertation, Yale University, 1974.

[52]J. Lomas, G. Veenstra and J. Woods, "Devolving Authority" Series, *Canadian Medical Association Journal* 156(3):371-77.

[53]A capitation payment is a payment by the government to the Community Health Service Organization (CHSO) (this is the central organizing body of the model being proposed by the Council) for each person for whom they hold responsibility for providing a designated range of health services. The amount of the capitation would vary depending on the age, sex, and health status/health needs of the rostered members. To roster means an individual formally acknowledges, by signing a roster agreement, to receive their care from a particular organization(s). The period of the agreement may vary but is usually annually ... [Under the MTDHC model] the ministry would [also] provide special funding to CHSOs for non-rostered populations such as the homeless, street youth, and the seriously mentally ill who may not roster with any organization. The capitation payment would cover all services which the CHSO would be responsible for providing. Allocations among programs would be based on the specific needs of the population served and the priorities of the rostered members of the CHSO. <http.www.dhc.toronto.on.ca/action7.htm> (MTDHC) 25/11/97, pp.8-9.

[54]Interview with member of MTDHC, 12 November 1998. Tuohy, *Accidental Logics*, p. 251.

[55]Interview with Dr T. O'Driscoll, president of the Ontario College of Family Physicians, 16 June 1998.

[56]See <http://wwwnfh.hwc.ca/releases/finrep/020497e.htm> (News Releases of the federal National Forum on Health), posted 4 February 1997.

[57]Tuohy has provided a good summary of the details surrounding this issue of clinical discretion. Tuohy, *Accidental Logics*, ch. 7. Earlier attempts at clinical review were left largely up to the medical professional bodies, and to date, governments have set up joint profession-government or arm's-length bodies to develop clinical guidelines, but they have been reluctant to "tie compliance to remuneration" (p. 249).

[58]Tuohy, *Accidental Logics*, p. 280. Ontario physicians, for example, recently won a deal with (Interim) Health Minister Johnson which will, in the words of one health-care reformer, "stop the Integrated Health System models dead [and] destroy primary care reform." Interview with long-time District Health Council participant, 20 January 1998.

[59]The profession has both an association and a governing body which are not always in agreement. (Overall service prices are negotiated between the state and the association.) Tuohy points to a division within the profession between the majority and a "strategic minority" (many academic/university-based physicians) primarily located in the medical schools and professional regulatory body. Tuohy, *Accidental Logics*, p. 236. Lack of voice was referred to in an interview with Dr T. O'Driscoll, 16 June 1998, as well as in interview with a provincial Ministry of Health official, 10J une 1998.

[60]Hugh Segal, "I am not convinced the physicians are part of the solution," *Studio Two*, 6 February 1998.

[61]Nurse practitioners are regulated within the profession of nursing. They do not have a legally protected title in any province or territory. Midwifery was first regulated in Ontario; other provinces such as British Columbia, Nova Scotia, Manitoba, and Quebec have followed with pilot projects and various stages of legislation. See <http://www.cna-nurses.ca/english/career/midwifery.html> (Canadian Nurses Association) both updated 9 February 1998.

[62]While the majority of nurses are in the hospital sector, many also work in long-term-care facilities and community health-care programs such as home care and public health services. The active practitioners of the profession are usually divided into registered nurses, registered practical nurses (or nurse assistants), and nurse practitioners. <http://www.cna-nurses.ca/english/publications/pubscat/pub_list/policystatements.html> (Canadian Nurses Association) 15 February 1998. See especially, "Reduced Quality and Availability of Health Services Top Concerns for Registered Nurses," 28 January 1998.

[63]Michael Decter, Health Care Panel, *"Studio Two" TV Ontario*, 6 February 1998. Interestingly, he also noted, despite public opinion to the contrary, "we are not losing (medical) doctors in any significant number."

[64]Rachlis and Kushner, *Strong Medicine*, p. 314.

[65]See <http://www.cna-nurses.ca/english/publications/pubscat/pub_list/policystatements.html> 15 February 1998.

[66]"94 per cent of Ontarians believe that Registered Nurses currently play an *important role* in ensuring that the public receives quality health care," *Pollara*, April 1997.

[67]Janet M. Lum, "Backward Steps in Equity: Health System Reform's Impact on Women and Racial Minorities in Ontario," *National Women's Studies Association Journal* 10(3):101-14. Armstrong and Armstrong also criticize this shift, *Wasting Away*, p. 129.

[68]See <http://www.whsc.on.ca/ncuts.htm> (Workers Health and Safety Centre, Ontario) 14 February 1998.

[69]Duane Adams, "Saskatchewan Health Reform in the 1990s," in *Saskatchewan Democracy 2000 and Beyond*, ed. H. Leeson (forthcoming). For discussion of these types of labour issues from the management perspective (across Canada), see recent articles in *Healthcare Management Forum*.

[70]Ibid.

[71]For example, the 1991 Ontario *Regulated Health Professions Act* both created and reinforced mechanisms of accountability for both the governing bodies of the professions and the activities of the practitioners themselves. Patricia O'Reilly, *Health Care Practitioners: An Ontario Case Study in Policy Making* (Toronto: University of Toronto Press, 2000).

[72]The Canadian Council on Health Services Accreditation has now developed new measures to survey interdisciplinary provider teams. CCHSE, *Health Reform Update*, p. 4.

[73]Some old rivalries have been dismissed and some have just been couched in the language of "quality" and/or "cost-effectiveness."

[74]"Canada's health care system relies extensively on primary care physicians (e.g., family physicians and general practitioners). They are usually the initial [point of] contact [for the patient] within the formal health care system and they control access to most specialists, many allied providers, hospital admissions, diagnostic testing and prescription drug therapy. Most doctors are private practitioners who work in independent or group practices and enjoy a high degree of autonomy. Some doctors work in community health centres, hospital-based group practices or work in affiliation with hospital out-patient departments." <http://www.hc-sc.gc.ca/datapcb/datahesa/hlthsys/Ehlthsys/htm> (Health Canada) Primary care physicians (GP/FPs) make up 51 percent of Canada's total physician supply. Medical specialist make up 49 percent. <http://www.cihi.ca/facts/rlseng15.htm> (Canadian Institute of Health Information) 15 December 1997. A 1996 Canadian Medical Association's (CMA) policy statement gives some indication of the medical perspective here. They recommend "the CMA and its divisions continue to advocate on behalf of patients and physicians"; "family physicians ... are the preferred point of entry into Canada's health care system" Canadian Medical Association (CMA), "Regionalization," *Canadian Medical Association Journal* 154(1996):572A-572B.

[75]Canadian supplementary health benefits (for elderly, children, and welfare recipients) include prescription drugs, dental care, vision care, assistive equipment, and appliances (prostheses, wheelchairs, etc.) to independent living and services of allied health professionals such as podiatrists and chiropractors. <http://www.hc-sc.gc.ca/datapcb/datahesa/hlthsys/Ehlthsys/htm> (Health Canada).

[76]See *Maclean's* December 1997 issue and January 1998 poll. For example, the (1996) Tzu Chi Institute at the Vancouver Health Sciences Centre is now testing the efficacy of some of these alternative and complementary therapies. <http://www.bcna.bc.ca/whatsnew.htm> (BC Naturopathic Association) 25/11/97. The federal government set up an advisory panel which reported on natural health products, or more specifically, herbal remedies, in May 1998. <http://www.hc-sc.gc.ca/hpb-dgps/therapeut/htmleng/herbals/html>. A review of the Health Canada Web site in April 2000 reveals no further developments.

See the Canadian Medical Association policy paper on "The Role of Physicians in Prevention and Health Promotion," *Canadian Medical Association Journal* 144(1991):232A. CPSO "Report of the ad hoc Committee on Complementary Medicine to the Council of the College of Physicians and Surgeons of Ontario, 22 September 1997. Plus the CPSO's response to the private member's bill on Alternative Medicine on <http://www.cpso.on.ca/articles.asp?>. OMA reports on complementary and alternative medicine (referred to in the above).

[77]See <http://www.bcna.bc.ca/whatsnew.htm> (BC Naturopathic Association) 25/11/97.

[78]Interview with senior federal civil servant, 29 January 1998.

[79]O'Reilly, *Health Care Practitioners*.

[80]The National Forum on Health stressed the importance of increased accountability in the system, "Canada Health Action: Building on the Legacy," *Final Report of the National Forum on Health* (Ottawa, 1997). <http://wwwnf.hwc.ca>. Provincial/Territorial Ministers of Health are also calling for more accountability throughout the system. Provincial/territorial Ministers of Health, *A Renewed Vision*.

[81]"The HEAL lobbying campaign included meetings with ministers, face-to-face briefing sessions with Members of Parliament, backgrounders with officials in the Departments of Health and Finance, media appearances and presentations to the Standing Committee on Finance. The objectives of the HEAL campaign were included in the brief "A Prescription for Medicare" presented to the House of Commons Standing Committee on Finance, 23 November 1995. HEAL called for: 1. Enough targeted cash transferred to the provinces/territories to provide reasonably comparable levels of health, social services and post-secondary education delivery across the country. 2.A health-r elated cash transfer of $250 per capita for each of the next five years guaranteed within the CHST program 3. Beyond the five-year period, preservation of the cash value of the cash transfer by means of an appropriate escalator." <http://www.cpha.ca/CPHA/Advocacy.eng.html> updated 27 January 1997.

[82]Interview with Kathleen Conners, Executive Director of the Canadian Health Coalition, 8 July 1998.

[83]Interview with Maureen Farrington, Secretariat for the Health Action Lobby, 6 July 1998. Interview with Conners, CHC, 8 July 1998.

[84]Ibid.

[85]Michael B. Decter, *Healing Medicare: Managing Health System Change the Canadian Way* (Toronto: McGilligan Books, 1994), p. 170.

[86]Rachlis and Kushner, *Strong Medicine*, p. 329.

[87]Both TQM and CQI focus on consumer involvement. Methods of improving informed consumer choice are elaborated by Decter. Historical provider dominance of "boards, commissions and other governance structures" is being increasingly offset by expanding consumer representation "in the 30-50% range." Decter, *Healing Medicare*, pp.170-71.

[88]See <http.www.dhc.toronto.on.ca/action7.htm> p. 4.

[89]The National Forum on Health, for example, engaged in wide consultation for its 1997 report: "Canada Health Action." <http://wwwnf.hwc.ca>. Most contemporary reports on health care are calling for increased public participation or community involvement in the health sector. Some provinces with regionalized systems have moved from appointed regional board members to a mix of appointed and elected board members. Professional governance bodies in Ontario and British Columbia have increased their public membership to just below 50 percent. In its discussion of participation the Metro Toronto District Health Council states, "People in Metropolitan Toronto have a responsibility for their own health and are accountable for their use of services." <http.www.dhc.toronto.on.ca/action7.htm> p. 4.

[90]A Canadian Health Coalition representative expressed concern for this, particularly with regard to the burden on women. Interview, Connors, 8 July 1998. An Ontario Health Coalition representative also expressed concern for the "growing onslaught and negative effects" of government actions (at both the federal and provincial level). Interview with Daniel Benedict, co-chair of the Ontario Health Coalition, 10J uly 1998.

[91]For example, the Metro Toronto District Health Council's Integrated Health System model "looks beyond formal health services to the positive impact that volunteers and informal family and community supports can have on health and fosters an environment that recognizes, respects and encourages them," <http.www.dhc.toronto.on.ca/action7.htm> p. 4.

[92]See the concerns of the CHC above. It should also be noted a Saskatchewan study did not find an increased burden on family members with increased introduction of home care. "Home Care Means Savings," *Maclean's Magazine*, 6 April 1998, p. 69.

[93]Armstrong and Armstrong, *Wasting Away*, pp.144-46.

[94]For example, documentation of the recent health professions legislation restructuring process in Ontario made frequent reference to the state's responsibility to

uphold "the public interest" at the same time the states moved to ensuring stronger accountability mechanisms for health practitioners. O'Reilly, *Health Care Practitioners*.

[95]Rachlis and Kushner refer to consumer pressure groups as "the new kids on the block" who lack cohesion and coherence. They point to Australia's Consumer's Health Forum networks as a model for Canada, Rachlis and Kushner *Strong Medicine*, pp. 328, 329-31.

[96]See <http://www.pollara.ca/surveys/news0303.htm>. Industry Minister Manley and Health Minister Dingwall have said (aside from some regulatory adjustments) that patent protection cannot be reduced "because of international trade obligations."

[97]The author also points out, Health Canada's funding of two recent projects related to alternative medications and therapies: "Alternative Medicine and Seniors: An Emphasis on Collaboration," *Expression: Newsletter of the National Advisory Council on Aging* 11:2(1996/97), pp.1, 4. See also <http://www.hc-sc.ca/seniors-aines/index.html>.

[98]Interview with Canadian Health Coalition representative, 8 July 1998.

[99]The federal government closed its Department of Consumer and Corporate Affairs in Health Canada (which used to provide some funding for the CAC), and set up a Consumer's Bureau in Industry Canada. Interview with Jean James, chair of National Health Council of the Consumers Association of Canada, 8 July 1998.

[100]Ibid.

[101]One of these important groups is the "Citizens for Choice." Interview with Gerry Nicholls, communications manager for the National Citizens Coalition, 7 July 1998.

[102]This is my own interpretation, having followed the documents of the Patient Rights group of Ontario during the review of the health professions legislation in the 1980s, followed by a more recent look at the "Victims of Health Care Abuse" group in Ontario. Interview with Gordon Lever, director of "Victims of Health Care Abuse," 9J uly 1998. Lever's opinion is that patient lobbying of governments does not work unless your group can show evidence of abuse.

[103]George Perlin, "The Constraints of Public Opinion: Diverging or Converging Paths," in *Degrees of Freedom,* ed. Banting *et al.*, p. 92.

[104]Leblanc says, "the Canadian public is squarely against the idea of restricting eligibility for [health care and elderly benefits] to lower-income earners," P.T. Leblanc, "Public Opinion and the Canadian Welfare State: The Question of Universality," MA thesis, Queen's University, 1996, p. 112. However, Perlin says there is "evidence of a shift" in the Canadian commitment to universality. Perlin, "The Constraints of Public Opinion," in *Degrees of Freedom,* ed. Banting *et al*., p. 93.

[105]"Preserving the health care system consistently ranked among the top actions that government could take in restoring a sense of optimism to Canadians," Ekos, *Rethinking Government,* p. 27.

[106]The statement on identity was, "Moving away from a system of universal health care will diminish my feelings of Canadian identity": 42 percent agreed, 38 percent disagreed, and 20 percent were neutral. Ekos researchers interpreted this as "a plurality of Canadians feel that erosion of universality will diminish their sense of national identity; this symbolic domain is of major significance." Ekos, *Rethinking Government*, pp. 31-32. I disagree with this interpretation; 58 percent disagreed with or were neutral toward this statement. I would argue "neutrality" is as good as a disagree for a policy-maker here, i.e., to be neutral toward a policy change is a green light to a policymaker in need of the policy.

[107]Ekos Research Associates Inc., *Rethinking Government*, p. 30.

[108]See <http://www.newsworld.cbc.ca/archive/html/1997/04/29/CMA.html>. Angus Reid Poll, (reporter's quote).

[109]See <http://www.cma.ca/news/cmanews/vol-7/issue-11/nov03a-e.htm>. Comments from Darrell Bricker of Angus Reid Group to the Canadian Medical Association, November 1997 (reporter's quote).

[110]CTV/National Angus Reid Poll, February 1998. Similar findings in 1997 ranked social program spending low (15 percent) in comparison to unemployment (34 percent) and the national deficit (18 percent) — even with regard to the spending of a federal government surplus of funds. *Maclean's*/CBC, December 1997, p. 44.

[111]Angus Reid Group, *Public Releases* from April to June 1998. "Top Issues on the Public Agenda and Federal Voting Intentions," Angus Reid Group, 6 February 2000.

[112]Angus Reid Group, "Healthcare in Canada," 2 February 2000.

[113]Ekos, *Rethinking Government*, p. 27.

[114]Ibid., p. 35.

[115]Tuohy, *Accidental Logics*, p.128.

[116]Regarding "universality," Leblanc argues "favourable attitudes towards highly universal programs ... [can be traced to] individual self-interest ... (however), social programs with lower degrees of universality are not unpopular as a rule ... Recipient deservedness ... [can also be seen] as a determining factor," Leblanc, "Public Opinion," p. 108.

[117]Banting, "The Social Policy Divide, p. 308.

[118]See <http://www.newsworld.cbc.ca>, 18 February 1998.

[119]The Alberta government, for example, has twice had to back down under the pressure of media-backed public dissatisfaction with its health policies: in the 1985 de-listing of some health services, and more recently in an attempt to override compensation for the mentally disabled. "Alberta Backs Down on Sterilization Compensation," *CBC Newsworld*, 11 March 1998.

[120]Rachlis and Kushner, *Strong Medicine*, pp. 308, 322. They also recommend, "political leaders looking for support ... need to establish forums so the voices of ... repressed interests (such as seniors, women, and people with HIV infection, mental illness, and chronic conditions) ... can be heard," p. 325.

[121]Overall, "in 1996, total health expenditures in Canada (in current dollars) was $75.2 billion (Cdn) or $2,510 (Cdn) per capita (approximately US$1800). Health expenditures accounted for 9.5 percent of Gross Domestic Product (GDP) in 1996, down from the 1992 peak level of 10.2 percent of GDP." <http://www.hc-sc.gc.ca/datapcb/datahesa/hlthsys/Ehlthsys.htm>. More specifically, the "Economic Burden of Illness in Canada, 1993" (released 6 July 1997 by Health Canada) provides a detailed accounting of the "costs to society and individuals as a result of illness, injury and premature death." <http://www.hc-sc.gc.ca/datapcb/communc/home/news/97-44e.htm>.

[122]The terms of the *Canada Health Act* intergovernmental relationship (as stated by the federal authority) are as follows: "The [federal] Minister of Health continues to be responsible for the determination of any deductions under the Canada Health Act. The transfer of responsibility for the payments does not affect the ability of the [federal] Minister of Health to enforce the provisions of the Canada Health Act, through the authorization of deductions. Provinces and territories are still required to submit annual estimates of user charges and extra-billing to Health Canada pursuant to regulations. Health Canada officials monitor provincial and territorial activities for compliance with the Act, and make recommendations concerning potential deductions to the Minister for approval. Once the Minister has authorized deductions, departmental officials communicate the amounts to the Department of Finance. The Department of Finance makes the actual deductions from the twice monthly CHST payments to the provinces and territories. The extra-billing and user charges provisions of the CHA provide for mandatory dollar-for-dollar penalties to be applied to federal contributions, based on the amount of such charges that have occurred. The CHA also contains provisions for the discretionary reduction or withholding of federal cash contributions in the case of failure by a province to satisfy any of the criteria or conditions." <http://www.hc-sc.gc.ca/medicare/index-e.htm>.

[123]This was reported by a reporter covering the Canadian Medical Association 1997 annual meeting. <http://www.newsworld.cbc.ca/archive/html/1997/08/18/doctors2.html>.

[124]Evelyn Shapiro, "The Cost of Privatization: A Case Study of Home Care in Manitoba," (p.1) and "The Cost of Privatization: Olsten Corporation and the Crisis in American For-Profit Home Care," Canadian Centre for Policy Alternatives, Manitoba Office. <http://www.policyalternatives.ca>, posted August 1997.

[125]"The amount that Canadians and private insurance companies spent ... in private sector expenses represented 30% of the country's health care bill in 1996." "Public Spending on Health Care Drops," <http://www.newsworld.cbc.ca/archives/html> posted 1997/08/11. CCHSE, "Health Reform Update," 1996-97, p. 9.

[126]See <http://www.hc-sc.gc.ca/hpb/onhp/welcome_e.html>. Herbal remedies alone were estimated to have a total Canadian market of $175 million in 1996 (17 percent growth over 1995). Patrick Sullivan, "Healthy Growth for Herbal Remedies," *The Globe and Mail*, 29 October 1996, p. C1.

[127]See <http://www.hc-sc.gc.ca/hpb/onhp/welcome_e.html>.

[128]A nationwide "pharmacare" program was proposed in the Liberal's 1997 election platform and in the federally-sponsored National Forum on Health. A 1998 conference on the proposal was boycotted by most provincial ministers of health. The federal health minister, Allan Rock, has been somewhat vague on the funding plans. <http://www.newsworld.cbc.ca/archive/html/1998.01.19/pharma980119e.html>.

[129]A *Maclean's*/CBC News Poll, *Maclean's Newsmagazine*, December 1996/ January 1997 found only 47 percent accepted a two-tier system (although it should also be noted 81 percent thought it "likely"). An Ekos 1995 poll asked if, "Individuals should be allowed to pay extra to get quicker access to health care services" and found 28 percent agreed, 60 percent disagreed, and 11 percent were neutral. Ekos, *Rethinking Government*, p. 35. However, a more recent poll in Alberta at the time of the government's introduction of Bill 11, showed "a bare majority against the provincial government's Bill 11." "Albertan's Views on Bill 11" Angus Reid Group, 2 April 2000. <www.angusreid.com>.

[130]*Maclean's*, "Health Special Report," 3 April 2000, pp. 42-51.

[131]CCHSE, *Health Reform Update*, p. 3.

[132]British Columbia Regionalization Assessment Team, *Report*, (not dated), pp. 12-13. <http://www.hlth.gov.bc.ca/cpa/regional/rindex.html>.

[133]Anne Crichton, Ann Robertson, Christine Gordon and Wendy Farrant, *Health Care: A Community Concern? Developments in the Organization of Canadian Health Services* (Calgary: University of Calgary Press 1997), p. 321.

[134]CCHSE, *Health Reform Update*, p. 1, 16.

[135]Rachlis and Kushner, *Strong Medicine*, p. 263 (see also pp. 264-68).

[136]"Public financing spreads the cost of providing health services equitably across society. In addition to the benefits derived from the single-payer attributes of the Canadian health system, financing health insurance through the taxation system is efficient since it does not require the creation of a separate collection process." <http://www.hc-sc.gc.ca/datapcb/datahesa/hlthsys/Ehlthsys.htm> (27/11/97), p. 6.

These "advantages include lower employee benefit costs and the promotion of a healthy and mobile workforce. While universal access to quality health care services helps ensure a healthy population and, therefore, a healthy and productive labour force, the national character of Canada's health insurance system enhances labour force mobility, which can be very important in responding to changing business requirements and opportunities. Public health insurance coverage in Canada is based solely on residency. The portability principle of the Canada Health Act ensures that people are covered when they move or while they are temporarily absent from their province. Workers, therefore, need not fear losing health insurance coverage for themselves and their families because they change jobs or move to another province in search of employment." <http://www.hc-sc.gc.ca/datapcb/datahesa/hlthsys/Ehlthsys.htm> (27/11/97), p. 7.

[137]Armstrong and Armstrong, for example, point (as do health economists) to the distorted nature of the health market where informed consumer choice is problematic due to the complex nature of the products. They also draw on the examples of the pharmaceutical industry and the American for-profit hospitals to illustrate tendencies toward monopoly in the former, and reduced quality of care *due to competition* in the latter. Armstrong and Armstrong, *Wasting Away*, pp. 206-09.

[138]See<http://www.offficial-documents.co.uk/document/doh/newnhs/wpaper1.htm> (posted December, 1997), p.1.

[139]The MRC is the major federal agency responsible for funding biomedical research in Canada with a mandate to promote, assist, and undertake basic, applied and clinical research in Canada in the health sciences, and to support research training of health scientists and act as an advisor on health research to the federal minister of health. MRC recently launched a strategic plan with objectives that include the establishment of partnerships and alliances with researchers in universities and institutes, health-care providers, provinces and the voluntary sector. MRC has also entered a partnership agreement with the Pharmaceutical Manufacturers Association of Canada for research and personnel support. <http://www.hc-sc.gc.ca/links/hother/funding.htm> (27/11/97).

The NHRDP continues to fund health-related research. As a result of a 1995-96 consultation process known as the Future Directions Initiative, the NHRDP (1975) has reaffirmed the importance and focus of its mandate to fund scientifically meritorious research that supports Health Canada's mission and national health priorities. For 1997-98, the NHRDP's strategic research themes are: ·Health Determinants ·Health Impact of Public Policies ·Renewal and Restructuring of the Health System ·Research on Transfer and Uptake of Knowledge. <http://www.hc-sc.gc.ca/links/hother/funding.htm> (27/11/97).

The NCE program ("designed to link and focus researchers in areas of economic and social importance to Canada") continues to fund major research projects, including health-related projects. NEC is managed by a steering committee consisting of the presidents of the three granting Councils (MRC, NSERC, SSHRC) and the assistant deputy minister, Industry and Science Policy, from Industry Canada. New networks in 1995 included an Intelligent Systems for Innovative Structures (ISIS) and a Health Evidence Application and Linkage Network (HEALNet). <http://www.rec.hc-sc.gc.ca/gag/9798/c/nce.html> (24/1/98).

The CFI was established by the federal government to strengthen Canadian capability for research by increasing the capability of Canadian universities, colleges, hospitals, and other not-for-profit institutions to carry out scientific research and technology development. <http://www.innovation.ca>.

The HTF was created by the federal government to support large pilot projects in key areas of health-system modernization in order to support provincial and territorial pilot projects and innovative models for health-care restructuring. Areas of priority include "pharmacare, home care, primary care, preventive health and evidence-based

decision making." <http://www.hc-sc.gc.ca/main/hc/web/datapcb/communc/home/news/97_10e.htm>.

The CHSRF is a public not-for-profit corporation with the mandate to "sponsor and promote applied health research, to enhance its quality and relevance, and to facilitate its use in evidence-based decision making by policy makers and health systems managers." <http://www.chsrf.ca/english/notices/preliminary_grant.html>.

CIHR operational funding was announced in the 1999 federal budget, along with $550 million in additional funding to promote health-related research and innovation over four years. <http://www.cihr.org>.

These programs were allotted $100 million in the 1997 federal budget. <http://newsworld.cbc.ca//budget97/index.html>.

[140]Interview with senior federal civil servant, 29 January 1998.

3

CANADIAN FEDERALISM AND THE DEVELOPMENT OF NATIONAL HEALTH GOALS AND OBJECTIVES

Duane Adams

The intergovernmental process to secure national goals and objectives, or a common national purpose in Canada's social union, is an arduous exercise. It occurs relatively infrequently in Canada because of the great diversity of interests and viewpoints in the Canadian federal state. In fact, the difficulty inherent in achieving intergovernmental consensus seems to be so great that principal stakeholders are at times unwilling to modernize, amend, or update an intergovernmental agreement for fear of unraveling the original consensus that formed the "national" foundation for the program. This dilemma is of particular importance to the Canadian health system because it is said that Canada's health system is one of the greatest accomplishments of the Canadian federal state and one of the most important contributors to Canadian unity. Kathy O'Hara reflects this commonly held view when she states that "our definition of Canadian citizenship is based on our social programs and the sense that these programs symbolize our membership in a community that shares values of solidarity and mutual responsibility."[1] It is essential to the country that the social union is made to work effectively if we are to retain common bonds as a country. One important aspect of this bonding is the requirement to confirm, renew, and modernize our national social programs' goals and objectives to assure that they meet the needs of contemporary society within the great diversity of our nation's interests.

This chapter reviews both successful and failed attempts over 40 years to establish Canadian national health goals and objectives. The purpose is to shed light on the effects that the choice of intergovernmental regime has had on those efforts. The methodology used in the case studies for assessing these intergovernmental regimes is outlined in the introductory chapter to this volume. The related political and social context will also be considered. The conclusions of this chapter provide an empirical basis from which one might analyze how to best modernize and improve Canada's health goals and objectives today.

There is more than one approach to creating a national social program whether in health or other areas within the Canadian federal state. The approaches range from a unilateral federal government initiative, through federal/provincial/territorial collaborative agreements, to interprovincial agreements leading to a voluntary countrywide solution. Each approach has been used with varying degrees of success at one time or another to advance the Canadian social union. Each approach has had different short- and long-term impacts on the Canadian federation. With respect to the health system specifically, the Canadian federation has been largely successful in creating the basis of a national health system, although it has had difficulties modernizing its goals and objectives.

The development of the Canadian health system has seen periods of unilateral federalism, at times provincial initiative disentangled from federal policy, and yet at other times varying degrees of federal/provincial/territorial collaborative policy action.[2] Each policy approach originates from the constitutional and jurisdictional strength of the particular order of government. The provincial/territorial governments constitutionally have very extensive powers in the field of social policy but widely divergent per capita tax revenues available to utilize fully their social policy jurisdiction either in the provincial or the national interest. The federal government has a substantial revenue base to support public spending, but more limited constitutional authority in the social program field.

The method (i.e., choice of intergovernmental regime) for introducing a national social policy has significant implications both for the state of the Canadian social union and for the success of the social program itself. Unilateral social policy action by the federal government through its spending power, to impose or supercede provincial policy and priorities, can be a source of unending and debilitating dispute. Nevertheless, this type of unilateral federal

action may help to create some form of unifying benefit for the Canadian people. It may enhance the value of Canadian citizenship.

A second option is social policy leadership through the initiative and innovation of individual provinces, acting on their own. While this may not disrupt federal-provincial relations, it can, however, contribute to the growth of economic and social disparities across the country. This kind of disentangled provincial policy may also inhibit, for example, the unencumbered movement of citizens from one part of the country to another.

A third option is for the federal government to use its spending power on a basis that is agreed to by provincial governments in order to reach a common social goal in the public interest. This collaborative model generally offers a more cordial basis for inaugurating a new social policy. But its utility seems to require the continuous and judicious use of the processes of executive federalism to sustain and adapt the model's effectiveness to changing societal needs and fiscal circumstances. The conditions for the effective use of executive federalism processes are not continuously present. Furthermore, the closed doors and low public profile of executive federalism lacks transparency and shuts the public out of social policy development.

In brief, there are pros and cons to the various approaches for developing a Canada-wide health policy.

Since this chapter is predicated on the assumption that there cannot be a Canadian "national" health system if there are not national health principles, goals or objectives to which all governments and stakeholders adhere, the question that will be asked here is whether there are compelling reasons to strive to modernize the existing national health goals and objectives for future generations.

THE VALUE OF NATIONAL HEALTH GOALS AND OBJECTIVES

In theory, establishing national goals and objectives is like setting an overarching vision or "domain consensus"[3] for the health system. Such a vision should provide, although likely imperfectly, a definition of expectations for the health system, and an idea of what the national health system will and will not do for patients and citizens. As in Great Britain, the goals might even go so far as to broadly outline the attitude and manner in which the goals will be met. If the goals are in tune with public needs and expectations, they can serve to galvanize

public support and provide a sense of public assurance and security in the system. Setting national goals and objectives to reflect a collaborative and contemporary vision of the future in itself offers a form of leadership that can be motivating,[4] mobilizing,[5] and stabilizing throughout the health system. The goals may also promote efficiency, effectiveness, and equity.[6]

Contemporary goals and objectives should be seen as offering a common appreciation of the future vision and priorities for the management and development of the health system. Without such a statement of common purpose, human effort can work at cross-purposes, production can become inefficient, morale in the health system may decline, patients frequently become dissatisfied, and the sectoral leadership is ultimately eroded. In the private sector, these conditions can lead to corporate decline or failure. In the public sector, it leads to political unrest.

While goals and objectives, along with vision statements, are seen by rationalists to be highly beneficial, it can be argued that agreements "in principle" are relatively meaningless without definitive initiatives to give life to the principle. Mintzberg describes how great generality can paralyze specific action.[7] Broad principles may actually get in the way of developing productive compromises, says Charles Lindblom.[8] In the context of Canadian health policy, national goals and objectives may remove the flexibility in the system which has been a crucial element in its development and survival. Or, depending on the intergovernmental process through which the goals are established, they may challenge the constitutional division of power between the federal and provincial governments. If national goals are defined too specifically, the goal statement may not be able to keep pace with the evolution of the industry itself, consequently creating the perception of a developmental limitation. Proponents of this viewpoint would contend that the Canadian health system has developed effectively with few national goals and objectives and that there may be merit in continuing as we have in the past.

The activities of the Canadian health sector are enormously diverse and extremely complicated. They are managed at thousands of unconnected points throughout the country. They range from the invention and production of specific health products, to the development and application of the most sophisticated technology of our times. We must educate and train more than 125 categories of health workers. The system operates the most complicated set of housing and food services imaginable. The system is dedicated to the preservation and enhancement of the quality of life for all our citizens and communities. It attempts to protect those citizens who cannot protect themselves

unaided. It treats and rehabilitates the sick and infirm. It offers support to caregiver families. It employs and is expected to provide nurturing work environments for over 700,000 health workers (including 55,000 doctors).[9] It must prudently manage an expenditure of $80 billion, of which about $55.6 billion is public money and $24.3 billion is private money.[10] All of this and more is to produce a responsive, compassionate service which is linguistically and culturally sensitive, historically and geographically appropriate, economically efficient and equitable, yet socially supportive, and above all, medically and communally helpful. The programs and activities are managed through the legal and administrative structures of 14 governments, thousands of local boards and agencies, and thousands of corporations both public and private.

What we have to guide the national character of this huge industry in Canada is a piecework quilt: the principles in the *Canada Health Act*; the unelaborated 1999 Social Union Framework Agreement (SUFA), some ministerial statements of intent and common interest (the First Ministers' Accord of September 2000), many intergovernmental micropolicy understandings, regulation by the federal government where its jurisdiction is clear, a regime of comparable interprovincial health professions' regulations, an alert press, and vocal citizens. Beyond this, there are no significant forces that define or enhance the national character of the health system. (Of course at the provincial level, there are rosters of laws, regulations, policies, and communication pieces to define and characterize the provincial elements and nature of health services.)

In the Canadian health system at present, the main national goals or standards are the principles of medicare stated first in the federal *Medical Care Act* of 1966 and restated in the *Canada Health Act* of 1984: universal, comprehensive, accessible, portable, and publicly administered physician and hospital services. These principles speak to the issues of "what" coverage, "who" pays, and "where" the coverage applies — the prominent health insurance issues at the time the principles were adopted.

The principles do not, however, speak to the contemporary concerns of quality of health service, relevance, responsiveness, and acceptability of services to the public, the efficiency, effectiveness or affordability of the services, the public accountability for the services provided and their outcomes, or the manner in which the services are delivered to and accepted by the public. The principles make no reference to health service providers or their involvement within the health system (except as reference is made in the *Canada Health Act* to the payment of physicians and the fact that they cannot receive any payment from public medicare funds if they have charged a patient an "extra"

amount beyond the negotiated provincial fee/payment schedule). Nothing is said about incentives or rewards for service excellence or innovation. All these and more are the burning health issues of our day. The fact that virtually no national statements have been made about these issues means that there is little guidance for the public and the health service providers regarding their rights and obligations in respect of matters that are of crucial importance to them.

The Canadian health system has generally been seen as a powerful symbol of the common citizenship rights of Canadians and, within the North American context, a differentiating characteristic of the Canadian community.[11] Even former Premier Bouchard of Quebec signed on to the intergovernmentally reconfirmed principles of the health system in February of 1999 (which has come to be known as the Social Union Accord, distinct from the Social Union Framework Agreement) and the September 2000 First Ministers' Communiqué on Health. Given this implied national commitment to Canadian health system solidarity, the most currently troubling and challenging public issue with the system, is the profound loss of public confidence in its ability to meet future, and perhaps, current public needs and expectations. This is not entirely surprising given the long list of contemporary public concerns that remain unaddressed in a national context.

This loss of public confidence materialized in large part as a result of huge federal and provincial cost-containment measures in the early and mid-1990s. The impacts of these initiatives were amplified at that time by the initial attempts to restructure the health system so as to better position it to meet public needs in the coming years. The governmental motives of the restructuring policies, introduced more or less simultaneously with the cost-containment policies, have caused much public confusion and cynicism.

The resistance across Canada to the impacts of some of the changes, coupled with a prolonged and unrelenting barrage of hardship stories in the press, seems to have thoroughly frightened the Canadian public. This public perception, reinforced by a series of very antagonistic health management-labour disputes and strikes across the country, magnified the unrest and the alleged insecurity of the health system.

While there is little, if any, scientific evidence that the quality of clinical care has deteriorated during these times of change, and in fact there is some evidence that clinical care has improved,[12] the public perception and belief in a deterioration in quality of care is pervasive.[13] This view is now so

entrenched that it will be exceptionally difficult to alter by the traditional method of throwing more governmental money at the political problem — although this technique will undoubtedly be tried. It appears highly unlikely that any single government can "buy" its way out of the current public confidence predicament because, although initially framed as a fiscal issue, the solution is not mainly about more money. Rather, the root problem in the system is that the system is not contemporary in terms of its leadership, goals, and objectives, its service attitudes or its medical and management behaviour. Medical and health management practices have not been able to accommodate to change as quickly as the fiscal and health system governance framework has changed and brought with it to the health system new performance expectations. There is now a very serious transition problem. The Canadian health system needs renewal of its soul, not simply replenishment of its food trough.

Such a renewal might be facilitated by a new set of national goals and objectives to which all players in the health system might commit themselves: the patients, the service providers, the families, the communities, and the general citizenry affected by health services, as well as the governments and third-party payers. Today the public knowledge of the status of the national health system is highly conditioned by the national news reports. The public's impression of the national system is an aggregate judgement of the entire country, not a single region. An individual's personal experience with the health system might be quite good, but the overall impression of the health system may be quite grim. Consequently, the solutions to the public confidence issue need to be aggregated for the country, not merely provincial or local. It is unlikely that a pervasive calm in the health system can prevail in a local area if calm does not prevail countrywide. Restoration of public confidence in the Canadian health system demands collective action by governments, starting with a statement of goals and objectives by federal, provincial, and territorial governments indicating what they are trying to achieve in the health system for Canadians. One could view the September 2000 first ministers' statement on reform objectives in the health system as a starting point for restoring confidence in the Canadian system.

Beyond the domestic front, there are other very good reasons why governing and managing the health system requires collective action among all the delivery partners. "In this era of globalization and an increasingly competitive world economy, it is no longer possible — if it ever was — to segregate public policy into neat, air-tight compartments between social and economic

policy, between federal and provincial or territorial responsibilities, or even between domestic and international considerations. The actions of one government increasingly affect other governments."[14] Furthermore, the recognition that population health status may particularly be affected by factors outside the world of health treatment services is relevant when establishing a domain for setting health goals. Greater public accountability for the outcomes of governments' health expenditures demands new information systems and accountability measurements that can most effectively be developed in some collective fashion. The need to contain health costs requires that economies of scale be considered wherever possible and that duplication and redundancy be removed. These and many other considerations press for collective, intergovernmental answers.

It is much easier to establish national goals and objectives in a unitary state than it is in a federal state, but by way of comparison to the Canadian system, the recent experience of Great Britain is instructive. After a time of major unrest in its health system, Britain's new national health goals were redeveloped to speak to the heart of the concerns of its society. The national goals of the British health-care reform, in the White Paper, *The New NHS – Modern • Dependable*, are broad enough to set a national directional path effectively, yet specific enough to address present local challenges. The goals address the concerns of the whole society as well as groups within it (patients, health service providers, local health authorities, and general practitioners). Striving for effective delivery of appropriate health care, health-care goals are to be set nationally, while the service delivery method is set locally.

Local responsibility for delivery of health care allows for a more responsive and flexible system. By increasing public involvement, the government hopes to rebuild public confidence in the National Health Services (NHS).[15] The British government has promised to consider seriously the views of the patient-care provider experience, to listen and respond to the opinion of the patient and care provider[16] regarding the quality of the treatment and care given. A new national survey has been developed in order to review the patients' opinions of the quality of care received. There will also be a new NHS Charter that clearly presents the issues that concern patients most, as well as the government's commitments to address these concerns. The British government has presented the blueprint of the future of the NHS, outlined milestones, and set timelines for implementing reform. The government hopes to improve public confidence by articulating objectives and showing commitment to the goals of the NHS.

Although the British health system is but one example of national goal-setting, other countries in Western Europe, New Zealand, and Australia, have also attempted to establish new national health goals in the past decade to reassure their societies and clarify future direction for their systems. Indeed, the second volume of this study examines how several other federal countries manage their health systems.[17] Each of the countries studied has a framework of national health goals and objectives, which serve in part to steer that country's health system. In addition, most countries worldwide are giving special attention to the confirmation or restatement of their national health objectives to assure themselves that the health system is working within a contemporary framework of national policy and expectation. Even in developing countries, governmentally stated goals and objectives of the health service are seen and accepted as a guide to the future direction of the health system, and consequently an indication of the policy direction of the government. Where these goals address the current concerns of the public, they serve to stabilize public confidence in the health service (and by implication, in the government).

In Canada, the principles of a national insurance scheme, which were adopted in the 1966 *Medical Care Act*, remain relevant today as a foundation, but they are not sufficiently comprehensive to frame a universal and publicly financed health service program. Given global comparisons that pervade our Canadian internal health market, and pressures to open it to private competition, the quality, consumer responsiveness, and public acceptability of these publicly provided services must compare favourably or exceed that of a privately funded and delivered health-care system if it is believed that these private competition pressures are to be resisted. Further, to retain the present Canadian type of national health system, national health goals must guarantee the superiority across the country of a publicly funded and delivered health system in terms of accessibility, responsiveness, and compassion.

Nearly all countries in the world use a statement of the goals and objectives of their health system as a flag to show leadership, direction, vision, hope and confidence. Where the establishment of contemporary health goals and objectives has been successfully undertaken, governments seem to expect that the goals and objectives will stabilize or enhance public confidence in the health system and the governments offering the program.

In the case of Canada, it may be expected that if Canadians cannot fashion some up-to-date statement of their expectations of the future public health system, then public confidence in this system will erode further — a grim prospect to contemplate.

THE HISTORICAL SEARCH FOR NATIONAL GOALS AND OBJECTIVES

Over the past 50 years there have been a number of significant efforts to develop national objectives for the health-care system. As illustrations, this chapter will review three older examples along with four fairly recent cases where the outcome is less certain. The historic examples are the national insurance of hospital services; the creation of the national medicare program along with the implementation of the Health Resources Fund; and the enactment of the *Canada Health Act* (CHA). The more recent attempts to establish modern goals and objectives are found in the report by the Conference of Provincial/Territorial Ministers of Health, *A Renewed Vision for Canada's Health System* (1997),[18] and in the work of the National Forum on Health.[19] The third case is the negotiation of the Federal/Provincial/Territorial Social Union Framework Agreement (SUFA), signed 4 February 1999.[20] The final case is the agreement of 11 September 2000 by the first ministers whereby, the federal government produced substantial new federal dollars to support and assist provincial health reform initiatives.[21]

These cases have been chosen because they represent the most important attempts in Canadian health history to create national consensus around national health goals and objectives. Also, the cases illustrate the implications of using different intergovernmental regimes in these attempts.

National Hospital Insurance

Toward the end of World War II and the years immediately following it, political pressure was exerted on the federal government to enter the health insurance field. This period has been fully documented by Malcolm Taylor.[22] For the purposes of this text, attention will be drawn mainly to the political and fiscal conditions that gave rise to the National Hospital Insurance program.

Despite the postwar national enthusiasm for a hospital insurance plan, it did not materialize as a national program until 1957 because of a collapse of federal-provincial consensus on other fiscal issues. In polls taken in 1944 and 1949, 80 percent of respondents said that they would contribute to a national hospital insurance plan.[23] However, the intergovernmental fiscal environment did not favour establishing new cross-jurisdictional financial agreements. For example, at a federal-provincial conference in 1945, the federal government

had offered to share the costs of a limited health insurance plan and to assume full responsibility for pensions and unemployment insurance.[24] In exchange, the provinces were asked to give up their taxation powers in the areas of personal income and corporation taxes as well as succession duties. Ontario and Quebec refused this package. The conference ended in failure, and a national health-care program was put on hold indefinitely.

Subsequently three provinces introduced their own hospital insurance plans: Saskatchewan in 1947, British Columbia in 1949, and Alberta in 1950. These provincial initiatives helped to renew the hope for a national program.

By the mid-1950s, the provinces and the federal government had come to an agreement over taxation issues. Interjurisdictional taxation issues receded as a factor in the negotiations for a national hospital insurance plan, and governmental attention focused on a federal-provincial cost-sharing agreement for this major new social program. Even so, it took public pressure and the coming 1958 election to convince the federal Conservative minority government in 1957 to support the plan.[25] Thus, in 1957, the *Hospital Insurance and Diagnostic Services Act* was passed unanimously by Parliament. The plan offered conditional shared-cost arrangements and permitted the federal government, with the eventual consent of all the provinces, to enter the health insurance field in a substantial way for the first time.

This was a collaborative intergovernmental venture in national health policy formulation, which respected provincial jurisdiction in the health sector. It was put on the political agenda by public need and pressure. It did not lay down minimum national standards for hospital services except for the criteria upon which the federal government would cost-share each dollar of provincial health expenditure. One of these criteria was that the service should be universal. In many ways the federal government was using its fiscal power to influence the management decisions of the provinces; that is, a province would likely choose to invest in a program or service where it could recover half the cost from the federal government, rather than pay itself 100 percent of the cost for a service not recognized by the federal cost-sharing program.

While this cost-shared program made it easier for the country to advance the goal of equity in the health system, it was only a first step. At the same time, a large degree of economic efficiency materialized from this program both for the individual citizens and for Canadian society as a whole by avoiding a profit-centred and duplicative hospital industry such as exists today in the United States.[26]

National Medicare

Political and fiscal conditions prior to the introduction of national medicare in 1966 were somewhat different. The Liberals had supported national medicare in principle since 1919, so it seemed only a matter of time before it would be implemented. However, a number of factors delayed its quick introduction in the aftermath of hospital insurance. Political opportunities narrowed in the political cycle throughout the late 1950s and early years of the 1960s. Also, there was a series of close federal elections that produced minority governments, limiting the opportunities for the negotiation or implementation of any significant new social program.[27]

Nevertheless, there was growing political pressure for a countrywide medicare program. With the revitalizing of the federal Liberal platform through the 1960 Kingston Conference, national medical insurance became an important part of the program of the Liberal campaigns of 1962 and 1963. Further, the introduction of provincewide medicare in Saskatchewan in 1962 had demonstrated the feasibility of such a program.[28] Then, in 1964, the Hall Royal Commission on Health Services[29] made a compelling case for national health insurance and recommended the principles that were to form its foundation: universal, comprehensive, accessible, portable, and publicly administered. These principles have become entrenched as the goals and objectives of the Canadian health system today.

At the Federal-Provincial Conference of First Ministers in 1965, notwithstanding another minority government in Ottawa, all provinces that submitted statements presented their support for the principles of a national program. Alberta did not submit a statement.[30] As in the agreement to implement national hospital insurance, it was not the actual program to which governments were opposed; it was the shared-cost formula. Resolution of this problem was seen as coercive, at least by Premier Robarts of Ontario who objected to the financial provisions in the formula that offered greater financial help to provinces with lower financial capacity to enter the scheme. The offer of 50/50 cost-sharing of medicare services was to be slightly adjusted to provide greater equity across the nation.[31] All provinces did not join the national scheme simultaneously, and when each province did eventually join, their individual rationales for doing so were somewhat different. Nevertheless, the attractions of the package taken as a whole were sufficient that within two and one-half years all provinces were participating in the program.[32]

Alberta opposed the program's principles because it contended that such principles limited freedom of choice and removed all direct financial responsibility for health care from individuals (that is, the program did not allow for patient user fees or similar charges).[33] However, Alberta eventually agreed to participate in the program. British Columbia, in fact, laid the groundwork for the acceptance of the other provinces by demonstrating the flexible use of the legislation to allow the program to be voluntary so long as 90 percent of physicians opted into the plan.[34]

By the 1960s, the quiet revolution and Quebec's drive for self-determination were clashing with the introduction of a federally imposed program. Quebec's objectives are outlined by Taylor as the following:

- complete autonomy in all areas of provincial jurisdiction, and
- fiscal capacity to finance programs independently of Ottawa's conditional grant system.[35]

Quebec's goals conflicted with Ottawa's also outlined by Taylor as:

- maintain a direct "federal" presence with Canadian citizens,
- maintain national standards and portability of program rights,
- strategic fiscal control of the economy, and
- develop and implement a program of *national* health insurance.

The political problems associated with funding and cost containment which would later envelop both federal and provincial governments were not seriously contemplated at this time (1966-67). There was a general awareness of increasing health costs, but according to Mitchell Sharpe, the federal finance minister at the time, the federal government thought that this trend was manageable at the national level.

As a first step in developing the national capacity to deliver the medicare program, the federal government set up the Health Resources Fund in 1966. The fund was designed to expand the education and training resources for health sciences personnel, especially through an infrastructure expansion of medical schools and teaching hospitals. The uptake of the program was voluntary for the provinces but offered a significant injection of much needed capital infrastructure money. There was no opposition to federal spending in this area, only debate about how much each province would get.[36]

Again one can see that the acceptance of the medicare program was a collaborative intergovernmental act, entered into voluntarily by provinces

although admittedly with some public and federal fiscal pressure on those provinces that were at first reluctant to engage.

Quebec considered Ottawa's offer of a national health insurance program as imposing upon the priorities of Quebec. However, Quebec faced a tense reality after a report, which it had initiated, urged the government to implement a universal program that would address Quebec's higher rate of infant mortality and lower life expectancy than Canada's average. Furthermore, Quebec had a high rate of unemployment; a high proportion of the population was situated in a low-income category; a low proportion of the population carried private health insurance; and Quebec was experiencing a shortage in health practitioners. Coupled with a large deficit and public pressure for medicare, Ottawa's dangling carrot could not be ignored. In 1970, the Quebec government entered into the cost-sharing program, and medicare became a truly national program.

The founding principles of national medicare broadened the provisions of national equity by using the federal spending power to influence the framework and policies of provincial medicare plans. The national principles of medicare did strengthen the protection of mobile Canadians (through the portability of benefits clause). It provided some standardization of insured health benefits across the country, and enshrined "public administration" as a feature in the Canadian health system, saving Canadians billions of dollars in health costs. These features have made the Canadian health system quite distinct from the American system. The provisions for universality of coverage, comprehensiveness of insured benefits, accessibility to service, portability of benefits, and public administration have cemented a character to the Canadian health system which has not changed much in 30 years.

The Canada Health Act

When the *Hospital Insurance and Diagnostic Services Act* and the *Medical Care Act* were passed by Parliament, the intergovernmental political environment was conducive to creating national health agreements. There were commonly perceived, widely shared public needs. There was recognition that between jurisdictional limitations and financial constraints, most governments could not meet these needs alone. There was a favourable political climate created by strong, committed ministers at all levels of government, and sufficient political pressures from the public to encourage governments to act. Funding problems had been worked out equitably and both orders of government

had accepted a proportionate level of financial risk in the national health programs by accepting the 50/50 cost-sharing approach. And there was enough political credit for all governments to share.

But by the early and mid-1970s, there was pressure on both federal and provincial governments to end cost-sharing. On the one hand, provincial governments felt that cost-sharing was too inflexible. They disliked the fact that some health expenditures were shareable (operating costs in acute bed hospitals, for instance), but similar expenses were not shareable (operating expenses in psychiatric hospitals, for example). This distorted priority setting even within the health envelope by making it attractive for provinces to spend on the hospital and physician services where expenditures could be cost-shared with the federal government and to underinvest in health services that were not shareable. On the other hand, the federal government had also come to dislike the cost-sharing arrangements. Ottawa was acutely aware of rising provincial health costs and of its inability to have much, if any, influence over the open-ended nature of these costs.

The resolution of these two sets of concerns was found in the adoption of the *Established Programs Financing Act* (EPF) which brought together in a single block fund the federal contributions for hospital insurance, medicare, and postsecondary education. The federal contribution was set as a fixed amount per capita based on the 1975-76 fiscal year and then was to escalate thereafter at a rate of growth linked to the growth rate of the gross domestic product. Moreover, provincial entitlements under EPF were made up partly through a transfer of equalized tax points to the provinces and partly through cash. In 1977 at the time the EPF was passed by Parliament, most provinces thought they would be slightly advantaged by the formula given the escalator indices that were used at the time of the negotiation of the formula. By the early 1980s, with Canada in a severe recession, and government deficits rapidly rising, the federal government started cutting back on its planned level of EPF cash transfers to provinces. This was a trend that was to continue until the late 1990s.[37]

The effect of the EPF was to create a cash transfer payment to the provinces that was unrelated to the actual costs of the services the transfer was intended to support. This had two effects. From one perspective, it ended the above-discussed distortion in the allocation of provincial health spending. This was in important respects a favourable reply to provincial demands. The corollary, however, or the other perspective, was that 100 percent of the risk of rising health costs was shifted to the provinces by the adoption of the EPF formula. At the same time, there was an *implicit* federal contribution to

provincial health spending since the base year EPF contribution had been determined in large measure by federal per capita contributions to provinces linked to their cost-shareable health expenses.

The rules of the game began to change, however, in the early 1980s, when Ottawa began reducing the rate of growth in the EPF formula. While driven heavily by fiscal necessity and reality, these unilateral federal decisions to reduce its implicit health contributions were also a breach of the social contract that the federal government had with the provincial governments and with the Canadian people. The imposition and continuation of this unilateral fiscal policy led to a long period of deterioration in the intergovernmental trust that needs to exist between federal/provincial/territorial levels of government in a federated health system. Moreover, if the fiscal policy was also partially intended, as some would contend, to seat responsibility with the provinces/territories for health system efficiency, then the policy failed as health costs rose in the 1980s by an annual average of 10.5 percent,[38] the highest rate of increase in Canadian history. Even today, after the substantial increase in federal transfers announced in September 2000, the continued lack of provincial trust in Ottawa's *bona fides* is palpable.

The concept of the *Canada Health Act*, 1984 was a federal government reaction to physician extra-billing which had emerged in small amounts mainly in British Columbia and Ontario as a consequence of provincial governments having to restrain to some extent run-away health costs of the 1980s and having, at the same time, to refuse doctor demands for huge increases in their medical reimbursement schedules. This was being done at the provincial level while the federal government was reducing the level of its planned EPF transfer payments to provinces and while all the provinces were trying to address the very high rate of health-cost increases referred to above. To have the federal government, at this point in time, unilaterally pass legislation to demand from the provinces health services with certain uniform national standards while simultaneously reducing its own contribution to these national standards was a major affront to provinces.

The passage of the *Canada Health Act* could be described more as a political flag-raising event than a unique moment in Canadian health history. It was not essential legislation to sustain the health system and the extra billing challenge was proportionally very small in Canada. But the legislation did allow the federal government to claim a trusteeship role of the health system on behalf of Canadians at no financial cost to itself. But there was nonetheless

a price — a political one. This arrogant act did provoke much intergovernmental conflict that has lasted for a generation.

The Act restated the principles of medicare in the context of a more broadly defined concept of "health." It consolidated previous legislation and outlawed "extra-billing" and user fees which were minor, but controversial issues at the time. But it did not alter or extend the previously established public insurance coverage of hospital and physician services. It did though allow the federal parliamentarians, over the opposition of provincial governments, to claim moral superiority in protecting the national health system against provincial erosion, while continuing to limit its own health spending. This political tactic ultimately proved to be highly divisive and corrosive to intergovernmental relations, but in the public mind it also firmly established the federal government presence in the health system.

Recent Attempts to Establish New National Health Goals and Objectives

By the early 1990s many health commissions,[39] advisory groups, independent researchers, and government officials had begun to conclude that the present health system was inordinately expensive, and population health status was not improving by investing more in the existing programs. There was a fear that the insured health services might be lost if they were not placed on an affordable footing by governments. Private health expenditures for non-insured services were increasing proportional to public expenditures, and some expenditures were moving abruptly from the public to the private purse.

The health system had become a captive of the "medical" model of health care as opposed to a model of "population health service." Evidence was now available that the balance of emphasis in the health system had to be moved away from institutional services and more toward "population health," that is, enhanced preventative measures coupled with a greater degree of individual and community responsibility for personal health. Targeting new health investments to high-risk groups such as children, Aboriginal people, and seniors was advocated to supplement the "universal" health programs of the past. The concept of "evidence-based medicine" was gaining ground among practitioners and decisionmakers, suggesting many medical procedures in the health system were of dubious value. Further, greater pressure was being placed on the health system to be more responsive, publicly accountable, and more inclusive of consumers in health decision-making.

While hospital, long-term care, and physician services remained essential and the most expensive services in the system — drug services and an extended range of community-based and preventive services such as home care— were being demanded for inclusion in a modern health program. Meanwhile, government insurance support tightened up and restraints were placed on institutional capacity and costs.[40] Challenges to a single-tiered health system increased and new forms of charging the public for some of the health-care costs were being implemented or advocated.

Serious cost restraints were applied in the Atlantic provinces, and soon were to be followed in Saskatchewan, Alberta, and Manitoba, and a bit later by the Ontario, Quebec, and British Columbia governments. The federal government, in an effort to balance its own budget, announced in 1995 large annual reductions in its cash transfers to the provinces. Under the Canada Health and Social Transfer (CHST), beginning in 1996-97, cash transfers to the provinces were to be cut by over $4 billion compared to 1995-96 and by over $6 billion in 1997-98. This was a serious blow to the health system coming on top of already very stringent provincial measures to contain health costs. Major efforts were undertaken to identify overlap and duplication between levels of governments and to eliminate these inefficiencies. Additionally, new attempts were made at the officials' level to adopt more collaborative federal/provincial/territorial (F/P/T) arrangements to obtain certain health system support services more efficiently.

Even before the CHST, in 1993, these various pressures on and in the national health system, along with increasing public concern about their consequences, had prompted first ministers, on the advice of F/P/T ministers of health, to agree that a national review of the health system was warranted. In September 1993, the health ministers and deputies met in Edmonton and agreed to cooperate in a review of the health system that would examine the need:

- for stable, predictable health funding for the future;
- for national strategies such as the delivery of services to Aboriginal people;
- to share results from governmental health reviews and to disseminate this information to the public;
- to develop a framework for a national dialogue with the public about the health system; and
- to involve Canadians in developing a vision for the health system in Canada.[41]

Although of low profile, this work advanced through the Conference of Deputy Ministers of Health to the ministers of health. The final report came to be known as *A Renewed Vision for Canada's Health System*.

The National Forum on Health

While this quiet federal/provincial/territorial work progressed on one front, the federal government was proceeding to implement its *Red Book* political commitments from the 1993 federal general election. The Liberals had promised a National Forum on Health (NFH) which would consider what the goals and priorities of the system should be as well as inform the public debate about the health-care system. At the February 1994 Conference of F/P/T ministers of health, federal Health Minister Diane Marleau tabled the draft terms of reference for a National Forum on Health. The terms stated it would be chaired by the prime minister and the federal minister of health; it would be composed of 24 members: professionals, researchers, economists, and policy advocates; it would meet at least three times per year over four years; and it was to inform Canadians about the future of the health system.

The provincial reaction to this announcement was not enthusiastic although the central purpose of the forum was not rejected by the provinces. In June of 1994 the western premiers stated as their position that since health is a provincial responsibility, the NFH should have restricted itself to building upon, complementing, and supporting the work of the provinces in health reform and meeting future needs. Indeed, they thought the forum risked undermining provincial initiatives which had been ongoing for two or three years. The provinces also wanted a provincial premier to co-chair the forum with the prime minister. This request was ignored publicly and rejected privately. Furthermore, the time frame for the forum was thought to be too distant for its recommendations to address effectively the pressing concerns in the health system.

Ignoring provincial concerns, the federal government announced the creation of the NFH in June 1994 without provincial government representation.[42] Despite the lack of direct provincial participation in the forum, the federal government claimed that there would be provincial/territorial participation through the nomination of participants to the forum, by assisting in the development of the forum's work plan, and by actively participating in the activities of the forum outside the conference room. Two provincial officials were designated as provincial observers. It was also accepted that the federal/provincial/

territorial health ministers were the decision-making body in the health system; the forum members were not.

With respect to its representation, the forum did enlist excellent members from all parts of Canada, some with the tacit support of their provincial governments and others without that governmental endorsement. While many of these representatives had good knowledge of the health system environment in their home province, none could claim to be representing governmental policy interests. Since national health goals or directions require federal/provincial/territorial government collaboration to deliver and finance them, this lack of recognized provincial government representation on the forum posed a significant constraint on what the forum could expect to achieve.

From the moment of its creation, the forum proceeded as a unilateral federal undertaking with provincial governments viewing the federal initiative as formally disconnected from provincial interests. But at the health officials' level, collaborative federal/provincial/territorial work continued quietly on the "Renewed Vision Statement." In 1995, the federal government introduced the Canada Health and Social Transfer, and fiscal transfers to provinces for social programs were reduced dramatically. The federal/provincial/territorial collaboration was further damaged by this unilateral federal action. The provincial governments believed that the federal government was trying to balance its own budget in part on the backs of the financially stressed provinces and the health system. Some observers claimed it was diverting public attention from its diminished financial role by using the NFH to claim federal leadership in the health field. The combination of these federal policy initiatives was deeply resented by the provincial and territorial governments. Former Premier Roy Romanow summed up this view when he said, "Ottawa has ignored the federal nature of the country and how this influences the shape of the social union. The federal government could have, and should have worked with the provinces in redesigning the federal transfer system and assisting in the redesign of provincial delivery systems."[43]

The strength of the forum's report was that it highlighted concepts such as the determinants of health, evidence-based decision-making in the health system, the need for new health information systems, the need for home care in the national health system, and the need to pursue a national pharmacare program. The forum assisted the country by encouraging the federal government to establish a "floor" on its reductions of CHST cash transfers to the provinces (at the level of $12.5 billion, up from $11 billion). However, the forum acknowledged that there was no particular evidence to prove or suggest

that this floor contribution was an appropriate balance of federal contributions to the health system, and that, indeed, there was "no magic number."[44] Perhaps most importantly, as Steven Lewis, a forum member adamantly stated in a private interview, "The Forum tapped into a very important reality: Canadians want both levels of government substantively involved in directing the system and do not trust the provinces to have exclusive domain."[45]

The weakness of the NFH was that it was not an effective intergovernmental vehicle to establish national health goals and objectives. Its composition did not reflect the range of key decisionmakers and financiers in the health system. Therefore it could not account for or reconcile different political interests in the health system. It was not an intergovernmental collaborative exercise. It excluded or could not address seriously the crucial factor of health financing options. Its eventual term was too short to undertake the analytical work that decisionmakers demand, and as noted, it could not deal with short-term urgencies in the health system.[46] It was also unable to make progress on the largest jurisdictional and intergovernmental framework problems and on barriers to national consensus-building. Similarly, the report did not address some of the very substantive challenges in the health system such as responsibility for Aboriginal health care, or the highly contentious issue of finding a more harmonious way to interpret the *Canada Health Act*.[47]

The "Renewed Visions Statement" of Provincial/Territorial Ministers of Health

Meanwhile, several intergovernmental conflicts had emerged in the development of the Renewed Vision Statement that could not be overcome. The first was that the provinces took issue with the policy approach that the federal government was taking with respect to its fiscal responsibilities, particularly with the CHST. The second major problem was the refusal of the federal health officials to discuss a joint interpretation mechanism for the *Canada Health Act*. The third conflict was a dispute over the roles and responsibilities of governments for health services, especially the responsibility for financing health programs for Aboriginal people, both on and off reserve.[48]

With these unresolved issues on the table, the federal government *de facto* opted out of completing this Renewed Vision Statement while positioning itself to show modest interest in the work. It maintained that the work of the National Forum on Health and the "renewed visions" activity could be integrated, especially if the report of the NFH was used as the starting point

for the Renewed Visions Statement.[49] The statement was completed by the provinces and territories, tabled before the Ministerial Council on Social Policy Renewal, and made public on 29 January 1997.

The Renewed Visions Statement laid out three principles for the health system and five major goals. The principles were:

- to preserve, protect and improve the health of Canadians;
- to ensure that Canadians have reasonable access to an appropriate and effective range of benefits anywhere in Canada, based on their needs, not their ability to pay; and
- to ensure the long-range sustainability of the health system.

The goals of the renewed health system were declared to be:

- maintain health as a shared responsibility of individuals, communities and society, recognizing our commitment to caring for each other;
- because many factors outside the health system determine the health of Canadians, health policy must be linked with economic and social policy;
- appropriate accountability for the use of public funds and for results must be ensured;
- health-care cost-savings to be achieved primarily through the use of single-payer public funding and purchasing of health services; and
- health policy to be based on collaborations and consultation with the people of Canada, service providers and federal/provincial/territorial governments.[50]

The part of the statement that was not acceptable to the federal government was the section on "Securing the Health System of the Future" which included the demand that the federal government provide "adequate, predictable and stable funding" and renew its fiduciary responsibility to Aboriginal people.[51] As well, the federal government objected to a section defining roles and responsibilities of governments, and it objected to phrasing that implied that the federal government was interfering in areas of provincial jurisdiction (i.e., direct federal access to the public in areas of provincial jurisdiction such as developmental support of community-based programs, senior citizens programming, youth services, etc.). And, of course, the federal government was strongly opposed to a recommendation that the *Canada Health Act* should have a joint interpretation mechanism. All these objections were at the very core of the federalism dispute.[52]

There were, nonetheless, some strengths in the intergovernmental approach taken in this renewed visions exercise. There was a provincial-territorial consensus (with the exception of Quebec) about the goals and objectives of the national health system in the coming years, about how it needed to be changed and improved, and about the key policy issues that had to be faced. The early drafts of the Renewed Vision Statement illustrated considerable sensitivity to the realities facing the Canadian health system and the financiers of the system while holding completely to the founding principles of the medicare system. And there was realism in the statement with respect to what could be implemented. Furthermore, there was a sense of urgency that the health system needed renewed goals and objectives that could potentially mobilize the energies of the entire health system.

However, there were substantial weaknesses in this renewed vision process as well. It did not have the mandate or authority to negotiate or seriously consider any new federal/provincial/territorial financing arrangements, or new public-private partnerships. It could not resolve fiscal responsibility for Aboriginal health services, in part because of entrenched federal policy and practice, which the federal officers were not willing to discuss. Also, Aboriginal people and Aboriginal financiers were not at the table. It could not advance a CHA dispute resolution process because of federal reluctance to discuss the issue and because of the precedent that a resolution might set for other federal/provincial/territorial discussions. Further, an assessment of federal/provincial/territorial political credit and accountability could not be made at this table, as some leading political stakeholders were not present.

In short, the renewed vision process was reasonably effective up to the point where high stakes political, financial, and jurisdictional issues became the barriers to resolution of the issues. The entrenched political positions, financial, and jurisdictional responsibilities, along with the spillover effects of a potential health agreement into other areas of intergovernmental activity, prevented the creation of an accord to modernize the goals, objectives, and directions of the health system.

Thus, neither of these two attempts at establishing national goals worked particularly well in facilitating the resolution of the biggest policy problems in the health system. Mandates were inappropriate to the challenge and structural concepts were outdated. The National Forum on Health produced some contemporary thinking on program concepts; the Renewed Vision Statement produced some valuable suggestions on health system objectives and did in

fact, either directly or by dissent among its participants, identify the main technical policy problems to be addressed in the health system. Neither process, however, could deal with financing, jurisdictional or horizontal policy linkage issues without an intergovernmental framework agreement. The NFH was a more transparent and democratic process that brought forward important public viewpoints. The renewed vision process was an exclusive procedure which yielded interprovincial consensus and was sensitive to governmental issues.

The Social Union Framework Agreement

In the latter half of the 1990s, Canadian governments and an ever-increasing number of citizens and keen observers began to articulate their sense that something was fundamentally askew with the traditional understanding of our Canadian social union. The most apparent recent crack in the carefully balanced social policy arrangement emerged in 1995 following the cuts in federal cash transfers to the provinces associated with the introduction of the CHST. These concerns led to a provincial challenge to the federal government's moral and political right to enforce standards of the national health program. More transparent public accountability for the health program and its public expenditures were demanded, perhaps more for the purpose of assigning blame for popular grievances than for understanding governmental responsibilities. Balkanization of social programs became a possibility with the conceivable loss of portability of benefits across Canada. The continued financial sustainability of the Canadian health system became an open question. And not inconsequentially, new intergovernmental options for the social union of the country were being sought as a means of dealing with the sovereignty challenges advanced by Quebec.

These pressures caused the provincial/territorial premiers first, followed later by the prime minister, to join in an initiative to renew the Canadian social union. In general terms, the social union discussions of the first ministers have been an attempt to demonstrate that federalism can work. More specifically, the negotiations were attempting to resolve for the long term the framework principles, intergovernmental roles and relationships, and financing and accountability requirements needed to ensure that an enduring Canadian social union could exist and flourish. The very existence of these talks was an implicit acknowledgement by first ministers that presently there are barriers to policy resolution and advancement within social policy subsectors.

The F/P/T Ministerial Council on Social Policy Renewal had expected that the subsectoral ministerial committees would advance plans to operationalize the Framework Agreement within the year 1999-2000. This would offer a further opportunity to resolve some of the outstanding national health policy issues. Nevertheless, by April 2001, little of substance had been made public if indeed any had been achieved.

The governments of Quebec, Ontario, and Alberta would have preferred that the federal government cede adequate tax room to the provinces so that they would have sufficient money to assume full financial responsibility for their health, education, and social services programs quite independently of Ottawa.[53] Since this was not acceptable to the other provinces or to the federal government, there was no change in the tax-sharing arrangements as a result of these negotiations.

When SUFA was signed on 4 February 1999 by the federal government and all the provinces and territories except Quebec,[54] each claimed a victory for its own goals. Nevertheless, the full impact and value of this agreement cannot be assessed until the details of its implementation are worked out. A preliminary appraisal is that it is either a creative first step in repairing intergovernmental relationships in the social policy sector, or it is an empty, ambiguous political document that has unconstitutionally favoured the federal government. If the agreement is simply taken as a statement of intergovernmental intent and hope, it has much to recommend it. It is a clear recognition that intergovernmental attitude and behaviour needs to be changed in the federation. If, on the other hand, it is presumed to be a statement of practice, without more elaboration, it has severe limitations. The agreement is ambiguous in places, and subject to quite different interpretations. It is intended that the agreement will be reviewed and adjusted where necessary at the end of three years (that is, after 4 February 2002). Some clauses will take many years to implement fully, but it is noteworthy that with respect to public accountability, the first ministers have directed their health ministers in their September 2000 communiqué to "collaborate on the development of a comprehensive framework using jointly agreed comparable indicators such that each government will begin reporting by September 2002."

Through SUFA, the federal government may have achieved a more prominent role in social policy formulation and implementation than it has had since the 1960s. This is not utterly transparent in the agreement itself, but could well materialize if the "collaborative" arrangements unfold in their implementation.

Ottawa also promised not to establish any new jointly financed social programs without the support of at least six provinces (which is slightly more restrictive than previously, although not a major deterrent). The federal government also retained its capacity to alter its own social and fiscal policy where it affects provincial jurisdiction by merely giving notice and consulting with provinces before doing so. The federal government achieved all its main objectives at a financial cost no greater than it withheld from the health system from 1995 to 1998 meanwhile balancing its budget in part on the savings of this withholding. While the agreement does require both orders of government to be advised of any change in a social policy or program, the agreement does little to ensure that the federal government cannot unilaterally reduce transfer payments for health, postsecondary education, and social assistance.[55]

From this author's perspective, the most important feature of the Framework Agreement concerns the promise of collaborative intergovernmental activity, and what appears to be a recognition that an improvement in *intergovernmental attitude* as illustrated in the preamble of the agreement (quoted below) and surfacing in many other clauses of the agreement, is necessary for the Canadian social union.

> The following agreement is based upon a *mutual respect* between orders of government and a *willingness to work more closely together* to meet the needs of Canadians.[56] (Italics added.)

One would like to hope that this preamble is a real commitment to intergovernmental behavioural change and not merely a rhetorical opening paragraph. The statement speaks to the very heart of provincial/territorial grievances with the federal government. If one examines carefully all the objectives of the provinces and territories in the social union framework discussions, each item addresses an issue that derives from what provinces and territories perceive as the federal government's "colonial" attitude and behaviour. The attitude has been exhibited in a disregard for provincial priorities and circumstances over decades. It assumes that unilateral federal action taken without due regard for the impacts on provincial/territorial governments and their social programs is acceptable "in the national interest." It assumes that the federal government alone can determine the national interest. It implies that provincial/territorial governments are immature and their administrations barely competent.

But poor attitude and behaviour do not reside solely with the federal government. The provinces and territories use the federal government as a scapegoat for all conceivable public sins of omission and commission, while at the

same time provinces and territories seek advantage, money or favour from the federal government at every available opportunity.

In rebuilding the intergovernmental relationships which support the Canadian social union, one might conclude that respectful attitude and sincere collaborative behaviour amongst governments are more important than any other structural changes proposed or advocated. The challenge for improved performance applies to all levels of government. If this is what is intended by the first ministers in the SUFA, then they are to be greatly commended for their insight into the problem, but their message needs to be well disseminated and effectively implemented.

First Ministers' September 2000 Communiqué on Provincial Health Reform Joined by New Federal Health Dollars

By the year 2000, huge public pressure had materialized on both orders of government to reinvest in the health system in order to stabilize it and reduce the public and professional criticism of a national health system in crisis. The federal fiscal environment had completely turned around so that the future federal fiscal prospects were very bright; but on the other hand provincial fiscal capacity alone was not up to the challenge of stabilizing the health system through its reform. The widespread recognition of the need for greater federal fiscal involvement in the health system had become overwhelming. The federal government conceded that it had the money to contribute to the health system if the provinces/territories had the plan for health reform. The plan was delivered by the provincial/territorial premiers in August 2000. The plan was accepted by the federal government, which then joined the plan with new federal funding of $23.4 billion over five years. A federal election was called shortly thereafter, returning the Liberal federal government with an overwhelming endorsement in Quebec and Ontario!

This 11 September 2000 agreement of first ministers is contained in their very detailed communiqué. The substance of the communiqué contains the goals and objectives for health reform in Canada. The method of arriving at these goals and objectives and stating them in writing did not offend Quebec's jurisdictional concerns, particularly since it is stated explicitly that the agreement is to be "interpreted in full respect of each government's jurisdiction." The statement of goals and objectives by the premiers was sufficiently insightful as apparently to be a good reflection of the federal government's view as well, thereby avoiding a federal/provincial clash on policy substance.

And, of course, the amount of the federal fiscal infusion into the health system was sufficiently large that no province could turn away from it.

Throughout this chapter, and in other chapters of this volume, several conclusions have been drawn about the Canadian national health system. First, it absolutely requires a significant amount of federal funding. Second, it needs clear contemporary goals and objectives to guide development activity throughout the system, especially at the governance level and the Canada-wide program level. Third, the system needs a much higher and substantial degree of collaboration and mutual respect between the orders of government and among other knowledgeable players in Canadian society. Fourth, without trampling on provincial health jurisdiction, there are many issues and matters in the health system that need joint or collaborative developmental attention by the two orders of government and also among the provinces and territories themselves. Where these areas of potential collaborative activity can be identified they should be pursued through one organizational mechanism or another or new institutional structures should be created to facilitate this collaborative work. And fifth, the system needs a regular and objective check and balance on the performance of governments in the system. One technique for achieving this is through a new system of regular health accountability to its citizens by governments.

Curiously, all of these conditions have been met to one extent or another in this September 2000 first ministers' agreement. Whether this is an accident or whether it reflects the fact that governments have learned the appropriate lessons from their failures of the 1990s is not yet known. It could also be that broader needs in the federation — fiscal, economic, political, intergovernmental, and national policy — all lined up with conditions that both demanded and permitted a new health accord.

What is so strange about the Canadian popular and professional reaction to this very important health agreement is the non-reaction to it. One wonders if the substance of the first ministers'communiqué is widely known. The media have not explored the content of the communiqué or its implications having spent years dramatizing the "crises" in the health system, the shortage of governmental money in it, and the behaviour and remarks of lead players influencing the health system. Perhaps the 1990s "crisis in the health system" has been largely a media event. The actual reforms to the health systems across Canada have mainly been about governance, service delivery arrangements, medical practice models, democratic values, and practices in

the system efficiency and effectiveness — not gripping headline stories! The funding crisis was forced on the system by governments needing to balance their own budgets in part off the back of the health system. Most of the public complaints heard through the press for a decade have related to alleged money issues, not the substantial issues of health reform. When the federal government infused $23.4 billion into the health system, at least for the moment it was difficult to protest that there was a financial crisis. No financial crises, no news story, no headlines, no anxiety for the public, no problem with the health system! But does any of this mean that the fundamental reasons for undertaking health reform in the first place have been corrected?

In addition to the five-year federal money infusion, another large benefit of the September 2000 agreement may be to lower the public attention on the health system for a short while so that the system can begin to address its real reform needs in a more systematic and conscientious way.

LESSONS LEARNED FROM THE GOALS AND OBJECTIVES CASE STUDIES

The case for the utility of national health goals and objectives, in addition to the observations made later in this chapter on the need for new national health policy, suggests that the health system requires a more effective national capacity, but one that is expressed in a collegial, non-hierarchical process. This is the type of process that SUFA claims should be the basis of the Canadian social union intergovernmental relationship. While the agreement itself lacks an implementation strategy, at least as far as health policy is concerned, the first ministers' September 2000 communiqué is a good start.

Arguments have been made for and against more precise national objectives, but the argumentation is often confused with respect to the differences between "federal" and "national" objectives. One does not frequently hear arguments advanced against "national" goals and objectives as such, but rather against a significant "federal" government role in establishing and enforcing those goals. This line of thinking suggests that the federal government has little constitutional authority in the health sector and should vacate the field to the provinces entirely to avoid the jurisdictional tension and confused public accountability that joint responsibility generates.[57] Proponents of this viewpoint argue that the provinces have exclusive constitutional jurisdiction in this field and know best how to serve the health needs of their people because of

their closer proximity to the people served, and because of their sensitivity to unique regional, local, economic, linguistic, and cultural differences within their provinces.

In theory, Canada-wide social programs based on interprovincial agreements could be developed with only limited involvement of the federal government. This study has shown that initially both insured hospital and medicare services began as provincial regimes disentangled from federal participation (e.g., hospital and medicare services in Saskatchewan, hospital insurance in British Columbia and Alberta). However, this would not be possible today unless the revenue-generation capacities of provincial governments were substantially adjusted and equalized, and if an alternate mechanism to the federal government was found to interpret, enforce, and sustain provisions in interprovincial agreements that assert the national character of the program. But today, the public demand for system efficiency and effectiveness, Canadian labour mobility, global economic pressures, and Canadian public opinion call out for collaborative intergovernmental solutions for the health system's challenges.

The work of establishing national health goals and objectives is really an exercise in nation-building. The outcome must reflect the values, aspirations, and needs of the great diversity of Canadian cultures and circumstances. The precedents set in the health arena are so important elsewhere in the social union, and the policy linkages so great horizontally, that renewing the goals and objectives of the health system is an intergovernmental political job that cannot be successfully delegated downwards to bureaucrats or horizontally to external expert committees. It must be the work of democratically elected people.

These several case examples illustrate that major national health policies have broad horizontal consequences that affect constitutional matters, fiscal issues, and interjurisdictional disputes about such matters as responsibility for off-reserve Aboriginal people, issues of public accountability for national health programs, political credit, political blame, and ultimately political leadership. When the fundamentally contentious issues in the health system are not resolved or balanced at the top of the intergovernmental political structure, no other advisory mechanism seems equipped, constituted or empowered to reach an enduring settlement.

Key political players to many of the most important issues in the health sector are first ministers and ministers of finance, more so than ministers of

health. The health ministers cannot resolve these issues alone as the implications extend into other governmental and intergovernmental jurisdictions and domains. Currently the F/P/T tables discussing policies that affect health in one dimension or another are separated. It is therefore difficult to obtain an integrated policy solution. Some form of multi-interest table is needed. The collaborative approach used in those successful case examples (hospital insurance, medical care, and SUFA) was not narrowly sectoral, but rather horizontal in terms of governmental interests. Power-trading and political credit-sharing were essential to settlements.

Once, however, a policy and fiscal framework is set, there is no evidence to suggest that the established intergovernmental health processes cannot complete the job so long as they work within a collaborative model. Even having approached national policy development in this manner, experience would suggest that there will be occasions when an impasse will be reached. There will still be a need for a "tie-breaker" mechanism or authority. If that is not to be found in the legal or moral jurisdiction of one level of government or another, then an alternate mechanism needs to be created. Thus far, no satisfactory alternative to the federal government has been found. And the chapter by Joan Price Boase in this volume suggests that this will remain the case.

Nor should the intergovernmental process be secretive or exclusive as is now the case. Such exclusivity has insulted the public expectation of greater inclusiveness in national social policy negotiations. It may be thought that the current governmental instruments for obtaining this public input are not appropriate for the task or the conditions of the task. Supplementary mechanisms or new mechanisms may be needed to augment the range of advice that can be made available to the principal negotiators of health policy, developed under terms and conditions that the negotiators can accept.

There are a number of "tools" by which the federal government contributes its added value to the health system. They include: selective use of its own constitutional jurisdiction, legislative authority, moral authority, suasion, potential superior expertise, political harassment, and money. With one exception over the past 40 years of health history (the CHA), the dominant and most effective federal tools have been its spending power and its political persuasion to affect provincial behaviour in the delivery of health treatment services. And with the fiscal tool, the federal government has been able to enhance its persuasive influence, possibly its moral authority, and consequently its power within the health system. While one should not underestimate the value of

federal activities in the field of health protection, First Nations' health services, health promotion, health research and development, and a variety of health information services, these pale in significance compared to the importance of the health treatment services delivered by provinces and territories.

This study has shown that federal government's fiscal contributions to social programs are absolutely essential. The most successful cases of national goal-setting have been based on a collaborative federal/provincial/territorial process that balanced the fiscal, political, and program needs of both levels of governments, giving each due political credit with the Canadian public. As Robin Boadway has observed: "The spending power is an indispensable policy instrument for the federal government to pursue its legitimate economic, social and constitutional obligations."[58] The federal fiscal contribution, its proportional size and its form, is the single most important tool available to create, ensure, and sustain the "national" character of social programs. The proportional size of the federal fiscal contribution (relative to provincial/territorial and private expenditures) is also relevant because the proportional federal financial contribution is a measure of its power in the health system, its capacity to influence provincial/territorial behaviour and its ability to enforce national standards.[59] Perhaps most importantly, the federal fiscal contribution is a measure of its own assessment of its added value to the entire health system.

Federal moral authority and its capacity to persuade rises or falls with its level of financial contribution o*r its ability to effect policy solutions of political value to the provinces*. (This latter thought has been understated as a point of specific analysis in the case studies chosen for this project. The fiscal influence has dominated the analysis.) Federal power and influence in national health policy will depend heavily on Ottawa's willingness to continue to invest in its national health role. But it can also play a useful role by contributing to the resolution of political and technical problems of health delivery, as well as by participating helpfully in collective functions needed by the health system and the provincial delivery partners. Most of these functions need to be performed as a facilitator, not as a judge.

Another tool available to the federal government to influence provincial behaviour in the health system is the *Canada Health Act*. It has been alleged that national objectives, such as those in the *Canada Health Act*, as well as targeted or earmarked federal money, put limits on the efficiency and experimental gains that the provinces can achieve. For example, John Richards states that decentralization "encourages innovation, constrains the ability of citizens

and interest groups to transfer costs to others, and lowers the costs of determining public preferences."[60] Furthermore, Allan Maslove reports that

> several analysts have reached the conclusion that the case for federal involvement to sustain national standards is not all that compelling. Widespread public support for the established Medicare principles, and common interests of health care professionals across provinces will constrain any moves by provincial governments to deviate from or dilute these principles. Thus, while national goals do exist, federal intervention is not necessarily warranted.[61]

While it may be true that federal intervention in the health system through the application of the *Canada Health Act* is rare, its influence on health decision-making behaviour is considerable. The Act serves as a clear statement of Canadian values and principles. It is a benchmark against which governmental political behaviour can be measured. It is a flexible national standard within which the health system can evolve. It serves to restrain major deviancy in the health system, but it rarely prevents reasonable experimentation and development.

Some critics like to think that this Act is widely powerful, very limiting, and excessively unilateral in its application. However, it is none of these. The *Canada Health Act* should be seen more as a political and moral standard than a fetter on sensible health system experimentation. Provincial experimentation and innovation are not limited by the *Canada Health Act* or by the CHST unless provincial/territorial proposals are intended to undermine the very essence of the Canadian health system.[62]

In the last ten years, despite massive changes that have occurred in the health system and the extraordinary experimentation with new governance models in the provinces, this Act has only been used in one instance to prevent a major deviancy (facility fees) from being established as a precedent in the Canadian health system.[63]

The claim that decentralized federalism promotes experimentation and innovation is useful to a point, but replication of some of these health experiments is highly inefficient and unnecessary. A coordinated approach to operational research and demonstration through a national coordinating vehicle should allow experimentation and results to be quickly generalized across the country. The "nationalization" of successful provincial innovation is one of the major advantages of our complicated form of federalism. This value was captured in a remark made by the Honourable Stéphane Dion, federal minister of intergovernmental affairs.

> The purpose of the negotiations [the Social Union Framework Agreement] is not to conclude an unwieldy compromise between two perspectives, but rather to draw on the best of each, so that we can enhance our capacity both to have common objectives and to try out different solutions … It requires much more imagination to strengthen both orders of government in their legitimate roles, and in particular, to enhance their capacity for joint action.[64]

The position of the government of Quebec on social programs vis-à-vis the federal government would virtually prohibit any further F/P/T extension of the Canadian health system through the *Canada Health Act* type mechanism. Indeed it would appear that Quebec could not support new national health goals and objectives with significant federal government participation in them. It might be able to accept national goals and objectives of a pan-Canadian nature if these goals emerged through an interprovincial arrangement that had only a voluntary enforcement and compliance capacity.

This then raises the question of whether one can have a Canadian national health system without Quebec's participation. Technically the answer is No. But then what do we mean by a "national health system"? The so-called Canadian health system as we know it today did not materialize across Canada at a single point in time, nor with a single set of program criteria. Furthermore, significant elements of a health "system" are not yet included as part of any Canadian national venture: like home care, drug programs, and wellness schemes. We have yet to define these services as part of a national package of health benefits, but to some extent these programs are already insured, or partially insured, health benefits in most provinces. Before one can be sure of the place of Quebec in any new "national" health schemes, one must consider very carefully the intergovernmental structural arrangements surrounding the scheme, as well as the criteria that make it absolutely essential to create a "national" social program in Canada.

One can conclude from these case studies that the federal presence is needed in the Canadian health system, that alternative bodies do not have the tools, authority or capacity to perform the essential national roles, and that the future of the health system demands more coordinated, collaborative, intergovernmental action at a minimum simply from a practical public policy viewpoint. This policy perspective may challenge Quebec in the Canadian federal state, and perhaps as well, Alberta. It may also challenge Canadians' conception of the essential national characteristics of our social programs.

Overall the Canadian public, perhaps with the exception of Quebec, is not so concerned with the nuances of the constitutional division of power, or the implications of intergovernmental regimes on its democratic rights. It wants positive and corrective governmental policy action in the social programs on which it depends. Fix the policy problems, and the federation or parts of it will carry on.

In summary, the case studies reveal that the essential federal contributions to the health system have been:

- Federal money and its redistribution effects assure the fiscal capacity of many provincial/territorial jurisdictions to deliver approximately equitable health programs.
- This federal financial contribution offers a mechanism to achieve and enforce a relatively common minimum standard for health programs across the country (the Canadian equity principle).
- Through its fiscal capacity, and the interpretation and enforcement capacity of the CHA, it can influence provincially funded health programs at the margin.
- It can serve as a "tie-breaker" in health policy disputes involving the national interest.
- Potentially it can serve as a "shepherd" in galvanizing collective action to address common interests in the health system (that is, a coordinating capacity surrounding issues of interprovincial and F/P/T political concern).
- It has some capacities to protect and advocate for both majority and minority interests in the health system.
- Through its research and development initiatives, it has the potential to foster experimentation, innovation, and evaluation in the health system, and thereafter to "nationalize" the successful outcomes.
- It is a vehicle to disseminate new knowledge.
- It can, and does, deliver certain country-wide, health-education, and health-protection services more efficiently than through other means.
- It has a legal obligation to, and does, provide or assure certain health services to certain Aboriginal people and to a small number of others.
- It has the administrative capacity to provide a wide range of support services to facilitate efficiency within the health system and to service intergovernmental agreements.

- It can, and is, a Canadian advocate for health-system changes at a national and international level, and at least in the minds of the Canadian public, serves as a trustee of the health system and as a check and balance to provincial unilateral action in the system.
- It has accumulated some considerable intelligence capacities and this should be used in the national and provincial social program interests.

INTERGOVERNMENTAL HEALTH POLICY CHALLENGES AND OPPORTUNITIES

In the year 2001, the challenge to the intergovernmental players influencing Canada-wide health policy is to collaborate to develop policy and system substance to the commitments made in general terms by first ministers in their September 2000 agreement. This task must be addressed within the stated context, spirit, and intent of SUFA and the September 2000 accord. Accomplishing this task will begin to shape the goals and directions for the health system for the next generation.

The communiqué of the first ministers was explicit in listing nine fields of activity that the first ministers saw as immediate priorities for policy and program development attention: (i) access to quality health care; (ii)a dvancement of the concept of wellness and recognition of the "determinants of health" as very important factors; (iii) accelerated advancement of policy and innovative models to renew primary health care; (iv) policies to obtain and stabilize the appropriate number of health provider personnel across Canada; (v)s trengthen governments' investments in home care, community care, and continuing care; (vi) policies and collective government initiatives to ensure Canadians access to new, appropriate, and cost-effective drugs, as well as "drug purchasing costs;" (vii) collective intergovernmental policy and action to strengthen a Canada-wide health infostructure to improve health care for Canadians and health system management; (viii) a commitment to invest in health equipment, new technologies, and health infrastructure where it is needed and/or where it is required to improve access to health services; and (ix) a commitment by governments to improve health reporting to their own publics for the health programs and services they deliver, with appropriate, independent, third-party verification of the facts and performance.

While this is an impressive and large policy agenda, it is by no means exhaustive of priority policy issues within the Canadian health system. In fact,

one could view the first ministers' policy agenda as mainly a short and intermediate term agenda. Longer term policy issues seem not to have found their way to the policy fore yet. So that some of these longer term health policy issues are not forgotten, they are listed here in part as an illustration of the vastness of the national health policy vacuum that has accumulated intergovernmentally after the contentious passage of the *Canada Health Act* and the breakdown in collaborative intergovernmental activity. Some of the more important longer term health policy issues that need to be addressed are:

- governmental commitments of intent as to the quality of the health system, its expected behaviour, attitude, relevance, appropriateness, responsiveness, affordability, and acceptability to the Canadian public;
- policies to advance the health system based on the value of affordable excellence and to measure the public investment in the health system on the criteria of population health outcomes (not quantity of services provided);
- governmental policies as to the nature and manner of the involvement of health providers in health system decision-making, and the expected behaviour of health providers toward patients and citizens;
- an F/P/T or P/T agreement for developing equitably across Canada new components of a health system, the benefits of which are portable throughout the country (e.g., home care, Pharmacare, community mental health services, Aids to Independent Living, Wellness Centres, long-term care, addiction services, etc.);
- an agreement to define the roles and responsibilities of levels of governments in the health system so as to enhance public accountability; (SUFA states that the governments agree to "publicly recognize and explain the respective roles and contributions of governments," but the roles and responsibilities must be clearly defined before they can be explained.)
- a protocol to prevent or at least limit the overlap and duplication of federal/provincial/territorial health activity where both orders of government have jurisdiction to service the same public directly (for example, seniors' services, health promotion, some health protection services, etc.);
- F/P/T and First Nations' policy to reflect a negotiated settlement of governmental obligation to pay for treaty right health services, and for health services to First Nations people living off-reserve;
- policy to establish the governmental responsibilities for assisting in the community and family development transition of helping disadvantaged

and new Canadians to harmonize with mainstream Canadian institutions and living conditions;

- an F/P/T agreement to assure reasonable comparability in the range of health services available across Canada and sustain Canadian portability of Canada-wide health services;
- specific mechanisms within the context of SUFA to resolve disputes between or among the federal/provincial/territorial governments over interpretation and requirements of the *Canada Health Act,* or future national health agreements;
- an F/P/T or P/T agreement as to the method of developing Canada-wide health-care standards and measurements where those standards are thought to be essential for the health and safety of Canadians;
- an F/P/T or P/T agreement on the method to reach and sustain the essential health standards;
- an F/P/T agreement to deal with ethical and service issues associated with the development of new technologies, particularly in the area of human genetics and new drug therapies;
- an F/P/T agreement for incentives to stimulate efficiency, effectiveness, and excellence in the health system in a collaborative way without provoking jurisdictional conflict; and
- an F/P/T agreement on protecting the privacy of health information in the electronic age.

Most of the policy issues listed do require, or should require, collaboration amongst all orders of governments, or at a minimum, intergovernmental coordination. It would appear that with the consent of all provinces and territories that the September 2000 agreement has opened the door to a federal government collaborative role in the development of at least the policy items listed in the first ministers' communiqué. A case could be made that there is an even stronger jurisdictional basis for the federal government to be involved in policy questions listed by the author as the longer term policy agenda. Presumably the welcome mat to the federal government will remain at the doorstep so long as its money is adequate and its intergovernmental behaviour does not strike a bad note. It is this latter point upon which some careful thinking should take place. It has to do with the purpose of this Queen's University project and the essence of the findings of the case studies. The choice of intergovernmental regime to undertake business in the health sector is critically

important and the selection of the regime needs to be a strategic decision given the subject or task to be addressed.

The F/P/T collaborative development of a Canada-wide policy on many of the issues listed by the first ministers is fraught with danger for the federal government. Without supplementing the tools, machinery, and processes to undertake intergovernmental work, it is difficult to see how the federal government can escape serious jurisdictional conflict with the provinces at some point in this policy exercise.

Picking up on the "collaborative" theme found in the Social Union Framework Agreement, and the "working together" theme found in the September 2000 document, an approach to national health policy development might be to adopt a variation on a theme from an earlier period in health history. Recall that hospital insurance and medicare were first introduced as provincial programs without participation by the federal government. When these programs were proven successful, the federal government, using its fiscal capacity and its legislative powers, passed legislation allowing provinces to opt into a national program if they so wished. Not all provinces opted in at the same time, or for the same reasons. But eventually the circumstances were right for all provinces to join at least the hospital insurance and the medicare national programs.

Perhaps now is the time when a series of collaborative F/P/T policy development initiatives could be mounted to address selected issues, the solutions to which could eventually contribute to a new national health policy framework. Any province wishing to could join these collaborative policy development networks. Several different policy issues could be addressed simultaneously throughout the country. Interdepartmental and intergovernmental linkage might be easier on an issue-by-issue basis than on a global basis.

When policy options are developed, they would be tested in the provinces of that particular policy network, and if the solutions were found viable, then they would be offered to all other provinces and territories in accordance with the conditions of SUFA or some newer intergovernmental understanding. As an incentive, new federal money could be tied to these initiatives and their implementation. Naturally the new goals, objectives, and processes would be phased into the national scene on a voluntary basis. It would take a little more time than the instant gratification that society expects, but not more time than past major health developments have required. Some policies might never be universally accepted, while others would. These policies would form the fabric

of the modernized Canadian health system. The entire process would test the spirit, intent, and value of the Framework Agreement and the September 2000 first ministers' agreement. It would also test the country's capacity to advance its social policy in a collaborative manner given the wide range of philosophies that currently prevail among the different governments of the federation.

A form of non-partisan Canadian health council would be useful to act as an advisory body to all levels of government and as a check and balance system on governmental and intergovernmental activity required to achieve the necessary new policy goals of the health system.

Such an experimental approach to intergovernmentalism to establish national health policy goals and objectives may be one way to proceed. This approach might seem somewhat timid to some and simplistic to others. But given the difficulties with the alternatives (the hostility frequently provoked by federal unilateralism, on the one hand and the practical difficulties in securing a long-lasting and enforceable set of national goals through interprovincial agreement alone, on the other), this might well be the best way of marrying a modernization and improvement of a Canada-wide health policy with a healthy federation.

NOTES

[1]Kathy O'Hara, with the collaboration of Sarah Cox, *Securing the Social Union: Next Steps* (Ottawa: Canadian Policy Research Networks, Inc., 1997).

[2]For a broad survey of the incidence of unilateralism, disentanglement, and collaboration, see Kenneth McRoberts, "Unilateralism, Bilateralism, and Multilateralism: Approaches to Canadian Federalism," in *Intergovernmental Relations*, ed. Richard Simeon, Research Studies, Royal Commission on the Economic Union and Development Prospects for Canada, Vol. 63 (Toronto: University of Toronto Press, 1985), pp. 71-129. For a more recent effort to specify the various formal structures and more informal patterns of Canadian intergovernmental relations, particularly as they apply to environmental policy, see Kathryn Harrison, "Inter-governmental Relations and Environmental Policy-Making: Concepts and Context," in *Managing the Environmental Union: Intergovernmental Relations and Environment Policy in Canada*, ed. Patrick C. Fafard and Kathryn Harrison (Kingston and Regina: School of Policy Studies, Queen's University and Saskatchewan Institute of Public Policy, University of Regina, 2000).

[3]James D. Thompson, *Organizations in Action: Social Science Bases of Administrative Theory* (New York: McGraw-Hill, 1967), p. 29.

[4]R. Hughes, R. Ginnett and G.J. Curphy, *Leadership: Enhancing the Lessons of Experience* (Boston: Irwin McGraw-Hill, 1996), pp. 283-87.

[5]Jack Koteen, *Strategic Management in Public and Non-Profit Organizations: Managing Public Concerns in an Era of Limits*, 2d ed. (Westport, CT: Praeger Publishers, 1997), p.125.

[6]Ibid., p. 239.

[7]Henry Mintzberg, *The Rise and Fall of Strategic Planning: Reconceiving Roles for Planning, Plans, Planners* (Toronto: Maxwell Macmillan, 1994), p.293.

[8]Charles Lindblom, "The Science of Muddling Through," *Public Administration Review* 19 (Spring 1959):79-88.

[9]Statistics Canada, *Census of Population Table. Nation Services Table* Cat.No.93f0027xdb96007 (Otta wa: Supply and Services Canada, 1996).

[10]Canadian Institute for Health Information, Web site: <http://www.cihi.ca/facts/nhex/hexdata.htm>, 1999.

[11]Lars Osberg, "The Equity and Symbolism of National Standards in an Era of Provincialism," revised version of paper presented to the 8th annual Health Policy Conference on Jurisdictional Roles in Health Policy: "Who's On First and What's Up Next?" Toronto, 18-19 May 1995.

[12]Health Services Utilization and Research Commission, *Assessing the Impact of the 1993 Acute Care Funding Cuts to Rural Saskatchewan Hospitals* (Saskatoon: Government Printers, 1999).

[13]Pollsters like *Environics* have made it clear that the term "quality of care" is understood by the public to mean a host of things such as accessibility to health services, waiting times, responsiveness, and compassion of the service offered. It does not mean purely the quality of clinical medical care.

[14]Anne McLellan, "Modernizing Canada's Social Union: A New Partnership among Governments and Citizens," *Policy Options* 19, 9 (1998):7.

[15]United Kingdom, Department of Health, *The New NHS – Modern • Dependable*, see <http://www.official -documents.co.uk/document/doh/newnhs/wpaper6.htm and wpaper7.htm>.

[16]Primary health workers will have an important role to play in the allocation of resources.

[17]This volume will compare how Australia, Belgium, Canada, Germany, and the United States manage their health systems.

[18]Conference of Provincial/Territorial Ministers of Health, *A Renewed Vision for Canada's Health System* (Ottawa: Supply and Services Canada, 1997).

[19]National Forum on Health, *Canada Health Action: Building on the Legacy* (Ottawa: Canada Communication Group, 1997).

[20]The Social Union Framework Agreement was signed on 4 February 1999 by Ottawa and all the provinces and territories except Quebec. A second accord dealing with federal spending for health services was agreed to by first ministers at the same time and did include Quebec. The federal government restored in its 1999 budget $2.5

billion in health-care transfer payments to provinces to aggregate to $11.5 billion new money over five years. Letter on behalf of all provincial/territorial premiers from the Honourable Roy Romanow to Prime Minister Jean Chrétien, 22 January 1999, committing all premiers to the principles of medicare and "that any additional funds made available from the Government of Canada for health care through existing CHST arrangements will be fully committed to core health services and programs in accordance with health care priorities within our respective provinces and territories." An acceptance letter was returned by the prime minister on 17 February 1999.

[21]First Ministers' Meeting Communiqué on Health, Ottawa, 11 September 2000.

[22]Malcolm Taylor, *Insuring National Health Care: The Canadian Experience* (Chapel Hill: University of North Carolina Press, 1990); or Taylor, *Health Insurance and Canadian Public Policy: The Seven Decisions that Created the Canadian Insurance System and their Outcomes*, 2d ed. (Montreal and Kingston: McGill-Queen's University Press, 1987).

[23]Taylor, *Insuring National Health Care*, pp. 54, 84.

[24]Ibid., pp. 56-58.

[25]Ibid., p. 232.

[26]In most cases, economists claim that private sector business and management practices lead to a more efficient production and delivery system for goods and services than does the public sector. Also, they claim monopolies are not usually efficient. The characteristics and behaviours of the health industry are different from those in other business sectors and do not emulate the general rules or reactions of private sector businesses. It has been found in those countries that encouraged high degrees of competition and entrepreneurship in the health sector that these behaviours have not led to an efficient sector (for example, Great Britain in the 1990s). The efficiency of the public health sector stems in part from the single payer system, with its bargaining advantage relative to providers and suppliers of health services. It is reflected as well in the avoidance of the costs of administering duplicative insurance schemes.

[27]Taylor, *Health Insurance and Canadian Public Policy*, p.332.

[28]Carolyn Tuohy, *Policy and Politics in Canada: Institutionalized Ambivalence* (Philadelphia: Temple University Press, 1992), p.111.

[29]Royal Commission on Health Services, *Report* (Ottawa: R. Duhamel, 1964-65).

[30]Federal-Provincial Conference, *Proceedings* (Ottawa: Queen's Printer, 1965).

[31]Taylor, *Health Insurance and Canadian Public Policy*, p. 375.

[32]See Tuohy, *Policy and Politics in Canada*, p. 112, n3.

[33]Tom Kent, *A Public Purpose* (Montreal and Kingston: McGill-Queen's University Press, 1988), p.368; Don Ross (Minister of Health) quoted in Taylor, *Health Insurance and Canadian Public Policy*, p.338.

[34]*Financial Post*, 29 June 1968, p.35.

[35]Taylor, *Health Insurance and Canadian Public Policy*, pp.380-81.

[36]Kent, *A Public Purpose*, p.369.

[37]The federal government was responsible for funding 50 percent of the costs of universal health care until 1977 when it replaced cost-sharing with the block funding

program: Established Programs Financing (EPF). The funding formula adopted for EPF was based on population growth and economic growth (GDP + 3 percent). Reduced or frozen transfers to provinces began in 1982. In 1986 the federal government restricted the growth of transfers by reducing the GDP escalator by 2 percent for 1986-87 and 1987-88. The escalator was reduced further in the 1989 federal budget by 1 percent for 1990-91. In 1990, EPF transfers were frozen at the 1989-90 level, this freeze was extended in the 1991 budget to the end of 1994-95. Ludwig Auer, Douglas E. Angus, J. Eden Cloutier and Janet Comis, *Cost-Effectiveness of Canadian Health Care: Research Report* (Ottawa: Queen's University–University of Ottawa, 1995), pp. 6-7. From 1994-95 to 1998-99, the federal government, through the Canadian Health and Social Transfer, cut provincial transfers by 35 percent, from $19.3 to $12.5 billion; Paul Booth, "Is it Time to Reform Fiscal Transfers?" *Policy Options* 19, 9 (1998):53.

[38]Health Canada, *National Health Expenditures in Canada, 1975-1994* (Ottawa: Supply and Services Canada, 1996), p.5.

[39]For example, see Alberta, *The Rainbow Report: Our Vision for Health* (Edmonton: Premier's Commission on Future Health Care for Albertans, 1989); British Columbia, *Closer to Home: The Report of the British Columbia Health Care Programs on Health Care and Costs* (Victoria: Crown Publications, 1991); Nova Scotia, *The Report of the Nova Scotia Royal Commission on Health Care: Towards a New Strategy* (Halifax: Royal Commission on Health Care, 1989); Ontario, *Deciding the Future of our Health Care: An Overview of Areas for Public Discussion* (Toronto: Queen's Printer, 1989); Saskatchewan, *Future Directions for Health Care in Saskatchewan* (Regina: Saskatchewan Commission on Directions in Health Care, 1990). For a complete list, see the final report of the National Forum on Health.

[40]Cost constraints put serious administrative and fiscal pressures on institutions and service delivery. This led to an increase in challenges to a single-tiered health system. New forms of charging the public for some of the health-care costs were being advocated. And, as government's insurance support tightened up and restraints were put on institutional size and costs, more costs for health care were shifted to the private and personal sector. Over the past two decades costs paid through the private sector rose from 25 to 28 percent prompting some observers to conclude that the system is slowly being privatized (*Striking a Balance*, Working Group Synthesis Report, <http://wwwnfh.hc-sc.gc.ca/publicat/finvol2/balance/three.htm7>).

[41]Conference of F/P/T Ministers of Health, Edmonton, *Press Release*, 16 September 1993.

[42]On 29 June 1994 Diane Marleau publicly announces the NFH "Plans Announced for a National Forum for Health" (Government of Canada, *News Release*, 29 June 1994). The mandate of the forum was to develop a new vision for Canada's health system, promote dialogue and identify priorities for the future. The forum was asked specifically to examine the "determinants of health" approach to health policy, the impact of technology on the health system, the impact of an aging society on the health system, the future financing of the system, the drug system, the usefulness of national goals, and research priorities for the future.

[43]Roy Romanow, "Reinforcing 'The Ties that Bind,'" *Policy Options* 19, 9 (1998):11.

[44]National Forum on Health, *Canada Health Action: Building on the Legacy* (Ottawa: Supply and Services Canada, 1997).

[45]Steven Lewis, interview, 19 January 1999. Mr. Lewis is executive director of the Saskatchewan Health Services Utilization and Research Commission and was a member of the National Forum on Health.

[46]The new federal health minister, David Dingwall, shortened the mandate of the forum by two years.

[47]Subsequently an attempt was made by the federal government to explore some of the forum's recommendations with the public and practitioners. The federal government has held national conferences on home care, a pharmacare initiative, and health information systems.

[48]Confidential interviews.

[49]Confidential Interviews.

[50]Conference of Provincial/Territorial Ministers of Health, *A Renewed Vision for Canada's Health System* (Ottawa: Supply and Services Canada, 1997).

[51]The federal government claims that it provides health services to Aboriginal people as a matter of policy, not as a matter of fiduciary responsibility, constitutional obligation, or treaty right.

[52]It should be noted that in 1998-99, positions have seemingly softened to some extent on the part of both levels of government and are reflected in the Social Union Framework Agreement.

[53]Barbara Cameron, *Rethinking the Social Union: National Identities and Social Citizenship* (Ottawa: Canadian Centre for Policy Alternatives, 1997).

[54]The agreement is unacceptable to Quebec because of its failure to ensure absolute provincial jurisdiction in the areas of health, education, and social services. Quebec claims that federal interference in social programs threatens to erode Quebec's uniqueness by imposing a national identity.

[55]*The Globe and Mail*, 5 February 1999.

[56]Preamble to the "Social Union Framework Agreement," 4 February 1999, reprinted in *The Globe and Mail*, 5 February 1999.

[57]For illustrations of this argument, see John Richards, *Retooling the Welfare State: What's Right, What's Wrong, What's to Be Done?* (Toronto: C.D. Howe Institute, 1997); Thomas Courchene, *ACCESS: A Convention on the Canadian Economic and Social Systems* (Toronto: Ministry of Intergovernmental Affairs, 1996); François Vaillancourt, "Alter the Federal-Provincial Powers Mix to Improve Social Policy," *Policy Options* 19, 9 (1998):50-52.

[58]Robin Broadway, "Delivering the Social Union: Some Thoughts on the Federal Role," *Policy Options* 19, 9 (1998):37.

[59]Fiscally, in 1998-99 with an 11.6 percent cash contribution to the insured health programs (or approximately 24 percent counting tax point transfers as well as

cash), the federal government's power in the system had diminished significantly from earlier days when it was contributing about one-half the cost of insured health services. After signing the Health Accord of February 1999 (the federal/provincial/territorial agreement to increase federal health fiscal transfers), it would appear that all the provinces had accepted at this date that the federal presence in the health system was legitimized by the infusion of $2.5 billion more in 1999-2000 and approximately $2 billion more annually in the succeeding three years, bringing its percentage cash contribution of total public expenditure on health services to approximately 18 percent (or 30 percent of total expenditures if cash and tax transfers are aggregated). A year later, it was discouragingly found by both levels of governments, that this infusion of money had done little to quell public unrest. Provincial/territorial premiers then demanded immediate restoration of the full $6 billion of annual federal cuts from 1995-98.

[60]Richards, *Retooling the Welfare State*, p. 246.

[61]Allan Maslove, *National Goals and the Federal Role in Health Care* (Ottawa: National Forum on Health, 1996), p.18.

[62]There are four types of challenged initiatives that infrequently occur:

- any proposal to apply user fees on insured hospital services,
- the acceptance by a province of extra-billing by physicians,
- the acceptance of any arrangement that would potentially lead to a major movement toward a two-tiered health system in Canada, and
- where a provincial proposal contains an element that affects, or could affect a fundamental change to the national foundations of the health system, the power in the Act has been used.

[63]This occurred in Alberta in 1994-95, where a large ophthalmological clinic was charging patients a "facility fee" in addition to the insured physician payment for cataract removal in a non-hospital facility. Since cataract removal is an insured benefit, the doctor was not entitled to charge a facility fee and at the same time charge the province for his medical service. The precedent of allowing a "facility fee" to be charged for an insured health service was seen by the federal government as the same as extra-billing and user fees under the *Canada Health Act*, which are not allowed. If this had been permitted in this case, undoubtedly other physicians in Canada as well as some health facilities would have adopted "facility fees" as a way to raise additional income or revenue. A two-tiered health system would have inevitably developed in Canada given the pressure on revenues and expenditures at that time.

[64]Stéphane Dion, "Social Union: Canadians Helping Canadians," Notes for an address to the women's Canadian Club of Toronto, Toronto, 10 December 1998.

4

THE FEDERAL/PROVINCIAL/ TERRITORIAL HEALTH CONFERENCE SYSTEM

Patricia O'Reilly

INTRODUCTION

Contemporary Canada-wide health sector policies and politics present one of the most serious public challenges to be faced in the twenty-first century. Central to this is the relationship between the government actors involved in the health sector.

The case study reviewed here examines the recent work of one important intergovernmental forum — the federal/provincial/territorial (F/P/T) conference system of ministers of health, along with their deputy ministers and other advisors — with a view to understanding the nature of institutionalized intergovernmental cooperation and policy development in the health sector. The review begins with a summary of the key Canadian health policy issues of this past decade and compares those in need of resolution with those treated by the F/P/T health conference system in the 1990s. The advisory function, policy decisions, and policy outcomes of the conference system are assessed in light of Canada-wide policy goals and needs, democratic values, and the principles and practices of federalism.

This study illustrates a general lack of capacity on the part of the existing intergovernmental mechanisms to deal with either the broader policies of the Canada-wide health sector or with some of the fundamental Canadian

principles of democracy and federalism. Despite some success in the areas of national technical and system-support agencies and programs and in a few targeted policies and population groups, the F/P/T health conference system has been unable to address successfully the broad governance issues related to political, legal, and financial intergovernmental disputes, or key programmatic issues related to health restructuring projects under way across Canada. The findings of this case study suggest the necessity for new mechanisms of intergovernmental cooperation and policy action in order to meet the needs of the contemporary Canada-wide health system.

CANADA-WIDE HEALTH POLICY ISSUES OF THE 1990s

In order to assess the effectiveness of recent intergovernmental efforts in the field of health policy, it is important to begin with a look at the key public issues of the sector. The major Canada-wide health policy issues of the 1990s included both broad governance issues and more programmatic issues. Broad governance issues have tended to centre around (i) the federal financial contribution to the health system; (ii) alternative ways to raise money for the health system and the resulting conflict with interpretation and enforcement of the *Canada Health Act*; (iii) the clarification of F/P/T roles and responsibilities; and (iv) the attempts to establish new national goals and objectives through the development of a national blueprint for future directions.

Important Canada-wide programmatic issues during the 1990s have centred on health-care restructuring. They have also occasionally targeted particular health policy issues and population groups. Key restructuring policies included: (i) cost containment and downsizing of the health delivery system; (ii) decentralization of health governance structures, such as through regionalization; (iii) accompanying governance issues such as public accountability; (iv) rationalization of health delivery institutions, especially hospitals; (v)mana gement of the politics of restructuring and the reduction of public confidence in the future of the health system (growing waiting lists, movements toward two-tiered medicare, and hospital bed and emergency service problems, etc.); (vi) reformation of primary care; (vii) resources utilization issues (particularly human resources such as physicians and nurses, but also pharmaceutical and technological resources); and (viii) the acceptance of and attempts to utilize the concept of the "determinants-to-health" approach for health promotion and prevention in order to improve population health. As well, there has been a development of more technical, or system-support, policies such as: support for applied,

evidence-based health research in Canada; the establishment of a new national health information agency and health technology assessment agency; the development of a national information highway; and ongoing efforts to establish and strengthen a national health surveillance system. Some health issues and population groups were targeted for particular attention in the 1990s: the Royal Commission on Reproductive Technologies was set up; considerable reform activity resulted from the crisis in the blood collection system; no-fault insurance for the health sector was examined; and the Royal Commission on Aboriginal Peoples highlighted Aboriginal health and social conditions.

If these were the key issues and policy problems of the Canadian health sector over the past decade, in what way did our Canadian intergovernmental forums contribute to their resolution or development? In order to address this question this chapter will examine an important example of institutionalized intergovernmental relations in the Canadian health sector: the federal/provincial/territorial conferences of ministers and deputy ministers of health.

THE F/P/T HEALTH CONFERENCE SYSTEM

There is a F/P/T Conference of Health Ministers which holds the mandate to share information and where possible to effect intergovernmental policy coordination. This ministerial group is supported by a parallel committee of deputy ministers and advisory officials. The advisory structure attached to the health sector conferences is the most elaborate in the federal machinery. Normally, both the (F/P/T) ministers of health and (F/P/T) deputy ministers of health meet twice a year, with the federal government acting as the host for one meeting and a "guest of the provinces" for the other. (There may be considerably more meetings during a policy-related crisis period.) There is also a chair and a co-chair for these conferences: the federal government and the provinces rotate in the positions on an annual basis. The minister and deputy minister of the host province become the automatic co-chairs of the F/P/T structure and also act as spokespersons for all P/T ministers and deputy ministers throughout that year. The secretariat to the conferences has some permanent structure in Ottawa coupled with provincial liaison officers working for each province involved.

The work of the F/P/T health conference system entails a three-way policy distinction between (i) an advisory function; (ii) a decision-making function; and (iii) policy action resulting from all the collective advice and decisions. The function of the system's secretariat is advisory only and the conference

meetings themselves result in decisions about how the governments involved are going to do business in a coordinated way, rather than actually undertaking joint implementation of a decision. Both the advisory function and the decision-making function of the F/P/T health conference system are ultimately driven by the mandate of the process itself.

In March 1992, a joint statement was issued by the first ministers "directing Health and Finance Ministers to initiate work ... to deal with issues related to the costs of the health care system ... to apply the broad principles of the Canadian health care system to the objectives of sustainability, affordability, flexibility, responsiveness and effectiveness of the system, [to be] funded without destabilizing provincial and federal finances."[1] The framework document which resulted, *A Blueprint to Ensure the Future of Health in Canada*, was coordinated by the Manitoba government and presented at a meeting of health and finance ministers in Hull, Quebec, 18 June 1992; it was endorsed by the F/P/T health conference deputy ministers and ministers in the summer of 1992.[2] We see here an attempt by the F/P/T health intergovernmental process to modernize itself in order to address the emerging health policy issues of the 1990s and the changing intergovernmental context for resolving these policy issues. The question, then, is: How successful has this attempt been?

The early 1990s modernization of the F/P/T health conference system resulted in both structural and policy changes. Prior to this there were several structural factors limiting the efficiency of the process. For instance, there was no direct connection between the advisory committees and the conference structures, so the work was not coordinated with the broad policy objectives of the ministers. Therefore, there was no logical way for the deputy ministers to delegate research. Every time a new issue arose a committee had to be formed so that committees "spawned like fish," which resulted in rising expenditures for all levels of government. In addition, advisory committee reports given during the meetings were "extremely detailed" and took up far too much of the limited time of the conference meetings. Reports "rarely made policy recommendations, but were merely a recitation of problems, leaving it to the deputy ministers to ... set up another structure to figure out what to do intergovernmentally."[3]

It was decided that the advisory committees would be streamlined into a few key functions, thus greatly reducing their number. They were to be headed by "the best senior health department officials in the country" and would provide summarized, policy-oriented material for the F/P/T health conference

meetings.[4] To ensure that the work of these committees "stayed on track" with the broader goals of the conference system, one or two provincial/territorial deputy ministers were assigned as liaison persons between these advisory committees and the full conference of deputy ministers. These liaison deputy ministers were asked to "guide and monitor the work of the advisory committees and make interim decisions about the on-going work of the advisory committees, on behalf of all of the deputy ministers, or convene at their own discretion conference calls of all deputy ministers."[5] Thus, the early 1990s' modifications to the advisory committee structures and process represented "an attempt to get relevant, meet the priority issues of the ministers and deputy ministers, and get decision making recommendations before the deputy ministers and then on to the ministers."[6]

The policy orientation that resulted from the 1992-93 restructuring of the F/P/T health conference committee system was reflected in the mandate of the five resulting standing advisory committees which were set up or continued from the previous committee system. (These were later simplified to three committees, see Appendix.) Prior to this restructuring, the establishment of advisory committees reflected an interest in Canada-wide medicare services, the supply of physicians, community health, mental health, environmental and occupational health, women's health, and alcohol and other drug problems. The activities of these pre-1992 advisory committees were then shifted into the five new advisory committees which focused on population health (mainly promotion and prevention), human resources (mainly physicians), service delivery (mainly cost and quality), health information collection, and public education.[7]

The policy agendas of the F/P/T health conference meetings were likewise revamped to better fit the modernized mandate of the system. Overall, from 1992 to 1998, the agenda issues that came to the fore focused, first, on matters of broad governance. These included such items as a "national forum" or "national dialogue" as a form of vision statement for direction in the health sector: by 1995, the "potential impact of the Canada Health and Social Transfer" and the "parameters of the Canada Health Act," and by 1998, "intergovernmental collaboration" and a "new social union" (see Appendix). Secondly, after broad-based governance issues, agenda items focused on *some* of the broad restructuring issues of the health sector at the time, particularly those related to expensive areas of concern to the provinces and territories (pharmaceuticals and physicians). More technical or system-support issues of

relevance to health restructuring projects, such as the collection of information, data, and "best-practice" models from health systems across Canada, were also brought to the table. Lastly, during this time, agenda items driven by the need for periodic political intervention tended to focus on media or socially targeted issues such as new reproductive technologies and blood, as well as particular groups such as women, children, and Aboriginal peoples.

Both the work of the conference advisory committees and the agendas of the conference meetings themselves after 1992 demonstrate an attempt to broaden the information-gathering and intergovernmental discussion toward more relevant or pressing policy issues in the health sector. However, when we compare the policy focuses of the F/P/T conference meetings and advisory committees to the breadth of concern being expressed by the public, media, provincial/territorial governments and other stakeholders in the health sector during the 1990s, we see some rather large omissions. Furthermore, this broadening of concern and debate in the F/P/T health conference system largely failed to result in concrete policy action, except in the technical or system-support health policy areas and in regard to politically targeted issues and population groups.

ASSESSMENT OF THE PERFORMANCE OF THE F/P/T HEALTH CONFERENCE SYSTEM

Policy Goals

In the light of contemporary Canada-wide health policy issues, the F/P/T health conference system has been relatively unsuccessful thus far in dealing with (or playing a major role in dealing with) broad governance issues related to federal financial contributions and transfer payments, alternative ways to raise money for the health system including the resulting conflict with the interpretation and enforcement of the *Canada Health Act* (CHA), attempts to establish new national goals and objectives through the development of a national blueprint for future directions, and (to a large extent) the clarification of F/P/T roles and responsibilities. In the end, the terms of the Canada Health and Social Transfers (CHST) and alternative funding sources for the provinces and territories continue to cause considerable conflict between the federal and provincial governments. Questions of the CHA interpretation were shuffled off to be treated by the Social Union Framework Agreement. Work on the dispute resolution mechanisms meant to deal with these controversies were

subsequently returned to the ministers of health, but serious disagreements remain over the appropriate way to resolve disputes about CHA interpretations. The attempt to obtain a joint F/P/T vision statement became two separate events: with the federal government relying on the report of the National Forum on Health, and the provinces relying on their report, *A Renewed Vision for Canada's Health System.* The clarification of F/P/T roles and responsibilities remained largely acrimonious and unsuccessful, except in a fairly technical programmatic sense.

Likewise, intergovernmental policy action resulting from F/P/T health conference decisions with regard to programmatic health policies have not reflected the major issues of most concern to health-restructuring projects across the country. Intergovernmental work in the area of specific health services or programs is hindered or perhaps made unnecessary by the fact that the management and delivery of these health services falls predominantly under provincial-territorial jurisdiction. Concrete policy action has resulted from decisions made at the F/P/T conference tables, mainly with respect to barriers to further efficiencies and effectiveness of resources utilization (particularly health professional and pharmaceutical and technological resources). However, the gains have been relatively small when compared to the restructuring needs of the sector as whole.[8]

During the 1990s, the F/P/T health conference system has been more successful with specific programmatic and targeted policies.[9] Targeted policy issues that were singled out for special attention in the 1990s (mostly because of a need for political intervention to offset potential liability or adverse media attention) included tobacco, organ and tissue donation, food, hazardous products, environmental contaminants, and contagious diseases.[10] Of the targeted issues, particular and concentrated attention was placed on blood-related issues involving HIV/AIDS and hepatitis C. From 1996 to 1998 the F/P/T health conference participants and supporting secretariat expended considerable energy on the development of a new blood-governance system.[11]

Population groups targeted for special attention during the 1990s included women, children, and Aboriginal people. While the conference focus on children did produce some concrete policy decisions (pushed by a cross-sectoral and general political interest in children's issues[12]), women's health issues all but disappeared. Furthermore, the focus on Aboriginal health has so far resulted in little more than process decisions.[13]

If we return to our earlier list of key Canada-wide health sector issues in the 1990s, we see other targeted areas that would be of importance to

contemporary health system modernization efforts; for example, reproductive technology, no-fault insurance, and until quite recently, tobacco use.[14] But unfortunately, these have made little or no concrete policy advancement through the F/P/T health conference system.

Democratic Principles and Practices

The effects of the intergovernmental relations of the F/P/T health conference system on democratic principles and processes are those common to executive federalism. A process that is described as an "old boy's club" by a former upper-level participant is obviously not going to fare well in any assessment of its democratic input and accessibility.[15] This is a system embedded in an intergovernmental climate of almost paranoid confidentiality at both government and bureaucratic levels. It is laced with secrecy and controlled from the top. Ministerial and deputy ministerial conferences are not open to public scrutiny; nor are their support secretariats able to be viewed by the public. As one participant said, "Most of the work at the intergovernmental level does not have a life until the Minister signs on."[16] Although the F/P/T health conference advisory committees can and do solicit research from external sources, they then act as the first point of control over this input in that they can choose to either utilize or discard it. They do occasionally make their reports public, but again, only on direction from the ministers. One advisory committee member admitted that ministers "are fairly hard to get."[17]

Aside from a few adjustments to the system, such as the placing of public members on some of the advisory committees, there has been no attempt to restructure the F/P/T health conference system along more democratic lines. In fact on more than one occasion there has been overt resistance from a small number of provinces to the inclusion of more public and non-government professional members. The fear was that if the advice of an advisory committee was not accepted by the ministers, a non-governmental member of the committee might feel enabled to take the committee's advice to the public and advocate externally for its adoption. Despite this fear, where non-governmental representatives have been used on advisory committees, a breach of committee confidentiality has never occurred.[18]

Another practical problem with advisory committee composition has also been noted. On the principal advisory committees, no F/P/T government is willing to have its interests represented by the others. Therefore, 13 governments have to be represented at the table before consideration can be given to

technical experts, public, and professional representation. There is limited additional room for external representatives on this kind of committee composition before the size of the committee becomes inefficient or dysfunctional. Nevertheless where external representation has been used, the committee chairs have reported considerable value added.

It might be argued that this F/P/T committee process differs little from our larger parliamentary democratic practices where ministers and their bureaucracies operate within the rules of Cabinet confidentiality, not direct democratic scrutiny, but rather parliamentary ministerial accountability. There is some truth to this, and perhaps it is unfair to hold these intergovernmental conferences and their secretariats up to higher democratic standards than that which already exists for them through the normal channels of ministerial responsibility and accountability. One former participant has pointed out,

> This structure was never designed to encourage or allow public participation; it was designed to meet the needs of the ministers and governments involved. The closed nature of the process may be entirely appropriate to a forum which requires a lot of balancing of values, political risks, program goals, financial options, jurisdictional capacity, and so on ... in the context of hugely variable options, lots of public pressure for one option or another, little timely research, and major stakeholders all pushing for special advantage and protection.[19]

It might also be noted, however, that there is no Opposition party or Question Period to air the implications of hidden negotiations and trade-offs in intergovernmental forums. Although some of the decisions of these forums may reach the legislative process, we will know nothing of either how or by what argument these decisions were reached, or even those options that were discarded. Regardless of the presence or lack of structural limitations to democracy, the larger problem at this point may well be that the closed nature of the intergovernmental conferences and their secretariats is at odds not only with the implicit intent of contemporary federal and provincial calls for more public transparency and accountability in health policy decisions, but also with the Social Union Framework Agreement.[20]

Despite the lack of democratic features in the F/P/T health conference system, some of its more successful policy initiatives entail or encourage a certain degree of democratic voice. New research institutes and agencies such as the Canadian Institute of Health Information (CIHI), the Health Transition Fund (HTF), and the Canadian Health Services Research Foundation (CHSRF) are soliciting public or stakeholder-oriented research in their projects.[21] When

these works are published, the public may use the information to lobby governments and local health-governing bodies and institutions for improved health services. This material, particularly studies with a health-care audit, such as the review of the major Canadian hospitals by CIHI reported in *Maclean's*, allows for greater public scrutiny enhancing the possibility of greater public accountability.[22] This public dissemination of research reports and statistics places an important responsibility on these agencies to ensure that the work is accurate and not misleading, and is reader friendly. The work of CIHI and the HTF points to an area where the public might be engaged in a debate around desired outcomes, choice of indicators, and who ought to do the public reporting. If this were backed by intergovernmental agreement on these same issues, it would provide a means of accountability for health-care action or inaction. Of course, responsibility for outcomes (governmental, health professional, institutional, public, etc.) would remain difficult to ascertain and would likely be a source of future conflict.

The targeted policies of the F/P/T health conference system provide a greater opportunity for public input. Health issues and population groups that receive political intervention, are often targeted because of their high public profile (at the time). A long-time participant of the conference meetings commented that public opinion and press reports have a considerable effect on the agendas of the meetings, adding that "if they are prolonged in intensity, they will eventually become a topic of discussion for the deputy ministers and ministers."[23] These issues and groups also illustrate the potential for the protection, through intergovernmental collaboration, of minorities or largely unprotected groups such as hepatitis C victims, Aboriginal people, and children. There are two problems associated with this, however. First, this episodic political intervention remains sporadic and discretionary, which translates into accessibility for some and inaccessibility for others. Second, this democratic strength may also represent a policy weakness: while the F/P/T health conference system was reacting to the media attention over the blood-hepatitis C issue, it did little else.

Federalism Principles and Practices

The F/P/T health conferences, depending on the issue and circumstance, illustrate both collaborative and disentangled intergovernmental relations. Furthermore, two of the key principles of federalism, respect for jurisdictional

sovereignty and respect for political sovereignty, have played an important role in the dynamics of the F/P/T health conference system.

The federal government acts within its constitutional authority when it transfers funds to the health sector through the CHST program and when it enforces the principles of the CHA. Ottawa also has jurisdictional responsibility for health protection and disease prevention, health promotion, health research, and responsibility for health-services delivery to specific groups, including First Nations and Inuit Canadians.[24] Provincial/territorial jurisdiction, in contrast, rests mainly in the management and delivery of health services.

Overall, collaborative efforts have been succeeding in the F/P/T health conference structure in areas where the federal government has jurisdiction and has chosen to involve the provinces, for example, health protection, disease prevention, health promotion, and health research (see Appendix). This includes programmatic policies involving innovative system-support projects for Canada-wide information gathering and research. Another area where F/P/T collaboration appears to have been quite successful is in targeted political interventions directed at particular health issues and groups. In both cases, either or both legal interdependence and political pragmatism have allowed for or necessitated the making of actual joint decisions.

Where broader long-term political and economic pressures and tensions such as those related to finance or the CHA are complicating decision-making, the conference system has stuck more closely to an advisory or knowledge-sharing function. Where legal jurisdiction clearly rests within provincial authority, namely in the very important area of health-service provision (where the majority of the health-care dollars are spent and where the main public and media concern is aimed today) the provinces and territories have carefully protected their jurisdictional territory from federal interference, particularly as the function of the collaborative conference forum moves from advisory, to decision-making, to policy action. The result is that, in this area, the intergovernmental regime is disentangled.

Recent tensions over jurisdiction (related, for example, to the federal government's wish to become involved in national Pharmacare and home-care programs) have resulted in a call for more clarity of F/P/T roles and responsibilities. Although health roles and responsibilities of governments have been studied throughout most of the 1990s, a new effort was made in 1997 with the F/P/T establishment of a new Working Group on Roles and Responsibilities. Its initial work focused on four main areas: health surveillance, public education

about health and health determinants, strategies for community involvement and participation, and the public health regulatory function.[25] The main conclusions of the working group (at the time of writing) have been: Aboriginal health issues would be best dealt with within the F/P/T arena in a tripartite, regional manner involving participation of Aboriginal peoples; funding issues identified in the working group reports ought to be followed up regarding future clarification of roles and responsibilities as well as system sustainability; and policy or program experts ought to engage in a more detailed clarification of specific roles and responsibilities at the policy or program level.[26]

This F/P/T health conference work on roles and responsibilities has led to (some) further clarification of the legal jurisdictional boundaries in the health sector, but, while this work would appear, on the surface, to be about legal jurisdiction per se, it is at the same time as much (or more) about political influence. Or as one former participant put it, "At the heart of the matter ... regarding roles and responsibilities is federal unilateral intervention in provincial fields of social jurisdiction ... This issue is not one of jurisdictional clarity; it is one of ... federal interference with the priorities of provincial governments."[27] This would explain why federal attempts at "promoting ideas" regarding the proposed national home-care and Pharmacare programs have been met with accusations of "direct intrusion" into provincial jurisdiction.[28] The political reality for the provinces and territories is that the federal government holds a greater influence in these policy areas than the amount of money it brings to the table through the spending power. Because the Canadian public tends to view the federal government as the guarantor of "national standards" in health care, they want both governments to cooperate in maintaining or improving the country's health-care system(s). In this sense the provinces are "trapped by public wishes."[29] So the political reality does not fit with a strictly legal interpretation of governmental constitutional jurisdiction. Thus, when the federal government pushes for involvement in new national health-care programs, such as Pharmacare and home care, both of which would impact heavily on provincial jurisdiction, Ottawa argues it has, or may well attain, the backing of the public. At the same time any such involvement on the part of the federal government, while attractive to some of the more financially strained provinces, carries connotations for intergovernmental relations as a whole which make it unattractive to the financially stronger provinces (and even at some level to the "have-not" provinces wishing to maintain their existing control over the management and delivery of health services). In general, the provinces

fear any new delivery programs which would involve federal influence and might act as "the thin edge of the wedge" of increased federal power in the sector.

Lastly, regarding conflict and dispute resolution associated with an intergovernmental impasse, there are no formal mechanisms in the F/P/T health conference system for such resolution (except as the disputed area pertains to the CHA). The decisions made at the conference meetings are not based on formal rules of consensus, and compliance is voluntary. These decisions, however, are often the result of considerable informal bargaining and negotiation among the health conference actors and their support staff prior to and during the conference meetings. This, plus the informal negotiations that take place at the meetings, might be argued to constitute a form of conflict and a dispute-resolution process. A good example of this might be the extensive work done on the blood issue which resulted in the successful development of an alternative blood delivery system. The politics of this issue also provided an example of provincial unilateral action when Ontario broke from the joint F/P/T decisions being made over hepatitis C compensation with a unilateral decision to compensate victims in Ontario more generously than other governments were intending at the time. This was viewed by the federal and other provincial governments with a considerable degree of disapproval and offense. This particular Ontario experience is not unlike the earlier experience when Nova Scotia agreed to compensate HIV victims when all the other provinces and territories had earlier agreed not to move unilaterally on this issue. Overall, issues that reach impasse in the F/P/T health conference system have no formal or mandatory mechanisms for settlement within that forum, as we saw in the case of broad governance policies associated with larger political and economic factors, several of which ended up at the social union negotiating table.

CONCLUSIONS

Policy successes for the F/P/T health conference system have been limited largely to technical and system-support programs and institutions related to health research, information databases, surveillance, and technology and pharmaceutical assessment, as well as specifically targeted health issues such as blood-hepatitis C, and a few specific policies regarding pharmaceuticals and physicians. Policy limitations of the F/P/T health conference system show up in almost all of the broad governance issues of the health sector: federal financial

contributions and transfer payments; alternative ways to raise money for the health system and the resulting conflict with interpretation and enforcement of the *Canada Health Act*; attempts to establish new national goals and objectives through the development of a national blueprint for future directions; and (to a large extent) further developments on F/P/T roles and responsibilities. Having said all this, however, it should be noted with regard to the conference system's capacity to deal with issues related to finance, the health ministers do not set fiscal frameworks; this is the role of finance ministers and first ministers. The best the health ministers could hope for would be to play the role of of partners, even junior partners, to finance ministers. The lack of such frameworks, and their ensuing predictability, leave the health ministers with considerably diminished policy planning capacity. Perhaps the 11 September 2000 First Ministers' Agreement which did give a greater degree of predictability with regard to federal transfers will allow for more development in key health program areas. So far, the programmatic issues of most concern to the health sector across the country have benefited little from F/P/T cooperation (e.g., downsizing and overall financial viability, decentralization and rationalization, governance issues such as accountability, reformation of primary care, management of discontent from both health personnel and the public, and the utilization of population health-determinants-based approaches to health promotion and prevention).

While some specific issues and groups have been successfully targeted for collaborative action, many more were either infrequently discussed (e.g., women, Aboriginal people, children, reproductive technology, no-fault insurance, tobacco) or never made the list in the first place, particularly those related to future development of the health system rather than attendance to short-term crises. In the end, the established health intergovernmental machinery has delivered little new health policy to the nation; the big issues in the media and on the public mind are not being addressed here.

Nor has the F/P/T health conference system provided much democratic access or public accountability for its deliberations or decisions aside from the process of ministerial accountability to Parliament. Except for the media and public attention given the politically targeted issues and groups, and the potential democratic side effects of information that will come from agencies like CIHI and the new research organizations, the conference system of intergovernmental health-system governance has been a closed elite system.

Existing intergovernmental relations, which consist predominantly of a balance between federal-provincial collaboration and disentanglement, have

allowed for considerable jurisdictional sovereignty on the part of both levels of government. However, as we have seen, protected jurisdictional sovereignty combined with political and financial turf wars and institutional limitations (of the conference system itself) have also led to a relatively ineffective forum in which to address the policy challenges and problems of most importance to Canadians.

What would it take to make this forum effective? There would, of course, be some institutional options to improve the productivity and relevance of the existing F/P/T health conference system. As it now stands, despite their efficiency and the high quality of the work that does get done, this is a relatively small group of people working within considerable time and budget constraints.[30] Despite the possibility of structural changes, however, the protected jurisdictional boundaries and political turf wars already embedded into the workings and options of the system would likely only result in "tinkering at the margins."[31] Alternative intergovernmental regimes (explored further in this volume) might produce different results. Further federal influence in health-restructuring projects is already being blocked by provincial jurisdiction and will likely continue to be. Increased interprovincial collaboration has a proven but limited track record of positive collaboration on the development of difficult service delivery restructuring projects in the 1980s and 1990s (such as the rationalization projects in the west)[32] as well as the advantage of greater clarity of lines of accountability associated with direct legal jurisdiction. However, increased interprovincial collaboration would not address the need to coordinate and solve broad F/P/T governance issues in the sector (as demonstrated by the need for a Social Union Framework Agreement).

One might postulate that any measure to make the existing system more effective in terms of modernizing itself to better address contemporary Canada-wide health-policy issues would have to entail an outside source of input into the F/P/T health conference system. An independent, objective body might act as an evaluator, reporter, and advisor for the existing intergovernmental machinery, as well as a potential advocate of the public interest. Any such body, however, would still need the cooperation of the same actors in the system who are now engaged in little more than collaboration at the margins. More important than formal institutions and mechanisms of collaboration, the crucial requisite may be informal friendly relations of trust and shared purpose among those with the power to reshape twenty-first century health policies.

APPENDIX

F/P/T Advisory Committee Issues (1992 to 1998)

Tracing the Advisory Committee on Population Health (ACPH) from 1992 to 1998, the early emphasis on health promotion, health surveillance and disease prevention was shaped during this time by questions of (a) what the goals and priorities of a healthy population would be, (b) what determinants would be used to assess the attainment of that status, and (c) what exists in Canada? These emphases were basically in line with the growing pressure to expand the definition and assessment of population health in broad social, economic, and cultural terms such as those utilized by the World Health Organization; to further efforts to develop population health research to "review disparities," produce a "national population health report card," develop standardized "population health indicators" and review the quality of national vital statistics collections. This work continues today with the addition of a stronger emphasis on intersectoral coordinated action for population health (as a result of the success of the intersectoral project for healthy child development). The pre-1992 emphasis of the population health advisory committee(s) had also targeted specific projects or health problems. Some of the areas aimed at in the past few years have been public education, children's health, environmental and occupational health issues, women's health, measles, folic acid, HIV/AIDS, and a Canadian contingency plan for pandemic influenza.

The focus of the Advisory Committee on Human Health Resources (ACHHR) from 1992 to 1998 continued with its emphasis on physician resource management (including remuneration, distribution, out-migration, postgraduate medical training) and other labour force adjustment issues such as those related to trade agreements. It also dealt with information issues regarding human resources, such as the transfer of the National Physician Database to the Canadian Institute of Health Information (CIHI). By 1998, the ACHHR agenda also included broader parameters such as their "Strategic Directions for realigning health human resources planning in the context of health system reform directions." The committee had also expanded its work on health professionals to include the "impacts of health reform on nursing" and "role shifts and implications relative to changes to education programs and health profession legislation." However, the ACHHR remained heavily focused on physicians, with little or no attention being given to the broader spectrum of health professionals and practitioners.

The focus of the Advisory Committee on Health Services (ACHS) from 1992 to 1998 continued its earlier emphasis on health-service utilization (hospital, physician, diagnostic, technological, and pharmaceutical) with an eye for the, by then, dominant concern in the sector for the balance between quality (or effectiveness) and cost (or "affordability"). Investigation into clinical practice guidelines, "appropriate care," and "medically necessary services" was coupled with investigation into "alternative payment mechanisms," "value-for-money," "no-fault medical insurance," and the regulation of private clinics. The work on pharmaceuticals expanded to include such issues as the National Pharmaceutical Strategy (NPS), Bill C-91, and direct to consumer advertising (DTCA) of prescription medicines. New specifically targeted areas such as national organ and tissue donation guidelines were added to the ACHS agenda along with broader areas of concern to the whole sector, for example, those pertaining to health policy research per se (regarding needs, priorities, barriers, dissemination, costs, and benefits) and those pertaining to restructuring emphases on rationalizing and consolidating health services (including health system renewal, primary care, continuing care, overlap and duplication, and accountability). This appears to have been the strongest of the three committees both in terms of the breadth of its mandate and the fact that it was allowed to cross over into ACHHR territory: with its focus on physician remuneration and the supply and integration of non-physician primary care providers. In fact one of the items on the 1994 agenda was overload of the committee itself.

F/P/T Health Conference Meeting Agendas (1993 to 1998)

The integrated system issues of the 1993 F/P/T conference meetings took the form of a discussion about a national forum and a National Dialogue on Health and other "vision" documents (plus, who should participate, and to what extent). The ongoing sectoral issues included continued discussion on non-patented drugs, and out-of-country health-care coverage (within the scope of the CHA). Targeted topical issues included a pre-natal nutrition program, as well as blood and reproductive technology issues. Targeted groups included women and Aboriginal people.

The 1994 F/P/T conference meetings focused again on the National Forum on Health, pharmaceutical and blood issues, plus violent offenders. The question of the value of external (public) representatives on the conference advisory committees was also discussed. The 1995 integrated system issues

examined the potential impact of the CHST on health care, the parameters of the CHA (particularly with regard to private clinics, but also including possible restructured institutions for home care, Pharmacare and public health insurance), as well as the National Forum on Health and the sharing of information between it and the conference advisory committees. Again, blood issues and new reproductive technologies were targeted for discussion, along with issues such as confidential data collection. Aboriginal people's health — particularly the Report on Aboriginal Health — was targeted for discussion.

In 1996 integrated system issues centred on the F/P/T Ministerial Council on Social Policy and Renewal and a possible F/P/T vision paper. Blood issues (such as blood-system governance) and pharmaceutical issues continued to be targeted for discussion, as were research issues such as the information highway or sharing information on the Internet, and the establishment of the Health Services Research Fund (Canadian Health Services Research Foundation, CHSRF). Targeted groups included Aboriginal people and children.

The 1997 integrated health-system issues again focused on an F/P/T vision statement, while health-service development issues centred on pharmaceuticals. Targeted debate continued over blood issues such as blood system transition (particularly the proposed National Blood Authority) and HIV/AIDS; as well as on research areas involving information gathering/interpretation/dissemination and pilot studies and projects. The former included issues such as the role of the Canadian Institute of Health Information (CIHI) as manager and public purveyor of national health expenditure data, and advisor to the Conference of Deputies; the Canadian Health Information System (CHIS) and its relationship to the Advisory Council on Health Information Structure; and the National Conference on Health Information. The latter included the Health Transition Fund (HTF) and the intent to avoid the duplication of work in the provinces/territories. Organ/tissue donation and distribution was also a point of discussion, as was the National Children's Agenda (NCA).

The 1998 F/P/T conferences focused on broad, integrated system discussion and debate over strategic directions for the future; intergovernmental collaboration; health-system integration and renewal through the Health Transition Fund; and broad priorities in population health, health services, and infrastructure for integrated health-services delivery (including a review of F/P/T conference advisory committees designed to focus on these areas). Health-service development issues such as cost pressures on the maintenance of access and quality of services, new and emerging risks to health, health surveillance, and continuing care/home care were also discussed along with the continued

focus on blood and pharmaceutical issues. Health information (for policy development and program monitoring and evaluation) was again under discussion, as were children's health and development and Aboriginal health.

NOTES

[1]This statement is quoted in F/P/T Health Conference Working Group, *A Blueprint to Ensure the Future of Health in Canada* (Ottawa: Queen's Printer, 1992), p. 1.

[2]Following the 18 June 1992 meeting, the "blueprint" was endorsed by the deputy ministers of health at Montebello, Quebec, 25 June 1992. It noted that the first ministers' "directives [were] indicative of the consensus that had developed among governments, providers and other stakeholders that the health care system required more effective management ... to ensure an affordable and efficient system that [could] appropriately meet the health care needs of Canadians now and in the future."

[3]Interview with former provincial deputy minister of health, 26 January 1999.

[4]These key advisory committees would also serve as the "line of reporting" for administrative and operational subcommittees which had previously reported directly to the deputies. Prior to a 1973 restructuring initiative, the advisory committees and groups of the health conference system had grown to 126. This number was considerably reduced in 1973, but by 1989 it had again grown to 50 committees, subcommittees, and working groups producing highly technical reports on the organization, operation, and projected needs of the Canadian health sector. After the early 1990s restructuring there were 10 advisory committees, 11 subcommittees, and 33 working groups. Health Canada, *Overview of the F/P/T Advisory Committee Structure*, September 1992. The advisory committee structure also had steering committees at the top and technical subcommittees below — into which, for example, the old Environmental and Occupational Health advisory committee was shifted. The work of the Health Services Delivery Committee and, to a lesser extent, the Population Health Committee had been influenced, for example, by a Manitoba-led Steering Committee on "Effectiveness and Appropriateness of Health Care Services." These steering committees were occasionally chaired by a deputy minister, particularly when a sensitive issue was on the table.

[5]Advisory committee reports are ratified by the deputy ministers. The above description was provided by a former deputy minister involved in this process. Personal Interview, 26 January 1999.

[6]And in doing so, limit the "day in the sun" performance of the committees at the conference meetings. Personal Interview, 26 January 1999.

[7]The Population Health Committee continued the work already in process on elements of population health such as health promotion, health surveillance, and disease prevention. It also expanded its work into the related area of determinants of health. The Human Resources Committee continued its work, focusing primarily on

physician resource management. (There was also a National Coordinating Committee on Postgraduate Medical Training and a National Action Plan for Physician Resources Management.) The Health Services Delivery Committee was to focus, at that time, predominantly on service issues such as hospital and diagnostic services utilization, physician remuneration, clinical practice guidelines, outcome indicators, quality assurance and case studies on quality champions, pharmaceutical utilization and cost, and the continued activities of the Coordinating Office for Health Technologies Assessment (CCOHTA) (later expanded to include pharmaceuticals). The new Health Information Committee was slated to be replaced by the Canadian Institute for Health Information (CIHI) which would provide a centre for the collection and analysis of standardized national databases. Last, the Public Education Committee was to focus and consult on strategies for communication between the public and policymakers, on patient education/empowerment, and on the appropriate and responsible use of the health-care system. The work of the Public Education Committee, however, was soon handed over to the Advisory Committee on Population Health.

[8]The conference work on physician and pharmaceutical resources dates back well before the 1990s. Recent policy developments with regard to physician issues includes agreement on plans for limiting physician residency programs and developing clinical practice guidelines. (The work on nursing resources is too new to assess.) Pharmaceutical cooperative policies include a Common Drug Commission for patent medicines (led by Ontario), and a federally and provincially harmonized drug-testing review and assessment process. The federal government had also suggested/offered to assist in the licensure of both patent and non-patent medicines, but "no one took them up on it." Interview of ACHS official, 6 August 1998.

[9]Applied and evidence-based health research is being funded and produced through organizations such as the Health Transition Fund, Canadian Foundation for Innovation, Canadian Health Services Research Foundation, and the Canadian Institute of Health Research. A national health information agency, the Canadian Institute of Health Information, is now producing interesting Canada-wide health sector information. A national health technology assessment agency, the Coordinating Office for Health Technologies Assessment, is now assessing cost/quality data for both technology and pharmaceuticals. A national information highway is now under development. The national health surveillance system has been investigated by Wilson in "The Role of Federalism in Health Surveillance"in this volume.

[10]"F/P/T Collaborative Priorities," materials sent to me in preparation for F/P/T health conference participant interviews in 1998.

[11]This work included a follow-up on the Krever Commission report on the issue; negotiations with the Canadian Red Cross Society; transitional arrangements including the setting up of a Transition Bureau; the development of a new blood agency (originally referred to as the National Blood Authority, now called Canadian Blood Services); a new Blood Services board with consumer representation and all of the scientific, legal, and political discussion and debate in which the whole issue was immersed.

[12]At a first ministers' meeting in June 1996, the prime minister and premiers identified support for low-income families as a priority and, with the exception of Quebec, subsequently agreed to back a new national initiative, the National Child Benefit, developed by F/P/T ministers responsible for social services and coordinated by the Council on Social Policy Renewal. Coordinated F/P/T health conference initiatives which began in 1992 in recognition of the "significant child health component" to the health programs, now include a Working Group on Early Child Development, a Community Action Program for Children (CAPC), and a Canada Prenatal Nutrition Program (CPNP).

[13]Following a 1993 report on Aboriginal health by a joint F/P/T Aboriginal working group, the F/P/T health ministers agreed in 1996 to a tripartite process between federal and provincial/territorial health ministries and First Nations to discuss any initiatives that might have an impact on any of the three parties. Provinces and territories have begun work with regional offices of Health Canada toward the development of processes for engagement with Aboriginal organizations located in their areas.

[14]Despite considerable work on this by the federal government, its revival was recently led not by the F/P/T health conferences but by a provincial premier. British Columbia revived interest in the issue when it passed legislation in 1998 which, among other things, allowed the government to take legal action against tobacco companies to recover health-care costs caused by tobacco smoking. *News Release*, "B.C.'s Tobacco Initiatives Prompt New National Action," British Columbia Ministry of Health, 18 September 1998. The federal government and other provincial governments have followed BC's example.

[15]Interview with former provincial deputy minister of health, 26 January 1999.

[16]Interview with advisory committee government official, 6 August 1998.

[17]Ibid.

[18]Interview with former provincial deputy minister of health, 15 March 2000.

[19]Interview with former provincial deputy minister of health, 20 April 1999. This is a small group of people who do this work in addition to their "regular jobs." They face considerable limitations on knowledge collection and assimilation and the requisite knowledge is highly complex. They also face a variety of stakeholder positions and lack of consensus, including that from the public. They do not have the resources to decide who is right and who is wrong in contradictory citizen group demands or in the sort of turf wars constantly being fought throughout the sector by vested interests. One (provincial) intergovernmental official commented with regard to professional interests, "There has been so much input, we have paralysed ourselves." Interview of provincial intergovernmental official, 16 December 1998. Nor are the public members necessarily equipped to deal with the politics of executive federalism, as exemplified by a comment made about the public members participating on the F/P/T health conference advisory committees, that they (the public members) have "a hard time with the politics ... the agenda from the top." Interview with advisory committee government official, 5 August 1998.

[20]In 1997, Federal Health Minister Allan Rock was publicly applauding the "more transparent and open approach" to issues of contention that had arisen within the F/P/T health conference system, including decisions regarding the CHA. Health Canada, "Health Ministers Pledge Collaboration and Openness," *Press Release*, 12Se ptember 1997. Likewise, the 1997 (federal) National Forum of Health report entailed extensive "dialogue ... to hear the views and values of the people in all parts of the country," and is replete with references to "community control and leadership" and "enhanced mechanisms of public accountability." "Canadian Health Action: Final Report of the National Forum on Health," 1 May 1997. <http://www.nfh,hwc.ca>. The 1997 Vision statement of the P/T ministers of health, says that in the "renewed comprehensive working partnership" of their vision "stakeholders, service providers, care givers, researchers, suppliers, local governments, communities and individuals will have opportunities to be involved in an effective, ongoing partnership." Provincial/Territorial Ministers of Health, "A Renewed Vision for Canada's Health System" 29 January 1997, p. 4. In the Social Union Agreement of 1999 federal, provincial, and territorial governments promised "to ensure appropriate opportunities for Canadians to have meaningful input into social policies and programs ... By enhancing each government's transparency and accountability to its constituents ... Canada's Social Union ... [can] ensure effective mechanisms for Canadians to participate in developing social priorities and reviewing outcomes." "A Framework to Improve the Social Union for Canadians," <http://socialunion.gc.ca> December 1998.

[21]This can be seen in their project descriptions and invitational lists. It was also reported with regard to CIHI by a member of an Ontario District Health Council. Interview, 15April 1999.

[22]*Maclean's*, "Health Report," 7 June 1999.

[23]Interview with former provincial deputy minister of health, 20 April 1999.

[24]Health protection and disease prevention measures which "(along) with the provinces and territories seek to monitor, prevent, control and research disease outbreaks across Canada and around the world; regulate health and safety risks related to the sale and use of drugs, food, chemicals, pesticides, medical devices and certain consumer products; and negotiate agreements regarding hazardous materials in the workplace and conduct environmental health assessments"; health promotion involving "research to increase Canadians' understanding of the factors that affect a person's health; making good information easily available to the public and informing them about issues of concern; promoting the healthy lifestyle choices (such as good nutrition, exercise and non-smoking) that contribute to long-term health; and helping to create the conditions which support healthy choices such as healthy child development, healthy workplaces, and healthy communities"; and research-related projects funded by bodies such as the Medical Research Council and the Health Transition Fund. The federal government is also responsible for health services delivery to specific groups including First Nations and Inuit Canadians, military personnel, inmates of federal penitentiaries, the Royal Canadian Mounted Police, refugee claimants, and

5

COST CONTAINMENT IN HEALTH CARE: THE FEDERALISM CONTEXT

Katherine Fierlbeck

INTRODUCTION

Intergovernmental cooperation within Canada can be a tenuous achievement even during times of prosperity. But during periods of cost containment, the incentive for federal and provincial governments to reach agreement on policy matters becomes even more fraught with obstacles. Periods of fiscal retrenchment are viewed as zero-sum (or even negative-sum) situations, with each government doing its best to protect its programs and sources of funding. As public choice theorists observe, this is a "rational" behavioural pattern for each individual state actor despite what the collective outcome may be. In some cases, indeed, a set of rational decisions taken by individual actors may be collectively irrational and self-defeating.[1]

But cost containment within the health-care sector can no longer be addressed in an ad hoc manner, and this is true for all contemporary health-care systems. In 1993, for example, the average per capita health expenditures (expressed in purchasing power parity) were more than 17 times what they were in 1960.[2] Cost containment in health care is a necessary and importunate variable that must be addressed rigorously and systematically. And while various "strategies of cost containment" have been discussed and undertaken under the rubric of economic policy in most Organisation for Economic Co-operation and Development (OECD) states,[3] much less attention has been paid to the

nature of intergovernmental relations as a component of cost containment. The question, in short, is whether (and to what extent) changing the nature of intergovernmental relations can lead to a more effective method of cost containment in health care.

The following section first briefly discusses the concept of "cost containment": what, precisely, is meant by the concept; and what period of time is most clearly characterized by cost-containment strategies. It then offers a descriptive account of how the federal government and the governments of three provinces (Ontario, Alberta, and Nova Scotia) attempted to address the need for cost containment in health care. Ontario was chosen because of its powerful influence as a provincial leader: because of its large population base, economic strength, and geographical location, Ontario figures largely in most overarching federal-provincial negotiations on social policy. It has, moreover, historically been one of the provinces most friendly to the federal government. Alberta, in contrast, has often taken paths quite distinct from other provinces in this area, both for ideological reasons and because it has the fiscal ability to take a more autonomous stance. Finally, Nova Scotia is used as a representative of the smaller, less wealthy provinces which generally depend heavily upon the federal government for social funding and which therefore frequently support a stronger federal role in social policy.

The final section of this chapter examines more closely the relationship between intergovernmental relations and cost containment in health care. There are two separate questions to be addressed here: first, what consequences did the existing relationship between intergovernmental relations and cost containment have for the provision of health care itself? And second, could these relationships conceivably be restructured in order to achieve better results, either in terms of efficiency, accountability, or equity?

It is perhaps worthwhile noting that, given the specific research question of this particular study, much of the analytical emphasis of this chapter is counterfactual, and is devoted to the consideration of what might have resulted had the circumstances been otherwise. This type of analysis is, of course, not without its drawbacks; one of which is the lack of causal certainty. But it does rely upon both the seasoned judgement of key political players, as well as an appreciation of historical precedent. While the conclusions cannot offer definitive answers, they can at the very least widen the spectrum of options open for consideration for policy actors and, in doing so, eliminate policy formation based upon false necessity.

COST-CONTAINMENT STRATEGIES IN HEALTH CARE

"Cost containment" is generally equated with "greater efficiencies" in the provision of health-care resources; yet it must be noted that the two terms are not completely fungible. As Saltman and Figueras observe, "while improved efficiency can lower costs for a given level of health services output, cost-containment does not necessarily involve greater efficiency. It is possible for cost-containment to lower costs and, at the same time, give rise to greater inefficiency."[4] This is a relevant issue for all Canadian jurisdictions which, to varying degrees, have passed costs on to health-care consumers in an attempt to achieve cost containment; and which, one may argue, have thereby decreased overall economic efficiency. This will be discussed more fully in the final section of this chapter.

Cost control in Canada has, since 1971, largely focused on four variables: insurance overhead (administration costs), payments to hospitals, payments to physicians, and prescription drug costs. As Evans *et al.* point out, it is almost entirely within these first three fields that cost containment relative to the United States has been achieved.[5] And what is notable about all of these health services (except drugs), of course, is that control over their conditions of delivery are set out in the *Canada Health Act*, a "centralized" legislative instrument in the Canadian health system. The measurement of cost containment is a very tricky business because of the variables involved: thus Neuschler can argue that "Canada has done no better than the United States in taming health cost escalation"[6] and that apparent cost discrepancies can be explained by differences in overall economic growth rates of the two countries rather than by the ways they finance and deliver health care; while Barer, Welch and Antioch can refute this claim simply by looking at the period of time under study and by reconsidering the choice of expenditure categories.[7] As useful as they are, however, what comparative studies cannot tell us is the extent to which cost containment in Canada is facilitated or constrained by intergovernmental relations.

The past decade of health policy-making in all Canadian jurisdictions has largely been an attempt to contain health expenditures. Due to numerous factors (including technological advances, pharmaceutical costs, the increase in the number of older Canadians as a proportion of the population, and higher expectations by those utilizing health services) health-care costs have risen dramatically for several decades. As the capacity of the Canadian economy to sustain this spending decreased, however, cost containment has become a

principal objective of policymakers. Yet as a public policy goal, cost containment in health care has been constrained by two principal factors: first, as Evans, Barer and Hertzman note, "successful cost containment must not simply contain costs," but must also incorporate a number of objectives including affordability, acceptability, comprehensiveness, and effectiveness.[8] Moreover, universal support for cost containment is limited not only by those who utilize such services but also by those whose incomes depend upon expenditure on health services: to the extent that cost containment is income containment for health-care providers, political resistance will inevitably manifest itself against such policy changes.[9]

Political resistance also very emphatically determines the cost-containment strategy attempted. Cost containment can be achieved in a number of ways, including a simple reduction of services, the restructuring of services to provide the same level of health care with less expenditure, and the off-loading of costs to other jurisdictions, to consumers, or to direct providers (i.e., in the form of income restraint). Because of advances in diagnostic tools (reducing the hospital time needed to observe symptoms and prepare a diagnosis), pharmaceuticals (newer drugs can accomplish more quickly and at home what surgical or other treatments once addressed), and surgical techniques (more non-invasive surgeries eliminate recovery time), the number of beds in modern hospitals can effectively be reduced. But precisely what form cost containment has taken in the past ten years is itself a topic of much political dispute. For every health administrator's explanation of the surfeit of hospital beds, there is a story of how an emergency case could not find a hospital with an available bed due to closures, or of how long waiting lists had fatal results. While there is little doubt that the motivation for the principal federal cost-containment measure (the Canada Health and Social Transfer, CHST) was "clearly federal expenditure and deficit reduction,"[10] there is less agreement on what consequences this measure had for various interests. It can probably be said that, for all orders of government, cost containment in the 1990s was some combination of all three strategies. The interesting question for our purposes, of course, is how the working relationship between governments led to cost-containment strategies (such as reduction or off-loading) which may have been less beneficial than reconstructive strategies requiring mutual negotiation.

A few comments should be made regarding the data used here. In the first place, it is difficult to make intergovernmental comparisons in health expenditure because of the variety of ways in which data are collected and measured.[11] In the second place, data are usually presented as an aggregate (as

they are here), while a clearer picture of the consequences of cost-containment strategies require that such information be disaggregated within the given sectors to see whether significant cost-shifting within each sector has occurred. Third, not all sources of data are equally reliable, and this is of especial concern when data from private sources are used.[12] Finally, much of the data from the Canadian Institute for Health Information (CIHI) used in this study is only available in nominal dollars. Where it is available in constant dollars, that also is presented. Comparisons over time must be read in light of this qualifier.

FEDERAL AND PROVINCIAL COST-CONTAINMENT PROGRAMS

Period of Cost Containment

The pattern of health expenditure in Canada can be measured in a number of ways. Total health expenditure (in current dollars) grew at an average annual rate of 11.1 percent between 1975 and 1991; then fell considerably to an annual average of 2.6 percent between 1991 and 1996.[13] Total health expenditure per capita showed an increase of 9.8 percent per year between 1975 and 1991, and again slowed to 1.4 percent from 1991 to 1996.[14] The calculation of health expenditure as a percentage of gross domestic product (GDP) shows us that health spending peaked in 1992 at 10 percent, and decreased gradually until 1997.[15] This measurement, however, must take into account that the GDP is itself not a fixed referent, but one that varies annually depending upon Canadian business cycles, economic conditions in major export markets, interest rates, and so on. Thus, a significant increase in actual health-care dollars may be associated with a decrease in the ratio of health expenditure as a percentage of GDP if the GDP happens to have expanded considerably; and, in the same way, poor GDP growth can make a limited increase in actual health expenditures appear quite large in any given year. Moreover, the calculation of health expenditure as a percentage of GDP does not take into account the variable of population, so that an increase in expenditure may actually mean less spending per person depending upon total population figures. In any case, for Canada as a whole since 1975, health spending has increased every year to 1999 as has the per capita health spending measured in current dollars. However, in constant dollars, while spending increased each year as well, per capita spending actually peaked in 1992, showed retrenchment from 1993 until 1996, and in 1997 recovered slightly.[16] This pattern is consistent with the cost-containment patterns of most other western countries.[17]

TABLE 1
Total Health Expenditure, Canada, 1984 to 1999

Year	*Total Health Expenditures in Current Dollars*		*Total Health Expenditures in Constant 1992 Dollars**		
	Total ($000,000)	*Per capita ($)*	*Total ($000,000)*	*Per capita ($)*	*Expenditure as a % of GDP-Change*
1984	36,870.0	1,439.8	51,653.7	2,017.1	8.2
1985	39,985.8	1,547.3	53,896.9	2,085.6	8.2
1986	43,499.8	1,666.6	56,477.4	2,163.8	8.5
1987	46,980.6	1,776.2	58,275.1	2,203.2	8.4
1988	51,154.9	1,908.9	60,746.0	2,266.8	8.4
1989	56,366.4	2,065.7	64,029.2	2,346.6	8.6
1990	61,305.7	2,213.1	66,068.8	2,385.1	9.0
1991	66,529.7	2,373.5	68,544.4	2,445.3	9.7
1992	70,061.6	2,469.0	70,061.6	2,469.0	10.0
1993	71,972.6	2,507.5	70,755.5	2,465.08	9.9
1994	73,578.9	2,534.1	71,261.4	2,454.25	9.6
1995	74,616.5	2,542.0	71,577.0	2,438.42	9.3
1996	75,601.9	2,547.9	71,953.6	2,424.98	9.2
1997	77,955.5	2,598.2	73,270.8	2,442.04	9.0
1998f	81,822.3	2,700.4	—	—	9.1
1999f	86,013.1	2,815.1	—	—	9.2
	(annual percentage change)				
1984	7.8	6.8	3.5	2.5	—
1985	8.5	7.5	4.3	3.4	—
1986	8.8	7.7	4.8	3.8	—
1987	8.0	6.6	3.2	1.8	—
1988	8.9	7.5	4.2	2.9	—
1989	10.2	8.2	5.4	3.5	—
1990	8.8	7.1	3.2	1.6	—
1991	8.5	7.2	3.7	2.5	—
1992	5.3	4.0	2.2	1.0	—
1993	2.7	1.6	1.0	–0.2	—
1994	2.2	1.1	0.7	–0.4	—
1995	1.4	0.3	0.4	–0.6	—
1996	1.3	0.2	0.5	–0.6	—
1997	3.1	2.0	1.8	0.7	—
1998f	5.0	3.9	—	—	—
1999f	5.1	4.2	—	—	—

Notes: f = forecast.
*Price indexes required to calculate constant 1992 dollars are available to 1997 only.

Source: Canadian Institute for Health Information, *National Health Expenditure Trends, 1975-1999* (Ottawa: CIHI, 1999), Table A.1.

For Canada, then, the period of cost containment in the health-care sector began approximately in the early 1990s and continued to the late 1990s, when the rates of health spending again began to increase. The year 1993 marked a decrease in health spending across Canada, and spending began to increase noticeably from 1997 to 1999 (the years for which data are available).[18] The slash in federal spending made little impact on provincial health budgets. One may conclude then that other provincial programs were severely cut in order to maintain health-spending. Furthermore, the provinces were three years into health spending reduction before Ottawa clawed back transfer payments.

In February 1999, in conjunction with the Social Union Framework Agreement between Ottawa and the provinces, Ottawa increased transfer spending specifically for health purposes. In its 1999-2000 federal budget, Ottawa agreed to increase health-transfer payments to the provinces by $11.5 billion over five years. The federal authorities set aside $3.5 billion in fiscal 1998-99 to allow the provinces to draw down early. The federal government then put an additional $2 billion into its 1999-2000 budget for health transfers against the remaining commitment of $8 billion. The federal government also earmarked 1.4 billion additional dollars for its own direct investment in health care to be spent over three years on health information systems, research initiatives, and First Nations health services.

More recently, the federal government agreed in September 2000 to give the provinces $23.4 billion over the next five years on the condition that the provinces issue independent "report cards" measuring health-care improvements in each province. The agreement was the culmination of several months' negotiation, and while all parties seemed to be satisfied with the result, critics noted that Ottawa still lacked the ability to force provincial governments to spend the new funds on health care.

The pattern of health expenditure does, however, vary somewhat between provinces. This is due to a number of jurisdiction-specific variables, including provincial revenue levels (Alberta, with its large petroleum income, deviates from the national cost-containment pattern more clearly than other provinces), spending priorities, existing infrastructure, the influence of interest groups (such as physicians' lobbies), provincial ideology, and election cycles. These factors will be examined more closely below. In sum, however, we can conclude that, within Canada as a whole, the period of major cost containment existed from 1990 to 1998; with the greatest emphasis upon the period 1993 to 1996.

What is notable about health expenditure in the 1990s, then, is the clear disjunction between federal transfer payments and overall expenditure patterns. Provinces were obliged to deal with fiscal constraint and federal transfer-payment reductions in the face of political pressure opposing health-care cuts; and, with some regional variation, the two strategies undertaken by provincial governments seemed to be to ease the pressure on public spending by off-loading some health costs onto the private sector, and by shoring up provincial health-care expenditures through the reallocation of provincial funds from other program areas to health care.

Federal Cost-Containment Initiatives

The spending patterns can be explained in slightly more detail by contextualizing the above tables. Total federal spending for 1990-91 had hit $151.3 billion, resulting in a national deficit of $30.5 billion (or $10,000 for every man, woman, and child in Canada). The federal government faced the unenviable challenge of attempting to control the deficit in the throes of a recession. The recession brought greater unemployment, with a concomitant 21 percent increase in jobless payments in the 1991-92 fiscal year. During the recession, the debt grew, thus increasing debt-servicing payments. Moreover, Ottawa had sent large amounts of cash to western farmers because of the depressed grain markets, and the Persian Gulf War led to a substantial increase in defence spending. While the federal government attempted to offset these higher costs through increasing Unemployment Insurance premiums and cigarette taxes, and by wage caps on civil servants, it was to be the provinces that would bear the heaviest burden in Ottawa's quest for cost containment. Yet, while transfer payments grew smaller and smaller during the early 1990s, the funding formulae did not change qualitatively until the announcement, in February 1995, of the Canada Social Transfer (soon thereafter renamed the Canada Health and Social Transfer).

The CHST, introduced in the 1995 budget bill, brought together federal social assistance funding established under the Canada Assistance Plan (CAP, 1966) and health and postsecondary funding made under the *Federal-Provincial Fiscal Arrangements and Federal Post-Secondary Education and Health Contributions Act* (EPF, 1977). The CHST, which came into effect in fiscal year 1996-97, was designed as a "super" block fund that could give provinces increased flexibility to allocate funds according to their own priorities in health, public assistance, and postsecondary education. It is administered by the federal

Department of Finance, although it is monitored by the federal Department of Health for compliance with the conditions and criteria of the *Canada Health Act* (CHA, 1984).

The principal purpose of the CHST was to reduce the federal deficit: specifically, transfer funds for health care, postsecondary education, and social assistance were to be reduced by over $6 billion (33 percent) from 1996-97 to 1997-98.[19] Critics charged that this form of cost containment was both unfair and inefficient: unfair because the reductions penalized provinces for the accumulation of the federal debt load; and inefficient because these cuts in quantity rather than quality did nothing to alter spending patterns or cost management.[20] Further, by reducing the already shrinking level of federal funding, there was marked concern that Ottawa would have little ability to enforce national health principles. The 1996 federal budget assuaged fears on two fronts: first, Ottawa made it clear that federal CHST payments (tax points plus cash) would be stabilized and would not be less than $25 billion until 2002-2003 (established under the *Budget Implementation Act 1996*); and second, Ottawa retained some degree of political clout vis-à-vis the provinces by setting the amount of the total cash component at $11 billion. The CHST was, nonetheless, an interim measure, and the provinces were hobbled not only by the recognition that Ottawa was willing to engage in unilateralism, but also by the uncertainty of what would succeed the existing measures.

It must be stressed that the fundamental objective of the federal government was not cost containment in health but rather the elimination of the federal deficit and the reduction of debt load, and intergovernmental relations were to be a casualty of that objective. Provincial officials involved in the pre-CHST intergovernmental negotiations have noted that federal cuts were expected by the 1995 budget. Two major complaints, however, were first, that the severity of the cut was not anticipated and, second, that it came just as most provinces had already completed a rather harsh set of adjustments due to provincial economic constraints. The key sets of negotiations that never took place were those between the provinces and territories with the federal minister of finance on the one hand and the federal ministers of health and human resources development on the other. Michael Mendelson has written regarding the replacement of CAP and EPF by the CHST, "the process set up by the 1995 Budget seems to split the negotiations — with the money going to one table and any discussion of objectives, principles, conditions or standards going to another. Having had a major public review of social policy effectively cancelled by the 1995 Budget, the Minister of Human Resources Development is now asked to play

poker when someone else is holding all the cards."[21] Thus, an important step toward a more effective system of cost containment is horizontal policy collaboration as well as vertical. Each government must have a fairly coherent conception of how health-care funding fits into its larger fiscal framework before it can negotiate efficiently or meaningfully with other governments.

In sum, the federal government was able to achieve cost containment within its sphere of health care merely by off-loading the costs onto the provinces. This strategy, however, had at least two separate costs: the first was the effects of the cuts on a wide range of programs and services run by the provinces. That the severe budget cuts were imposed immediately after several years of sustained cost-containment programs by the provinces themselves was particularly oppressive, as most provinces perceived with no little justification that "all the fat" had already been sliced, and further cuts would slice to the bone itself. But a second, and more onerous price, of the federal cost-containment strategy was the less obvious chilling of relations between federal and provincial governments. And the particular problem with such a breakdown of trust was the opportunity costs that arose in terms of the loss of planning for the medium- and long-term future of public health care itself. The federal strategy, while placing its balance sheets in a more salubrious position, did nothing to make the health-care system itself more efficient; and the very real problems that confront the Canadian single-payer system remain and, indeed, loom closer than before. While Ottawa can congratulate itself for placing the economy as a whole on surer footing, almost four years' worth of planning time had been lost to deal with quite severe issues about the future of health-care funding in Canada.

Ontario's Cost-Containment Initiatives

The move toward cost containment in health care has, in general terms, been quite similar across Canada, with a shift in the role of provincial governments from simply insuring and funding health services to planning and managing them. Several variables were common to each province: all received funding through Ottawa's EPF program, which increasingly tightened fiscal transfers; all were subject to the restrictions of the *Canada Health Act*; and all faced drastically tightened budgets after the recession of 1990. Indeed, throughout the 1980s, the net debt of the federal, provincial, and local governments combined climbed to 71 percent of GDP ($460 billion), compared to only 37 percent a decade earlier.[22] Some analysts charged that the provinces had not reduced

their deficits sufficiently during the growth years of the 1980s, leaving them especially vulnerable to the 1990 recession.[23]

Overall, what becomes most apparent in Ontario's efforts at health-care reform since 1990 is the shift from a hope that the health-care system would reorganize itself in response to cuts in funding increases, to an active reorganization and management by the province in an attempt to achieve this re-ordering. The small irony, of course, is that the former measure characterized the New Democratic (NDP) administration of 1991-95; while the "hands-on" approach has been adopted by the Progressive Conservative (PC) government. Both administrations have endeavoured to achieve efficiencies through various programs such as controlling drug costs, health insurance coverage, and outcomes assessment, but (likely due to the widespread public opposition to hospital closures under the NDP) a new tack was taken when Premier Mike Harris introduced the *Savings and Restructuring Act* and the *Health Services Restructuring Act* in 1996. This allowed the province actively to coordinate and monitor changes; and this strategy has been underlined by Ontario's clear refusal to engage in a formal policy of regionalization of health-service administration. Part of this strategy of active management has (following Alberta's lead) involved the use of such mechanisms as business plans and performance indicators, all of which emphasized financial accountability and transparency. This strategy has been highly successful in its articulated objective of containing health-care costs; but the criticisms most frequently levied against it have been that it has defined itself too closely with "cost containment" rather than with "health care," and that it does not provide sufficient opportunities for public input.

The province of Ontario is especially significant for the amount it spends in the health-care sector. "Ontario," noted the preamble to the province's 1997 business plan, "spends more per person on medical care than nearly any other jurisdiction in the world and nearly 20 per cent more per capita than the average of other provinces."[24] Indeed, Ontario's health expenditures have consistently been amongst the highest, both in terms of a percentage of total government expenditure and on a per capita basis compared to other provinces.[25]

Partly because of its stronger economic base, Ontario could afford to remain at the status quo in health spending somewhat longer than either Nova Scotia, which had faced earlier and harsher economic constraints, and Alberta, which relied heavily upon the vagaries of a resource-based economy which had suffered a series of substantial setbacks. Some "restructuring" did occur in Ontario throughout the 1980s in response to the decline in the percentage of

revenues expended on hospitals; but this policy resulted in few significant structural changes: indeed, there is evidence that these reductions resulted in both a spatial inequality and a failure to close smaller facilities in favour of larger regional facilities.[26]

Ontario reformed and restructured its health-care sector considerably throughout the 1990s. By the end of 1991 the government had realized the extent of its economic troubles and began by slashing $219 million in administrative spending and delisting minor procedures such as electrolysis from its insured services; but there was already some recognition that this would only be the beginning. Ontario's health budget grew considerably throughout the 1980s, and by 1992 it was consuming 36.3 percent of the provincial budget. A further fiscal problem was disclosed at the end of 1992, when the province lost a further $2.1 billion because Ottawa's predictions of Ontario's share of personal income-tax revenue for the previous two years had been too optimistic.

It is notable that Ontario's cost-containment program began under the auspices of the NDP, a government elected in October 1990 to a large extent by those who expected public sector spending, at the very least, to remain stable. No government, given the wider economic problems and the specific structural weaknesses of the health-care sector, could have accomplished that; but the fact that such cost containment occurred under a social-democratic government was an outrage to many of those who had most strongly supported the party. In the spring of 1993 the government announced to employers and unions in the public sector that they would be expected to achieve $2 billion in payroll deductions. This "social contract" legislation, passed in the summer of 1993, resulted in a breakdown of ties between the NDP government and the Ontario Federation of Labour. Attempts at controlling costs through wage restraints were ultimately unsuccessful, and employees were obliged to take unpaid days off work.

In retrospect, Ontario's cost-containment strategy was, in the end, more systematic and proactive than that of Nova Scotia, and more ordered and cautious than that of Alberta; but early attempts at keeping costs down were noticeably piecemeal. Eventually, however (and largely under the PC government, elected in June 1995), Ontario was able to present a systematic cost-containment program that, until 1998 at least, managed to keep health expenditures firmly curtailed.[27] Rather than narrating a chronological account of Ontario's cost-containment strategy, the following will briefly note its individual components and will focus upon the methods that the government chose

to use (business plans, new information technology) and those it did not (regionalization).

Funding Cuts

The first major cutbacks in Ontario were to the hospital sector. Between 1989 and 1990, the rate of funding increases to hospitals fell by over six percentage points.[28] By 1991 Ontario hospitals were running a deficit of $200 million, obliging them to impose an unprecedented level of layoffs and bed closings. Because the hospitals were expected by law to balance their budgets while at the same time receiving a smaller proportion of provincial funding and meeting the salary increases recently won by nurses, the result was the elimination of 5,000 full-time positions and the closure of 3,500 beds over 1989-90 and 1990-91. Soon after the Conservative government was elected, a much more significant cut was imposed. Unfortunately for Ontario's health sector, the accession of the fiscally conservative administration occurred soon after the announcement of CHST cuts (Harris had run on a campaign pledge to reduce government spending by 20 percent, or $9 billion annually). Part of the funding dilemma for the new government was that federal transfers were being absorbed by the province while the provincial government was being hamstrung by its election promise to cut personal income tax rates

Controlling Drug Costs

Ontario, like other provinces, was facing enormous increases in the drug costs paid by the Ontario Health Insurance Plan (OHIP). Throughout the 1980s, drug-cost increases averaged over 15 percent per year; and by 1990-91 OHIP was spending $916 million annually, compared to $44 million in 1975.[29] In 1991 the minister of health, Francis Larkin, tightened the price increases allowed under OHIP for certain drugs; and this measure was strengthened a year later by implementing a mandatory review and possible removal of any drug from the plan if its price went up by over 2 percent. In 1993 the province introduced the Health Network, a computer system linking all Ontario pharmacies. This program identified and rejected duplicate Ontario Drug Benefit prescriptions (over 15,000 in 1993 alone). Under the Harris government, the Department of Health became increasingly involved in drug prescriptions "by working with the professions and through reviewing how drugs are used."[30] An expenditure

control plan announced in the 1993 budget included stringent measures to control drug costs, including the imposition of a price limit on new generic drug products. This set of strategies seemed to show some success: by 1993 drug costs had slowed to single-digit increases, and remained under 8 percent for the rest of the decade. A co-payment system was introduced for 2.1 million elderly and welfare recipients in November 1995, a move that saved a further $225 million annually.

Integrating and Restructuring Health Services

Systematic hospital restructuring began with a 1991 report by the Essex County District Health Council that focused on the duplication and fragmentation of services in the region. This led to a study on "total health-system reconfiguration," which resulted in hospital mergers in Windsor. Following this pattern, approximately 30 communities prepared plans to end the duplication of services by the end of 1994. And, in September 1994, Metropolitan Toronto began what was described as "the largest hospital restructuring project anywhere in the world," a project that was to take several painful years to effect any significant structural changes. Yet hospital restructuring was, until 1997, simply a process of responding to continual funding cuts; and each hospital addressed such cuts through closing beds, laying off staff, reorganizing information systems, and cutting inventories.

In 1996, the Harris government began to address the problem of hospital restructuring more vigorously, and introduced Bill 26 (the *Savings and Restructuring Act*) which gave the government sweeping powers to merge and close hospitals, and created the *Health Services Restructuring Act* (in order to better coordinate the rationalization and integration of hospital services). Beginning in 1996, too, the Harris government's ministry budgets were presented in terms of "business plans" and "performance measures." These business strategies were to assist in cost containment by obliging the drafters to think in terms of long-term strategy, to stipulate the objectives for which it was to be held accountable, and to integrate all aspects of the health system to these ends. The vision of the new Health Ministry was one of "an active manager" rather than a "passive payer and service provider." Indeed, the department has maintained a relatively active role, especially compared to other provinces in which much planning and power is delegated to regional or community councils (see "regionalization" below). In the 1996-97 fiscal year the province set up

the Health Services Restructuring Commission to facilitate hospital restructuring in a move to eliminate duplication and to improve efficiency in the provision of services; but not until March 1997 did the commission disclose which Metro hospitals would be slated for closure.

Outcomes Assessment

Another early method undertaken by the Ontario government was the attempt to evaluate the medical procedures used by medical practitioners. In a 1991 speech to the Ontario Hospital Association, the health minister acknowledged that "we simply haven't done much assessment of the health outcomes for the dollars we are spending ... at least 25 to 30 per cent of everything we currently do in the health-care system has no proven value." She estimated that $5 billion of the province's $17 billion budget was wasted and "could be better directed."[31] In 1994, a study released by the Institute for Clinical Evaluative Science compiled detailed information on medical practices across Ontario, and found wide variations in services provided across the province. And, in 1997, the Ontario Health Quality Council was established to "promote quality of health care by improving the use of the most relevant scientifically based health research and to monitor and evaluate health reform in Ontario."[32]

New Information Technology

One of the strategies announced by the Harris government was the introduction of a computer-based, provincewide information system that would give health providers information on patients' drug histories and laboratory test results. Dubbed the "Smart System," this network was designed to reduce the duplication of services as well as improve treatment decisions.[33] Despite some concerns regarding the privacy of this information, by 1998 the Ministry of Health had decided to expand the pilot project.[34] The 1997 business plan presented by the ministry also noted how advances in surgical, drug, and medical technology could improve the "speed, convenience, and quality of patient care," though the cost reductions of having microsurgery (such as laparoscopy) instead of more invasive surgery were doubtless also considered.[35] These technological advances, however, seem to be pursued more systematically at the level of individual hospitals rather than through the ministry itself.

Health Insurance Coverage

In addition to the steps taken to limit the cost of drugs under the provincial drug plan (above), Ontario by 1991 had changed its out-of-country health insurance coverage from a complete-coverage policy to $400 per day for emergency treatment, which was still relatively generous compared to many other provinces. Non-emergency treatment was not covered after October 1993. After July 1996, small co-payments were required for seniors and those on social assistance. In its 1998 business plan, Ontario noted its intention to pursue fraudulent use of the health-care system, including the increased investigation and prosecution of the health system.[36]

Health Prevention and Community Care

These terms have been used by all health jurisdictions since the concept of strengthening non-acute care programs was articulated by the World Health Organization (WHO) *Health for All* program in 1977; yet these concepts are vexingly difficult either to establish or to evaluate. In December 1994, the NDP government passed Bill 173, which established a new system of long-term home care. Under this plan, over 1,200 diverse agencies were amalgamated into a few hundred centralized organizations (called multi-service agencies, or MSAs) throughout the province. Only a year and a half later, however, the new PC administration halted the development of the MSA system on the grounds that the system was, paradoxically, "too bureaucratic," and that the organizations had been granted far too many "sweeping powers." In its place the government set up 43 "community care access centres" which would act as referral points for services that were contracted by autonomous, non-governmental agencies. By 1997 the province had shifted 50 percent of the funding responsibility for long-term care to the municipalities, although the Ministry of Health maintained its role in setting standards and developing policy.

Medical Personnel

Physician costs rose steeply throughout the 1980s. As Peter Coyte points out, the number of physicians practising in Ontario between 1981 and 1987 increased by 23.1 percent, while the fee-benefit schedule increased by 66.6 percent. Moreover, the utilization of physicians' services outgrew the rate of

population growth.[37] These cost increases were brought under control by 1988, but not before an acrimonious strike by Ontario physicians over extra-billing legislation in June 1986. A billing cap of $400,000 negotiated by the ministry and the Ontario Medical Association in 1991 further reduced the cost increases to just under 1 percent, though this was met with much bitterness by many specialists. As approximately one-third of the health budget rests in physician fees, the government has been anxious to control these costs.

In addition to billing constraints, Ontario has moved in concert with other provinces which have medical schools, to control the number and type of doctors being trained by limiting basic enrolments and then the number of funded residency positions. By 1992, approximately 12 percent of the medical training positions were phased out.

In addition, changes in licensing requirements have limited the number of out-of-country doctors. More recently, Ontario has begun to encourage paramedical staff (such as nurse-practitioners and midwives) who can perform some of the functions of physicians although at a lower overall cost. In 1993, as part of the Social Contract between the province and those working within the public sector, a number of utilization management measures (such as mandatory days off) were implemented to contain costs. And, reimbursement for new physician practices in the city of Toronto were restricted in order to encourage physicians to work outside the city.

Finally, there has been some success in persuading physicians (generally at teaching hospitals) to accept set salaries in place of a fee-for-service billing arrangement.

Regionalization

One set of reforms notable for its absence is the move to the regional governance of the province's health-care programs. While Ontario was early in developing its District Health Councils (DHC) in 1973, the delegation of responsibility to these councils was quite limited, and the DHCs were seen as having primarily an advisory function. But it was precisely this premature development which, according to one commentator, prevented the DHCs from evolving into stronger entities;[38] and the councils are now under greater control and direction from the Department of Health than they were previously. An attempt to expand the role of DHCs in 1989 turned out to be a damp squib and a similar recommendation of the 1994 Orser Report was equally neglected.

Discussion

What were the effects of federal policy upon Ontario's health-care containment strategy? It must, in the first place, be kept in mind that by 1995 Ontarians were in the mood for more cost containment, and this most likely would have been true regardless of federal moves. The combined debt and deficit were putting a damper on investment as well as jeopardizing Ontario's credit rating; and it is arguable that federal strictures merely provided an additional impetus for what the Tories intended to achieve in any case. Well before the PC government began its series of reforms, the NDP administration was attempting cost containment through "shock therapy": as Michael Decter, Ontario's deputy minister of health conceded in 1991, the only solution to the vast inefficiencies growing within the health sector was to withhold money in the hope that the system would reorganize itself from the ground up by hospitals cutting and rationalizing their services and by physicians finding "more entrepreneurial" ways of running their clinics.[39] And well before the CHST cuts, Ontario's health minister was placing responsibility onto Ottawa for "imperilling medicare." Said Frances Larkin in 1992, regarding then-current federal cuts, "That bucket of cold water has been good for everyone. It wakes them up. They roll up their sleeves and get down to it. No one's talking about going back to the old days. Shock therapy has had an effect. But we must still have adequate and stable financing from the federal government."[40]

Finally, one of the most dramatic of the Tories' cost-containment moves in health care — the closure of several Toronto hospitals — was a strategy that had also been recommended by an earlier restructuring committee appointed by the Rae government (although the NDP government had been unsurprisingly reluctant to implement the recommendations). It is perhaps notable that the Tories actually acted on this recommendation; but it is also significant that it took them two years to do so. It is perhaps even arguable that the Tory government was able to impose its cost-containment strategies so effectively because its predecessor had set the precedent.

Interestingly, the effect of Ottawa's cost-containment strategy may be felt most resoundingly in areas outside health care. In the first place, because Ontario had already experienced deep cuts in the health sector, other departments were obliged to bear many of the costs of the cuts. In the second place, the years of federal cuts to Ontario, one of the few "have provinces," have made Ontarians much more aware of their role in financially supporting other Canadian provinces while Ottawa is seen to reap the credit. This, too, is constant

across both NDP and PC administrations. In 1992, Bob Rae commented that the previous three years of federal cuts in health care, postsecondary education, and social assistance are "simply unacceptable given the needs of the province. Ontario will not put up with, any longer, a fiscal federalism or a fiscal arrangement between the various parts of the confederation which leave us with so little in terms of a fair sharing of what in fact comes out of Ontario anyway ... 43% of the federal revenues come out of Ontario and we've been getting back 30%."[41] Similarly, the PC government had by 1996 made it clear that it was jettisoning its traditional position as the province that was the most supportive of Ottawa, and was re-establishing itself as a proponent of interprovincial collaboration.[42]

Nova Scotia's Cost-Containment Initiatives

The main cost-cutting initiatives in Nova Scotia focused upon the locus of control over spending. The 1994 *Blueprint for Health System Reform* (under the Liberal government) created four regional health authorities, stating that this strategy would lead to cost efficiencies and greater potential for public input; in 2000, a new strategy (undertaken by the PC government) dismantled the regional health authorities and replaced them with nine district health authorities, arguing that such reforms would lead to "administrative efficiencies" and "more decision-making powers in communities."[43] (Because Nova Scotia is a relatively small province, however, it is likely that some administrative changes were made in response to physicians' perceptions that they had less influence under a system of regional health authorities than under a system of district health authorities.) Despite the rhetorical emphasis upon regionalization, however, the real focus of health-system reform has been upon containing health costs. The issue is merely whether regional or district health authorities would be in a better position to do so. (Currently, the district health authorities are to "consider the advice" given to them by community health boards, and to submit business plans which must be approved by the Department of Health. No authorities are allowed to run deficits.) There is little direct evidence from the experience of Nova Scotia to show that "greater regionalization" is either more or less effective at cost containment (or at representing popular opinion).

While the province of Nova Scotia began limiting its spending increases in the field of health care by 1990, its attempt to coordinate changes in the provision of health care were set out in the 1994 *Blueprint for Health System Reform*. Organized partly to address the WHO drive to expand primary health

care, the health-care reforms were executed concurrently with attempts by the provincial Finance Department to rigorously cut all government spending. The unfortunate result was that the health reforms became very much a cost-containment strategy, driven more by Finance officials than those within the Department of Health. Rather than attempting to address economic issues first, waiting for a period of equilibrium to return, and then embarking on qualitative health reforms, both were undertaken simultaneously. Thus, public cynicism about "health reform" was quite marked, as it was seen as little but window-dressing for the more political objective of fiscal restraint.

Nova Scotia's cost-containment strategy was quite simple, and focused primarily upon budget cuts, hospital mergers, and downsizing. While the 1994 reform program addressed the creation of four regional health authorities, health promotion strategies, and community care, little creative policy-making could be achieved within the tightly constrained budget. In the spring of 1994 the government announced that services would be scaled down in 29 institutions throughout the province (either in the form of bed loss or conversion to community health centres), while three other hospitals were closed outright. It must be recognized, however, that Nova Scotia's health system had been cost ineffective, largely for historical and cultural reasons. Nova Scotia, for example, had one of the highest ratios of hospital beds per person in Canada by 1993. This is to a large extent because a major function of hospitals was seen to be that of keeping people employed. In areas of considerably high unemployment, such as Cape Breton, the health-care sector was a major source of local employment. The first move therefore was a dramatic cut to the number of hospital beds: between 1994 and 1998, 1,672 beds had been closed, which was 34 percent of the 1994 level. Public displeasure at this move was compounded by the failure of community-care programs adequately to absorb the cuts. The integrated Home Care Nova Scotia program, for instance, was not established until 1995, a year after bed closures began, leading critics to complain that bed closures prior to revamped home-care programs was poor policy-making. (One health policy analyst has, however, noted that home-care programs have a seemingly infinite demand; and that if home-care programs were established in the first place the difficulty in cutting beds would only increase.)

Because of its small size and limited economy, the province of Nova Scotia is, in contra-distinction to Ontario and Alberta, very limited in its ability to develop new health programs. It cannot provide the infrastructure to set up major alternative methods of providing health care, nor can it establish information resource units permitting it to analyze and design such systems. When

the federal government executed its major cuts under the CHST, Nova Scotia had the second-highest debt load per capita of all Canadian provinces ($8,491 per person, compared to Ontario's $7,295, and Alberta's $1,281); and it still spends approximately $1 billion per year in debt payments. One of the first cost-containment measures undertaken by the province was the attempt to control drug costs. The rate of increase in spending on drugs decreased from 15.4 percent to 6.9 percent between 1987 and 1988,[44] largely in response to a generic drug substitution restriction, which dictates that physicians use the cheaper generic drugs in most instances (brand names can be prescribed but all such requests to do so must be justified). Then, in 1990, spending increases dropped to 6.7 percent (from 10.7 percent the previous year), and in 1993 fell to 0.4 percent.[45] In 1994, the province began optimistically to increase its spending in health care but, by 1996, when the CHST cuts were being absorbed, the province recorded its first decrease in real spending in health care.

Despite the grim statistics for the year 1996, however, this spending pattern is not a simple reflection of the CHST cuts. In the first place, the significant spending cuts noted for capital were part of a predetermined cyclical pattern that was relatively independent of annual federal transfers. Although the annual percentage change in capital spending was -75.5 percent (compared to 10.5 percent in 1993, 31.9 percent in 1989, and 139 percent in 1987), the sharp decrease in spending was merely due to the fact that the construction of two large hospitals (one in Cape Breton, the other in Halifax) had been completed. Second, due to a series of cuts already visited upon the health sector, provincial officials decided that the decrease in federal health transfers simply could not be borne by the health-care sector, and were thus distributed to other line departments (such as transportation). As federal transfers prior to 1999 were placed in provinces' general revenues and not earmarked for health services per se, the effects of the cutbacks cannot be identified merely by looking at health budgets but would have to be considered by examining provincial budgets in some detail. An impressionistic account given by directors and executive directors in several departments was that the cutbacks were spread relatively evenly between all departments, rather than localized in a few.

Like other provinces, Nova Scotia pursued cost containment throughout the 1990s independently of federal health policy. The 1994 *Blueprint for Health System Reform*, for example, included health promotion, system integration, and program evaluation. At the same time, Nova Scotia had established a system of regional (and community) health boards with an eye to better cost containment. By improving responsiveness and flexibility, by increasing

coordination and cooperation, and by establishing clear geographical responsibility for a full range of services, regionalization was undertaken in the expectation of greater economic efficiency. That regionalization is a benign method of cost containment, however, is disputed by some commentators, who note that community involvement can be used by the provinces in order to offload difficult and unpopular political decisions. Nova Scotia health activist Fiona Chin-Yee has remarked, "if regionalization is being used to 'de-politicize' the health-care system — the community can only be used in the most cynical of ways — deflecting attention for unpopular actions from politicians to a board of locally appointed people, this is doomed to failure."[46]

By the spring of 1998, however, the province had reversed its stringent cost-containment policies and had added $100 million to the health budget; a reversal that was likely related to an impending provincial election. Liberal Premier John Savage, a physician who had had to deal with the fallout from the CHST, resigned in July 1997, and was succeeded by Russell MacLellan. In March 1998 a CBC/Angus Reid poll determined health care to be the top election issue for 68 percent of respondents.[47] MacLellan, elected on 15 March 1998, had run on an essentially single-plank platform of health-care renewal, pledging an additional $80 million for health services. Almost a year and a half later, his government was defeated by the Conservatives despite promising a massive injection of money into the province's health-care system.

Other cost-containment measures have included changing the roles of a number of hospitals (for example, rural hospitals becoming multi-care centres), hospital mergers (especially of the Halifax hospitals), and the implementation of a "labour adjustment strategy" for health-service employees. Attempts were made to close expensive hospital beds by establishing Home Care Nova Scotia, which serviced over 15,000 individuals by the end of its first year of operation. More politically contentious was the move to oblige senior citizens to cost-share their drug insurance plan with the province; a strategy that received much negative media coverage. Despite the federal cuts, then, many minor health-reform strategies (many, but not all, of which focused upon cost containment) were executed throughout the 1990s. Yet what is notable is that most of these reforms focused upon short- and medium-term objectives. According to many provincial health officials, what was lacking in the scramble to rethink cost-containment strategies throughout the 1990s was the articulation of long-term fiscal planning. This lack of foresight is troublesome in at least two ways.

First, there is little attempt to focus upon specific long-term challenges to health care, such as shifting demographics, rising drug costs, the supply of medical personnel and, above all, the ability to provide good quality services on a universal basis. For those provinces such as Nova Scotia with such a limited ability to provide planning information, establish large-scale trial programs, or address wider health determinants, a national integrated effort is needed to "get ahead of the problem." The current practice of addressing specific problems when they arise is both short-sighted and, in the long term, highly inefficient. The lack of coordinated long-term planning is equally problematic in its failure to consider the more abstract (but no less pressing) issues of sustaining the twin pillars of medically necessary care (physician and hospital services) that make Canadian health care so unique. Possibly because of Nova Scotia's inability to establish significant sustainable health policy independent of the national framework, provincial officials seem particularly concerned with the overall problem of containing cost pressures within the framework of the *Canada Health Act*: What type of rationing ought Canadians to consider? Is a two-tier system a viable possibility, or even a necessity? How can drug costs, which to a large extent are out of the hands of provincial health officials, be better controlled?

These are cost-containment issues that concern most maritime provinces, and cannot be addressed by a "disentangled" macro-health policy, especially when these provinces have no discretionary budget surpluses. The willingness to engage in a coordinated health policy with other governments is thus relatively high in Nova Scotia. This should not, however, be confused with provincial willingness to support federal unilateralism. While Nova Scotia could benefit substantially from a coordinated policy, it must be able to retain a considerable degree of control over its health policy for the very reason of its financial limitations: in other words, it cannot afford to be obliged by more solvent governments (either federal or provincial) to sustain a level of health provision which it cannot afford. Coordination may have obvious benefits for cost containment; but ceding provincial authority to enthusiastic health reformers is seen as problematic to the extent that the province may find itself responsible for unexpected costs incurred by economically stronger provinces providing "leadership" into expensive territory. For Nova Scotia, cost containment can only realistically be accomplished through a form of intergovernmental collaboration, but the specific form of collaboration is very important.

Alberta's Cost-Containment Initiatives

Overall, Alberta's cost-containment initiatives have been the most dramatic, both in terms of the speed and the depth with which they were implemented, and in terms of their controversial nature. By 1993, the Alberta government had accumulated a level of debt to which it had become unaccustomed, and was able, because of a significant degree of public support (and a clear political will) to impose a severe series of cutbacks widely across the public sector. Thus by 1994, when the federal government began to implement its own funding cuts, Alberta had already managed to cut its deficit in half. And, by 1996, when the consequences of three years of federal cuts were beginning to be felt in the rest of the country, the province was able (partly due to its economic housekeeping, and partly due to improving oil revenues) to begin a five-year process of reinvestment in health care. The second area, privatization of health-care services, was relatively inconsequential in terms of short-term cost containment, but is potentially momentous in influencing the rhetoric of health-care funding over a much longer period.

As in most areas of provincial policy, Alberta's health-care sector has been notably influenced by its strong (but unpredictable) economy and its consistently conservative outlook. In 1979, for example, when oil revenues were accumulating at $8.6 million per day, health expenditure had increased by 21.3 percent. By 1987, when the province not only had stopped making contributions to the Heritage Fund but was also spending the interest income on the fund, health expenditure increases had fallen to 1.1 percent.[48]

In 1991 Alberta's budget was quite respectable: it spent only $7.6 million more than it was taking in. A year later, the province's deficit stood at $3.4 billion; higher, on a per capita basis, than Ontario's deficit. At the end of 1992, Ralph Klein was elected on a campaign promise to bring in a balanced budget within four years by reducing spending by 20 percent. Unlike Saskatchewan, Alberta planned to do so without tax increases, including sales taxes. The cuts in health spending in Alberta were perhaps the most dramatic in the country, especially given the short time frame for their implementation. How was the province able to achieve them?

By May 1993, the accumulated debt was over $20 billion and growing. The new administration took the position that desperate times required drastic measures; and, by Albertan standards, the debt level was quite dire. But the Klein government was nonetheless cautious enough to ascertain that it had the public support for its cost-containment strategies. Notwithstanding the fact

that the government had been convincingly elected only months previously on a mandate of cost control, it took careful measure of the collective position of the electorate both through extensive polling in May and through a series of public consultations, including the Red Deer Roundtable in March, the Financial Review Commission (also in March), and the Tax Reform Commission (February 1994). The resounding concern expressed for the province's economy emboldened the administration to implement its cuts, and in 1993-94 the deficit was cut in half (from 18.6 percent to 9 percent of total expenditure). The cost-containment strategy was secured in provincial legislation with the *Deficit Elimination Act (1993)* followed by the *Balanced Budget and Debt Elimination Act (1995)*.

Ministries geared up for the four-year austerity program by adopting "business plans" requiring not only clearly stated objectives and strategies (later adopted by the Harris government in Ontario) but also performance measures to judge the progress of the department. In 1993-94, the $4 billion Health Department budget was cut by 3.1 percent. These cuts took five principal forms:

Public Sector Wage and Benefit Rollbacks. As part of a larger labour strategy, wages and benefits in the health-care sector were reduced by 5 percent on 1J anuary 1994, and then frozen for the following two years. Rather than directing where, precisely, these cuts would be felt, the provincial government simply dictated across-the-board rollbacks to municipalities, universities, school boards, and hospitals (the so-called "MUSH" sector) and expected these bodies themselves to distribute the cuts as they judged most appropriate. Given the general downturn in the provincial economy, and the relatively small proportion of the population in the public sector (approximately 100,000 workers were expected to be affected), there was little sympathy outside the public sector unions for these cuts.

Hospital Funding Cuts. Like the public sector rollback, cuts in hospital funding were seen as a political struggle between urban and rural areas, as hospital cuts in the large urban areas of Edmonton and Calgary amounted to 4 percent while rural areas — the traditional stronghold of the Progressive Conservative party — were limited to 1.5 percent. Officials defended the discrepancy by arguing that cuts were higher in the urban centres "because that's where the largest dollars are." Others challenged this position, observing that, like Saskatchewan, Alberta was flush with a plethora of small rural hospitals built with oil-boom money. The 110 rural hospitals were faring better than their urban counterparts, on this account, largely because the governing party was

represented in almost all of the province's 35 rural ridings. Malcolm Brown, Professor of Health Economics at the University of Calgary, noted that "because the party's base is overwhelmingly rural, it seems clear that the changes in health care are designed to weigh heavily on the urban centres. The truth is we should have been cutting rural hospitals first, to take the savings where we could get them easily."[49]

By its second budget announcement, the Klein government was able to point to a dramatic reversal in provincial finances. The deficit had been cut by over a billion dollars, and serious hospital restructuring had been undertaken. But further belt-tightening was underway; and in March 1995 Edmonton's newly created Capital Health Authority (CHA) approved a further $51 million in cuts, which was expected to result in the loss of 2,300 jobs in the health sector in that city alone. Yet by the end of the year the backlash to fiscal restraint had become apparent, and it was led by the physicians, who argued that the quality of health care was reaching an alarmingly low level. The doctors may well have been motivated by the province's attempt to cut their salaries by almost $100 million over two years, but the Capital Health Authority itself was pointing to low staff morale, long waiting lists (especially for replacement and cardiac surgery as well as MRI testing), and a lack of home-care funding. The CHA pleaded with the minister to delay the further $37.5 million in cuts slated for the Edmonton region. At the same time, the United Nurses of Alberta went on a work-to-rule campaign, while hospital workers in Calgary went out on a vociferous and illegal wildcat strike.

Unlike the public sector disruption in 1993-94, however, the Klein administration seemed to take particular heed of these campaigns. Interestingly, polls taken during the period found the public unsurprisingly dismayed about the health-care cuts, but at the same time they also showed a steady approval rating for the premier himself: two-thirds of Albertans disapproved of what had happened to health care, yet Klein's approval rating sat at 73 percent.[50] In 1993 the public approval rating for the province's health-care system had reached 91 percent, but by 1995 it had fallen to 57 percent.[51] Two days into the Calgary strike, the health minister agreed to restore $50 million in cuts, and soon afterwards Klein cancelled his plans to cut a further $123.5 million in 1996.

Health Insurance Coverage. Cost containment was also addressed by distributing costs onto health-care consumers. While Klein had committed himself to a moratorium on tax increases, health insurance premiums were raised by 11

percent in 1993-94 alone. Senior citizens' advocacy groups were dismayed by the government's decision to oblige all seniors (except low-income) to pay medicare premiums. This was followed by a reduction in cash benefits for seniors' eyeglasses and dental care. This, in addition to a number of other cuts in support programs, led advocates to charge that seniors, with a 12-percent decline in income, were shouldering the highest burden of Klein's cuts. A 1993 report also called for "deductible" fees for all non-essential medical services, a user fee that would operate on the same principle as automobile insurance.

Regionalization. By the end of 1993, plans had already been made to establish regional health boards, a strategy undertaken for manifestly economic reasons. Dianne Mirosh, minister responsible for the Health Planning Secretariat, stated that the biggest cost-savings in health-care reform would come from replacing the province's 204 hospital boards with 17 regional bodies.[52] This move was accomplished by June 1994, and by October the boards were put to work in determining how three-quarters of a billion dollars would be cut. Again, the regionalization of Alberta's health boards was seen as a highly political move, as the actual implementation of the funding cuts (as well as their announcement) would now be made by appointed managers rather than by politicians, thereby shielding the latter from political resentment and discontent.[53]

Privatization. Unlike Ontario, Alberta was much more willing to pursue market-oriented strategies of cost containment. At a federal-provincial meeting in September 1994, Alberta was the only province dissenting from the agreement regulating the development of mixed-fund clinics. Three months later, the federal health minister, Dianne Marleau, informed Alberta that several clinics operating in the province did not meet standards set out in the *Canada Health Act*, and gave the province a deadline of 15 October 1995 to address the issue. At stake was approximately $7 million a year in transfer payment penalties; but the Alberta government was quite aware of the public support it had for mixed facilities. In April 1995, for example, delegates to Alberta's PC Party convention voted to allow private interests to use closed hospitals as a means of attracting lucrative out-of-country clients, an idea that was roundly condemned by all provinces regardless of ideological stripe.[54] By July 1996, Alberta had agreed to abide by federal restrictions on mixed-fund facilities, and Ottawa ended deducting penalties from its transfer payments.

At the beginning of 1996, Klein declared the deficit to be officially dead. The health budget received an injection of $11.4 million in order to clear up a backlog of patients waiting for replacement joint and cardiac surgery. This

was due more to better-than-expected resource revenues than to the cost-containment program itself: instead of the $506 million deficit projected a year previously, the Treasury was enjoying a surplus of $570 million. In addition to the resource revenues themselves, of course, were the increase in corporate income tax revenue and the savings on debt-servicing charges. Thus, at a time when most provinces were beginning to feel the true impact of the federal transfer cuts, Alberta was able to begin reinvesting funds into its health services. Doctors almost immediately were offered a deal which left their funding virtually untouched for three years (which bitter workers of the Canadian Union of Public Employees, who had suffered significant cuts, labelled a "sweetheart deal" between the Alberta Medical Association and the province).

What stands out in Alberta's cost-containment strategy is the immediacy and depth of the cutbacks. This can partly be explained by the reification of the deficit as an overwhelming threat to the province's well-being. As a member of the Edmonton Capital Health Authority's medical staff council observed, the government was able to use the deficit as a political symbol, "powerful enough to justify cuts without first finding out how patients would be affected."[55] The public support for deficit management is quite strong, and, except for the unions, there was little political opposition to the principle of total debt reduction. Even the official Opposition agreed with the need to cut health-care costs, and limited their criticism to the particular nature of the cuts. The province's cost-containment program can also be understood by keeping in mind the distrust between the province and its health-care workers. Believing that any cuts would be fought by the medical community at every step, the government neither attempted to communicate the changes with these groups, nor offered any incentives to secure their cooperation. "I will admit," acknowledged the premier, that "it was a mistake not to involve in a more significant way the medical community at the outset. It was thought at the time that they have such a vested interest we would never get through the restructuring because they had a lot of turf to protect."[56]

But the costs of the strategy were enormous. The city of Edmonton, originally facing a 19.9 percent reduction in funding, ultimately lost only 13.2 percent, but nonetheless bore the highest proportion of the cutbacks, leading the first CHA president to resign, citing the pace of change. While change was necessary, stated Brian Lemon, "it was too fast. The changes were too rapid. It was very hard on people."[57] Indeed, one of the most consistent criticisms of Alberta's cost-containment strategy was not only the amount of cuts per se,

but the lack of planning and coordination with which they were implemented. There were no consultations, no clear short-term plans, and insufficient expansion of community-care programs. "There was no planning," noted one advocate. "It was an imposed change, not a planned change."[58] By 1997 Edmonton had 1.5 beds for every 1,000 people, down from 4.3 beds per 1,000 residents (Saskatchewan, in contrast, reduced its beds from 4.63 to 3.34 per thousand). In 1988 there was one registered nurse for every 108 Albertans, by 1995 this had changed to a 1-251 ratio. In Edmonton, 3,000 of 15,000 health-care full-time jobs had been lost by 1997. And, while the region was given $12 million by the end of November 1996 to buy new equipment, the CHA noted that it required $426.2 million a year merely to replace worn out equipment.[59] Further, there was little concerted effort made in gathering data in order to monitor the effects of the cuts. The premier has acknowledged the lack of planning, but argued that it was up to the regional health authorities themselves to make such plans. That was, to a large extent, the very point of regionalizing health services.

Of all provinces, Alberta is manifestly the most independent. The federal CHST cuts had less impact on Alberta first, because the province had already undertaken significant cuts in its health sector, and second, because the province's unpredictable revenue base had presented the province with a windfall just as the federal cuts were beginning to take hold in other provinces. Where Alberta was more directly influenced was in Ottawa's ability to face the province down over its health "facility fee" policy. (This issue is fully explored in this volume by Joan Price Boase in "Federalism and the Health Facility Fees Challenge.") Given that the annual penalty for the province amounted to approximately $7 million of total federal transfers of around $2 billion, the financial implications for the province were not significant; the principle of private health care was. When asked why the province backed down, one official complained that the province was forced to comply with federal regulations while being unfairly treated by Ottawa on the facility fee issue. In the first place, the individual noted, Ottawa had agreed with Alberta for the decade preceding the CHA dispute over facility fees that the province's policies regarding private sector involvement were acceptable. This led a number of private clinics to invest heavily in certain areas, which meant that a longer time was required for the province to deal with measures brought in under the *Canada Health Act*. Not only was this time period denied, but according to this source, Ottawa gave other provinces a longer transition period before imposing penalties.[60]

Discussion

What can be gathered from this is that all three provinces appear to have lacked an overarching coherent strategy for cost containment and, to the extent that they had one at all, it was piecemeal and subject to change. Interestingly, the smallest (and, one would assume, the most manageable) province had the most difficulties in addressing the issue of cost containment. Part of this was due, as previously noted, to Nova Scotia's lack of economic flexibility. Not only does it have a relatively small economic base, but it also has one of the highest levels of per capita debt payment in the country. This severely constrains the amount of funds it can spend on health and by 1999, it was spending less on health care per capita than any other province.[61] But one must also note that Nova Scotia also had a higher turnover of elected governments, including a period of minority government, which hindered the development of rigorous and coherent policy-making (the levels of political support for Klein and Harris, as well, have generally been higher than that of any Nova Scotia premier for the past decade). Moreover, Nova Scotia (especially in contrast to Ontario and Alberta) has a political culture that exhibits a much greater tolerance for achieving social redistribution through employment in the public sector. Alberta has had a very forceful and thorough strategy of cost containment in the health-care sector; but it was the speed and severity of these cuts that led to significant turnarounds and reversals of policy. Despite being administered by a social democratic government, followed by a strongly fiscally conservative one, Ontario has perhaps had the most fluid and consistent of all cost-containment experiences. While the Conservative administration has also engaged in a fairly rigorous and exhaustive overhaul of its health spending, it learned several lessons from the experiences of Alberta and implemented its strategy somewhat more cautiously. While the level of economic dependence upon Ottawa is thus an important variable in explaining the relative success of the provinces' cost-containment strategies in health care, it must be tempered with other factors such as political culture, the level of public support and, most ambiguous of all, political prudence and judgement.[62]

COST CONTAINMENT AND INTERGOVERNMENTAL RELATIONS

The relationship between cost containment and federal states, broadly stated, seems to be a positive one: that is, federal states have, all things being equal, a

somewhat greater capacity to control expenditure than centralized states.[63] Despite the observation that federal states have more points of access to decisionmakers for interest groups than do centralized states, federal states generally have some system of checks and balances that curbs the ability of governments to spend in a number of significant areas. This correlation is, of course, an uneasy one, as a number of different variables can influence the causal relationship (some, for example, have noted that centralized governments are more easily "captured" by left-wing parties, which therefore accounts for higher rates of expenditure). One might observe that, in the case of health care, it is generally accepted that a higher degree of centralization has accounted for Canada's greater ability to control costs vis-à-vis the United States; but it is important not to confuse this centralization of expenditure *in the public sector* with the centralization of governmental control per se. As long as health-care expenditure remains largely within the public sector, there is no convincing evidence to date that a centralized government structure has a greater ability to control costs than does a federal one. What, then, *can* be said about the relationship between Canada's federal structure and the attempt to control expenditure in the health-care sector?

This final section has two objectives: first, it will examine the implications of the current structure of intergovernmental relations for the policy goals of health-care provision: How did the move to cost containment by both federal and provincial governments affect the health-care system itself? Second, it will discuss potential alternatives: Could intergovernmental relations conceivably be restructured to achieve better results within the field of health care for Canadians?

What Were the Effects of Cost-Containment Strategies on Health Care?

In the first place, Ottawa's cost-containment strategy affected the provinces' own policy goals by creating a very specific policy-making environment. To the extent that federal unilateralism informed the move to cost containment in health care at the provincial level at all, one might observe that it was useful in an abstract (but not unimportant) way by influencing the range of credible alternatives perceived by actors within the provincial sphere. Especially in Alberta, where the politics of debt-management are most pronounced, but also in all provinces to varying degrees, the federal cuts throughout the 1990s (and particularly post-CHST) were perhaps useful to provincial policymakers in

dampening the demands being pressed by those within the health services (where a considerable amount of cost is in wage and salary outlay). It is also important not to overstate this factor, for the most severe federal cuts occurred when the provinces were already engaging in cost containment in any case. Nonetheless, the federal move did serve to legitimize the overall direction of the provinces' own cost-containment strategies and provides a political foil for the provincial initiatives.

A second, and more deleterious, instance where the federal cuts, and especially the CHST, affected the provinces was in crippling the provinces' respective attempts to make the transition to more efficient and integrated systems. Especially in the cases of Ontario (because of its sheer size, the number of its programs, and net population influx) and Nova Scotia (because of its debt load and high social spending), additional federal funds could have facilitated a smoother and speedier transition to a more integrated and efficient system. For Ontario, for instance, the problem was not that the province could not afford to create new programs per se, but rather that it was obliged to enact closures and cuts before the other programs had been properly established. Had the province had the capacity to accelerate some of these programs (especially the so-called "drugs and devices" programs), according to the province's Ministry of Health, it would have been able to make the changes without as many problems as it ultimately encountered. Even where such programs were not included in federal transfers, provinces' need to devote existing funds to the maintenance of "basic" services prevented the establishment of a more modern and effective community-based system.

It must be acknowledged that this position, articulated by all three provinces, is a counterfactual construction that cannot be substantiated empirically. Some commentators, such as Michael Mendelson, have argued that provinces tend only to spend a certain amount on health care regardless of what funding they would receive from Ottawa.[64] (Mendelson was predicting provincial behaviour on the basis of *greater* federal funding; though it is interesting that his argument was certainly accurate given a *decrease* in federal funding, which is essentially a more counter-intuitive proposition.) If this is true, then there is some doubt that the provincial treasuries would have permitted the additional funding for such programs, despite the expectations of the respective Departments of Health. Nonetheless, there is certainly some precedent of federal unilateralism acting as an obstacle to program reform insofar as provincial governments refused to work with Lloyd Axworthy on social security reform because of their perception that such cooperation would make them jointly

accountable for cuts imposed upon Axworthy by the federal finance minister. Mendelson may be correct that, had provinces significant *extra* funding, they might well not have used it in the field of health care. But it is nonetheless likely that, had major cuts not been forthcoming, provinces could have used stable funding patterns to transfer monies from "inefficient" areas (such as excess capacity in acute-care hospitals) to community-care systems. As it happened, the amount saved through rationalization was merely used to prop up existing programs, rather than to establish new ones.

A third concern, and one noted by Lazar and McIntosh, addresses the implications for cost containment in health care given a regime that is largely "disentangled": this concern is that the redistributive focus in such a regime "would tend toward the achieving of intra-provincial [or internal] equity rather than national or inter-provincial equity."[65] And, indeed, this is very much the case for the provinces examined here. Interestingly, however, provincial autonomy in cost containment meant that two of the wealthiest provinces were implementing some of the harshest reforms; and it is arguable that the quality of health care in the mid-1990s was better in Saskatchewan, one of the "have-not" provinces, than it was in Alberta, one of the few "haves." Thus, the concern for national equity does not simply reflect variations in the respective fiscal capacity of provinces, but also the political will of the governments. This does not mean that intra-provincial equity is necessarily achieved *at the cost* of interprovincial equity; merely that provinces, if left to their own devices, have a clear political interest in achieving equity amongst their own populations, and relatively little motivation to be concerned with the level of services in other provinces (unless, of course, they have a direct effect on population migration).

Nonetheless, one might point out that the drastic funding cuts in Alberta (as in the other provinces) were soon addressed due to public pressure, and that Ottawa's inability to enforce national standards (beyond its carrot and stick of economic incentives and *Canada Health Act*) is mitigated by the relatively similar expectations of Canadians across the country. Some, such as Thomas Courchene, have argued that "[i]n the final analysis, medicare will survive only if it has the support of the residents of the various provinces,"[66] and that federal imperatives are unnecessary as well as useless. The argument of public pressure may also be used to address the concern that an interprovincial competition for resources can lead to a "race to the bottom" as social services "are restricted in order to create a more favourable climate for capital investment."[67] It is more difficult to gauge the public support for health care, however, when voters elect governments dedicated to cutting costs, including

health care, and yet consistently tell pollsters that health spending is their primary concern.

A fourth and related concern regarding the impact of federal unilateralism on cost containment in health care is, paradoxically, not in health care at all. Because of the "disentangled" nature of provincial cost-containment strategies, and because of the emphatic public support for health care above all other forms of social spending, all provinces tended to subsidize their health budgets in the face of the federal CHST cuts. But this practice has led to an interesting manifestation of externalities; for despite the fact that other provincial departments' budgets were cut in order to maintain health spending, the recent increases in federal transfers are conditional upon only being used within the health sector. What will this mean for the departments that lost funding in the past decade? Said one wry provincial health official, "resentment? No, they'll be grateful that we won't be stealing from them again this year." The impact of the federal cuts upon other provincial departments is very difficult to ascertain, and would involve a detailed investigation into the funding of all provincial departments over the past five years. It would also be necessary to examine the implications of the cuts for specific programs, such as those designed to address the needs of children, the disabled, the elderly, and various preventative services. But the practice of federal unilateralism in health-care containment has had consequences well beyond the sphere of health care, and it will be some time before the precise social costs of the CHST can be quantified.

A fifth concern is that the uncoordinated move by all levels of government to contain costs has exacerbated the tendency of governments to off-load costs to the private sector. As Deber *et al.* note, "Government has incentives to off-load costs, even if off-loading threatens the system."[68] This is accomplished in a number of ways, including the determination of certain treatments and tests as "not medically necessary," or simply limiting the access to publically-funded drugs and treatments by shortening hospital stays. Such off-loading is a concern for a number of reasons: it undermines the universalism of the health-care system, in effect creating a tier of services which some can afford and others cannot; it is economically inefficient; and it is generally accomplished "invisibly" with little public knowledge or accountability. This tendency to off-load costs to the private sector is especially troubling in the context of the significant rise in private spending vis-à-vis public spending over the past decade,[69] especially as there is a strong argument concerning the positive causal relationship between private health spending and higher levels of overall

expenditure.[70] By increasing the level of health care that individuals are required to pay out of their own pockets, one places increasing pressures on lower income groups, thereby calling into question the provisions of universality and accessibility.

The sixth and final concern regarding policy goals in health-care containment within a "disentangled" regime is the problem of a "lack of coherence" both between federal and provincial programs, and between the provinces themselves. This was not seen as a particularly worrisome issue to any of the provincial officials interviewed. Partly, one would assume that this is an inherent and understandable bias on the part of those working within relatively self-contained jurisdictions. But they noted that the lack of federal and provincial actions resulted more from a lack of communication than a lack of political will, and that intergovernmental communication was being facilitated both through the federal/provincial/territorial (F/P/T) councils and the CIHI (as well as becoming a formal obligation under the Social Union Framework Agreement). A more structured and obligatory system of policy formulation was not seen as a useful option, first, because provinces simply have different priorities, so that policies necessary in some jurisdictions would be useless or inappropriate in others. Second, provinces have different abilities in monitoring and collecting the data necessary for creating sound policies: Nova Scotia or Newfoundland, for example, simply could not match the detailed program analysis being done in Ontario, and using Ontario data to establish new programs in the former provinces could lead to distorted program implementation.

Finally, all three provinces noted that a great deal of interprovincial communication existed at an informal level: most interviewees noted that they had been talking to their counterparts in other provinces "just the other day." This communication seems to be consistent and extensive, although it addresses technical issues (how are programs operated? what works? what doesn't?) more often than overarching policy strategies. Thus there is anecdotal evidence to support the premise that "disentanglement may entail the development of multiple policy regimes that enable each jurisdiction to learn from others and cumulatively acquire the knowledge more quickly of 'what works' and 'what does not work' than would be possible in a regime that admits of less choice."[71] A number of officials noted that the information needed already exists in other jurisdictions: Why reinvent the wheel? (One of the disadvantages of such an informal system, however, and one of some concern to interest groups, is that such informality severely reduces the availability of potentially important information to individuals and groups outside government.)

What can we conclude about the effects of governmental cost-containment strategies on policy goals? Overall, it is arguable that the short-term price of federal unilateralism combined with disentangled decision-making (on cost containment) is not as severe as some observers might have expected it to be. It is conceivable that more collaboration may well have mitigated some of the more adverse effects; nonetheless, the nature of provincial health-care systems was probably not immediately affected by the lack of more extensive collaboration. Greater concerns may be expressed, however, in considering the longer term needs, strategies, and investment in health-care systems. While a disentangled/unilateral combination did not significantly affect the status quo (concerning, for example, the current operation of services and programs), the most serious consequence of this relationship on policy goals was the opportunity costs incurred which prevented governments from embarking upon serious consideration of long-term strategies. This is not to argue that a disentangled regime *cannot* achieve this, nor that a collaborative regime necessarily *will*; merely that the structure of a collaborative regime, by definition, more easily facilitates such long-term planning.

Fiscal Health, Physical Health and Intergovernmental Relations

Just as the idea of a social union overlaps the concept of fiscal federalism, the management of the physical health of Canadians rests in an uneasy tension with the management of Canada's fiscal health. As it currently stands, the cost-containment regime in the field of health care is predominantly a "disentangled" one, with most of the restructuring occurring at the level of provincial decision-making. In the first place, as explained above, each of the provinces examined here was well into a significant retrenching of their health-service systems before Ottawa implemented its own considerable cutbacks in the form of the CHST. There is very good reason to believe that the federal cuts were designed more as an attempt to contain overall federal spending than as a clear rethinking of health policy. Nonetheless, given that Ottawa's preeminent role in health policy is to spend money and allow its use to be determined by the respective provinces (subject to the *Canada Health Act*), there is little substantive redesign that Ottawa could have undertaken independently (although it is eminently arguable that the new federal investments in health and the health transition fund are efforts to supply the provinces with the tools that will assist them both in restructuring and cost containment). Second, again described above, when the federal cuts were introduced they had little direct, observable

effect on provincial health programs (beyond the counterfactual declaration of what provinces could have used the funds for had federal funds remained intact). Despite the observation that most provincial health budgets dipped noticeably after the introduction of the CHST, the depth of the provincial cutbacks were not proportionate to the federal ones: federal health cost-containment policy, in this respect, seems paradoxically to have had a much greater impact upon other areas of clear provincial jurisdiction (such as municipal affairs) than upon health care.

There is, of course, also a limited amount of federal/provincial collaboration in the form of the federal/provincial/territorial conferences at both the ministerial and deputy-ministerial levels. But more interestingly, there exists a considerable degree of interprovincial collaboration, both formal and informal. T here are provincial/territorial ministerial and deputy-ministerial conferences, both at the national and regional levels, which are structured in a manner similar to the F/P/T conferences; and there are also provincial/territorial collaborative efforts in the collection of data, research projects, and rationalization studies (some examples of these collaborative efforts include the physician management scheme and the attempt to determine better utilization rates in specific areas, such as laboratory testing). But these formal structures pale in comparison to the sheer volume of informal communication that occurs between provinces at the technical level. No study of the nature of this communication has ever taken place, but the impression from interviews is that the subject matter is information-sharing, not joint policy development and decision-making except as it pertains to provincial/territorial responses to federally advanced policy positions.

All those officials interviewed had no little experience in the field of provincial health-care administration, and all were unanimous in agreeing that the level of interprovincial cooperation, both formal and informal, had increased dramatically in the past decades — indeed, it had done so quite markedly in the past ten years. Slightly different reasons were given for this phenomenon: some noted, for example, that the nature of health-care management itself was driving the need to seek new information. As health care makes the transition from a system of acute care, which can be addressed largely autonomously within self-contained hospitals (and where the main interchange of information is within and between health-care professionals and hospital boards) to a system of integrated care, which required a much greater scope of coordination, it is essential for officials to find "more effective ways of doing things." Even a decade ago, some noted, health care was characterized by a series of

largely independent "stovepipes" (acute care, mental health care, cancer care, etc.). Largely because of the pressing need for cost containment (itself due to demographic change and advances in medical technology and pharmacology), but also due to the increasing unwieldiness of the "stovepipe" system, provinces were more obliged to consider redesigning the way in which health services were provided.

It is important to keep in mind that health-care restructuring is *not* solely a consequence of cost containment: even if Canada's economy had been incomparably wealthy, major reforms would still have been necessary. The iron hand of cost containment did, of course, oblige the provinces to undertake reconstruction in order to achieve a more integrated system: most bureaucratic systems are, to large extent, essentially conservative, and intensely resist extensive change. This was especially true for health-care systems, both because of their disproportionately large size and their very protective client (and provider) populations. Yet, while cost constraints were useful in forcing the issue, the need for cost containment quickly overwhelmed system restructuring and the terms "reform" and "cutback" ultimately became synonymous, thereby undermining much political support for the much-needed reforms. But the move toward health-care restructuring has continued in the face of such a hostile economic environment, and interprovincial discussion has facilitated many of these changes, especially in terms of how to integrate services and, as importantly, how to communicate to the public where to go for specific needs. Because of the importunate need to make system changes, and because of the very constrained economic climate in which these changes are having to be made, provinces seem to be relying upon each other in an informal pooling of information resources.

It is perhaps important not to overemphasize the nature of interprovincial communication. It is, in the first place, measured quite subjectively: could, for example, it possibly be the case that many *fewer* provincial officials are communicating with each other far more (thus giving them the *impression* that net levels of communication have increased)? As well, such communication is occurring in a very unsystematic and selective manner, which does not necessarily facilitate a long-term, overarching strategy for cost containment. In addition to this, others have noted that the nature of interprovincial relations has changed considerably over this same time period. Again, for a number of reasons, including those noted above, provincial bureaucracies have become more willing to engage in a greater degree of intergovernmental communication: as one official stated, "we simply can't afford to be personal."

Whereas interprovincial relations at one time might have been distinguished by a higher degree of interpersonal relationships, current bureaucracies are simply more impersonal and professional in their relationships. Thus, provinces with such disparate political outlooks as Alberta and Saskatchewan are more likely now to communicate with each other because of the similarity in geography, social culture, and so on. Underscoring this Weberian observation that bureaucracies simply tend to become more professional and less personal as they mature, however, is the observation that provincial bureaucracies are, at the same time, becoming *more* personal. More specifically, officials in most government departments simply tend to see each other more often, as there are more conferences, more insistence by governments on horizontal policy development and the consequential requirement for officials to interact and communicate more widely. Furthermore this interaction is facilitated by electronic communications networks.

But interprovincial relations should also be placed within the larger context of a greater diffusion of policy ideas.[72] In a number of areas in public administration, including health policy, there has been, since at least the mid-1980s, a marked tendency for bureaucrats to engage in "comparative learning" (the drastic British health-care reforms of the early 1990s, for example, were born within American health policy institutes). This phenomenon itself has a number of explanations, including the use of high-tech communications networks and the role of policy institutes. In addition to this must be added the emphatic increase in the number of, and the use of, professional consultants within the field of public policy in the past ten years, another factor that accounts for the diffusion of ideas within health policy.[73] Thus the phenomenon of increased interprovincial collaboration, both formal and informal, must be considered within a much wider political and bureaucratic environment.

But if current cost-containment strategies in health care are characterized by independent provinces which are nonetheless communicating energetically with each other in the attempt to reconstruct, integrate, and contain their health services, the question must still be asked whether these relations could conceivably be restructured to achieve better results, either in terms of efficiency, accountability, or equity. What, in particular, ought the role of the federal government to be in the transition to a more integrated health-care system?

Efficiency is, by definition, the first virtue of cost containment. Would more centralization of power in the federal government lead to a more cost-effective health-care system? As noted above, numerous comparisons of the

American and Canadian (or British) systems seem to indicate quite conclusively that a more centralized system is considerably more adept at containing costs. Again, however, the fact that Canada's health-care system is decentralized at the national level should not obscure the fact that it is also very centralized at the provincial level. Even in provinces where substantial regionalization has occurred, the provincial governments tightly control the amount of resources going into the health-care system; the regional health authorities simply determine the distribution of funds allocated to them. Moreover, it is quite arguable that if Ottawa did have exclusive (or greater) jurisdiction over funding one would see greater cost inefficiencies. In the first place, Ottawa would be subject to much more direct political pressure to infuse funds into health care; by allowing the provinces to "take the heat" from consumers (and providers) of health care it can more easily curb overall (transfer) spending in this area (it is this same logic of dissociating funding per se from the distribution of funds which may have motivated many provinces to enter into the same relationship with their respective regional health authorities). Secondly, it is also arguable that the political negotiations between the provinces and physicians (and other health-care workers) are more conducive to cost containment insofar as centralized negotiations in a federal state are likely to be averaged up to the demands or requirements of the provinces with the highest remuneration.

Thus, in terms of pure cost containment, a highly disengaged system with some federal funding works relatively well. In terms of "efficiency" more broadly considered, however, the lack of communication and coordination between jurisdictions can have negative results. "Efficiency" exceeds simple cost restraint insofar as it includes long-term consideration of needs, strategies, and investment in health-care systems. What is apparent in the relationship between provincial and federal governments over the past decade is that marked inefficiencies occurred in relatively successful cost-containment strategies because of the inability of provincial administrations to plan transitional strategies effectively because of a lack of information regarding long-term funding patterns, a shortage in funds necessary to implement transitional strategies, and an atmosphere of general distrust and wariness. In terms of long-term efficiency in health care, broadly stated, all jurisdictions cannot work at cross-purposes in their cost-containment goals; and coordination in governmental objectives requires at least a minimum of communication and planning. Again, one obvious example here is the tendency of each government independently to off-load costs to the private sector, the consumer or lower levels

of government the collective result of which is an increasing overall rate of expenditure in health care.

Accountability is a much more difficult objective in areas of shared jurisdiction. A "fully-integrated" system of health care will never occur because provinces will always be more responsive to their local populations than to any national standards simply because that is the political imperative of democratic systems. Different provinces have different needs and abilities; but they also have different objectives. This is especially true in the relative weight that each jurisdiction chooses to give to the fiscal health of the province vis-à-vis funds placed into health care.

Ought there to be concern that the most vibrant form of interprovincial collaboration is quite informal and thus not particularly transparent? As Lazar and McIntosh note, " a key issue has to do with whether it would be binding or not."[74] And, as it stands, interprovincial collaboration exists largely at the level of communication and discussion, with very little interprovincial policy collaboration of a binding nature. Of greater concern, perhaps, is the phenomenon of policy-making through consultants. This, however, is a matter relatively dependent upon individual government policy, as consultants' reports may or may not include popular consultation, and as the release or implementation of these reports may or may not be subject to public response.

Again, greater federal involvement would not likely result in a more "accountable" system largely because, as noted above, it is not the federal government which directly "feels the heat" in its health-care funding decisions. Moreover, the February 1999 intergovernmental agreement notwithstanding, Ottawa is limited in its ability to direct any increases in provincial transfers specifically to health spending. Thus, concludes Michael Mendelson, "[t]he level of health care spending is a matter for which we will have to hold our provincial governments accountable."[75] To the extent that a "disentangled" structure characterizes current regimes in health-care cost management, accountability is not a significant problem, although there are two caveats to this. The first is the observation, noted above, that the phenomenon of regionalization can influence the perceived accountability and transparency of provincial health policy; the second is the issue, also discussed above, of the extent to which direct citizen involvement is or is not a useful variable when cost containment is a pre-eminent objective.

The most important area of federal involvement in cost-containment strategies is in the issue of *equity*. To the extent that health care in Canada is formally a provincial responsibility but is nonetheless viewed as a right of Canadian

citizenship, some federal presence is likely necessary. Yet it is the very move toward cost containment that jeopardizes this guarantee of some degree of national equity: how, if at all, is it possible to maintain equity within an environment of cost containment in health care? Some, including Thomas Courchene, argue that Ottawa's moral authority as well as its political ability have been diminished by ongoing cuts in cash transfers, and that the "ultimate guarantors" of the principles of Canadian health care must be Canadian citizens, "acting individually and collectively": "it is they who have ensured that the provinces preserved medicare over the past decade of federal cuts and freezes and caps."[76] This, however, would seem to place the guarantee of equity — one of the most important concepts underlying the *Canada Health Act* — on a notoriously less-than-disinterested public, given the wide disparities in wealth between provincial electorates. Individuals may, separately or collectively, be responsible for pressuring provinces to maintain health care more vigorously than Ottawa has been, but there is little motivation for these citizens, individually or collectively, to enforce an *equitable* scheme of national health care.

This issue is, of course, at the heart of the health-care debate in Canada, and no set of pointers could address the problem satisfactorily. Nonetheless, one may at the very least identify some of the more imperative issues that follow from the drive to contain costs in health-care provision. The most obvious consequence of the multi-governmental move toward cost containment is the off-loading of expenses and responsibilities, both to other governments and to the private sector. The former has resulted most notably in the partial withdrawal of a federal presence in health-care funding, and the problem that this entails is that there is increasingly little motivation for provinces to concern themselves with equity in the provision of health care across Canada.

Although there is some debate concerning the exact share of federal funding for health care, Ottawa was by late 1999 probably providing little more than an approximate average of 15 percent of provinces' health-care spending, and is attempting to regulate national equity on this basis. Unless one subscribes to Courchene's view, some method of sustaining the real value of federal transfers over time must be implemented in order to preserve at least a modest degree of equity in the health-care system. One possibility, for example, is the conditional revenue-sharing scheme suggested by Allan Maslove, in which the CHST cash transfer is set "equal to the total amount of revenue generated by a specified number of (say) personal income tax points."[77] Thus the federal government (not the provinces) would continue to collect the tax revenue and distribute the funds, but such funding would be distributed to the provinces on

an equal per capita basis, subject to the *Canada Health Act*. This arrangement would ensure stability and predictability, and would also be "more insulated from Ottawa's normal budgetary pressures."[78] One potential drawback, of course, is that such a system would not be immune from federal unilateralism, given the political will for such action; but it does address two of the primary fiscal concerns.[79]

A more unobtrusive but no less worrisome form of off-loading involves the shift from public to private provision of health care. As noted above, this has mostly taken the form of de-listing services (treatments and tests) and items (pharmaceuticals, oxygen, prostheses, etc.), and shortening hospital stays (thus limiting access to publicly paid drugs and services). How can this be prevented? Ought it to be? As Deber and Swan note, there is overwhelming evidence, both global and international, that cost control is most effectively secured "in the sectors where there is significant public funding (e.g., hospitals), and most problematic where the private role is greatest (e.g., pharmaceuticals)."[80] And, if one chooses to use "efficiency" as the primary criterion, then, as Deber and Swan argue, there is a very good case for shifting costs in the *other* direction (i.e., from the private to public sphere).[81] This would be especially true for programs involving pharmaceuticals and home care. Despite the fact that this would be a "politically difficult" move (as it would increase *government* spending) there is good reason to believe that it would decrease *total* health-care expenditure. The issue of shifting costs back to the public sector aside, however, how is it possible to prevent further off-loading to the private sector within the current federal-provincial relationship?

One possibility is to focus upon the "accountability framework" suggested by the Social Union Framework Agreement. This clause, which was designed to support the provision that "each provincial and territorial government will determine the detailed program design and mix best suited to its own needs and circumstances to meet the agreed objectives," could potentially include the stipulation that this off-loading be prevented in specific areas (usually "grey" areas where the argument is made that they are not "medically necessary"). On the presumption that most off-loading is usually "invisible," by making such moves more transparent and thus accountable to the federal Department of Health (and to public opinion) such off-loading may potentially be forestalled.

A final concern addresses the need to facilitate communication between (and within) all levels of government. At least four areas or types of communication must be identified. First, it would be useful for all jurisdictions to have access

to a common data centre in order to plan and build policy, and also to compare provincial statistics with those of other provinces. A major commitment was undertaken at the First Ministers' Meeting on Health in September 2000 "to work together to strengthen a Canada-wide health infostructure," including the development of electronic health records and common data standards to ensure the compatibility of health information networks.

Second, there should be a free and ongoing exchange of experiential data, both in terms of policy direction and technical implementation. This, too, exists informally at an interprovincial level.

Third, governments must be willing to discuss some of the more general yet more difficult questions regarding the long-term future of Canadian health care: Ought rationing to be more formalized? Ought we to think more articulately about whether we can in fact afford the system to which we have committed ourselves through federal legislation? The problem here is that either one utilizes a committee of third-party "experts" (such as is called for by the Social Union Framework Agreement's provision on dispute avoidance and resolution), which risks the same fate as the National Forum on Health, or a committee of bureaucrats from the respective Departments of Health, which faces becoming polarized by the political agendas of their respective governments. At the very least, an optimist might point out that the Social Union Framework Agreement's stipulation that governments collaborate on the "development of objectives and principles" will oblige them occasionally to take into account the long-term horizon.

Fourth, governments, and especially Ottawa, must get their own houses in order before attempting to widen the channels of communication between governments. Interdepartmental communication within each government must also be facilitated before effective policy-making at an intergovernmental level can occur; and allowing some branches of government to make policy decisions that are quickly negated by others sets a poor environment for negotiation.

Very few policy structures, if any, are ideal. Even the best administrative arrangements must address political constraints, and any determination of an "ideal" system must depend upon the political values that it attempts to protect and maintain. These values, unfortunately, are far more elusive in their articulation, and far too frequent in their tendency to contradict each other. In the case of health care, we do as a nation have a relatively clear conception of the general values that our health system ought to encompass (articulated in the *Canada Health Act*), but there is no similar public understanding of how these values are to be measured against the similarly strong public desire for

fiscal health. In evaluating the respective regime types according to how they best promote specific principles of federalism, democracy, and social policy in the sphere of health care within an environment of cost containment, one can perhaps suggest that the current primarily disentangled regime is fairly effective. The exceptions to this are, first, the observation that greater intergovernmental collaboration is required for the long-term *efficiency* of health care in Canada; and, second, that some strong federal presence is likely necessary to ensure the social *equity* of the system. The particular nature of these relationships is, of course, open for discussion and evaluation. In the final analysis, perhaps, no structural constraints will be able to prevent calculated acts of political will such as the CHST. But nudging political and administrative structures in slightly different directions may, nonetheless, have the virtue of facilitating greater cooperation where the will exists.

NOTES

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[12]See Raisa Deber and Bill Swan, "Puzzling Issues in Health Care Financing," in *Health Care Systems in Canada and Elsewhere*, ed. National Forum on Health, p.319.

[13]Canadian Institute for Health Information (CIHI), *National Health Expenditure Trends, 1975-1999* (Ottawa: CIHI, 1999), p. 2.

[14]Ibid., p. 3.

[15]Ibid., p. 4.

[16]Ibid., Table A.1.

[17]See Saskatchewan Health, "Health Expenditures in Canada and Selected OECD Countries," in *Interprovincial Comparisons: Provincial/Territorial Health Services and Selected Data* (Regina: Government Printers, 1996), p. 88.

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[21]Michael Mendelson, "Looking for Mr. Good-Transfer: A Guide to the CHST Negotiations," (Caledon Institute of Social Policy, 1995) <http://www.caledoninst.org/full82.htm> (2/19/99).

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[30]*Ontario, Ministry of Health. Business Plan*, <http://www.gov.ca/health/english/pub/ministry/bplan96.html>, 1996, p. 8.

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[35]Ontario. Ministry of Health, *Business Plan, 1997*, p. 5.

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[40]Ibid., 17 June 1992, p. A1.

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[43]*Halifax Chronicle-Herald*, 30 March 2000, p. A3.

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[55]*Edmonton Journal*, 22 February 1997, p. H1.

[56]*The Globe and Mail*, 3 December 1996, p. N6.

[57]*Edmonton Journal*, 22 February 1997, p. H1.

[58]Ibid.

[59]Ibid.

[60]Telephone interview with Dave Alexander, Senior Team Leader, Federal-Provincial Relations Branch, Alberta Department of Health, 12 April 1999.

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[67]Lazar and McIntosh, *Federalism, Democracy and Social Policy*, p. 37.

[68]Raisa Deber *et al*., "The Public-Private Mix in Health Care," in *Health Care Systems in Canada and Elsewhere*, ed. National Forum on Health, p. 534.

[69]See CIHI, *National Health Expenditure Trends, 1975-1999*, pp. 22-53.

[70]See, e.g., Deber *et al*., "The Public-Private Mix in Health Care,"; and Deber and Swan, "Puzzling Issues in Health Care Financing."

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[75]Mendelson, "No Treasure CHST for Health Services."

[76]Courchene, *Redistributing Money and Power*, p. 81.

[77]Maslove, "The Canada Health and Social Transfer: Forcing Issues," p. 297.

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[80]Deber and Swan, "Puzzling Issues in Health Care Financing," p. 329.

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6

FEDERALISM AND THE HEALTH FACILITY FEES CHALLENGE

Joan Price Boase

The Canadian health-care system is a remarkable achievement in a federal country where strong provincial governments are fiercely protective of their legislative jurisdiction. It is an example of intergovernmental cooperation, however tenuous, to sustain a national program that has the support of a large majority of Canadians. Because it is so popular, yet requires the coordination and good-will of naturally competitive governments, minor irritants in the system occasionally escalate into full-blown federal-provincial acrimony. The health facility fees issue in the mid-1990s was one such incident. The dispute was exacerbated by concurrent and unwelcome unilateral federal moves, and it escalated into a serious and bitter political dispute that soured relations in other policy areas as well.

The case study of this issue underlines the inadequacies of the existing intergovernmental mechanisms that are available for dispute avoidance and for the resolution of specific disagreements. To the federal government, the imposition of facility fees on patients receiving necessary medical care in a private clinic was an unacceptable infringement of the principles of the *Canada Health Act*, 1984 (CHA). To the provincial governments, especially that of Alberta, federal "re-interpretation" of the CHA definition of "facility" was an offensive and coercive intrusion into a field of provincial jurisdiction. Yet it is unlikely that the issue would have become so bitter were it not for other festering irritants.

This chapter describes the background issues that led to the dispute, assesses the ability of the existing intergovernmental regime to resolve questions related to the funding of the CHA, and posits and evaluates potential alternative intergovernmental regimes. Public disputes over the interpretation and enforcement of the Act have been few, and the ease with which this one became such a rancorous political issue is instructive. Clearly, if Canadians are to benefit from a health-care system that continues to be universal, portable, accessible, comprehensive and publicly administered, dependable and transparent dispute-settling mechanisms are essential. These mechanisms must be more sensitive to the federal nature of the country, the constitutional division of powers and the need for meaningful democratic participation. In its final section, the chapter attempts to outline the skeleton of a more cooperative mechanism.

This is one of several case studies in this volume that assess the effects of different intergovernmental regimes on achieving national health policy and democratic goals while respecting federalism principles. The research methodology involved a combination of telephone and personal interviews during the months July to November 1998 and document examination. The analytical methodology conforms broadly with the methodology enunciated by the Institute of Intergovernmental Relations at Queen's University for this collaborative project and which is explained in detail in the introductory chapter to this volume.[1] Specifically, the analytical methodology seeks to locate the intergovernmental relations evident in the study on a continuum from unilateral or hierarchical federalism through cooperative federalism to disentangled federalism. The study concludes that this case is evidence of hierarchical more than true unilateral federalism,[2] and that democratic participation, in conjunction with coordinate intergovernmental relations, is essential to sustain a health-care system that is truly "national" in character.

BACKGROUND

In the dying days of the Liberal government in the Spring of 1984, the *Canada Health Act* was passed, unanimously, by both the House of Commons and the Senate. It received Royal Assent on the same day as its Senate passage.[3] The ease with which it became law belied the controversial objectives of the Act, and obscured the divisive nature of its political implications. It was passed in response to the recommendations of a Royal Commission (the second Hall Commission)[4] reviewing health services, and which had reported in 1980. This commission concluded that extra-billing by physicians and hospital user fees

endangered the accepted principle of reasonable access to health care. It argued that if these practices were allowed to continue, medicare would eventually be destroyed, reversing the equity in access to health-care services enjoyed by Canadians. The Act was a consolidation of the existing *Hospital Insurance and Diagnostic Services* (1957) and *Medical Care* (1966) *Acts*, and its objective was the elimination of the extra-billing and hospital user fees in the provinces that permitted these practices.[5]

In section 2 of the *Canada Health Act*, a hospital is defined as including "any facility or portion thereof that provides hospital care, including acute, rehabilitative or chronic care," and sections 14 to 22 of the Act specify the action that the federal health minister can and should take if a province is deemed to be in default of the Act. The definition of a "hospital," however, was clearer in the early 1980s than it became later in the decade, as rapid technological advances permitted many services which had previously required several days in hospital, to be carried out on an out-patient basis. One such service is cataract surgery. This medical procedure has become much more extensively required as increasing numbers of Canadians live into their 80s. The combination of these three factors — the CHA definition of hospital or facility, technological advances allowing out-patient surgery, and Canada's aging population — combined in the late 1980s and early 1990s to precipitate a very public dispute between the federal and provincial governments, particularly the Government of Alberta, over the policy of allowing private facilities to charge extra fees for medically necessary out-patient surgery.

During the early 1980s, government revenues were negatively affected by a stubbornly high unemployment rate and a sluggish economy. In addition, a high interest rate monetary policy and fluctuations in world financial markets ensured that Canada's deficit/debt conundrum rapidly worsened. To address this complex and escalating problem, successive Canadian governments chose to make unilateral reductions to the rate of increase of transfer payments to the provinces. After the *Established Programs Financing Act* (EPF) was passed in 1977, the growth in federal government transfers to the provinces for health care and postsecondary education slowly eroded, and the total transfer payments from 1994-95 to 1997-98 actually dropped by about $4.5 billion.[6] Under EPF, the basic cash transfer was originally determined by an escalator that considered the per capita rate of growth in the gross domestic product (GDP), based on an initial amount determined in the 1975-76 fiscal year. This amount was multiplied by the escalator and then by the province's population, to determine the total entitlement. During the 1980s, the escalator was modified

several times, and from 1986-87 to 1989-90, the escalator used to calculate the total EPF transfers was reduced by 2 percent. From 1990 until 1994-95, per capita transfers were frozen at their 1989-90 levels, so that the total amount of transfer payments increased only with the population increases in each province (about 1 percent). In 1995-96, the escalator was decreased by 3 percent, and the result was a negative escalator (-1 percent, according to the Federal-Provincial Relations Division of the Department of Finance). This resulted in a decrease in transfers, since the per capita GDP growth was less than 3 percent.

A further aspect of the EPF was that the transfers had two components — periodic cash transfers and the transfer of tax points to the provinces — and federal revenue was thus reduced by an amount equivalent to the transfer of tax points. The taxpayer then paid more provincial tax, but less federal tax. While no specific requirements were imposed in respect of the proportion of fiscal transfers that should be assigned to postsecondary education, the provinces all had to adhere to the conditions and criteria of the *Canada Health Act*. They were subject to cash penalties if they did not.

In the February 1995 budget, the federal government sent a clear message that it was prepared to withdraw from its long-standing financial commitment to support social welfare programs in Canada. In this budget, the finance minister announced a new plan for transfer payments to the provinces for social programs. Originally titled the Canada Social Transfer (combining payments for health, postsecondary education, and welfare), it quickly became the Canada Health and Social Transfer (CHST), in response to wide-spread alarm about its implications for medicare.[7] The CHST block transfer was slated to be implemented on 1 April 1996, and some observers argued that the formula presented for gradual reduction indicated that the cash transfer would be phased out for all provinces by the year 2008.[8] Subsequently, the government announced that the transfer would not drop below $11 billion, and then, during the 1997 election campaign, promised that the floor cash transfer would be set at $12.5 billion. Relieved supporters of the CHA believed that this would at least ensure that the federal government would retain some leverage to require provincial compliance with the Act. Provincial government representatives were not assuaged, and they quickly pointed out that this was some $6 billion less than they should have received (according to the old financing formula). In the Fall of 2000, however, following extensive negotiations with the provinces, and in the wake of announced budget surpluses, the federal government pledged to increase the CHST by $23.4 bilion over the next few years. This appears to be a reversal of the retreat announced in 1995.

The implementation of the CHST was the culmination of what, from the provinces' perspective, was a decade and a half of uncertainty and apprehension concerning their own and the federal government's financial responsibilities for health insurance programs. They argued, with some justification, that they were bearing much of the burden of the federal fiscal miasma, yet they were legally and politically required to maintain the programs. From the federal perspective, the sheer size of the fiscal transfers made them an obvious target for its concerted effort to deal with its own budgetary deficit.

Thus, the stage was set for confrontation between the federal government and the provinces. Dismayed provincial governments argued that Ottawa had broken the "Golden Rule": if it was not going to provide the gold, then it must relinquish its right to make the rules.[9]

The Facility Fee Confrontation

Provincial governments had been spending, on average, well over 30 percent of their total budgets on health care. Although the rate of increase in spending was much less generous from 1994-97 than it was in the early 1990s, medical care continued to consume a major portion of all provincial budgets. Wrestling with their own serious deficits and debts, and reduced revenues due to the recession of the early 1990s, most provincial governments had already begun restructuring their health-care systems, reducing or restraining health expenditure allocations. They therefore responded to the federal budgetary moves with alarm since, to maintain their health programs at their newly constrained expenditure level, other provincial departments and programs would have to absorb the impact of the federal cuts.

The financial strain also induced some provinces to attempt to cut costs by encouraging a gradual, veiled shift toward privatization of their systems, leading to an increased assumption of costs by the consumers of care. For example, all of the provinces reduced the scope of coverage by de-listing some services such as eye care, drug benefits, and physiotherapy, and some severely cut out-of-country coverage; private insurance companies quickly began to pick up the slack. There were private clinics operating in several provinces, and while a few of them received no government money, many of them billed the public health plan for physicians' fees, and charged a "facility fee" to the patient. These private clinics began to proliferate in the 1990s, especially in Alberta, whose premier, Ralph Klein, had openly challenged the relevance of the *Canada Health Act* prohibition of user fees for hospitals.[10]

Private clinics were not a new phenomenon in Canada, they had long existed to provide services such as plastic surgery, abortions[11] and physiotherapy. Ontario was the only government to have legislation regulating private clinics and in the 1960s, it had, for example, designated some private physiotherapy clinics as "facilities" to comply with the definition of hospital under the 1957 *National Hospital and Diagnostic Services Act*. These clinics received payment for treatment from the Ontario Insurance Plan, (which was reimbursed 50 percent of the cost by the federal government) but they were prohibited from extra-billing their patients. The problem that developed, and spread, in the 1990s was the increasing number of private clinics in several provinces which were reimbursed by both the government and their patients. Although this clearly contravened the spirit of the CHA, under the Conservative government of Brian Mulroney these private clinics were not considered to be problematic, and they were allowed to proliferate. The Chrétien Liberals, who came to power in 1993 (and inherited a growing problem) quickly distanced themselves from their predecessors in this area, and identified these clinics as a threat to the medicare system. They argued that the private facilities effectively allowed those who could pay faster access to medical treatment, therefore contravening the accessibility provision of the CHA. Many provincial governments and Health Department officials expressed similar concerns.

In June of 1994, a conference of federal/provincial/territorial (F/P/T) deputy ministers met to discuss the growing problem, and they established a working group to collect information on private clinics in Canada.[12] This group completed a study in August of that year, and in September, the F/P/T ministers of health met in Halifax to address the issue and to attempt to develop an appropriate policy. All the ministers (with the exception of Alberta's health minister, Shirley McClellan) agreed with the working group's findings and recommendations; there was, in fact, a threat to accessibility, and their communiqué stated that they must "take whatever steps are required to regulate the development of private clinics in Canada."

The deputy ministers met again in December, in Vancouver, to review the recommendations of the working group of F/P/T officials and to discuss, among other issues, the forthcoming federal reinterpretation of what constitutes a facility under the CHA. The interpretation was elaborated in a letter from Health Minister Diane Marleau to each of the provinces and territories on 6 January 1995. Her letter stated that the definition of "hospital" contained in the CHA includes any public or private facility that provides acute, rehabilitative or chronic care. If a provincial insurance plan pays a physician fee for

medically necessary services delivered in these facilities, it must also pay the facility fee. If it does not, it will be subject to a reduction in its federal transfer payments equal to the amount of the fees being charged directly to patients. To allow the provinces time to comply with this requirement and to adjust their policy/regulatory framework, Marleau's letter established 15 October 1995 as the date on which penalties would begin.

Following the federal minister's ultimatum, many F/P/T meetings were held to discuss issues related to the interpretation of the CHA and the implications and implementation of the new policy on private clinics. In February 1995, working groups of officials held round table discussions, and in March an informal meeting of F/P/T deputy ministers proposed that multilateral and bilateral meetings should continue. A letter from the federal deputy minister in May confirmed the intention to hold bilateral discussions. These discussions were held with all provinces and territories (except Quebec) from May to August. On 4 July, the ministers of health reiterated their commitment to the fundamental principles of the CHA. Another meeting of officials on 28 August was a follow-up to the bilateral discussions and a further clarification of the policy. On 20 September, an F/P/T ministers meeting reaffirmed the 15 October deadline for compliance with the federal policy.

According to the CHA under the section *Extra-Billing and User Charges Information Regulations*, penalties are to be calculated on estimates provided by the provinces, thereby allowing the federal government to calculate the monthly deductions in cash transfer payments. Where provinces do not submit such estimates, the Act empowers the federal minister of health to estimate the user charges/facility fees imposed on residents of the province, and to thus calculate the penalty unilaterally. The clear intention is to ensure that medically necessary services being provided in private clinics are fully covered by provincial plans. As a result of the policy and the 15 October deadline, several provinces were penalized, but the largest penalties were imposed on Alberta, and it was the Alberta provincial government that was the most intransigent. The other provinces signalled their intention to comply with the federal interpretation of the Act, but the Government of Alberta refused. By many observers, the issue was perceived to be a federal-Alberta issue.

The events of 1994-95 were somewhat more complex than the simple chronology outlined above would indicate. For example, the impetus for the June 1994 deputy ministers meeting came from the federal government, which had expressed its determination to address the issue of private clinics before it escalated out of control. Following the near-consensus of the June meeting,

the F/P/T working groups held ongoing meetings to try to establish guidelines that would govern the process for the interpretation of the Act. Some progress was made, but before the guidelines could be fine-tuned, the federal finance minister, Paul Martin, unexpectedly announced a transformation in the funding formula for social programs in Canada: the Canada Health and Social Transfer.

The details of this fundamental shift, which were devised by the Department of Finance, were claimed to be a surprise both to the federal Health Department officials and their provincial counterparts, even though they had been forewarned through the F/P/T finance ministers that unilateral reductions would occur. It brought a new sense of urgency and a sharp edge to the F/P/T discussions. In retrospect, it would appear that if federal financial officials even considered the impact of their budget-cutting moves on provincial revenues, it was in the context of an assumption that the established programs were firmly established, and political pressure in the provinces would ensure the continuation of the health programs. It would appear that the federal government never seriously considered the spillover effects of this budgetary decision on other provincial programs. Much of the federal government's political capital within the provinces and territories dissipated with this unilateral move, and its subsequent, belated reversal of policy did not restore provincial trust.

The provincial and territorial governments were dismayed by the CHST announcement, and they demanded a meeting with the federal health minister, which occurred in July 1995. At this meeting, although they all repeated their commitment to the principles of the CHA, provincial ministers complained that the interpretation of the Act was too unilateral and unnecessarily declaratory. They pressed the federal government to share decision-making with them in determining the parameters of the Act. The federal government's preference was to regularize the interpretation of the Act through the process that was being developed; this would allow for bilateral consultation and include an advisory body of provincial representatives. Some of the provinces wanted more than this: they demanded a binding body, and the discussions became bogged down, further complicated by a lack of consensus among the provinces.

The Alberta Case Example

In the 1993-96 period, the Conservative government of Ralph Klein in Alberta was the most outspoken of the provincial governments in its determination to broaden the role of the private sector in the health-care system.[13] It was in

Alberta that private clinics were proliferating, particularly ophthalmology clinics, but MRI scanning was also migrating to the private sector. By April 1996, more than 30 clinics were billing patients directly and receiving reimbursement from the provincial insurance plan.[14] Often the Alberta government had been and continued to be ambivalent in its support of "public" health care, and Premier Klein frequently expressed his belief that the CHA should be "opened up" to allow the growth of private health clinics. He stated that he was planning to push the federal government to allow alternatives, such as private hospitals. Furthermore, in July 1995, he appointed a deputy minister of health, Jane Fulton, who was an outspoken supporter of an expanded two-tiered health-care system.[15] The federal government could hardly be unaware that the greatest threat to the public system was Alberta.

The Marleau letter of January 1995 brought political grief to the Alberta government, which in its attempts to eliminate the deficit, had cut over $500 million from its health-care budget.[16] The government was already in the midst of a consumer backlash over the cuts, the closing of hospitals and the regionalization of the province's system and it received increasing public pressure to justify the expected financial penalties for allowing private clinics to "double dip." Nevertheless, the premier, who became personally involved in the dispute, refused to back down, and insisted that the private clinics helped medicare by taking the pressure off the public system. A prolonged and public rhetorical battle between the premier, his health minister, and the federal health minister, frequently couched in terms of provincial autonomy and jurisdiction, obscured an underlying and fundamentally opposite ideological approach to health care. The Alberta government envisioned an entrepreneurial, two-tiered parallel system, and the federal government (supported by a very large majority of Canadians), was determined to uphold the principles of the CHA.

The bilateral and multilateral meetings which took place during the summer and fall of 1995, did not resolve the problem. Alberta was adamant, and although Premier Klein met with Prime Minister Jean Chrétien in early October to attempt to obtain a further nine-month delay in the imposition of penalties, the penalties began, as scheduled, on 15 October. Other provinces (for example, Manitoba, Nova Scotia, and British Columbia) with fewer double-dipping private clinics, were also penalized, but the Alberta government began to lose approximately $420,000 per month. It threatened to take the federal government to court over the penalties, and aggrieved officials in the Alberta Health Department believed that they were unfairly being targeted by the federal minister, and that Alberta was being more severely penalized than the other

provinces. Health Department officials argued that by 15October the y were already attempting to find an acceptable compromise position and that extensive media attention drawn to the dispute prejudiced their relationship with the people of Alberta. There was evidence from Alberta and other provinces that this had become much more an intergovernmental dispute than a discussion of the future direction of health care.

The issue was finally resolved in late 1997-98. The Regional Health Authorities (RHAs) in Alberta worked out an arrangement with the clinics to negotiate their volume of treatments and compensation. They signed contractual agreements that allowed the clinics to operate within the CHA requirements, and the RHAs picked up the facility fee, so that there were no direct fees to individuals.

In the spring of 1998, Alberta introduced Bill 37, its *Health Statutes Amendment Act*, which allows the government to regulate private clinics. It is modelled on the Ontario *Independent Health Facilities Act*. All provinces and territories had agreed at an F/P/T meeting in September 1994 that provincial legislation should be passed to regulate private health facilities within the context of a publicly governed health program. But in Alberta, the extensive and rancorous legislative debates in April reflected the deep philosophical divisions over the health insurance system in that province. The Bill was temporarily withdrawn, but the government promised to reintroduce it in the fall 1999 session. Its supporters argued that this Bill would allow the government to prevent the spread of private clinics, and its opponents claimed that it would allow further licensing of private clinics.

In November 1999, the Klein government promised to reintroduce Bill 37 in the spring 2000 session. It was reintroduced as Bill 11 and was enacted by the Legislative Assembly in the spring despite much negative commentary in Alberta and in the national news media. The government stated that the purpose of the Bill was to contract out certain surgical procedures to private hospitals in an effort to reduce the pressure on public hospitals. The legislation would permit private hospitals, under contract with the government, to expand their services to include surgical procedures that require overnight hospital stays. Although the government insisted that the private hospitals would not be permitted to charge extra fees, and both the letter and spirit of the CHA would therefore be upheld, critics immediately suggested that the erosion of health care could occur by stealth. It is difficult to determine, however, how Alberta's plan for private hospitals would differ from the private Shouldice Clinic in Ontario. This clinic has, for many years, performed hernia surgery

that requires overnight stays, and is paid by the Ontario health insurance plan. Furthermore, the Shouldice Clinic routinely charges a fee for semi-private care. (They do not have ward facilities.) To my knowledge, this has never been questioned by the federal government.

Many of the premiers have repeatedly pressured the federal government to join them in defining the criteria of a "medically necessary service," which is covered under the *Canada Health Act* and which then must be provided by the provincial plans.[17] Presumably unlisted services could then be covered by private insurance. This is a very sensitive issue. The federal government and some provinces are resistant to developing such a list, arguing that it is important to maintain flexibility and an adaptable definition of medically necessary services. Federal officials have also argued that in the case of facility fees, if the province agrees to fund the physician who provides the service, it is reasonable to assume that the province considers that service to be medically necessary, and therefore no facility fee should be permitted. In this sense, the provinces already determine the scope of medically necessary services,[18] but rapid technological change makes this an increasingly complex issue.

National Health System Reviews

At the same time as the events described in the preceding sections were unfolding, two important exercises were being conducted. The first of these, the *National Health Forum*, was a work commissioned by the federal government in 1994. To ensure that the efforts of this committee would receive a high profile, the prime minister became the nominal chair[19] and the minister of health was vice-chair. The original plan for this committee was to have provincial representation, but the provinces refused to participate when they were not permitted to name a premier as co-chair with the prime minister. The forum members did attempt to involve the provinces in their Canada-wide discussions, but forum members said that they received only half-hearted responses. They also said that they found that the provincial and territorial governments are frequently in disagreement over the direction of health policy, justifying a hierarchical federal response.

The forum presented its final report in January 1997, and it strongly supported both the continuation of federal protection of the principles of the CHA, and the need for provincial flexibility in the detailed administration of the system. The committee had uncovered widespread concern for the future of the health-care system, and health was a clear priority for most Canadians.[20]

Among its recommendations for action were suggestions for home-care services and public funding for medically necessary drugs. Provincial government reactions to these recommendations were mostly negative. Although many of them had or were attempting to incorporate home care into their existing provincial health programs, and most provinces had limited pharmaceutical plans, the federal fiscal cutbacks precluded expansion, or in some cases maintenance of these provincial schemes. Provinces were understandably apprehensive, and they were ready to unite in their resistance to any conditions that might be placed on new money from the federal government.

A second work entitled *A Renewed Vision for Canada's Health System* was released a few days before the forum's report (January 1997). This second study was initially commissioned by the F/P/T Conference of Ministers of Health but was completed as a provincial/territorial document. (The explanation of this F/P/T intergovernmental experience is provided in this volume by Adams in the chapter entitled "Canadian Federalism and the Development of National Health Goals and Objectives.") The document, *Renewed Vision*, reflected the frustration and anxiety felt by provincial and territorial governments who, burdened with their own financial problems, interpreted federal strategy as an attempt to off-load health-care costs onto them while sharing the credit for sustaining or expanding the system. The underlying provincial message given to the federal government was that if it no longer was prepared to make adequate cash transfers for health care, then it could no longer expect to make the rules, and it should relinquish its role in the interpretation of the CHA. The provincial/territorial paper revealed a somewhat different vision of Canada's health system from that articulated by the National Health Forum. While it expressed support for a public system, it referred to additional national goals that were more equivocal than the standards or principles articulated in the CHA. It was clear that the provinces/territories shared a desire to have more control over the interpretation of the CHA, and that they supported the establishment of a committee to "define the exact bounds of Medicare."[21]

Renewed Vision was evidence of interprovincial cooperation and a rare united provincial-territorial front to challenge the role, performance, and policy of the federal government in the health system. Since the provinces/territories are always governed by political parties with various ideological leanings, they have often found it difficult to present a unanimous, and therefore strong front in response to a unilateral federal government policy initiative. Several federal officials remarked on this ideological disjunction and said that it presents a problem for policy development on a national scale. It sometimes results in no

decision being taken at all, or in the requirement for a unilateral or hierarchical decision being made by the federal government. Unilateral federal action in the 1990s (such as the CHST) appears to have precipitated a feeling of solidarity in resistance among the provinces and territories. One particular incident illustrates the transcendent nature of united provincial resistance. During the difficult period of the Alberta government's refusal to change its position in the facility fee dispute, Premier Klein appeared at a news conference with the premiers of Saskatchewan and British Columbia, both NDP premiers. Ideologically, they did not support Alberta's position on facility fees, but they were willing to declare their solidarity in the upholding of provincial autonomy over health policy during Alberta's dispute with the federal government. This incident was reminiscent of the support given by the Government of Quebec in the 1980s to Saskatchewan and Alberta when these two provinces sought to deny services to their French-language minorities. Canadian politics makes strange bedfellows indeed!

Underlying the development of solidarity among the provinces and territories was a shared lack of trust in the federal government. The unilateral federal moves of the early 1990s that drastically reduced provincial transfer payments and the dramatic announcement of the CHST in the February 1995 budget were perceived by many as a breach of the Canadian social contract. They combined to undermine the long-standing spirit of cooperation and collegiality among federal public servants and their provincial and territorial counterparts, especially among finance and intergovernmental officials (curiously not so greatly among F/P/T health officials). The insecurity engendered and shared by provincial and territorial governments transcended ideological differences and drove them together in resistance to the federal unilateral moves. Scepticism and suspicion lingered during the Social Union Framework Agreement discussions of 1997-99.

A further noticeable effect of this dispute was the triumph of "high politics" over "low politics." It became so politicized and public that it had a spillover effect, creating tensions in other fields of intergovernmental relations. Intergovernmental Affairs officials and the premiers themselves became so closely identified with the discussions, that the health ministers and their departments were forced to the background. Several officials in the provincial Health Ministries spoke of being "trumped" by Intergovernmental Affairs officials, and of the feelings of diffidence instilled by their intra-governmental difficulties. Many of the provincial Health Ministries have also been greatly thinned out as a result of deficit-cutting exercises, and consequently as a result

of limited preparation time felt at a disadvantage in their negotiations with their federal counterparts. Furthermore there is a perception by provincial/territorial officials of a federal attitude of arrogance and condescension — an unhealthy attitude when cooperation is so essential.[22] It is unfortunate that such tensions between F/P/T Health Ministry officials exist when it is clear that they are in fundamental agreement with the principles of the CHA, and almost all are strong supporters.

ASSESSMENT OF THE EXISTING REGIME

The facility fees issue cannot reasonably be separated from broader federal and provincial goals in the health-care system. The federal government's immediate goal was to prevent further privatization of services through the imposition of user fees for necessary health care. Its broader goal was to send a message to the provincial/territorial governments that the federal government had the will and the persuasive power to interpret and uphold the five principles of the CHA. The goals of the provincial governments were to contain public spending on health care and to send a clear message that the continued withdrawal of federal financial support was a real threat to the viability of the medical-care system. Certainly in the case of Alberta, by encouraging increased privatization, it was testing the strength of the federal resolve to uphold the CHA. The principal difficulty with the resolution of the issue was its emphasis on hierarchical federalism, and its negative effect on intergovernmental relations. In the areas of achieving various national policy goals, respecting democratic values and respecting federalism principles, a regime that allows a hierarchical approach to interpret and enforce the CHA has both strengths and weaknesses.

Achieving National Policy Goals

Equity and efficiency are attainable goals through adherence to the CHA. All citizens, regardless of income status, are guaranteed access to comparable services without extra-billing fees levied. Canada's general health statistics confirm that the health needs of Canadians are being met through the present health system. Canada continues to rank favourably in comparison with other Organisation for Economic Co-operation and Development (OECD) countries in regard to the percentage of GDP spent on health care, evidence that privatization likely increases cost.

CHA does not take into account the varied approaches to health-service delivery, which can depend on the needs of the local community, financial capacity, location or other considerations. At the provincial/territorial level, delivery and coverage of service may differ from one jurisdiction to another, thus undermining the goal of equity. Access and quality of care can differ among jurisdictions.

Democratic Values and Goals

The broad range of democratic support for the system suggests that majority and minority rights are protected. The legislative role of both levels of government is an effective one, since the CHA is federal legislation which the federal government has the legal right to uphold, and the provincial governments have the legal right to legislate outside the CHA, if they are willing to renounce the federal funding share. Furthermore, each province/territory has a broad scope within which to pursue its own priorities.

Under the existing intergovernmental regime, there is little citizen involvement in decisions and dispute resolution, due to the highly secretive nature of intergovernmental relations. Transparency and accountability are serious concerns, since many Canadians (probably a majority) are unclear as to which level of government is responsible for which aspect of the medicare system. Few Canadians could identify the five principles of the CHA as federal legislation and other aspects of their plans as provincial. Complaints about micro levels of service are often aimed at both levels of government.

Respecting Federalism Principles

The legal division of powers is respected in the sense that all specific legislation regarding individual plans is passed at the provincial level. Although this legislation must conform to the CHA to qualify the province for federal funding, the federal legislation does not, in the *de jure* sense, trench on provincial jurisdiction. Thus, the political sovereignty of each level is respected in the strict legal sense. The ongoing intergovernmental negotiations and frequent meetings of political and departmental officials indicate a commitment at both levels of government to work together through the political processes to resolve conflict and improve outcomes for society.

The strengths in this area are also its weaknesses. The federal legislation is coercive, since it forces the provincial governments to pass conforming legislation if they accept federal funding, with the threat of financial penalties

if they do not later conform. This regime is perceived by many of the provincial/territorial governments as unacceptable unilateral federalism. Furthermore, this case study of CHA interpretation and enforcement has shown that the intergovernmental negotiations to resolve conflict tend to be highly politicized, confrontational, and competitive. This has resulted in residual feelings of intergovernmental resentment, suspicion, and frustration well beyond the health arena.

POSITING ALTERNATIVE REGIMES

Three broad alternative regimes are considered: first, a centralized regime with continued federal reliance on intergovernmental hierarchy and unilateralism; second, a decentralized regime wherein the federal government relinquishes its role in the determination of national health-care standards; and third, a more cooperative, collegial regime that depends on meaningful consultation and a genuine recognition that Canada's health insurance program is of equal importance to federal, provincial, and territorial governments and to individual Canadians. An emphasis on this last intergovernmental regime promises to be more fruitful, since it addresses the essence of a federal system and recognizes the legitimate concerns of the two levels of government in a clear area of national interest.

It is important to emphasize that several intergovernmental regimes have historically existed within the health policy arena, as governance relationships have oscillated between centralization (hierarchy and unilateralism) and cautious disentanglement interspersed with tenuous cooperation and enduring intergovernmental tension. The intensely politicized nature of health policy tends to obscure the four decades of federal-provincial cooperation at the officials' level that has sustained this important program. The facility fees issue is an example of one of the low points in intergovernmental relations, and it underlines the complexities of the issues and the fragility of cooperative federalism in Canada. Of itself, the facility fees dispute was not a major health-care issue, but its resolution became a major political issue. Analogous to the extra-billing debate in the early 1980s, it had the potential to increasingly undermine universal access to health care if left unaddressed. It therefore precipitated a heavy-handed federal response. The efforts to resolve the dispute suffered from the lack of a mutually acceptable and effective conflict-resolution process, and it quickly became a flashpoint on which several provinces could focus their frustrations with the federal unilateral and hierarchical moves of the 1980s and 1990s. It was this last aspect rather than the health issue in dispute that caused its escalation into a serious intergovernmental disagreement, highlight-

ing the inadequacies of existing dispute-settling mechanisms, and the unanimous rejection by provincial governments of coercive unilateral federal behaviours. Nevertheless, this is one of the regimes that needs to be examined.

Centralization and Federal Unilateralism

One of the clearest examples of federal unilateralism came in response to the threat to equal access to health care by the introduction of user fees. The federal response was the 1984 *Canada Health Act*, which reinforced the historical hierarchical position of the federal government and restored its ability to penalize provincial governments considered to be in contravention of one or more of the five principles of medicare. The Act was perceived by the provincial governments as a return to the *Father Knows Best* approach of the earlier, conditional grant years and it brought bitter recriminations. Some provincial governments threatened to pursue a constitutional challenge to the CHA although they all conformed to its conditions within the required three-year period. The passage of the coercive CHA after minimal consultation with the provinces angered the provincial governments and it was described as an "unwarranted, powerful and potentially hazardous federal intrusion into a field of provincial jurisdiction."[23] The resentment carried over into the next federal unilateral moves of the 1990s, particularly the imposition of the CHST and the heavy-handed resolution of the facility fee dispute.

The facility fee dispute provoked the federal government to enforce its will on recalcitrant provinces. This was a more hierarchical than unilateral move, however, since with the important exception of Alberta, the provinces had agreed in theory that facility fees were a problem, although there were several permitting the practice. The federal response was to reinterpret the definition of "facility" and to set the 15 October 1995 deadline for conforming legislation. This was a curt reminder that Ottawa retained its will and power to act to dispel threats to the health system. Residual provincial resentment over the passage of the CHA and the imposition of the CHST exacerbated the tensions, and the facility fee issue quickly took on a life of its own, souring relations in other policy areas as well. Clearly, the existing intergovernmental machinery, and the consultations that took place, were inadequate to prevent the issue from escalating into an acrimonious and debilitating disagreement at all levels of federal-provincial relations.

It is often difficult to distinguish perception from reality, however. One must assume that federal officials do not intend to alienate provincial

governments, and they believed that concerted efforts had been made to achieve provincial compliance with the CHA reinterpretation requirements. The chronology of consultation released by Health Canada appears to support this perception, and in fact, from the first federal-provincial meeting dealing with this issue in June 1994 to the imposition of penalties in October 1995, 16 months had elapsed. This was adequate time for provincial governments to indicate that they were preparing legislation that would conform, if they intended to do so. British Columbia officials, for example, expressed relief at the resolution and quickly prepared legislation to comply.

The perception of the dispute of some provincial officials differs, however, from that of the federal officials. Some provincial officials believe that the federal actions, especially the Marleau letter announcing the reinterpretation of the definition of facility and the imposition of financial penalties, were precipitate, paternalistic, coercive, and condescending. The alleged shocking announcement of the CHST during the midst of these discussions reinforced their perception of federal unilateralism and arrogance. Under the existing regime, however, the federal government had little choice but to move unilaterally to resolve a dispute if high-level federal-provincial consultations had failed to do so. During the facility fee dispute, the federal government was determined to uphold the health-care program, and it chose to subordinate an elusive federal-provincial harmonious relationship to what it perceived to be good (and politically popular) public-health policy.

On the other hand, the existing regime has enabled the federal government to uphold the democratic will in the sense of preserving a broadly supported program, and ensuring universal health-care coverage continues in a reasonably efficient, cost-effective, and equitable way. Polls have consistently shown that Canadians rank their health-care program at or near the top of their concerns, and want both levels of government involved in its planning, management and support.[24] Thus, there is democratic support for a continued and meaningful role for the federal government, although it is clear that increased federal centralization in this area, while utilitarian in the short term, carries with it a threat to the peaceful continuation of the Canadian federation.

Decentralization/Devolution

The facility fees issue underscored the entrenched government interdependence in the health-care sector, although there have been two major federal initiatives that were clearly a shift toward disentanglement in this policy area. The first

initiative, the EPF arrangements of 1977, was a massive transfer of money and power to the provincial governments[25] and drastically reduced the federal government's ability, in any practical sense, to enforce the standards of the *Medical Care Act* on a recalcitrant provincial government (for example, it could no longer partially penalize a province for infringement). The result of this disentanglement was a move by substantial numbers in the medical profession in several provinces, particularly Ontario and Alberta, to opt out of the medical plans and to extra-bill their patients. The provincial governments tolerated this erosion of the principle of universality of access, and the equity goal of medicare was clearly threatened.

The implications of a second, major disentangling thrust, the CHST in 1995, were almost lost amid the provincial shock of the accompanying reductions in transfer payments. This unexpected move was a clear federal signal to the provincial governments that the *quid pro quo* for the autonomy they desired in the social welfare arena was a precipitous drop in cash transfers. When many provincial governments responded with caps on increases in health-care spending and cutbacks in covered services (already begun in most provinces) and a shift toward privatization in a few provinces, the facility fee dispute ensued. The irony of the vociferous provincial demands for restored federal funding is that more federal funding will restore more federal influence over social programs, which it was apparently prepared in 1995 to relinquish.

The disentangling move, although precipitated by fiscal necessity, also recognized the desire for devolution that several provinces, especially Quebec, have expressed. This involves a retreat by the federal government from its legal right to unilaterally interpret and uphold the principles of the CHA, in favour of joint interpretation or even provincial interpretation. There have been arguments in support of such a move.

In a 1998 article, Ronald Manzer concludes that after decades of national standards in social policy set by the federal government, "voluntary interprovincial standards now should have their day." [26] His arguments against federally-determined standards in health care are based on what he perceives to be the inadequacies of the CHA standards, which focus on the process of health-services delivery rather than on such issues as identifying health deficiencies and specifying the content of services.[27] In addition to being narrowly conceived, existing standards are "aggressively hostile," thus becoming a "divisive barrier to federal-provincial cooperation in the development of national health policies."[28] Manzer's argument to allow provincial governments to determine national standards through voluntary interprovincial agreements

is predicated on the optimistic expectation that provincial societies, informed by common social policy ideas, will put pressure on their governments to conform to the level of services in other jurisdictions. Provincial direction of health policy also provides the opportunity for independent innovation, such as the early forays into health insurance by Saskatchewan which led to the development of the present Canadian health system.

There are compelling arguments against allowing provincial determination of national health policy, or even joint interpretation of the CHA with some form of provincial veto. They are based on two broad categories of objection: (i) effects on existing provincial economic and social disparities and (ii) the implications for democratic governance.

Canadians are sharply aware of the social, economic, and power disparities that exist among provincial and territorial societies, as well as the potential for exacerbation of these disparities if the federal government should abandon its commitment to economic redistribution. For example, it is difficult to imagine provincially-determined standards that are higher than the lowest common denominator, or, as Roger Gibbins argues, "standards will be set by the government that is able to pay the least, for other provincial governments cannot force it to pay more than it is able to pay."[29] And it is unlikely that a federal government denied voice in the determination of standards or principles would be interested in giving financial support to the smaller provinces. Thus, a patchwork of programs would develop, with only minimum standards adhered to by all; and even this is questionable, with no central authority to ensure compliance.

Gibbins argues that it is unlikely that any form of national standards would survive, since provincial governments have rarely exhibited an ability to broaden their perspectives beyond narrow, territorial considerations. Further, he does not believe that national unity would be enhanced, since the influence of larger, wealthier provinces would be increased. Howard Pawley, former premier of Manitoba, concurs and adds that although the provincial governments are better equipped to effectively administer social programs, the basic standards must be established by the national government, which is the only government capable of maintaining a national perspective.[30]

The threat to democratic governance flows from the discussion above, regarding increased regional disparities and declining standards. If it is accepted that a majority of Canadians outside Quebec believe that the federal government should be actively involved in national social programs such as health care,[31] then the continuation of this involvement is an expression of the

democratic will. Standards set by provincial governments, or both federal and provincial governments, would lead to increasing complexity in Canadian government, in the sense of an escalation in the need for intergovernmental conferences, an increased diffusion of democratic accountability, and a loss of, or the need for a new national standards enforcement procedure.[32] This last is perhaps the largest threat to a continuation of any semblance of a national plan if ten provinces and three territories are individually responsible for its enforcement. It is difficult to conceive of any mechanism that could be employed to enforce standards (voluntary or otherwise) on recalcitrant provinces.

Decentralization or devolution has another implication for health policy, since it is being pursued, for the most part, by provincial governments that are eager to experiment with increased privatization of their health-care systems, for ideological as well as financial reasons. It is not only the neo-conservative governments of Alberta and Ontario that have pursued aspects of privatization, however, but some of the smaller provinces as well, who have found themselves in financial difficulty following federal cutbacks.

The evidence in this study strongly suggests that if Ottawa acquiesced to provincial demands for at least an equal say with Ottawa over the interpretation of the CHA and the setting of national standards, the public nature of medicare would soon be undermined. First, the reluctance of some provincial governments to ban extra-billing in the 1980s, despite the threat to accessibility, and the efforts of others to introduce elements of privatization and market forces into their systems, indicate that universality of coverage and equity of access are not priorities with some governments. The early intransigence and anti-CHA rhetoric of the Alberta government during the facility fee dispute is a clear indication of its eagerness to embrace private sector delivery systems. Second, it is highly improbable that ten provincial and three territorial governments charged with defining the health-care system and interpreting the CHA could reach a consensus acceptable to the majority of Canadians. These governments are ideologically disparate, they speak with a myriad of partisan voices, and several of them have particular economic and political agendas, quite dissimilar from others. The provincial collaborative effort that led to the document, *Renewed Visions*, brought a rare consensus that could soon dissipate with federal disengagement, producing factions and fragmentation. Finally, the elimination of national direction would effectively remove Ottawa from its role as gatekeeper, with the potential inequitable effect of the development of 13 quite discrete health systems, with no nationally shared standards. There would be little incentive for federal contributions to programs over which it

had no control and for which it received no political credit, thus worsening the position of the smaller provinces.

Meaningful Consultation and Collaboration

Although the present regime has served Canadians well, it has often caused intergovernmental friction, and it would be unproductive to simply preserve the status quo. The periods of tension have primarily had two origins: unilateral reductions in federal transfer payments, which precipitate an angry provincial response, and provincial government moves that have threatened access by permitting extra-billing charges and by shifting toward privatization, precipitating angry federal responses. Existing mechanisms to resolve these tensions amicably have been inadequate. The consultative, coordinative, and cooperative language used to describe intergovernmental relations in the Canadian federal system has often been empty rhetoric. It must be given substance. The firm federal undertaking of September 2000 to sustain adequate and dependable funding as a *quid pro quo* for a renewed provincial commitment to the five principles of the CHA was perceived as the minimum requirement to achieve the intergovernmental peace that Canadians desire.

After the corrosive CHST experience, provincial governments are understandably apprehensive about long-term federal initiatives that involve a major new commitment of provincial revenue. For its part, the federal government has reason to believe that, left alone, several provincial governments would take irrevocable steps toward increased privatization of services and perhaps user fees. Nevertheless, the reality of Canadian federalism is that the coercive use of the federal spending power has become an unacceptable, colonial act, and renewed attempts to pursue *Father Knows Best* federalism would only further dissipate Ottawa's already meagre political capital with the provinces. The reality is that in social policy especially, the interdependence of the two levels of government is entrenched. Both levels of government must be involved in the determination of national goals, principles, and standards if social programs are to be widely accepted as truly national. After consensus has been reached, a single (national, almost certainly federal) body must be entrusted with enforcing compliance,[33] and a process could be developed to assist this body in its interpretation and enforcement of federal Acts such as the CHA. The 1998 Social Union Framework Agreement (SUFA), endorsed by the federal government and nine provincial and two territorial governments, lays the groundwork for a reconciliation of these intergovernmental realities. It explicitly

recognizes and legitimizes the interests of both levels of government, as well as the public, in the development and oversight of national programs — in particular, the health-care program.

The SUFA discussions established a link between increased federal transfer payments to the provinces for their health programs, and the acceptance by all the provinces of the five principles enunciated in the CHA. Although the SUFA language is not memorable (for example, it expresses a desire for Canadian governments to "work more closely together to meet the needs of Canadians") it does reflect a shared and renewed commitment to move toward more amicable intergovernmental relations. Through the proposed Ministerial Council, the governments have committed themselves to concerted efforts to consult, share information and avoid duplication, and to collaborate to avert and resolve disputes. The document clearly recognizes the debilitating and wasteful effects of recent bitter disputes, and seeks to implement efficient, effective, and transparent mechanisms to identify alternatives to divisive actions. Perhaps of most importance to provincial governments, the Government of Canada agreed to refrain from the introduction of new initiatives in provincial jurisdiction without broad consultation and the consent of a majority of the provinces.[34] Further, it has committed itself to three months notice and an offer to consult before new transfers to individuals (such as the Millennium Fund) are introduced, and it has promised to pursue at least one year of consultation in the all-important area of changes in funding of existing social transfers, to ensure a greater degree of funding predictability. At a minimum, another unilateral CHST announcement should be avoided.

The SUFA does attempt to go further, although its language is indefinite and lacking in detail. In section 3, where it provides for public accountability and transparency, it is reminiscent of *Renewed Visions* which suggested that mechanisms be devised to enable Canadians to participate in developing the priorities of their medical care plan, and in evaluating the effectiveness of its services. The implications of this notion, if it is meaningfully pursued, are very broad, even iconoclastic, given the deeply entrenched proclivity for in-camera negotiations; the SUFA discussions themselves were widely criticized for their excessively secretive nature.

The SUFA calls for the appropriate use of third-party experts to provide advice, and increased government-citizen reciprocal interaction. This could be achieved with a small standing consultative group, perhaps called the Canadian Health Council, consisting of federal and provincial appointees, knowledgeable citizens, academics, and members of the attentive public. This

has the potential to greatly increase democratic input and reduce the perception that the health-care programs and other social programs are primarily a political football. This body could be effectively employed in the mediation or facilitation of solutions to micro irritants (which the facility fee issue originally was) with the potential to reduce intergovernmental political tensions before they escalate and spill over into other policy areas.

The Canadian Health Council (CHC) would have a clear mandate to investigate, arbitrate, publicize, and make recommendations for the resolution of intergovernmental complaints brought before it, although it would not have the power to make binding decisions. To preserve democratic accountability, final decisions would rest with governments, and in the last instance, an impasse would be resolved by the federal government. It is the one government entrusted with a Canada-wide vision and legislative authority, and therefore the responsibility to resolve an impasse. Nevertheless, a neutral, external and well-recognized body of experts as envisioned in the SUFA document, could make a meaningful contribution to continuing efforts to transcend the difficulties inherent in a constitutional division of powers that provides the federal government with the lion's share of taxation powers, and gives the provincial governments jurisdiction over the crucial and expensive social welfare sector. To increase the perception of transparency and fairness, a subcommittee of the CHC might act as a medicare ombudsman, giving citizens an opportunity to register their concerns.

CONCLUSION

Despite the unfortunate and serious friction that this case study has chronicled, the existing intergovernmental health policy regime has, in a broad sense, realized the goals of redistributive equity, efficiency, human development, and mobility. Compared to most other countries' health systems, the Canadian system has delivered necessary health care on the basis of need in a cost-effective way. More amicable, consultative, and collaborative efforts should lead to a further realization of these goals, while increased disentanglement would threaten them. At the micro level, there are now many program differences among jurisdictions (within the confines of the CHA). While this is constitutionally appropriate, it often reduces redistributive equity, mobility, and human development. However, there is some evidence to support arguments that these inequities have been driven more by fiscal considerations than by policy preferences, and they could be reduced if sufficient funding is assured.

In the democratic sense, opinion surveys have consistently shown that Canadians view their valued health-care system as a national system, one with which they strongly identify and which they expect both levels of government to support and uphold. Its universal nature has strengthened the expectation that treatment will be based on need rather than on the ability to pay. Its highly technological nature means that the public, in whose name the medicare program was implemented, must essentially trust their elected representatives to act on their behalf to preserve this social program. Their confidence in democratic government is shaken when health policy becomes a divisive and contentious political issue that focuses more on disputes over legislative jurisdiction than it does on methods to strengthen and protect the system and the health of Canadians.

The present intergovernmental regime is one that discourages citizen involvement and encourages secretive and confrontational intergovernmental negotiations. The important political discourse at intergovernmental conferences and first ministers' meetings is held in camera, and citizens learn of discussions and decisions only from the media. This is poor citizen representation for such a crucial area, and it increases the potential for an escalation in the perception of conflict and political division. This type of regime also creates problems with transparency, as well as the determination of political accountability, but it may, to a certain extent, be a necessary trade-off for enhanced intergovernmental coordination and collaboration. The SUFA, however, in its suggestions for increased openness, collaboration, and a third-party advisory and consultative body makes an important contribution to efforts to reduce intergovernmental tension, restore intergovernmental trust, and enhance democratic participation.[35]

The federal government's spending power has long been recognized, and a strong case can be made that under the "peace order and good government" clause in the preamble to section 91 of the *Constitution Act, 1867* the federal government can become involved in provincial areas of jurisdiction with an important national dimension. Health care has been identified by both federal and provincial governments as one such area. The resulting lessening of provincial sovereignty must be carefully negotiated, managed, and kept to a minimum if destructive and hostile disputes and a perception of hierarchical or unilateral federalism are to be avoided. Nevertheless, at the end of the day, the federal government must be the government entrusted to make the final decision. It seems clear that if Canadian governments want to preserve the health-care regime from the corrosive and negative effects of acrimonious

intergovernmental relations, innovative intergovernmental cooperative, collaborative, and coordinative mechanisms are essential.

NOTES

Much of the information in the chapter was obtained through interviews with federal and provincial public servants. Although they remain anonymous, I am grateful for their assistance. I would also like to thank Professor Howard Pawley at the University of Windsor, Harvey Lazar, Duane Adams, and participants at the roundtable in June 1999, for many helpful comments.

[1]See other case studies in this volume for elaboration, especially the introduction.

[2]There is, I believe, a fine distinction. Unilateralism entails federal action with little or no consultation (such as the CHST). Hierarchical federalism involves federal imposition of its will over the objections of some, but not necessarily all, of the provincial governments. In the case under discussion, many federal officials argued that most of the provinces agreed with the need to enforce the access principle of the CHA.

[3]The respective dates for passage were 9 April and 17 April. See Malcolm Taylor, *Health Insurance and Canadian Public Policy* (Montreal and Kingston: McGill-Queen's University Press, 1987) for an excellent chronology and description of the evolution of the health-care system.

[4]The first Hall Commission released its report in June 1964. This led to the adoption of the national *Medical Care Act*, 1966.

[5]The 1957 and 1966 Acts included their own funding formula, whereas the CHA refers to fiscal arrangements legislation.

[6]This discussion is taken from Odette Madore and Claude Blanchette, "The CHST: Operation and Possible Repercussions on the Health Care Sector," Library of Parliament, 1996.

[7]A federal public servant dismissed this concern, saying that the original title never posed any threat to health insurance.

[8]There was considerable debate about this, but in any event, even prior to the CHST, the cash portion would soon have disappeared in some provinces.

[9]This is Tom Courchene's very appropriate description.

[10]Much of the debate coalesced around the Gimbel eye clinic in Calgary, which developed an innovative and highly successful procedure for the treatment of cataracts, and charged a facility fee of more than $3,000. It attracted large numbers of patients, but it was one of several such clinics.

[11]Some of the abortion clinics almost certainly contravene the Act, but there is another dimension to this debate that governments are loathe to address.

[12]The following chronology is taken from the Health Canada Release, "Chronology of Federal/Provincial/Territorial Consultation Events Related to Private Clinics," October 1995.

[13]For example, Klein was quoted in *The Globe and Mail*, 5 April 1995, p.A4, saying the CHA should be changed to allow the growth of private health care.

[14]Richard Gwyn, "The Real Battle Lines Forming Around Health Care," *Toronto Star*, 7 April 1996, p.F7.

[15]Fulton did not last long as deputy minister. She was found to have exaggerated her qualifications on her CV and made a quick departure. It is important to note here that Canada's system has always been "two-tiered," since many services are not covered (for example, drugs), provinces often cover different services (for example, private physiotherapy). Approximately 30 percent is already private, and the percentage is increasing.

[16]*The Globe and Mail*, 30 November 1996, p.A17.

[17]It is unlikely, however, that Canadians — or indeed, many of the provincial governments — would wish to draw up an arbitrary list such as they have in Oregon. The Canadian system allows flexibility and room for the discretionary decisions often required by health-care practitioners. This debate, however, is another example of provincial disagreement.

[18]It is important to note here that most of the provinces have in the past (and at their own expense) gone well beyond the coverage of services (hospitals and physicians only) as originally conceived in the Medical Care plan. Alberta has been one of the most generous.

[19]This was probably not a very good idea, since it was a further provocation to the provinces.

[20]Polls consistently find widespread democratic support for the health insurance system.

[21]*The Globe and Mail*, 11 September 1997, p.A10.

[22]This perception is not without foundation. Federal officials were frequently dismissive when asked about provincial concerns.

[23]Taylor, *Health Insurance*, p. 435.

[24]See quotation by Steven Lewis in chapter by Duane Adams, "Canadian Federalism and the Development of National Health Goals and Objectives," in this volume, p. 81.

[25]Taylor, *Health Insurance*, p. 435.

[26]Ronald Manzer, "'Any Dog Will Have His Day': National Standards in Canadian Social Policy," in *Cross Currents: Contemporary Political Issues*, ed. M.Char lton and P. Barker (Toronto: Nelson, 1998).

[27]There are many who would argue that this flexibility is the strength of the CHA, in its recognition of provincial jurisdiction over the administration of the health-care program.

[28]Manzer, "Any Dog Will Have His Day," p. 153.

[29]Roger Gibbins, "Decentralization and the Dilemma of National Standards," p. 142.

[30]Personal Interview, 26 March 1999.

[31]Gibbins, "Decentralization and the Dilemma of National Standards," p. 136.

[32]Ibid., p. 139.

[33]I am grateful to Allan Maslove for this suggestion.

[34]It is interesting to speculate whether the original *Medical Care Act* would have been possible under the SUFA, probably not. *The Medical Care Act* proceeded gradually between 1967-71, by provinces opting-in, coerced by federal funding. The CHA might be possible under the SUFA, since it is a reinforcement of an existing program, rather than the imposition of a new one.

[35]What has not been addressed in this agreement, or discussions to date, is the possibility that a future federal government may wish to abandon the national nature of Canadian social programs. That is, the implicit assumption is that the federal government will uphold and initiate national programs that conform to the wishes of a majority of provinces and meet the expectations of Canadians. No reciprocal mechanism is suggested that would prevent a determined federal government from withdrawing its financial and legislative support, provided it gives "due notice" of its intentions. Although this would be a politically unpopular move, the Canadian parliamentary system allows a majority government to proceed with nation-changing legislation that is objectionable to a majority of Canadians and a majority of provincial governments (for example, the Free Trade Agreement and the Goods and Services Tax). Some consideration should be given to developing a mechanism to prevent unilateral federal abandonment of social programs and that respects the democratic will of a majority of Canadians, as well as their provincial/territorial governments. This could involve a recognition of "social rights," as envisioned in the Charlottetown Accord 1992. This concern was expressed by Howard Pawley, contemplating a future federal government led by the Canadian Alliance.

7

THE ROLE OF FEDERALISM IN HEALTH SURVEILLANCE: A CASE STUDY OF THE NATIONAL HEALTH-SURVEILLANCE "INFOSTRUCTURE"

Kumanan Wilson

INTRODUCTION

Health surveillance is an often overlooked yet vital component of the Canadian health-care system. Health surveillance authorities are responsible for tracking and forecasting health events and examining the determinants of these conditions. These authorities may, for example, identify the development of an infectious disease outbreak or draw attention to gradually increasing rates of cancers and their association with an environmental risk factor. Surveillance information provides public health officials with the knowledge they require to intervene early and effectively to prevent or control emerging health problems.

Over the past several years concern has emerged among all orders of government that current standards of health surveillance are grossly inadequate. In 1995, federal, provincial, and territorial (F/P/T) officials, in conjunction with epidemiologists and public health authorities, began a coordinated effort to develop a new national approach to health surveillance. This initiative was primarily motivated by concerns over the existence of serious gaps in current surveillance activities. It was believed that if these gaps were not addressed a large-scale, public health crisis, similar to what the blood system had experienced

with HIV and hepatitis C, could occur. The overall approach, currently in the process of being developed, is referred to as the Network for Health Surveillance in Canada (the Network). The most advanced component of the Network is the National Health Surveillance Infostructure (NHSI), an Internet-based network/infrastructure, designed to build capacity to help coordinate health-surveillance activities across the country.

Beyond their impact on health, the development of the Network and the NHSI are important because they represent a fundamental change in the manner in which Ottawa and the provinces interacted in the field of health surveillance. A new collaborative approach replaced the previous relationship in which the two orders of government had acted relatively independently of each other. To this point, the collaborative approach has been considered a success, allowing for the emergence of a widely supported national plan in a relatively short period of time.

This case study will describe the design and development of the Network and the NHSI as well as Health Canada's closely related Health Protection Branch (HPB) Surveillance Transition project. In order to give context to this case study, selective background information on public health and health-surveillance activities in Canada will be provided. The constitutional ambiguity surrounding jurisdictional responsibility for health surveillance in Canada is described as well as how this led to a highly fragmented health-surveillance regime throughout the country. The important contribution of the Krever Inquiry into the Canadian blood system crisis is offered as an example of the serious consequences that can emerge for governments and the public caused by the neglect of addressing structural problems in the management and delivery of this important health subsystem. The impact of different forms of federalism in the field of health surveillance will be evaluated and a comparison will be drawn between the experience in health surveillance and the experiences in environmental harmonization. The methodology and criteria for this assessment are provided in the introductory chapter of this volume.[1]

The complete analysis of this case is limited because the programs being examined are not all in place as of yet. Therefore the focus will be on the impact of federalism on the development of these programs. The case study will attempt to determine why a collaborative form of federalism was chosen and its advantages and disadvantages compared to the previous disentangled model. Based on the analysis, an attempt will be made to determine what characteristics of a policy initiative make it best suited to a collaborative form of federalism.

BACKGROUND ON HEALTH SURVEILLANCE

The Canadian health-care system consists of three components: health care, health promotion, and health protection. Health surveillance falls under the category of health protection. Public health surveillance refers to the process of collecting, analyzing, and disseminating health data. Surveillance authorities collect data to monitor and investigate health events or determinants of health, analyze and interpret this data, and disseminate this information to those who require it. The objective of surveillance is to provide timely, accurate, and strategic information and analysis to assist the health system in areas of policy, planning, and evaluation.[2] Health surveillance can deal with both communicable disease such as infections and non-communicable diseases such as diabetes, heart disease, and cancer. Communicable disease surveillance is particularly important since its implications transcend all geographic and jurisdictional boundaries.

Under the *Constitution Act, 1867* the majority of health care falls under provincial jurisdiction. Provinces are responsible for "the establishment, maintenance and management of hospitals, asylums, charities and (charitable) institutions in and for the province, other than marine hospitals." Responsibility for health protection is less clear with federal and provincial governments sharing responsibilities. Public health is considered primarily a provincial concern under section 92(13) of the *Constitution Act, 1867* which gives the provinces responsibility for property and civil rights. Further provincial authority in this field is derived from the power they are given in section 92(16) over matters of a local or private nature in the province. Health surveillance falls into both of these categories and is therefore considered a provincial responsibility.

The federal authority in the field of health protection derives from a number of sources. Under section 91(27) of the *Constitution Act, 1867* the federal Parliament is assigned power over criminal law allowing it to pass legislation to prevent transmission of a "public evil." This permits it to pass legislation to control transmission of health risks. The residual power given to Parliament under the national concern section of the "peace, order and good government" power of the *Constitution Act, 1867* also allows it to enact legislation to regulate matters of national health and welfare. These must be issues in which intra- and extra-provincial implications of the issues are linked, in which provinces are not able to regulate effectively on their own and in which failure of one province to regulate would affect the health of residents of other provinces. Health surveillance falls under this category. The federal government

also obtains authority over health protection by the power it is given to quarantine and to regulate trade and commerce of an interprovincial or international nature.[3]

Therefore, under the constitution, the provinces and the federal government share responsibility over issues of health surveillance. Both orders of government have used their authority in the area to pass legislation. The federal government, through the *Statistics Act* and the *Department of Health Act* has a mandate to collect information on public health risks of a Canada-wide nature.[4] Provincial governments have also passed similar, but not complementary legislation to address intra-provincial health risks. Despite the existence of this legislation, there remains a lack of jurisdictional clarity in the area. Importantly, Ottawa lacks the constitutional authority to enforce legislation that compels provinces to transfer surveillance information to federal officials. Therefore, such transfers must occur voluntarily.

Federal public health functions are carried out by Health Canada and in particular its Health Protection Branch (HPB) (see Appendix B). Health-surveillance activities of the HPB are primarily the responsibility of the Laboratory Centre for Disease Control (LCDC). The LCDC collects information from the provinces and territories on these diseases, assists provinces in the diagnosis of communicable diseases and helps provinces, upon request, to react to health threats from these diseases. It monitors public health and emerging diseases nationally and internationally and provides an overall health surveillance function for the country. At the provincial level there is considerable variability in the organization, financing, and administration of public health activities.[5]

Federal health surveillance has traditionally focused on communicable diseases. Ottawa has collected information on these since 1924. It interacts with the provinces in this area via the LCDC, which in 1988 assumed full responsibility for collecting information on notifiable diseases from Statistics Canada. The LCDC assists the provincial health ministries in the diagnosis of communicable diseases and helps them identify and react to health threats. Provinces and territories supply information on notifiable diseases to the Bureau of Infectious Disease at the LCDC via the Canadian Communicable Disease Surveillance System.[6] However, there is dissatisfaction at the national, provincial/territorial and local levels about existing relationships in this area.

An example of previous federal-provincial interaction in non-communicable disease surveillance is the now discontinued Sentinel Health Unit Surveillance System. In 1993 the LCDC launched this system in an attempt to improve the

scope of its surveillance activities beyond communicable diseases. Provincial epidemiologists identified key health units within their jurisdiction that would participate in this program. The LCDC dealt directly with these units and collected information that could be used for developing public health policy (demographic, incidence, risk factor data, etc.).[7] Provincial ministries of health could be bypassed in this process. A current example of non-communicable disease surveillance is cancer surveillance. Provincial cancer registries send cancer incidence and mortality data to a national cancer registry at Statistics Canada. This process is, for the most part, voluntary. Voluntary agreements also exist for sharing data on hospital discharges. These are then sent to the Canadian Institute of Health Information (CIHI).[8]

Several problems currently exist in health surveillance. Experts in the field see many "islands of activity" in health surveillance with a lack of coordination and standardization and provincial, interprovincial, and national links. They believe this results in an inefficient, fragmented system with duplication and, especially, important gaps. Their major concerns include a lack of integration of existing health-related databases, inadequate linkage between laboratory-based diagnostic data and public health data, and lack of information on determinants of health. There is also confusion over federal-provincial roles and responsibilities in health surveillance, which is largely a result of ambiguity in the constitutional division of powers.[9]

At the federal level there are major difficulties with the considerable variation in the format of the information provinces send to the LCDC as well as the variety of computer programs used. The LCDC also recognizes it has significant resource and organizational limitations in carrying out effective surveillance.[10] At the local level, public health officials support Health Canada's assistance of provincial public health laboratories. There is satisfaction with communicable disease surveillance activities of Health Canada but non-communicable disease health surveillance is felt to be inadequate. There have been concerns with the fragmented approach to surveillance taken by the LCDC and its tendency to bypass provincial ministries when dealing directly with local health units. Some public health officials have found the organization of the LCDC difficult to understand and have had trouble communicating with this directorate. There is also a belief that communication between the various bureaus of LCDC is not optimal. However, more importantly, public health officials are looking for a greater federal role in coordinating surveillance activities across the country.[11]

The Auditor General's 1999 report highlighted many of the current deficiencies of the present state of health surveillance. It identified the need to coordinate current health-surveillance activities, address important gaps, clarify roles and responsibilities, have clear rules and procedures to deal with emerging health threats, improve levels of communication and have a mechanism to evaluate quality of surveillance. This report drew particular attention to the nationwide outbreak of a food-borne salmonella infection in spring of 1998 as an example of the consequences of an inadequate health-surveillance system in Canada.[12]

PARALLELS WITH THE CANADIAN BLOOD SYSTEM

The experience of the Canadian blood system in addressing the problem of blood transmission of hepatitis C and human immune deficiency virus (HIV) provides further insights into the motivation of the current health-surveillance initiatives. The difficulties of the blood system have been described in detail by the Commission of Inquiry on the Blood System in Canada (Krever Commission).[13] To summarize the report of this commission, it was identified that the operator and regulator of the blood system, the Red Cross and Bureau of Biologics, had responded too slowly to the emerging evidence of blood transfusion of hepatitis C and HIV. This delay resulted in numerous potentially avoidable infections and it created a public health disaster. The commission attributed these delays to several systemic problems. Among these were a dysfunctional relationship between the major players in the blood system, problems in the method by which decision-making occurred and inadequate and inappropriate use of existing evidence of risk of transmission.

The state of the blood system prior to the HIV and hepatitis C crises and the current state of health surveillance share many features. The pre-Krever blood system was a low-profile field which allowed it to operate free of scrutiny despite the existence of serious governance and systemic problems. Only after the emergence of a public health crisis did the blood system draw public attention to its deficiencies and only then were the problems addressed. Health surveillance also does not receive much public attention and has developed several of the problems faced by the pre-Krever blood system. In describing the systemic problems of the blood system, the Krever Commission stated that:

> responsibility for the blood system is fragmented … the various functions integral to the supply of blood, such as regulation, funding and planning, are

> undertaken by different stakeholders. The respective functions, authority and accountability of each party are not well defined … This lack of definition may affect accountability within the system, and ultimately its safety.[14]

The issues of fragmentation, unclear roles and responsibilities, and lack of accountability have been identified as some of the major deficiencies to be overcome as the health-surveillance system is being reformed.

The Krever Commission had a profound impact on decision-making at all levels of government, particularly in public health circles. It sent a strong message that inadequate information was not a justification for inappropriate decision-making. Officials in Health Canada recognized the risk of a repeat of the blood crisis in other public health sectors. The potential risk provided a strong motivation for the development of the new surveillance initiatives.

DEVELOPMENT OF THE NETWORK FOR HEALTH SURVEILLANCE IN CANADA AND THE NATIONAL HEALTH SURVEILLANCE INFOSTRUCTURE

The Network for Health Surveillance in Canada is an attempt by federal, provincial, and territorial partners to address the deficiencies in the field of health surveillance. The objective of this project is to build capacity at all levels (local, regional, provincial/territorial, and national) to acquire and share health-surveillance information so as to improve evidence-based decision-making in the public health sector. It is believed that the Network will deliver better quality surveillance information, easier access to this information, timely sharing of the information, and tools for the integration and analysis of this information. It will also provide standards for the collection of surveillance data and provide an adaptable system which can accommodate changing health-surveillance needs. However, it is *not* intended to be a comprehensive plan for health surveillance. Individual partners can choose to operate outside the Network if they so desire and will still remain accountable for many surveillance functions.

The NHSI operationalizes many of the concepts put forth by the Network project. The NHSI is a federal-provincial collaborative effort to develop Internet-based tools that will allow for national and international surveillance of disease and other potential risks to health. Its objective is to develop an electronic infrastructure that will improve coordination of the presently fragmented health surveillance activities occurring throughout the country. Some of its key elements include[15]:

Integrated national public health architecture. The NHSI will link key public health nodes such as public health laboratories, hospitals, and physicians' offices.

Global surveillance and early-warning networks. The NHSI will coordinate with international health-surveillance systems to provide early information on emerging global health risks.

Policy and program decision support systems. The NHSI will assist in the analysis and interpretation of surveillance data. This will facilitate the tracking of risk factors and diseases as well as health expenditures, the economic burden of disease, and the effectiveness of health programs and policies.

Integration of human health-surveillance information with other determinants of health information. The NHSI will collect information on factors such as socio-economic status and level of education and assess their impact on health (although this is not an immediate priority).

Development of a comprehensive Internet-based health information resource. The NHSI will link health-surveillance data across the country via the Internet.

The NHSI is intended to develop on the basis of an implementation strategy of successful local pilot projects which are then voluntarily generalized across the country. Local public health officials who identify gaps in current health-surveillance activities are encouraged to approach federal officials for assistance. The federal government, through its HPB Surveillance Transition office, will provide supportive funding to build the electronic infrastructure to address the surveillance needs for that particular site. These initial pilot projects will be tested and evaluated at the local level and, if found to be successful, will be offered to other sites across Canada. In this way the NHSI will provide ongoing needs-based investment in infrastructure which is intended to be function specific (i.e., building information-collection capacity) as opposed to disease specific. Some of the components and support systems which are in the process of being developed are described in Appendix C.

The development of the Network and NHSI initiatives has involved a complex interaction of several federal, federal/provincial/territorial, provincial, and non-governmental organizations (some of these organizations and their contributions are outlined in Appendix D). A bottom-up pressure from local epidemiologists and public health officials to change the current system of health surveillance coincided with recognition at the federal and provincial levels that an improved system was necessary. Also critical to the development

process was the presence of new information technology that made a national surveillance system possible.

Over the 1990s Ottawa reduced cash transfers to the provinces for health care. The provinces also constrained or reduced funding to regional and local health organizations. The reduction in funding to the regional level was accompanied by a devolution of power, the objective of which was to contain costs and improve health outcomes.[16] Local public health units, as a result, came under increasing pressure to improve the efficiency of their activities. However, achieving these efficiencies required improved methods of data collection at local levels and the facilitation of information-sharing between provinces. Traditional health-surveillance activities could not adequately carry this out. This explains the grass-roots pressure from local epidemiologists and public health officials to improve health-surveillance systems.

At the same time, at the federal and provincial levels, there was a growing recognition that a more coordinated approach to surveillance was necessary. In March 1995, the deputy ministers of health, in an effort to improve communication between levels of government, established an F/P/T working group to examine the health roles and responsibilities of each level of government. The main focus of this F/P/T collaborative effort was to search for overlap and duplication. The task force noted that there were few areas of overlap and duplication in health protection. Instead, large gaps were found, especially in health surveillance.[17]

Pressure also began to emerge from other sources for improved health surveillance. In September 1995, the Information Highway Advisory Council (IHAC) called for a federal leadership role in developing a unifying health information infrastructure. This was followed by a report in September 1996 by the Canadian Network for the Advancement of Research, Industry and Education (CANARIE) which called for Health Canada to work with the provinces and territories to develop a national strategy for the institution of an integrated health information network. In February 1997, the federally commissioned National Forum on Health recommended the development of an evidence-based health system based on a nationwide information system.

In response to these reports, particularly the National Forum on Health, the February 1997 federal budget committed $50 million over three years to develop a Canadian Health Information System (CHIS — now referred to as the Canadian Health Infostructure), an electronic "network of networks," to support evidence-based decision-making. In April 1997, the Advisory Council on Health Infostructure was created to advise the minister of health on

developing a long-term strategy to establish a Canadian Health Information System. This strategy included a call for the development of several pilot projects as well as the launch of a three-pronged Health Canada initiative to accelerate the development of an information system. The initiatives called for were a Population Health Clearing House, a First Nations Health Information System and a National Health Surveillance System. The health-surveillance system eventually developed into the NHSI. The responsibility for designing and developing the system was given to the HPB. The assistant deputy minister (ADM) of this bureau brought in surveillance and epidemiology experts from the LCDC to design such a system.[18]

Surveillance Transition

At the same time that the CHIS initiatives were being launched by Health Canada, the HPB was going through a process called "Transition." During the Transition, HPB reviewed several of its responsibilities through in-depth consultations and made appropriate adjustments to adapt to changing health-protection demands. Surveillance is one component of Transition. The original objective of Surveillance Transition was to coordinate the surveillance activities of all HPB directorates as well as develop a surveillance framework for Canada and a coordinated national approach to surveillance activities. The Surveillance Transition initiative would eventually produce the Network for Health Surveillance. The NHSI operationalizes many of the concepts embodied in the Surveillance Transition initiative and the two projects share several key personnel.[19]

The federal government approached Surveillance Transition as a collaborative process from the outset, working closely with the provinces and territories. The deputy ministers of health supervised the overall project. Initial work on the Surveillance Transition project was conducted by an Integration Design Team. This team built on the work of the previous F/P/T working group on roles and responsibilities. (The working group had preliminarily assigned to federal, provincial, and territorial governments specific responsibilities in health surveillance.) The Integration Design Team, also F/P/T in nature, expanded on this work by determining who is to be responsible for what aspects of a national health-surveillance system. It recommended functional roles and responsibilities of the main partners involved in national health surveillance and recommended processes whereby the F/P/T partners can, in a collaborative manner, establish, review, and amend — when necessary —

national surveillance priorities. The Integration Design Team presented a draft report to the deputy ministers of health in June 1998 which led to the publication of a discussion paper on an Integrated National Health Surveillance Network for Canada in September 1998. These reports initiated a broad series of consultations across the country.[20]

Work on the development of the Network was assumed by the Health Surveillance Working Group, another F/P/T organization, from August 1998 onwards. This F/P/T working group is to advise on development and coordinate the implementation of the surveillance network. This includes strategic planning and priority setting as well as determining evaluation strategies. It will be responsible to the Advisory Committee on Health Infostructure, which will report to the Conference of Deputy Ministers. Currently the Network has received F/P/T approval by the Conference of Deputy Ministers of Health. All provinces *including* Quebec have endorsed the project in its current form. The NHSI component of the Network is in the process of developing and implementing several pilot projects and has received approval for funding for the next three years.[21]

The NHSI, at this point, is considered a successful F/P/T initiative. While primarily federally conceived, its ongoing development and implementation has been an F/P/T collaborative process. In a comparatively brief period, Ottawa and the provinces have been able to work together to develop a design and proceed with implementation of pilots. There are several reasons for the success of this project. All levels of government recognized the need for a coordinated approach to surveillance, the information technology was available and the individuals involved in the development of the project shared a common vision. Also key was the collaborative way in which Ottawa and the provinces have worked. Ottawa has approached the NHSI as a national, joint federal/provincial/territorial initiative. This appears to have been essential to ensuring provincial cooperation. During the F/P/T meetings on roles and responsibilities significant levels of disagreement existed between Ottawa and the provinces, especially in areas where the federal government had taken a *dejur e* unilateral approach, as in the case of interpreting the *Canada Health Act*. Provinces, having already experienced sizable cutbacks to their health-care transfer payments with the introduction of the Canada Health and Social Transfer (CHST), reacted negatively toward further federal initiatives in health. In the area of health surveillance, however, there was recognition by both Ottawa and the provinces that progress could be made and there was a willingness to work together to bring about a national plan. At the federal level there was also

recognition that, in general, a more evidence-based and program-rational approach to decision-making in health was necessary. Health surveillance, as one of the least contentious federal/provincial areas, was believed to be the area in which progress could be made relatively quickly.

Some concerns have been expressed regarding the development of the NHSI. The initial development excluded the provinces to a large extent. Partly as a result of this, the scope of the project may have been too large with too many pilots. The intent of the project subsequently changed from emphasizing the creation of an overall system to emphasizing the development of infrastructure on a project-to-project basis. This satisfied some provinces (Ontario and Quebec) which felt that the previous attempt to create a national system was too much of an infringement on their jurisdiction and too ambitious. Other provinces (Saskatchewan and Manitoba), however, had been more supportive of the development of an overall national system with national goals and objectives.

While F/P/T relationships in the development of the NHSI have to this point been generally positive, concerns have been expressed that the relationship among federal agencies may itself threaten the project. Specifically, concerns have been expressed that the directorates, particularly the LCDC, had been left out of the initial NHSI decision-making processes resulting in duplication of surveillance efforts in the HPB. Changes in the approach to the NHSI have, for the moment, addressed these concerns. The NHSI, however, currently remains separate and independent from the other HPB directorates.

Problems which may develop between the federal government and the provinces relate to the following issues: funding of surveillance activities, standards related to data collection, and ownership of information. With respect to the issue of funding, currently the federal government has been responsible for financing the coordination of the process while information-collection costs are being borne by the provinces. The continued development of the NHSI will require further investments in infrastructure at the local level, such as the expansion of current surveillance activities and training of personnel. Financing for this has not been finalized, although it will likely be obtained from a combination of federal, provincial, and private sources. However, it is expected that overall costs will be modest as the NHSI makes use of existing surveillance systems.

The issues of data quality and data ownership are also currently being worked out. Data quality is important to ensure a minimum standard of data collecting and processing. This will likely require strategic investments by national agencies such

as the Canadian Institute for Health Information. Data ownership is a more contentious issue. Provinces have expressed resistance to surrendering their data to federal officials due to concerns about how the data may be analyzed and for what purposes. The use of legislation to mandate transfer of provincial surveillance information to the federal level is considered unconstitutional. Conditional cost-sharing could be introduced to obtain this objective. However, the current commitment is to arrive at an agreement through cooperative means.

ROLE OF FEDERALISM IN THE DEVELOPMENT OF THE NHSI

The form of intergovernmental regime that best represents the historic relationships surrounding the health-surveillance activity is "disentanglement" or classic federalism with some collaborative components. With the exception of communicable disease surveillance both orders of government act relatively independently of each other and the relationship is non-hierarchical.

The development of the Network and the NHSI represents a move toward a more collaborative approach to federalism. While the initial development of the NHSI was primarily a federal initiative with little consultation with the provinces, Ottawa has subsequently worked closely with the provinces in developing pilot projects and planning for implementation. The NHSI can move ahead initially with federal funding. However, it will eventually require provincial funding at the level of specific projects. The Network, on the other hand, has been a collaborative process from the outset with Ottawa working closely with the provinces to develop a coordinated approach to national health surveillance. Its development has been supervised by the deputy ministers of health. Both levels of government must approve funding for the project in their respective budgets. The federal/provincial/territorial nature of the Design Team and Network working group as well as the cooperative approach to determine roles and responsibilities in the field of health surveillance highlights the essentially collaborative nature of this relationship. The federal government, to this point, has not relied upon any coercive measures to gain provincial cooperation for either the Network or the NHSI. Overall, the relationship has been mutually interdependent, non-hierarchical, and professionally respectful.

The collaborative relationship for the Network and the NHSI developed out of recognition by both provincial/territorial and federal levels that they would not be successful in achieving surveillance reform independently. Moreover, all levels of government shared a concern to reduce health risks and

improve public safety. Of the areas of jurisdictional dispute in health, health surveillance was viewed by both Ottawa and the provinces as the one in which progress was most likely to be made. The impact of federal reductions in transfer payments on provincial attitudes also contributed to the development of a collaborative relationship. After the federal reduction in transfer payments in the mid-1990s, the provinces were hesitant to enter into further shared-cost programs with Ottawa, particularly if there were conditions attached to funding. The collaborative approach adopted toward health surveillance is likely the only relationship the provinces would have agreed to because, after the initial roles and responsibilities were established, each level of government then funds what it sees as a responsibility of its own jurisdiction.

Several issues, such as developing a national standard of data collection and sharing, remain unresolved. There is a potential for Ottawa to take unilateral action in order to resolve this issue. In this approach, Ottawa would apply conditions to any federal funding for local surveillance activities. This might allow the federal government to set the standard of data quality and help to ensure that provinces supply data to federal agencies. This approach, however, would also represent a more hierarchical relationship between Ottawa and the provinces. Therefore, it is unlikely that provinces would agree to this form of arrangement due to concerns about how federal officials might use surveillance data. Provincial concern in this respect surrounds the federal government using surveillance information to "audit" provincial health-care systems.

If the federal government fails to continue to provide leadership in the area of national surveillance, provinces may choose to proceed on their own, resulting in the emergence of interprovincial collaboration. However, such an initiative would likely be difficult in the absence of federal coordination given the scope of the project and the initial investment needed for infrastructure. This suggests that a genuinely collaborative federal-provincial arrangement would be the most effective.

Policy Goals and Outcomes

The Network and the NHSI, unlike most health "care" initiatives, do not impact directly, but rather indirectly, upon individuals. The major impact of the collaborative approach in this area is to have allowed for the development of a coordinated national plan and the advantages and disadvantages that go along with this. However, collaboration has not, as of yet, resulted in the development of national health-surveillance standards as some provinces were resistant

to this approach. Instead, with respect to the NHSI in particular, issues surrounding standards and sharing of data will take place on a project by project basis. Overall, in the area of policy goals and outcomes, collaboration has been an improvement over the previous disentangled regime by allowing for a Canada-wide system with improved economies of scale and identification of gaps and duplication.

Efficiency. There are important efficiency advantages of a coordinated program in health surveillance insofar as there are massive costs and duplicated efforts in collecting this data separately across the nation. The major advantages are the coordination of governmental efforts allowing for clarification of roles and responsibilities and the identification of critical gaps and the elimination of duplicated efforts among governments. These potential benefits prompted the push for cooperation in the first place. A coordinated program will also allow for benefits due to economies of scale. The one-time investment by the federal government to develop projects for the NHSI will provide for an infostructure that can be shared by all provinces. The federal investment should be less than the combined expenditures of the individual provinces attempting to improve their current state of surveillance. Under a coordinated program, improving the sharing of information and building common infrastructures will improve health outcomes.

A theoretical disadvantage of a coordinated program compared to 13 provincial/territorial ones is a lack of responsiveness and delays in reaction time in an emergency. The NHSI likely will not incur these problems as there will be a reliance upon local surveillance infrastructure. Coordination of surveillance activities could also potentially lead to a loss of local experimentation. However, significant experimentation has not occurred to any large extent under the regime of disentangled provincial systems. It is expected that the NHSI should actually encourage experimentation by funding new surveillance initiatives at the local level.

Overall, collaborative federalism, by allowing for the development of a national plan, has a clear efficiency advantage over the more disentangled model of federalism due to the particular importance of coordination in this field.

Human Development. The NHSI is not explicitly designed to provide for human development in the sense that, for instance, an employment training program would. However, the existence and easy access to this improved health information may well contribute extensively to new research and intellectual development. In addition, a national approach to surveillance should result in

improved health outcomes by reducing morbidity and mortality and, consequently, prevent loss of human capital. The coordinated approach will also allow for the development of an overall vision and long-term surveillance strategy for the country. Eventually, investments will be made in the area of the determinants of health which should further contribute to human development. The new system will address the emerging public demand for monitoring changes in health status, although it will be difficult to determine if better measurement is a result of the new health-surveillance system or of other changes being made in the health system at the same time.

The collaborative approach, by allowing for the existence of a voluntarily coordinated national program, is expected to yield improved health outcomes for Canadians and thus result in less loss of human capital than the current state of surveillance under disentangled federalism. The degree of benefit in this area cannot be determined at this time and is dependent on the success of the implemented program.

Social Equity. Under disentangled federalism, there exists considerable variability from province to province in levels of health surveillance and consequently the potential for variability in health. The Network and the NHSI will attempt to reduce the regional discrepancies by promoting sharing of surveillance infrastructure. Establishing national standards could further reduce variability. Under collaborative federalism, standards will be determined by discussion on a case-by-case basis. The ability to establish and ensure that national standards are maintained would be more effective with a more unilateral federal approach if that were possible to achieve jurisdictionally, which it probably is not.

The move to collaborative federalism will not have a great impact on social equity except by reducing discrepancies in levels of surveillance across provinces.

Democratic Principles

The low profile and technical nature of the field of health surveillance along with the form of federalism influence the relationship between the NHSI, the Network, and principles of democracy. Collaborative federalism appears to be an improvement over disentangled federalism in addressing these principles.

Citizen Participation. Due to its technical aspect, and generally a lack of public information about the prevalence and risks to Canadians of the diseases being monitored, health surveillance currently has a low public profile.

Consequently, the major impetus for the development of improved health surveillance has not been public pressure but rather pressure from experts within the field. It is widely accepted by experts that the current situation is inadequate and could possibly lead to adverse health consequences. Political fear of another Krever inquiry has also acted as a motivator for change. The majority of the consultation that led to the development of the NHSI has occurred between non-elected officials and content experts in the field. There has, to now, been little public involvement in the process.

Collaborative federalism, in theory, may further contribute to the lack of public involvement by forcing each level of government to focus first on satisfying the other levels of government, with the Canadian public interest coming second in priority attention. However, there was little public involvement in health surveillance under the previous disentangled model, suggesting that it is the low-profile, technical nature of this issue that is the major factor. Ultimately collaborative federalism may actually increase public involvement by allowing the development of a national plan and thereby raising the profile of the field. In addition, by developing a coordinated approach to health surveillance, health information should be more readily available to the public. An argument could be made that the current low-profile nature of the field may actually benefit a collaborative regime to advance a common policy settlement by allowing for a consultative process that has not had to answer to the public.

Legislative Role. There has been a limited role for the legislature in matters pertaining to health surveillance. The federal government and the provinces have passed legislation to allow for tracking of public health risks as well as vital statistics. The legislatures have also been needed to approve funding for surveillance activities through federal and provincial/territorial budgets. Importantly, any potential federal legislation to compel provinces to share data with federal officials is considered unconstitutional. This has necessitated the development of a collaborative process to achieve agreements regarding this issue. The legislature's main role in the development of the NHSI will be to approve funding for the program. The low public profile of surveillance is, again, an important contributor to the limited role of the legislature in the area.

Transparency and Accountability. In theory, collaborative federalism can potentially confuse issues of accountability allowing governments to blame each other for failures and reducing the pressure on governments to consult citizens. However, accountability for health surveillance under the previous system

was not clear. This was due to a combination of ambiguous constitutional division of powers and disentangled federalism which has not forced the issue to be addressed. The collaborative approach has resulted in an assignment of roles and responsibilities for health surveillance and therefore should make accountability more clear.

Under both disentangled federalism and collaborative federalism there has been a problem with transparency. There, in particular, appears to be a transparency issue with the process that led to the NHSI. This is partly a consequence of the numerous levels of government, government agencies, and stakeholders involved in the development process as well as its relatively complicated nature. Individuals in the HPB have expressed uncertainty over who is responsible for decision-making and how some of the decisions were arrived at. These concerns have contributed to a change in the focus of the project from initially providing a comprehensive information system to developing infrastructure for the ongoing collection of information on a project-by-project basis. The development of the Network initiative has been more transparent with a clear definition of individuals, organizations, and levels of government involved at each point of the development process.

The move to collaborative federalism has improved accountability by clarifying roles and responsibilities. The complexity of the discussions associated with the collaborative model may have contributed to poor transparency.

Protection of Public Interest. In theory, provincial and federal elected officials involved in the NHSI should be representing the interests of their respective electoral majorities. However, the technical nature of the NHSI has required reliance upon non-elected content experts who are not as accountable to the public. This combined with the lack of public awareness of the project and problems with transparency of the process increases the possibility of ignoring specific stakeholder concerns.

The parallels between the regulation and management of the blood industry and health surveillance demonstrate the potential negative implications for society of not addressing known concerns about the Canadian governments' oversight of health surveillance. The regulation of blood products is a federal matter, while the management of the blood system was an interprovincial arrangement. Like health surveillance it had been a low-profile, technical field with a lack of public involvement in the process. The management board of the blood agency, composed extensively of provincial representatives, did not have

the authority of provincial/territorial treasuries to commit unbudgeted provincial money to repair emergency problems. This created a structural environment where the best interest of neither the F/P/T governments nor the Canadian public could be met on a timely basis and resulted in the failure to introduce appropriate HIV and hepatitis C tests when essential. Like the current state of surveillance, the blood industry had fragmentation of responsibility with a lack of clear accountability and poor transparency, as well as an ineffective intergovernmental management structure. The reformed blood system involves the public, is more transparent, and has made accountability clearer.

Health surveillance in its present state could be considered to be at risk for the same problems that the blood industry experienced. In an attempt to avoid a health crisis due to inadequate surveillance, experts in the field have pushed for reform. The reform, however, has not involved the public and thus is still susceptible to not addressing their concerns. Decisions may be made for financial reasons that limit certain surveillance activities or prevent action on early surveillance results that would not be made if the public were more aware of the process.

Collaborative federalism is an improvement over the previous disentangled system in protecting public interest by improving accountability. However, the overall lack of public involvement in the current surveillance projects leaves them susceptible to not addressing the concerns of important stakeholders.

Federalism Principles

The collaborative model was adopted to reform the health-surveillance system partly due to the fact that provinces were reluctant to allow further federal involvement in their jurisdictions after the introduction of the CHST. One of the primary goals of the collaborative process is to ensure that there is respect for jurisdictional boundaries.

Respect for the Jurisdictional and Political Sovereignty of both Levels of Government. The responsibilities for health surveillance are not clearly defined in the constitution. Both levels of governments have some responsibility for the function. Due to the lack of clarity of roles the potential for the federal government infringing on provincial jurisdiction exists. For example, the LCDC deals directly with local health units, often bypassing the provincial government. However, there does not appear to have been much provincial objection

to possible federal involvement in these technical matters. Rather, the greater concern was with the lack of a federal presence in providing leadership to develop Canada-wide coordinated surveillance activities.

The lack of jurisdictional clarity necessitated a collaborative approach to surveillance reform. The F/P/T Working Group on Roles and Responsibilities was an example of federal-provincial cooperation and the Network and NHSI have continued this collaborative style. In order for the NHSI and other Network initiatives to be fully implemented they must receive approval at both federal and provincial levels. The development process also undergoes F/P/T reviews at several stages.

The issue of national standards in the field of health surveillance has created some jurisdictional sovereignty concerns among some provinces. Related to this issue is the concern over ownership of surveillance information and how it is to be used. A federal-unilateral approach, if used to enforce sharing of surveillance data, could potentially infringe upon provincial sovereignty. The NHSI project, at present, will address these issues on a project-by-project basis. In general the approach taken by the NHSI to develop projects on a pilot basis in one region and then offer them to other interested regions appears to have reduced concerns over jurisdictional sovereignty violation.

The move to collaborative federalism has resulted in greater attention being paid to issues of jurisdictional sovereignty in this field of health. It is one of its most important features in contributing to health-surveillance reform.

A Commitment to Intergovernmental Processes for Conflict Resolution. At present neither the Network nor the NHSI have any formal mechanism outlined to deal with conflict resolution. Instead, issues will attempt to be addressed by discussion and through the achievement of a consensus on a case-by-case basis. Essentially, this requires unanimity on any major decision and will likely slow the development of the overall system. It has contributed to a decision not to proceed with national standards. This remains a potentially important problem for the establishment of an effective Canada-wide program.

A collaborative form of federalism is superior to the previous disentangled model in managing intergovernmental conflict. Surveillance under the disentangled form of federalism did not have any mechanism to address intergovernmental conflict other than the court system. A federal-unilateral approach would likely rely upon decisions at the federal level to withhold funding if standards were not being met.

PARALLELS WITH ENVIRONMENTAL HARMONIZATION LEGISLATION

A further understanding of the collaborative process, its strengths and its weaknesses, can be gained by reviewing the experience in the field of environmental harmonization. Two major F/P/T initiatives have occurred in recent years in environmental harmonization; the ambitious but failed Environmental Management Framework Agreement (EMFA) and the less ambitious Canada-Wide Accord on Environmental Harmonization (EHA). Both of these were attempts to address issues surrounding lack of coordination of governmental efforts in this area and concerns about overlap and duplication.[22]

As with health surveillance, the roles of federal and provincial governments in relation to environmental harmonization are not laid out neatly in the constitution. The initiative to harmonize environmental policy between F/P/T governments was partially borne out of concerns regarding this constitutional ambiguity. At both levels of government a spirit of cooperation marked the initial stages of the policy process. The collaborative process eventually led to the development of a draft version of the EMFA in 1994. This agreement was a detailed document which recast F/P/T roles in the area of environmental protection.

However, several concerns appeared regarding the development of the EMFA. A perception emerged that the consultation process that produced this agreement was not inclusive enough and it consequently came under criticism from several non-governmental environmental organizations. There were also concerns regarding the content of the agreement. It was viewed as being overly ambitious in attempting to assign a comprehensive set of roles and responsibilities *a priori*, before problems arose. Further, it did not outline an effective decision rule for resolving disputes and was believed to create a system that would exclude the public from decision-making. These problems with process and content ultimately resulted in the failure of the EMFA to be ratified.

F/P/T officials then embarked on another attempt to achieve environmental harmonization eventually leading to the EHA, which came into effect in 1998. The EHA primarily outlined general objectives that all parties agreed should govern policy-making. Issues of assigning roles and responsibilities are to be handled on an issue-by-issue basis. The effectiveness of the EHA in achieving agreements has yet to be determined.[23]

Further insight into the nature of the collaborative process can be gained by comparing the experiences in health surveillance and environmental

harmonization. In both areas there was unclear jurisdictional responsibility and a mutual recognition of the need for improved coordination. These features, combined with concerns over jurisdictional boundaries, made both fields well suited to collaborative federalism. However, in each area the collaborative process encountered difficulties for similar reasons. One of the primary reasons for the failure of the EMFA was its attempt to address too many issues at once. Similarly, the NHSI ran into problems in its initial stages due to concerns that it was too broad in scope. The ambitious nature of both projects appears to have heightened the concerns of stakeholders who believe they have been excluded from the development process. This led to the adoption of an incremental, case-by-case, approach in both fields. This approach has also been beneficial in reducing concerns over jurisdictional sovereignty and may represent the most effective method of implementing policies developed by a collaborative process.

OVERALL ASSESSMENT

Health surveillance is a shared federal-provincial responsibility. The present intergovernmental relationship which exists in this area would best be characterized as disentangled federalism with some collaborative components. Partly as a result of this relationship, there have emerged problems in health surveillance, such as large gaps in the F/P/T surveillance program activities as well as duplication. At local, provincial, and federal levels it was recognized that change was necessary. This mutual recognition encouraged the development of a more collaborative relationship between Ottawa and the provinces. To this point, the relationship has been successful. Compared to other health initiatives, there have been substantial levels of agreement between Ottawa and the provinces. An example of this has been the development of the Network and the NHSI.

The failure of disentangled federalism in this area can be attributed to several factors. There is a lack of clear constitutional jurisdiction in health surveillance resulting in uncertainty of roles and responsibilities. This uncertainty has in turn contributed to important program gaps. Under a disentangled regime, coordination of efforts across provinces, which is of particular importance in health surveillance, could not be accomplished. Also under disentangled federalism, the efficiency benefits of a national program could not be realized. There do not appear to be any major advantages of disentangled federalism over collaborative federalism in this particular area.

In many ways health surveillance is the ideal arena for collaborative federalism. Its success in this area is due to several factors: (i)the na ture of health surveillance which requires a national plan and coordinated approach to improve efficiency and effectiveness; (ii)the r ecognition at all levels of government that surveillance improvements require intergovernmental collaboration on a developmental and ongoing basis; (iii) the lack of jurisdictional clarity in this field, requiring a cooperative approach to determine roles and responsibilities; and finally, the provinces are opposed to Ottawa introducing federal, unilateral initiatives to address the surveillance concerns.

The main disadvantage of the collaborative style of federalism is the lack of public involvement as well as the lack of transparency in the developmental process, problems that also existed under the previous disentangled regime. These are primarily issues related to the low profile and technical nature of health surveillance, as well as the lack of public information, but these may have been reinforced by the federalism regime adopted. If unresolved, these issues could place the new surveillance system in danger of not addressing the public's concerns about their specific health risks. In addition, collaborative federalism appears to have produced a more incremental approach than would have occurred under a federal, unilateral system. This is partly a consequence of the importance of respecting issues of jurisdictional sovereignty under this form of federalism. Nevertheless, incremental progress is better than a total impasse precipitated by a jurisdictional dispute.

It is important to recognize that the development of the NHSI has only recently been completed and several issues surrounding implementation need to be addressed. Some of these, such as funding and standards, may result in intergovernmental conflict leading the federal government to take a more unilateral approach with respect to national standards of health surveillance. The main disadvantage of any such unilateral action — infringements on jurisdictional sovereignty — could threaten the entire national program as well as destroy the effective working relationship that now exists between the levels of government to address this public safety issue.

If the current collaborative approach fails, it is possible that some form of interprovincial collaboration may emerge. This will likely be regional and have some advantages of efficiency over the traditional arrangement while also preserving some degree of competition. However, provincial and territorial officials believe that a Canada-wide system is essential and this would require a greater federal role than would exist under interprovincial collaboration.

CONCLUSION

The development of the Network for Health Surveillance in Canada and the National Health Surveillance Infostructure provide valuable insights into the nature of collaborative federalism. Based on this case study, collaborative federalism appears to be effective in developing a rapid degree of consensus between levels of government. It is best suited for policy areas that involve some of the following characteristics:

- a recognition at both levels of government of the need for policy or program change in a field of shared jurisdiction;
- a need for a Canada-wide capability to coordinate activities at both levels of government to achieve effective policy and program implementation; and
- an area where provinces are hesitant to allow further federal unilateral involvement.

Also, based on this case study, it appears as if a pilot approach to collaborative federalism initiatives may be an effective way to reduce concerns over jurisdictional violation as well as reduce the concern of stakeholders who feel they may be left out of the decision-making process. This approach, however, does slow program implementation.

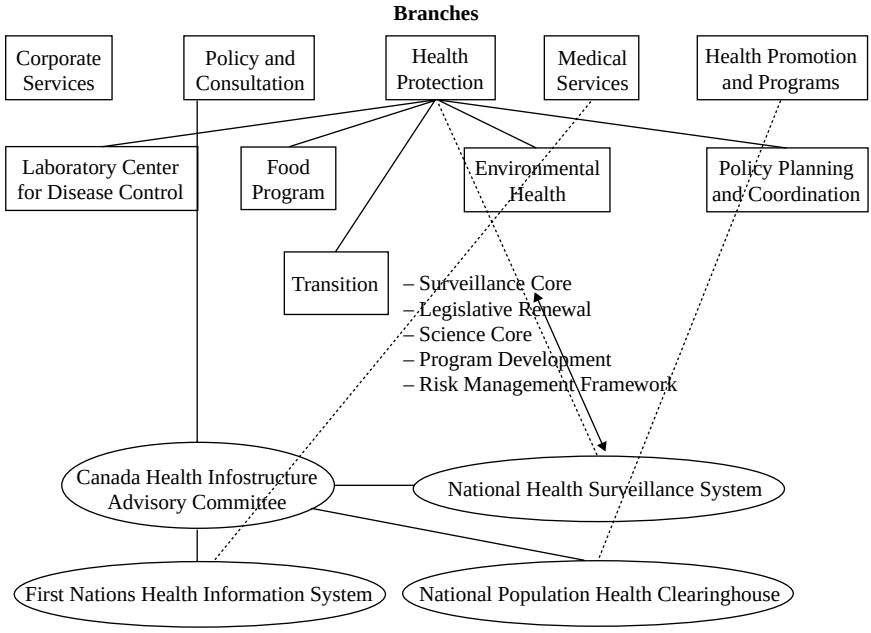
It is important to note that the full impact of collaborative federalism on realizing policy goals could not be fully assessed by this case study as the projects are still being developed.

APPENDIX A
INDIVIDUALS INTERVIEWED

1. Susan Tessier (9/7/98). Executive Secretary to Alexa Brewer.
2. Jane Welden (13/7/98). Strategic Planner HPB Transition.
3. Dr. David Butler-Jones (17/7/98). Chief Medical Officer for Saskatchewan.
4. Dr. Rick Mathias (15/7/98). Professor, Division of Public Health and Epidemiology, University of British Columbia. Consultant to Office of National Health Surveillance.
5. Dr. Paul Gully (22/7/98). Director, Bureau of Surveillance and Filed Epidemiology, LCDC.
6. Alexa Brewer (23/7/98). Former Director, Surveillance Transition. Former Project Manager for NHSI. Currently Director of Program Analysis in First Nations/ Inuit Health Program.
7. Greg Sherman (27/7/98). Associate Director HPB Surveillance Transition. Associate Director of Office of Health Surveillance.
8. Stephan Gabos (11/8/98). Senior Team Leader Health Surveillance, Alberta Health. Director of Surveillance for Alberta.
9. Stephen Chase (17/8/98). Corporate Policy Advisor, Federal-Provincial Relations. Co-chair Integration Design Team.
10. Dr. Joe Losos (14/9/98). Assistant Deputy Minister HPB.
11. Cecilia Lord (29/9/98). Assistant Deputy Minister Alberta Health. Chair of federal-provincial Advisory Committee on Population Health. Co-chair of Public Health Working Group to the Advisory Committee on Population Health.
12. Dr. John Spika (5/10/98). Director of Bureau of Infectious Diseases, LCDC. Integration Design Team Member
13. Deborah Jordan (29/7/99). Executive Secretary for Surveillance Transition.
14. Dr. David Mowatt (9/11/99). Project Manager for NHSI.
15. Dr. Harvey Lerer. (7/10/99) Director General at Canadian Environmental Protection Act office.
16. Michael Wilson (13/10/99). Senior policy advisor to Environmental Protection Service.

APPENDIX B
STRUCTURE OF HEALTH CANADA (1995-1999)

Minister
Deputy Minister
Associate Deputy Minister



Important Individuals in the Development of the NHSI

Alan Nymark	–	Associate Deputy Minister (responsible for CHI Initiatives)
Dr. Joe Losos	–	Assistant Deputy Minister HPB
Alexa Brewer and Dr. David Mowatt	–	Project Managers for NHSI, Directors of Surveillance Transition
Dr. Rick Mathias	–	Co-designer of NHSI
Dr. Greg Sherman	–	Co-designer of NHSI
Ian Shugart	–	Visiting Assistant Deputy Minister in charge of HPB Transition

APPENDIX C
DESCRIPTION OF THE NHSI

At present the core components to the NHSI are the Canadian Integrated Public Health System (CIPHS), the Local Public Health Infrastructure Development (LoPHID), and the Spatial Public Health Information Exchange (SPHINX). These are supported by the NHSI infrastructure which is composed of the Public Health Intelligence Database (PHIDB) and the Geomatic Information System Infrastructure (GIS). These are described in more detail below.

Core Components

Canadian Integrated Public Health System (CIPHS): A computer-based system designed to capture, integrate, and report surveillance data. This will link, in a standardized manner, data from a variety of health units across Canada.

Local Public Health Infrastructure Development (LoPHID): This component is designed to strengthen the local public health capacity to conduct surveillance, with attention to information on determinants of health. It will also generate and use local information for decision-making.

Spatial Public Health Information Exchange (SPHINX): This component is designed to access information already residing in health-related databases.

NHSI infrastructure

Public Health Intelligence Database (PHIDB): A repository of information from NHSI and Health Protection Bureau (HPB) surveillance activities.

Geomatic Information System Infrastructure (GIS): This infrastructure will allow for the development of the spatial information needs of the NHSI project.

Global Public Health Intelligence (GPHIN): A global early warning system designed to monitor international sources of information to allow for early detection and validation of health risks.

APPENDIX D
SOME KEY ORGANIZATIONS INVOLVED IN THE DEVELOPMENT OF THE NHSI AND NETWORK

Federal Organizations

Information Highway Advisory Council: Created by the federal government to provide advice on how to develop the Canadian Information Highway. It also required a federal leadership role in developing a unifying health information infrastructure.

National Forum on Health: An initiative launched by the federal government in 1994 whose objective was to consult with the public and advise the government on ways to improve the health of Canadians. It proposed the development of an evidence-based approach to health decision-making which led to the introduction of the Canadian Health Infostructure.

Advisory Council on Health Infostructure: A group of key individuals in health care who advise the federal minister of health on the development of a national strategy for a Canadian health information system.

Canadian Health Infostructure: Created following recommendations from IHAC and CANARIE and in direct response to the National Forum on Health report. The NHSI is one component of the CHI.

Surveillance Transition Team: Individuals assigned with the responsibility of strengthening and expanding the HPB's overall surveillance capacity. This team was responsible for the development and management of the NHSI. In coordination with the provinces it developed the Network.

Federal Provincial Territorial Organizations

Conference of Deputy Ministers of Health: This consists of federal, provincial, and territorial deputy ministers. Responsible for final approval of national surveillance initiatives prior to implementation. It initiated development of the Network in response to recognition that important gaps existed in health surveillance due to lack of coordination between levels of government.

Working Group on Roles and Responsibilities/ Overlap and Duplication: An F/P/T group originally designed to examine areas of overlap and duplication

in health between levels of government and clarify roles and responsibilities. This group reported to the Council of Deputy Ministers and identified that large gaps existed in health surveillance.

Integration Design Team: Evolved from the Working Group on Overlap and Duplication. Comprised of health-surveillance experts from across the country, this Design Team was established to create an integrated national health-surveillance network. It reported to the Surveillance Transition Team and the Council of Deputy Ministers.

Network for Health Surveillance in Canada Health Surveillance Working Group: An F/P/T working group which built on the work of the Integration Design Team. This group is to be responsible for advising on the development and implementation of the surveillance network. It will report to an F/P/T Advisory Committee on Health Infostructure.

Other Advisory and FPT Committees Involved in Surveillance Initiatives

- Committee on Environmental and Occupational Health
- Council of Chief Medical Officers of Health
- Public Health Working Group Subcommittee of the Advisory Committee on Population Health
- Advisory Committee on Epidemiology
- Technical Advisory Committee on Public Health Laboratories

Other Key Stakeholders

Industry: CANARIE (the Canadian Network for the Advancement of Research, Industry and Education), a private, not-for-profit organization working to assist in the development of a Canadian Internet infrastructure. It is supported by Industry Canada. CANARIE called for Health Canada to work with the provinces and territories to develop a national strategy for the institution of an integrated health information network.

Community epidemiologists and local public health officials: created a bottom-up pressure to develop a coordinated approach to health surveillance to address major gaps in health surveillance.

NOTES

[1]See Duane Adams, "Introduction and Overview," in this volume.

[2]Government of Canada, *A Network for Health Surveillance in Canada: Summary* (Ottawa: Minister of Public Works and Government Services, 1999).

[3]United Kingdom, *Constitution Act, 1867*, 30 and 31 Victoria, C.3; P.W. Hogg, *Constitutional Law of Canada* (Toronto: Thomson Canada Ltd., 1998); M. Jackman, "The Constitutional Basis for Federal Regulation of Health," *Health Law Review* 5, 2 (1996):3-10.

[4]Canada, *Department of Health Act*, 1996, c. 8; *Statistics Act*, 1970-71-72, c.15, s. 1.

[5]C.P. Shah, *An Introduction to Canadian Health and Health Care System*, 2d ed. (Toronto: Department of Preventative Medicine and Biostatistics, University of Toronto, 1987).

[6]P.N. Sockett, M. Garnett and C. Scott, "Communicable Disease Surveillance: Notification of Infectious Diseases in Canada," *Canadian Journal of Infectious Diseases* 7(1996):293-95.

[7]"Welcome to 'The Sentinel,'" *The Sentinel* (1997):1.

[8]*Partnership for Quality, Timely Surveillance Leading to Action for Better Health*, proposal to Develop a Network for Health Surveillance in Canada (Ottawa: Minister of Public Works and Government Services, 1999).

[9]Consulting and Audit Canada, *Canadian Health Information System: Business Requirements*, 8 May 1997; Advisory Committee on Epidemiology Working Group on National Surveillance, "Results of an Inventory of Provincial/Territorial Surveillance Activities," Draft results, 6 October 1997.

[10]Sockett, Garnett and Scott, "Communicable Disease Surveillance"; Report of the Task Force on Surveillance <Http://.hc-sc.gc.ca/main/lcdc/web/survlnce/tfrep_e.html>.

[11]R. Schabas, *Health Surveillance National Survey*, prepared by Schabas Associates Inc., 15 November 1997.

[12]Auditor General of Canada, *Report* (Ottawa: Office of the Auditor General of Canada and the Commissioner of the Environment and Sustainable Development, 1999), Chapter 14, "National Health Surveillance: Diseases and Injuries."

[13]Commission of Inquiry on the Blood System in Canada (Krever Commission), *Final Report* (Ottawa: Canadian Government Publishing, 1997).

[14]Ibid.

[15]Government of Canada, *A Network for Health Surveillance in Canada*; Health Canada, *Building Partnerships to Improve Health Surveillance Across Canada: The National Health Surveillance Infostructure* (Ottawa: Supply and Services, 1999); EXOCOM Consulting Corp., *National Health Surveillance System, Program Charter*, Version 1, May 1998.

8

REGIONALIZATION AND COLLABORATIVE GOVERNMENT: A NEW DIRECTION FOR HEALTH SYSTEM GOVERNANCE

Ken Rasmussen

INTRODUCTION

At first glance the regionalization of health-care delivery structures in all Canadian provinces except Ontario appears to have little to do with the changing federal/provincial regime for governing social policy. However, when we step back and examine the changing nature of Canadian federalism the connection appears more apparent. In fact, it can be argued that regionalization is entirely consistent with the direction of change occurring in the relations between provinces and the federal government. This new direction has recently been described as one in which Ottawa has less capacity to shape national policy and influence provincial priorities; provinces are gaining greater power; and national polices are increasingly developed in intergovernmental processes.[1] Within this context of decentralization and devolution, the regionalization of health-service delivery seems natural.

Yet, however neat and symmetrical we might like to see the process of regionalization it is also clear that this is a multifaceted process reflecting the complex nature of the health-care system which is technically sophisticated, resource intensive, emotionally charged, and politically volatile. Thus, regionalization at this time seems to mirror changes associated with either

disentangled or collaborative federalism. It is also carrying the heavy baggage of multiple provincial objectives for health reform. In particular, regionalization is pursuing political objectives such as increasing community control and enhancing accountability while advancing the administrative objectives of greater efficiency, innovation, integration, and effectiveness. These objectives of improved democratic accountability and increased efficiency are fuelled by a growing consensus in a number of policy domains which suggest that if the regime itself is not regarded as legitimate, responsive, and accountable to citizens it will be difficult to build support for structural, procedural, or policy changes.[2] In short, regionalization appears to be an attempt to find a middle way in which we can have a much more provincially decentralized and disentangled system in the delivery of health services, and a system of collaborative intergovernmentalism in setting broad provincial health priorities.

The results of provincial efforts to accommodate these competing objectives through regionalization can be seen in Table 1. It is clear that the devolution of responsibilities varies from province to province, and regionalization is a patchwork with broadly similar objectives, but widely varying implementation strategies. Regionalization can be seen as a series of individual responses by provincial governments to local needs and conditions. This is not to say that greater convergence in these structures cannot be anticipated in the future, only that currently there is more divergence and very little cross-jurisdictional policy learning with regard to regionalization.

This diversity in the implementation of regionalization may be consistent with changes in Canadian federalism, but it is also creating its own type of intergovernmental dynamic between the emerging Regional Health Authorities (RHAs) and provincial governments. These emerging relations are particularly relevant in light of the Social Union Framework Agreement (SUFA) which contains provisions that call for governments to "monitor and measure outcomes of its social programs and report regularly to its constituents on the performance of these programs" and to "work with other governments to develop, over time, comparable indicators to measure progress on agreed objectives." These activities are clearly aimed at the health-care sector where demands by the federal government for increased accountability have been the greatest. But the emerging roles assigned to RHAs, which have their own local priorities and commitments, may make such aims politically more complex, subject to negotiations and ultimately might require some mechanism by which the experiences and needs of RHAs become part of the broader health-care policy debate in Canada.

TABLE 1
Variations in Regionalization

Prov.	*Health Boards*	*No.*	*Board Members*	*Elected Officials*	*Appointed Officials*	*Year*	*Mental Health Regional*	*Funding Formula*	*Average Population in Region*	*Community Health*	*Long Term Care Regional*
BC	Regional Boards	11	Max 15	1/3 Proposed	2/3	1996	Yes	N/A	86*	34 Centres	Yes
Alta.	Regional Authorities	17	12-15	1/3 Proposed	2/3	1994	Separate Provincial Board	Capitation	164	Yes	Yes
Sask.	District Boards	32	12-14	67%	Yes	1993	Yes	Capitation	31	Yes	Yes
Man.	Regional Authorities	10	15	No	Yes	1996	Yes	Historical	114	Yes	Yes
Ont.	District Councils	16	16-20	No	Yes	Under Review	Yes	N/A	703	55 Centres	No
Que.	Regional Boards	18	23-25	Yes	Yes	1991	Yes	By program	411	25 Centres	Yes
NB	Regional Hospital Corporation	8	12-16	No	Yes CEO	1992	No	Global	95	Yes	No
NS	Regional Boards	4	15-17	No	Yes	1994	Yes	By program	196	20 Centres	No
PEI	Regional Authorities under a Crown Agency	5	7-10	No	Yes	1993	Yes	Global	27	Yes	Regional
Nfld.	Regional Boards	4	10-18	No	Yes	1990	Yes	Global	143	Yes 4 Regional Boards	Yes

Note: *Because the regional health and community health districts are complementary, the calculation is based on 45 regions (11 regional bodies and 34 community structures).

Source: HEALNet, Regionalization Research Centre, *Regionalization in Canada* (May 1999) and J.L. Denis, D. Contandriopoulos, A. Langley and A. Valetta, *Les modèles théoriques et empiriques de régionalisation du système socio-sanitaire* (Montreal: Groupe de recherche interdisciplinaire en santé, Université de Montréal, 1998).

No matter how regionalization evolves, it inevitably creates a series of intergovernmental challenges for provinces and the federal government. At the provincial level, regionalization requires a shift from a highly regulated structure characterized by provincial unilateralism, to a more collaborative system in which authority over the provincial health-care system is increasingly divided between regional authorities and provincial governments. This requires provincial ministers of health to make their objectives sufficiently explicit and transparent so that the link can be made between the desired policy outcomes and the inputs ministers are willing to pay for in pursuit of these outcomes. Moreover, the change means that provincial Ministries of Health must manage a new contractual relationship rather than the previous hierarchical one. The implication of this change, though not fully accepted in most provinces, is that ministers, or their departments, should not intervene in the operation of the regional authorities unless they are willing to make their interventions public through an alteration of the contractual relationship with RHAs.

For the federal government the implications are not so clear, but with only the few broad principles of the *Canada Health Act* (CHA) at its disposal and a diminished financial contribution to provincial health-care budgets, the national role in health care has been weakened while it is in the act of being reinterpreted. The federal government, of course, can play an important role both with provincial governments and RHAs in terms of working to limit innovations throughout the system which violate the national character of the program, to create outcome measures and comparable indicators, and to help "measure progress on agreed objectives." At some point it may even come to link its financial transfers to provincial or regional performance measures. Indeed, it is not impossible to imagine that the federal monitoring role could help reinforce relations between citizens and governments, and not just between two or three levels of government as in the past era of "executive federalism."[3] The federal government could well play a crucial role in mobilizing citizens, RHAs, and provincial governments around priority outcomes. Equally, new structures and relations associated with regionalization may affect the capacity of the provincial and/or federal government to ensure consistent practices and compliance with provincial or national priorities and regulations.

While it has long been clear that intergovernmental regimes can influence the substance of public policy, the exact nature of the relationship between regime type and its consequences is far from evident.[4] This chapter will begin the process of assessing this new form of intergovernmentalism associated with regionalization and the impact it might have on public policy goals and out-

comes, democratic values, and basic principles of federalism. These variables were established in the methodology associated with this project as described in the introductory chapter of this volume and are to be analyzed against a series of possible intergovernmental regimes that range on a continuum from federal unilaterialism to federal-provincial collaboration, intergovernmental collaboration and the extreme end: disentangled federalism. More specifically these regime types will be examined on the basis of the policy goals associated with regionalization. These policy goals are obviously multiple but at a minimum can be said to include increasing efficiency in resource allocation, improved population health and shifting resources from institutions to community services. Democratic values assessed on the basis of regime type will include responsiveness to community, transparency, and accountability and the role of regionalization in fostering and protecting regional minorities. The chapter will conclude with an assessment of the impact of regionalization and how the integovernmentalism associated with it can be made to create an improved national health-care system.

FEDERAL/PROVINCIAL REGIMES AND REGIONALIZATION

The role that federal-provincial relations have played in the establishment and character of regionalization regimes across the country is difficult to assess. There are, however, two possible ways in which to understand the influence of federalism on regionalization. The first would be that regionalization was a product of disentangled federalism in which provinces acted within the limits of their jurisdictional authority in establishing a regionalization policy framework. In this view, the massive restructuring of authority relationships within provincial health-care systems was entirely done by autonomous provinces acting independently of the federal government and one another. In this health governance initiative independence rather than interdependence would be said to characterize the relationship between the two levels of government.

The other interpretation of the impact of federalism would see regionalization as a product of a joint jurisdictional exercise in authority in that all provincial regionalization efforts must remain consistent with the health policy framework established by the *Canada Health Act*. In February 1999, this framework was reconfirmed by all the provincial/territorial premiers through the Social Union Accord, a supplement to the Social Union Framework Agreement (where Quebec was not a signatory). Indeed it is evident that

many of the provinces, notably Alberta, would have engaged in a much different form of regionalization in the absence of the CHA. Thus, when examining the influence of the federal government, it is not entirely accurate to say it was without influence over the nature of regionalization. Federal legislation has in fact set the parameters within which such regionalization efforts have taken place.

Within these two interpretations it is important to note that while the CHA set the parameters of regionalization, no formal consultation or discussions between provinces and the federal government took place at the political level and only a few relatively minor consultations at the bureaucratic level were reported by provinces. At the bureaucratic level federal officials acknowledged "the need for reform of the health care system to reduce escalating costs."[5] But beyond this, the federal government was quite satisfied that regionalization was entirely consistent with their concerns about maintaining public administration, comprehensiveness and accessibility, portability, and universality.

It would appear that the current intergovernmental regime can be described as involving federal-provincial interdependence in terms of establishing the overall policy framework, but it is disentangled in terms of policy implementation. That is to say, the policy associated with regionalization must be consistent with the CHA, but the means by which provinces implement regionalization, which services they wish to include, how much authority they want to devolve, and how and what form citizen involvement should take is within their individual jurisdictions and not subject to any federal action.

Even though provinces have now formally endorsed the principles of the CHA through the Social Union Accord, the CHA is nonetheless a classic example of the use of the federal spending power to establish a policy framework over the strong objections of many, if not all, the provincial governments. Indeed, initially in 1984, the Act was a highly politicized reaction against initiatives of some provincial governments who were beginning to implement service fees and move away from many of the aspects of universality associated with medicare.[6] While there have been periods of high intergovernmental collaboration in health-care policy-making in the past, such as during the introduction of hospital insurance in 1957, and national medicare in 1966 the CHA was a different matter and was imposed despite the virtually unanimous opposition from the provinces.[7]

Ottawa clearly had a critical and indeed paramount role in establishing the policy framework and creating the appropriate incentives to ensure strong interprovincial and consequently, national linkages in the health system. Yet

despite this, Courchane has noted that "as the programs became established and as the system needed to adapt to the changing environment, Ottawa lost its advantage because it was too far removed from the actual delivery of services."[8] This problem is now compounded as a result of the progress of regionalization in which Ottawa finds itself two steps removed from the actual delivery of services, and potentially will lose even more influence over the health system. Even more troubling is the fact that RHAs are expected to deal with holistic or wellness approaches to health, but the principles of the CHA are those of the old vision of health (based on health-treatment services) and thus the remaining vessel of federal legitimacy might come to be seen as something that is a burden and needs to be incrementally eroded by the actions of RHAs.

The federal government has always maintained that health reforms, including regionalization, can be accommodated within the parameters of the CHA which was designed to be flexible and evolve over time. Federal officials have noted their concern, however, that there remain significant differences "from province to province in the scope of reporting requirements and in the capacity of health districts to use information effectively."[9] As such, the federal government sees itself playing some sort of role in the dissemination of information and the determination of reporting requirements, although the exact nature of this role is still far from certain.

Yet by and large regionalization initiatives were undertaken by provincial governments in the face of a notable silence from successive federal governments who did not perceive regionalization as a threat, nor acknowledge any such threat, but thought it was nonetheless a good way for provinces to gain control of escalating health-care expenditures.

The delivery of health services is obviously disentangled and is becoming more disentangled as provinces move further down the road of reform, creating provincial structures that clearly demarcate the delivery of services from the creation of provincial health policy. Can and should the federal government play a role with RHAs and provincial governments in determining ways to measure effectiveness and outcomes? This issue remains unclear, but both provinces and RHAs will wish to be involved in any effort to create a reporting regime that provides comparable information to Canadian citizens about the performance of the health-care system in either their region or their province.

In summary, regionalization can be seen as largely the product of provincial governments pursuing their own respective policy and political

objectives within an overarching framework established by the *Canada Health Act*. The policy framework, while now confirmed as a by-product of a new collaborative arrangement worked out with the federal government and the provinces, was initially an example of the federal government's aggressive use of its spending power to establish a national policy framework. The provinces themselves have also acted aggressively in establishing policy objectives for regional authorities which included the facilitation of a more efficient, effective, equitable, and integrated health-care delivery system throughout the provinces. RHAs are established to facilitate a redistribution of decision-making power at the regional level within the health-care sector, increase the responsiveness of health-care decision-making to community preferences, and enhance the overall accountability of the system. Yet for RHAs to meet these objectives and improve the national health-care system requires collaboration with provincial governments, but also will require an attempt to include the federal government or some other national agency as an agent to disseminate those features of regionalization that prove effective, while providing a system of transparent performance reporting to Canadian citizens.

ROLES, RESPONSIBILITIES AND REGIONALIZATION

It is important at the outset to understand that regionalization entailed a consolidation of the roles and responsibilities that were being performed by local and facility-based decision-making bodies, rather than a substantial devolution of roles and responsibilities that were previously performed by the provincial government. Unlike the various boards that they supplanted, which were essentially single-purpose and in some cases even single-facility authorities, RHAs tend to be multi-purpose authorities established to manage various elements of the health-care system within a defined region on a consolidated or integrated basis.

The creation of these agencies usually entails a shift in authority for planning, managing, administering, and funding health facilities, programs, and services primarily from the defunct local authorities they are supplanting. In Saskatchewan, 32 district health boards replaced over 400 individual boards responsible for various elements of the system such as hospitals, nursing homes, community health, home care, and ambulance services. In New Brunswick, 51 hospital boards/management committees were replaced with eight regional hospital corporations, but that government did not give the boards power to manage a fully integrated health service. And in British Columbia, the latest

plan sees the creation of 11 regional health boards in urban areas, and 34 community health councils in rural areas. In some cases, however, it may also include a shift in authority from the provincial government to a new board. The shift of such power from both the local and provincial levels renders regionalization an exercise in centralization and, albeit to a much lesser extent depending on the jurisdiction, decentralization. Saskatchewan has perhaps gone the furthest in that responsibility for mental health, public health, and addiction treatment have all been decentralized to the regional level.

Although they are mandated and expected to deliver core services to their populations based on provincially determined global budgets, RHAs do have managerial and administrative discretion. Currently most RHAs have a substantial amount of latitude in making decisions about funding facilities, programs, and services in their respective areas. The key issue determining how much authority is devolved, according to Jonathan Lomas, will

> depend on the attitude and approach of the local boards — their willingness to grab power and run with it until they are stopped — and the attitude of the provincial government — their tolerance, for instance, of local boards that diverge from the central objectives of cost containment, health outcomes and so on, as well as their willingness to allow significant variations in service delivery patterns to emerge across their province in the name of "local preferences."[10]

This shift of authority downwards, aimed at bringing health-care services in line with local needs, may well contain the possibility of the further erosion of the *Canada Health Act*.

Provincial governments all maintain overall control over the financing of health-care facilities and services because RHAs do not have their own independent source of revenues. This monopoly on the spending power allows provincial governments to retain a tremendous amount of control over the RHAs. Funds are made available to RHAs by provincial governments according to a pre-determined formula. Whether this will change in the future remains to be seen. In Saskatchewan, for example, municipalities are already exhibiting concern that there is pressure on them to contribute to funding regional health districts, or at least to share the property tax base with health care.[11]

Clearly, provinces are proceeding with the intention that regionalization would decentralize and disentangle service delivery while leaving themselves unilateral control over the provincial health policy framework. Likewise, regional authorities have been encouraged to manage the day-to-day operations of the health-care delivery system with considerable autonomy, although the exact

nature of the parameters of this authority varies from province to province. What has been created in most provinces is a situation formally characterized by a division of authority, in which provinces have macro-policy control and regional authorities have control of implementation and operational activities. Yet changes in provincial policy and funding levels can have a profound influence on regional authorities. Likewise, an RHA decision to discontinue a service, reduce beds, or shift resources to different uses, will have equally troubling consequences for provincial governments, creating inevitable demands for less disentanglement and more collaboration.

On the surface, regionalization appears to be a hierarchical relationship in which the provincial government sets standards, budget levels, and quality guidelines and RHAs fulfil their appointed functions for planning, assessing health needs, and coordinating service delivery. Most provinces assume that ministers of health, aided by their staff, can be reasonably specific about what services they want as outputs, the resources that RHAs will need to provide this quality of service at a particular standard, and the measures needed to determine the performance of RHAs.

Yet in the case of Saskatchewan, which has devolved the most extensive set of responsibilities to RHAs, the province is finding that it is held accountable for delivery issues such as waiting lists and nursing shortages that often generate maximum publicity and pressure from well-organized interest groups and communities. Equally, in order to bring about change, the province of Saskatchewan is finding that it must now consult RHAs on issues related to the overall policy framework because these issues often have financial and other resource commitments that strain the capacity of RHAs. In this sense most provinces retain formal control over the policy framework, but changes to policy without prior consultation produces mistrust and resentment between the provincial government and RHAs. Even with consultation there are examples of regional resistance to provincial policy in which some districts actively oppose provincial requests or policy, and may even attempt to obstruct them.

For their part then, RHAs have quickly become jealous of their own authority and the relationship they are establishing with their local community and they resent provincial attempts to intervene directly with their communities. In Saskatchewan RHAs have displayed a willingness to deal directly with their communities on controversial issues like hospital closures, sometimes even to the exclusion of the provincial ministers of health. Provinces, justifiably, feel that their responsibility for accessibility, quality of health care, and the provincial health system should give them a powerful voice in these kinds

of decisions, perhaps even a veto power over the RHA decision. The lesson from Saskatchewan would appear to be that provincial ministers of health can expect to lose some discretion related to the micro management of the health system as a consequence of regionalization.

Developments like those noted above lend some texture to the comment made earlier that regionalization combines aspects of both centralization and decentralization. It is centralizing what was really a highly fragmented system in most provinces in which coordination, integration, and economies of scale were almost impossible to achieve under the old regulatory regime. Thus one of the thrusts of regionalization was the desire to bring coherence to an unwieldy, uncoordinated, and inefficient system. The kind of consolidation associated with regionalization allows a government the ability to hold one local body responsible for the planning, management, and delivery of health care within a specified region. Yet it has to accept that it has created a series of new political power centres which are much more capable of confronting the provincial government than were the previous 400 institutional and service centre power sites.

It is also true that regionalization is about decentralization in that governments are devolving more managerial decision-making authority from a centralized department of health to the regional level in an attempt to have community input over what might be the most appropriate balance of services. And while decentralization has sometimes been taken to mean the extent to which a decentralized authority can determine its policy objectives completely unfettered by the empowering statute,[12] RHAs appear, over time, to find that they are becoming at best junior partners in the policy-making framework.

Provinces recognize that their focus must be on funding, standard setting, accountability measurement, monitoring, and establishing policy direction. But provinces also recognize that these things are closely related to management and delivery functions which means ongoing consultations with RHAs on major issues of policy, standards, funding, reporting, and so on. Provinces are also sensitive to charges of acting unilaterally, particularly given that RHAs are supposed to represent the voice of the community, and provinces regularly speak of developing a collaborative relationship based on communication, trust, and mutual respect. As a result, provincial governments will have to back away from the notion of their health-care system as an integrated hierarchy, and accept some negotiated settlements with RHAs if regionalization is to have substantive meaning.

Shifts in the balance of power associated with regionalization are leaving the provinces without all the levers necessary to affect the health-care system at the community level. Even so, complaints have been voiced by RHAs in Saskatchewan that the province has tried to micro-manage at the regional level while not providing the leadership (i.e., funding) at the provincial level. On the positive side it has been argued that this type of intergovernmental competition will likely maximize governmental responsiveness to citizen preferences.[13] However, it is just as likely that the competition for power will be so imperfect that it will not constrain governments, and instead lead to escalating provincial/regional conflict and a widening gap between government policies and popular preferences. In such a situation, a collaborative framework appears to be the missing ingredient in the regionalization process.

RHAs vary considerably in terms of structure and responsibilities and thus it is very difficult to generalize about them. While RHAs may some day come to be commonly defined across a continuum of authority and autonomy, at present the variations are so great as to prevent much interprovincial collaboration or learning. Instead, each provincial government is struggling to develop its own unique relationship with its RHAs.

REGIONALIZATION AND ITS IMPACT ON POLICY GOALS AND OUTPUTS

The kinds of conflicts emerging out of the division of responsibilities associated with the new governance regimes will ultimately have effects on both the selection of policy goals and on specific policy outputs and outcomes. This is especially so given that a central idea behind regionalization is to break with the old top-down, hierarchical, institution-based health system that emerged out of federal spending priorities associated with the CHA and Established Program Financing and find new more appropriate, local solutions.

To achieve this end, provincial governments have provided RHAs with a policy framework that makes clear the goals that regional authorities are to pursue. Such goals include: increasing efficiency in resource allocation through streamlining and elimination of duplication, improving population health and wellness, and redistributing resources from institutions to community services. Some of these are purely procedural and clear in intent, but some of the goals are vague and difficult to quantify. Typically policy goals are stated in terms of "meeting the needs of communities," "involving communities more directly in

decisions," "shifting more emphasis to prevention, promotion and wellness," and "focusing more on outcomes."

Yet both the vagueness of policy goals, their mutually contradictory nature, and the difficulty in attaining improved health outcomes means that RHAs may find themselves with latitude in defining and implementing policy goals. In such a scenario, the danger is that the first policy goals likely to fall by the wayside will be those related to outcomes, particularly notions of "healthy public policy," "wellness" or "health promotion." Whatever name they go by, such goals assume that RHAs, working along with various other local, provincial or federal authorities, should attempt to change the behaviour of individuals. Even more than this they are trying to have doctors change their methods of practice, moving them away from the treatment focus to more emphasis on prevention which, of course, will be crucial for any other fundamental changes to take place. Yet the behaviour of individuals, let alone doctors, is often resistant to change, and success in the area of wellness has been, and will likely continue to be, illusive.

The result of the difficulties associated with achieving health promotion goals may mean a continued emphasis on traditional policy goals like access, waiting lists, reduced costs, fewer beds, and so on simply because they are more easily within the control of RHAs. Such goals are easier to achieve than access to improved health status for a particular population. Improving population health is difficult to secure, time-consuming, and may even require that resources be moved from existing facilities for an outcome that is both speculative and distant in time.

Provinces will retain the ability to influence the policy goals and outcomes that RHAs pursue through their control of budget allocations. These allocations can proceed in a number of ways, but two dominate.[14] The first is the traditional "static capacity," meaning "patients follow money." In this model, planners decide where a particular service will be provided and fund such services on some agreed-upon rules, and patients are obliged to go there for services of a certain nature. This is the system that came to be seen as being unresponsive to the needs of clients. The other "fluid capacity" system is one in which "money follows patients" and funding is allocated on the basis of the ability of RHAs to respond to the needs of clients. It is this latter model that is at the basis of many of the funding changes that are occurring in tandem with the movement to regionalization. Such changes to the funding mechanisms are fully consistent with the *Canada Health Act*, and there are a variety of

experiments taking place in alternative funding, including things such as the population health, or needs-based funding, model in Saskatchewan. The desire is to shift attention from the level of activity to an evaluation of the actual health needs of the individual subpopulation. In this sense the policy goal is intended to achieve more funding for those in greatest need, and consequentially health status equity among all people.

The issue of equity in the regionalization plans centres around this notion of weighted capitation or fluid capacity which ensures that money follows patients as opposed to continually being poured into institutions where funding decisions are based more on historical resource consumption use than on the needs of a particular service population. This is seen as something that would lead to greater "equity in the ability to address health needs among health districts; that is, health dollars go where health needs are the greatest."[15]

Yet such a system of equitable resource allocation is not without its consequences. When funding becomes based on the service population and not the census population, there may be battles between health districts over funding, which will almost certainly result in money moving from rural areas to urban areas where most of the extensive and expensive list of services take place, particularly after reforms that result in acute-care bed closures in rural areas. This might lead to some serious interregional bargaining and there might be a "significant diversion of funds from the delivery of services toward protecting existing budgets and manipulating regional accounting systems."[16] That is, RHAs might attempt to shift to other regions certain of their patients if these patients are exceedingly costly to service. Depending on how a budget allocation for service is calculated, a regional fiscal strategy might evolve to send expensive patients elsewhere and treat low-cost patients in the home health district.

A further problem with this system is that while RHAs will find it easier to equalize funding through the so-called needs-based funding approach, what needs-based funding really implies is that resources will be redirected to a subpopulation within the community who have been identified as being able to benefit the most from increased expenditures. This might be characterized as a movement away from universality in the name of better outcomes. Thus we might well predict that RHAs may bring about a more equitable distribution of health dollars, and better health outcomes, but this will not automatically lead to a voluntary reduction in the level of health-care expenditures. The simple reason is that there are few incentives for RHAs to reduce costs in the absence of provincial reductions in fiscal grants. Like other public organizations, any

efficiency savings that are found will be eagerly fought over by rent-seeking interest groups who will attempt to profit from any additional funding without any commensurate improvement in the quality of service they are providing.

Provincial governments are well aware of all the potential pitfalls in constructing their version of fiscal federalism. If anything, provinces learned from the failure of previous federal-provincial financial arrangements for health care in which costs became "out of control" from the 1970s due to a lack of incentives in place to control costs. The same mistakes were not repeated by any province that provided fixed, centrally determined, global budgets for their regional health authorities. Such "block grants" may not decrease in size but provincial governments hope they will not grow as quickly as they did in the past. The assumption therefore is that regions will be able to live within the budgets that are provided for them. Whether that assumption is correct, however, remains to be seen. Recent evidence suggests that this is not always the case as many struggle to maintain service levels.

To deal with reduced levels of fiscal growth most RHAs have tried a number of strategies including some of the following: reducing the number of hospital and nursing home beds, restricting access to institutional services, sometimes limiting the numbers of doctors, increasing waiting lists, and sending patients to larger centres. Yet such actions have put the RHAs on a collision course with providers, unions, interest groups, and even their own communities whose incentive is always to have as much access to health care as possible. Indeed, because there are so many diffuse interests within any health-care community losers in the process of reallocation and financial adjustment have mobilized to try and maintain existing levels of service through whatever avenues of influence are open to them. In such an environment, the policy goal of improved efficiency gains are possible but only through a prolonged political battle, similar to what would have occurred without going through the regionalization process.

In summary, the impact of regionalization on varied policy goals such as greater equity and efficiency in the distribution of funds, not to mention improved population health and community decision-making is ambiguous at best. Entrenched provider groups, high levels of client expectations, interregional disputes and high voter salience of health-care issues all make the conflicting policy goals associated with regionalization difficult to reconcile and prioritize. In addition, no matter how well designed the funding mechanism might be, RHAs are more than simply resource allocation agencies. They are structures that are assigned substantive policy goals with the

intent that these policy responsibilities are to be exercised in a manner that ensures local communities and individual citizens have some voice in the dynamic of health-care reform. The result is that RHAs must balance multiple policy goals with local accountability in an environment in which provincial governments establish their overall budgets. Given this complex and contested environment some thought must be given to finding a way for the national and provincial governments to provide more precise guidance as to how RHAs are to fit into a health-care regime with national and provincial priorities.

REGIONALIZATION AND DEMOCRATIC PRINCIPLES: RESPONSIVENESS TO COMMUNITIES

Responsiveness to community wishes is an appropriate measure in discussing the nature of the new regionalized governance regime in health care that was at least partly designed with the intention of improving the connections between provincial health systems and the needs of local communities. Thus it should be possible to measure the responsiveness of the system based on the accuracy with which the wishes of citizens are transformed into public policy. Yet it is possible to reason that regionalization might simply result in a kind of "executive federalism" that will lead to secret, non-participatory, and non-accountable decision processes between the RHAs and provincial governments, as occurred, and still occurs, at the federal-provincial level.

This concern is fed by the fact that citizen engagement through their regional boards is quite weak. An assessment of regionalization in British Columbia noted that many people thought that "the same individuals and interest groups who had previously been involved in hospital societies, etc., continue to be involved in the community health centres and RHAs, as a consequence, decision-making around health-care services continues to favour institutions rather than community services. The way in which community input is gathered and decisions are made leaves a great deal of breadth for RHAs to formulate their decisions irrespective of citizen input."[17] Despite the fact that some RHAs are partially elected bodies, they all essentially act as trustees of the health-care system. A fundamental concern is how communities can gain control over decisions. How are community wishes discovered? More importantly, how are competing values within the community reconciled? This is never stated in any explicit manner in the documents and legislation establishing RHAs and should lead to concerns about the possibility of any meaningful form of community input.

Fears of a new form of unaccountable decision-making between provincial governments and RHAs are expressed by interest groups who would prefer to see RHAs at the centre of a new kind of interest group pluralism. Of course, such a system would be different from community responsiveness and could possibly lead to the growth of an "iron triangle" between RHAs, provincial governments, and provider groups. Yet interest groups in health care tend to be well-established, well-organized, and have significant lobbying capacity and resources to pressure both RHAs and provincial governments. This fact in itself will encourage consultations by both RHAs and provincial governments with such groups. In addition, these groups will often be involved in discussions because their support is essential to make changes work. The point is that interest groups may well gain access to provincial-regional negotiations based on the understanding of well-established client relations with the government.[18]

Yet it is also true that regionalization means that the shift in health-care decision-making is away from the provincial departments of health to a new form of intergovernmental negotiation between RHAs and the provinces. The danger for interest groups is that past experience with federal-provincial negotiation, in which interest groups have had difficulty in keeping up with policy changes, let alone gaining access to the process, will be replicated at the provincial-RHA level.[19] Similarly, there is the well-known tendency in intergovernmental forums dominated by officials to allow technical considerations to override responsiveness to community wishes and interest group input. Previous research has indicated that clashing professional perspectives or competing "grand designs" will often supercede the issue of responsiveness to citizens, communities or interest groups who would nominally benefit from a particular program.[20]

It is then an open question whether regionalization will mean a greater responsiveness to community interests and interest groups or to the mass of unorganized and diffuse opinion. The potential exists for the complexity of the health system to effectively insulate decisionmakers from public pressures as it often did in the past. This may be particularly true in the new health policy environment where there is no single dominate view. This produces a situation in which decisionmakers have tremendous latitude to pursue their own preferences. If anything, the concept of community is broadly appealing to a wide range of political interests, but its ambiguous nature also makes it a difficult concept around which to centre policy-making.[21]

Adding further uncertainty is the fact that regionalization is positioned in the middle of a classic conflict between community control and professional autonomy. Local control is in many ways synonymous with lay control and lay control is something that all the disparate professional groups in the health system will bristle against. Health professionals will often work against community influence and preferences when the issue of allocation of resources is discussed.

There are then valid concerns about regionalization merely creating another partner in the politics of executive federalism, shutting out both community and interest group input. In fact, the demand for accountability from federal and provincial officials might well condition the nature of the services offered by RHAs. Responsiveness to local communities might be sacrificed to the requirements of a national reporting regime worked out between provinces and the federal government. It is precisely because of this danger that the RHAs should demand to be consulted and included in the development of any accountability regime or outcomes measures that might be established if they wish to remain the voice of their community.

REGIONALIZATION AND DEMOCRATIC PRINCIPLES: ENHANCING ACCOUNTABILITY

One of the fundamental issues at the heart of the emerging governance regime is the question of who will be held accountable and how will outcomes be measured. This is important because shifts in power have both an impact on the accountability for, and performance of, the health system.[22] The problem is confounded by the complexity of the health system and the increasing reality of shared jurisdiction among provinces and RHAs, and the recent emphasis on structures of collaborative federalism. Regionalization might well be consistent with the desire of contemporary advocates of federalism to increase opportunities for individual participation in public decision-making and enhancing the ability of ordinary people to get governments to respond to their concerns. However, whether or not a regionalized health system will be able to accommodate the differing demands of such mixed accountability remains unclear.

For provinces, the key to increased accountability rests with the notion of the increased operational autonomy of RHAs. In British Columbia it was noted that: "regionalization is based on the twin principles of autonomy and accountability. Autonomy means that health authorities are able to determine

how to manage services. Accountability means that they do so within certain boundaries, namely the requirements and conditions established by the Minister and the Ministry." Yet in the next breath it is acknowledged that RHAs will have confused accountabilities: "Health authorities have other formal and informal accountabilities in the system, including to the populations they serve, their employees, local health providers, and their funding agencies." [23] This will clearly make holding RHAs accountable for provincially determined goals very difficult and extremely controversial, particularly when local populations have different health goals in mind. Provinces also recognize that there are more pressures for accountability throughout the system. The Government of Alberta, for example, acknowledges that its citizens "are now demanding more accountability from everyone, from the individual, to boards, to the department of health, to institutions, professionals and government. Albertans are becoming conscious of the true costs of their health system and they want to ensure that we are receiving full value for the investment."[24] The key, however, appears to be that regionalization allows both provincial governments and regional communities to participate in goal-setting, and then they can both hold one local body accountable and responsible for the planning, management, and delivery of health care.

The other form of accountability that regionalization can achieve is in having RHAs act as a new accountability mechanism for provider groups. There is some expectation that RHAs will begin to move to increase the accountability of the medical profession, something that was always a major frustration for provincial governments and continues to be a source of conflict in most provinces. In many provinces doctors and other medical professionals have been specifically excluded from membership on these boards for reasons similar to the ban on having teachers on local school boards — their potential conflict of interest. Exclusion from these boards is a tremendous source of concern among medical professions who feel that they are losing important decision-making power to layperson decisionmakers, which is something that professions find disconcerting at the best of times. Yet if regionalization is about anything, it is about increasing the level of lay-control over the health system.

What really concerns the providers, and particularly the doctors, are fears that RHAs will introduced new lines of economic accountability, price competitions, managed care, and increased monitoring of their activities. Thus physicians want to see the power of RHAs limited; and indeed provinces, to this point, have maintained centralized control of fee structures as well as other

policy levers affecting the medical profession. Nonetheless, the arrival of RHAs may have the unintended consequence of reducing the control that the medical profession has over the health-care system, which implies a decline in status, bargaining power, benefits, earnings, etc. It is not surprising then that all medical professionals, and not just doctors, have been the loudest in proclaiming a "crisis" in health reform, demanding a vast infusion of public money, all the while watching the erosion of their ability to manipulate the system.

In fact, when we examine the basic notions associated with regionalization such as population health, community participation, local elections, and so on, it seems clear that provinces were at least partially trying to constrain the role of doctors and provide some other perspectives in the health system. There is a feeling in the rhetoric surrounding regionalization that the medical profession has placed too much emphasis on treatment and not enough on preventative medicine.

Regionalization has been sold as a process in which it is possible to clarify and affirm the roles, responsibilities, and expectations of all major health-care system participants. Once this is done, it is possible to set performance expectations, measure results, and ensure that the right people and organizations are held accountable for achieving the desired results. However, the complex nature associated with achieving some uniform accountability for service standards in a system, which by definition is going to be more diverse and less uniform, will be a very difficult task.

While enhancing accountability is difficult, it is not impossible. When a new accountability structure is agreed upon by federal and provincial officials, it will certainly be more outcomes-based, while the former measures were mostly tied to inputs. When health care is primarily focused on the issue of access, provinces are inclined to count beds, doctors, number of hospitals, and so on. Such measures indicate how accessible the medical system is and the measures are easily quantifiable. However, with the coming of regionalization, accountability will be expected to reflect health outcomes. In this light, one of the most obvious weaknesses with regionalization is that provincial governments did not initially provide an adequate structure within which to assess the performance of individual RHAs; nor did they provide any expectations as to desired health outcomes.

It is on the issue of outcomes and accountability for outcomes that much federal concern is justifiably focused. Ottawa wants the health system to achieve and measure results while ensuring fair and transparent practices. While the federal and provincial governments can act unilaterally in establishing such a

new performance measurement regime for health care, given the diversity of organizational forms in the health system and the many combinations of roles and responsibilities associated with a radically decentralized delivery structure, it will be difficult to get meaningful comparable data. More important, it will be difficult for provincial governments to hold each RHA accountable for the same level of performance and outcomes, particularly as provinces slow the rate of financial growth in their health-care systems.

Accountability is clearly an aim of all the participants in the health-care sector, specifically an outcomes-focused accountability. There are many unanswered questions surrounding this issue, not the least of which concern the process for establishing the goals and performance indicators for which the provincial and regional health-care systems are to be held to account. Questions concerning the process of, and participants in, establishing any accountability regime will have implications for the intergovernmental regime that emerges in the health-care sector. The answers may even have implications for the principles of federalism in Canada.

REGIONALIZATION AND FEDERALISM PRINCIPLES

Regionalization has neither enhanced nor diminished the constitutional division of powers between the federal and provincial governments. Only a constitutional amendment could do that. Furthermore, the creation of RHAs has neither enhanced nor diminished the degree of political sovereignty of the federal or provincial governments. Both orders of government have continued to operate within their sphere of jurisdiction much as they did before regionalization. The federal government has continued to use its spending power to influence the nature and scope of provincial health-care systems in much the same way it did prior to the creation of RHAs.

The major constraint to the influence of the federal government's spending power on social programs is not coming from the creation of RHAs but from the Social Union Framework Agreement under which the federal government has agreed not to fund any new joint programs within areas of provincial jurisdiction without the consent of a majority of the provinces. Regionalization has not compromised the federal government's legal or political ability to use its spending power as it did in the past, subject to the SUFA. But the extent to which regionalization might constrain the federal government sometime in the future is contingent on several key factors.

The first is the extent to which provincial governments empower RHAs by giving them considerable authority and autonomy in policy and programming matters. RHAs with extensive authority and autonomy might feel that they are being constrained, or unduly affected in their autonomy by the federal spending power. It is not inconceivable that in such a scenario a provincial government might allow a regional health district to develop policies and programs that contravene national principles or standards, provided they were prepared to absorb any resulting loss of revenues from federal health transfers that were withheld.

The second factor is the financial capacity and fiscal need of regions. In the future, as in the past, the degree of influence and compliance that the federal government's spending power can purchase either with provincial governments or RHAs will be a function of the extent to which there is a need for federal government funds. With federal reductions in the past, many provinces argued that the federal government is losing moral authority to influence the behaviour of provinces.

The third factor is the degree of community support within each region that will help RHAs withstand the federal government's spending power, and by extension, corresponding national principles and standards; or alternatively, the community support that can be obtained to withstand federal social spending in a region where this spending has the potential to distort the region's priorities.

These factors may well have been at the base of the concern expressed by the National Forum on Health regarding regionalization when it concluded that even the current level of regionalization is not entirely consistent with the needs of a national health-care system. The implicit concern is that these more integrated governing regimes could lead to the fragmentation of programming both at the provincial and national levels endangering the notion of a "national" health-care system.

Future provincial governments may well find that RHAs have become more powerful than was initially expected. It is not inconceivable that the RHAs will expand their influence on the health system at the expense of provincial governments. This is particularly true when regional authorities are elected. Already many of the elected and appointed officials have come to see themselves as the legitimate representatives of citizens regarding health-care issues. As such they believe that it is their duty to challenge provincial officials on policy matters when provinces are not acting in the preferred interests of a

regional community. Such efforts could limit the ability of provincial governments to exert the same degree of control over the system that they previously exercised. At the very least, provincial governments will have to enter into a more complex process of negotiation and bargaining to influence policy, programming and management practices than was the case in the past when provinces operated in a hierarchical, regulated system.

If tensions do emerge between the parties it will likely be related to the manner in which regionalization is altering the distribution and range of services in a particular geographical area. Pressures associated with these changes are likely to have spillover effects on the provincial and national character of the health system. This national system in particular was designed to ensure that all citizens have access to a reasonable level of service in any part of the country. Given the provincial/regional fiscal framework described above, the motivation of RHAs may well differ given that they are shifting resources to areas of health care that reflect the needs of their local communities and not necessarily those associated with national priorities. Thus more eldercare in some rural areas may potentially mean less pre-natal care in others. If you are not part of a particularly well-represented health community you may find services that used to be available are eroding or eliminated and replaced with others, forcing some citizens to go to larger centres for their services.

This concern about the pressures emanating from the fiscal framework requiring RHAs to tailor their mandate to match the needs of the community may well come into conflict with the federal government's desire to have a uniform range and quality of services available across the country. This debate over diversity versus standardization, while tempered at the moment, is bound to become more contentious as time goes on. It may eventually involve a form a tripartite negotiation. Thus, as the federal government tries to create a larger national profile through home care and/or pharmacare, these priorities may clash with those of RHAs who find that they are having their budgets distorted by priorities determined in federal-provincial negotiations, just as the provinces themselves experienced in a previous era.

In another respect the pressures associated with the fiscal framework might come to create a new type of regionalism within provinces, creating pressures similar to those associated with provincial-federal relations. That is, the existence of regions might mean we could witness the mobilization of regional interests that would not have occurred in the previous unitary provincial systems.[25] While there will always be difficult decisions that provinces will

have to make about allocating resources, provinces will have to have sufficient character to be able to engage in compromises and trade-offs in order to manage conflicts among health regions.

A new political force, the "politics of regionalism," might emerge in the provinces where issues of regional equity come to supercede issues of provincial efficiency in deciding about health-care allocations. Indeed, one of the reasons that regionalization was seen as being a good idea in the first place is that the central planners in provincial capitals did not have the necessary sensitivity to the interests of the regions. It would be ironic if a new sensitivity to regional interests meant that provincial efficiency objectives are being sidestepped in favour of regional equity.

It remains to be seen whether regionalization will contribute to the fragmentation of the health-care system by producing regional subsystems with powerful regional governing authorities who want more power vis-à-vis the provincial and federal governments than was possible by the more localized and facility-based health-care authorities that preceded them. It will be particularly interesting to see what will happen if the provinces manage to wrest greater control of their health-care system from the federal government in setting and enforcing national principles and standards. If that were to happen, it would make it easier for the provinces to decentralize more independent authority for the delivery of health services to RHAs. Could such developments make a system — which to date has been characterized by a relatively high degree of centralization at the policy level (in light of the federal government's role in setting national principles and the province's role in designing policies and programs), and a high degree of decentralization at the administrative level (in light of the multiplicity of local health authorities that have been involved in the delivery of services) — more decentralized at the policy level and even more decentralized at the administrative level?

REGIONALIZATION AND MAJORITY RULE

To what extent has regionalization enhanced or diminished the principle of majority rule within the health sector at the regional, provincial, and national levels? The effect of majority rule at each of these levels is discussed below, but in all three cases the effect of regionalization on majority rule is highly debatable. However, at the same time it is clear that regionalization has created new majorities and minorities. Whereas prior to regionalization the majorities were either local or provincial depending on whether decision-

making authority for a particular policy or program rested with the provincial government or local boards, the new majorities are regionally based.

In the jurisdictions that have elected or partially elected health boards, regionalization has obviously contributed to democratization within the health sector in that the majority of the members of these bodies are now elected by voters in general elections. It is questionable, however, whether it has contributed to majority rule. At best it has increased the number of people who participate in the selection of decisionmakers, but it has not led to majority rule, because the majority is not involved. Voter turnout at elections of RHAs has been very low. Indeed, it has been even lower than it has been for municipal or school board elections in some parts of Saskatchewan where less than 25 percent of the people participate in RHA elections. Moreover, only a small proportion of those might have voted for any of the winning candidates. With those factors in mind it might be more appropriate to say that regionalization and the introduction of elections for some of the health board members have fostered rule by a small plurality, rather than an absolute majority.

Regionalization in itself does not threaten or compromise the principle of majority rule. The effect of regionalization on majority rule at the provincial level is a function of the extent to which the preferences of the regional and provincial majorities either coincide or conflict and, more importantly, the extent to which the former decides to impose its preferences on the latter when there is a conflict. Regionalization could compromise the principle of majority rule at the provincial level. This could occur if the preferences of the regional majority do not coincide with those of the provincial majority, and the latter imposed its will on the former.

There are two ways in which the provincial government could impose the will of the provincial majority on regional majorities. The first is by enacting policy and programs on a provincewide basis for which there is considerable support among the majority of people in the province, though not necessarily the majority of people in any one or more of the RHAs. The second way is for a provincial government to introduce provincewide plebiscites or referenda as a decision-making tool in the health-care sector which should pit the provincial majority against the regional majority.

When examining the relationships between national majorities and regional majorities, the one area of potential tension is the support for the application and enforcement of the national health-care principles and standards pursuant to the *Canada Health Act*. Currently the national, provincial,

and regional majorities all favour a health-care system with national principles and standards. The notable exception may be the provincial and regional majorities in Quebec. There may be instances, however, where the regional majorities and the national majorities may differ on such matters. It is not inconceivable that at some point the regional majorities may decide that it is not in their interest to support national principles and standards. This might occur, for example, in the application of service or facility fees or any other types of levies on users, or in allowing certain types of medical procedures to be performed at privately-owned facilities for a fee which may be contrary to the letter and spirit of the *Canada Health Act*. It is not inconceivable that some provincial governments may well support the decisions of RHAs to contravene the CHA as a means of providing appropriate health care and balancing the budgets. This is more likely to happen in those provinces where the provincial governments are opposed to what they see as unreasonable restrictions imposed by Ottawa on how health care is managed and financed in the provinces. Quebec governments are not the only ones to express such opposition in recent years.

In summary, regionalization creates some possibilities for tensions to emerge between the regional, provincial, and national majorities. What was previously a potential problem between national and provincial majorities now gives rise to the possibility that tensions will emerge between national and regional majorities, as well as national and provincial majorities and provincial and regional majorities. While there have been relatively few of these tensions emerging to this date, as regional authorities become more entrenched we may begin to witness more conflicts.

RECAPITULATION AND ASSESSMENT: COLLABORATIVE GOVERNMENT AND SHIFTING INTERGOVERNMENTAL REGIMES

Regionalization is creating a complex intergovernmental regime involving a new set of relationships between provinces and RHAs, and slowly forcing changes to the existing relationship between the federal government and the provincial governments. While the contractual relationship between provinces and RHAs is different than the constitutional relationship between provinces and the federal government, the fact remains that both senior governments face the risk of losing touch with the actual delivery of health services in Canada. Currently the exact location of responsibilities and accountability for service

delivery between provinces and their regional authorities is evolving and often particular issues fall between the cracks. This has the potential to impact federal-provincial relations particularly at the program level where official responsibility might become difficult for federal officials to locate, let alone influence.

It is nevertheless clear that the federal government will have to continue to play a role in the evolution of the Canadian health-care system. But to continue to play a role in the progress of regionalization might require the federal government to reassess the strengths and weaknesses of the CHA in light of the diversity of needs of RHAs. In particular, the CHA might be in need of updating in terms of its provisions for comprehensiveness, accessibility, and portability which have already come under fire from some RHAs who are refusing to take patients from other provinces due to a lack of acceptable reimbursement from their own provincial governments.

The pressure to reassess the CHA will come from RHAs and provinces which are to be held more accountable for improving health-care outcomes in the years to come. In order to have the flexibility to improve outcomes, RHAs might require that some of the principles of the CHA evolve so as to become more consistent with a needs-based, or evidenced-based approach to decision-making. This may even include social and institutional pressures to redirect health funding in a more intersectoral direction, resulting in the transfer of health funds from traditional institutional approaches to alternatives that have a greater proven impact in improving health outcomes. Clearly, feedback from the process of regionalization and the results of local experiments will have to be used in any evaluation of changes to the CHA that the federal government might contemplate.

If developments at the regional level are to influence changes in the national health-care system some mechanism will need to be found to transfer knowledge of what works and what does not work to federal and provincial policymakers. This might take place through some existing structure such as the Canada Health Services Research Foundation or even the Canadian Healthcare Association, even though the latter is more of an advocacy group than a research body. Alternatively, other chapters in this volume by Joan Boase and Duane Adams, for example, have suggested that the creation of either a Canadian Health Council or a National Health Oversight Commission that could have RHA representation. Alternatively, a specific mechanism might be found which would involve a tripartite relationship between some representative sample of RHAs sitting at a common table with provinces and the federal

government. While there are too many RHAs with too many divergent viewpoints to ever establish a common front, valuable input could be gathered by having rotating representation, such as having delegates from one RHA from each province at federal-provincial health meetings to observe and provide information. A final approach might be to have a national association of RHAs that would publish the experiences of RHAs as a vehicle for learning and influencing federal and provincial decision-making.

The point about the foregoing is not to find a definitive mechanism for serious policy input by RHAs, but only to suggest that some voice which would allow RHAs to contribute to the process of policy learning, could be valuable. Whatever mechanism is chosen, it seems evident that the national health-care system would benefit from learning about the varied experiments occurring at the regional level. The full benefits of regionalization cannot be exploited through federal-provincial collaboration alone, but rather will come from some structure that would allow senior governments to learn from the experience and experiments of RHAs. The final mechanism will naturally be based on the evolution of RHAs, either toward autonomous elected bodies or more limited health-care service delivery mechanisms. Provinces should determine how best to include RHA input into national debates, but a strong and legitimate feedback mechanism is important if regionalization is to have the positive impact on the evolution of the national health-care system that its advocates hope for.

At this stage, the jury is still out on the merits of regionalization, and some reports, like that of the National Forum on Health, noted that regionalization may be problematical for a national health-care system in that "there is a great deal more that can be done to improve resource allocation through integration and allocation mechanisms without creating another level of government and an additional layer of bureaucracy." Another student of regionalization concluded that "there is little or no prior research or evaluation to reassure us that devolving authority is likely to achieve provincial governments' objectives of cost containment, improved health outcomes, more responsiveness and flexibility, and better integration and co-ordination."[26] Clearly the kind of data-gathering and the development of common standards needed to make the regionalized health system function effectively requires facilitation at the national and not just the regional or provincial level. Moreover, the creation and expansion of social and educational programs to help with many aspects of regionalization, like health promotion and the need to overcome socio-economic inequality, can only be accomplished with federal support, federal money, and federal political will.[27]

While scepticism concerning regionalization is justified at this stage, it must be assumed that provincial governments were responding to genuine pressures for increased participation and more "democratic administration" in the health-care sector when they proceeded down the path to regionalization. In fact, this type of a decentralizing response may be something that occurs in more and more policy areas in the future in the wake of the social union negotiations which imply that citizens will be given a bigger voice in policy choices.[28] It is almost an axiom in the creation of governance regimes that subsidiarity is something that is desirable — getting government right, providing services to clients, getting closer to the community, linking costs and benefits, and so on. Governments appear concerned about having policies that are more responsive to local needs and preferences, and politicians of all stripes promise increased community control and greater input in decision-making and improved results-based accountability. The assumption is that mere consultation is, in itself, not enough. Thus there is momentum to create more "empowered" forums and institutions that will allow for more local control of decision-making based on the assumption that local control will produce policy outputs more in tune with the needs of the specific population.

The central tension with regard to regime type that emerges from this understanding of health reform is that on the one hand it requires a much more decentralized and disentangled system in the delivery of health services, and on the other, it needs a system of collaborative intergovernmentalism in setting broad national health priorities. Can the interests of citizens as represented by RHAs become part of a national health-care governance regime? Should regionalization become part of the governance regime used to establish the national policy framework? At a minimum, RHAs will be part of the governance system in that accountability, performance indicators, and outcomes measures will be related to their activities. Not to find a mechanism that would gather RHA input in the establishment of these measures will result in charges of interference, unilaterialism, unfairness, and lack of concern for local preferences. To avoid this kind of politicization, the emerging collaborative governance regime will need to find some method of determining how to involve RHAs in the establishment of the goals of the health-care system. While it is important to have clear goals and performance expectations for all parties within the system, for one or two partners in a tripartite relationship to establish these unilaterally is to replicate the mistakes of the past.

The key will be to ensure that RHAs are part of a chain of collaborative relations leading through provinces and provincial associations, and even

perhaps in some very limited form, directly with the federal government. While a new role for the federal government is possible in ensuring that the views of RHAs are heard in policy debates, and that experiments and innovations are disseminated throughout the system, this in itself will not end the ambiguities inherent in the system of overlapping powers that has always existed and to which regionalization adds. These ambiguities have in the past made for an ongoing dynamic in which provincial governments experimented with various enterprises. In this situation, the federal government played a role in fostering the diffusion of those successful initiatives through its role in ensuring the existence of a national framework and it can still play this role.[29] However, it is not clear that such a dynamic would emerge in the regionalized health-care system without some formal, collaborative structure linking developments within RHAs with provincial governments and the federal government. Some mechanism must be found in which local experiments sustained in the face of entrenched opposition may be disseminated throughout both a provincial and national health-care system, providing a more cost-effective and responsive system in tune with the needs of local communities. Ironically, the full potential of regionalization as a cost-containment and accountability mechanism may not be realized unless the federal government has a role in ensuring that the benefits are diffused throughout the entire Canadian health-care system. For collaborative relations to exist in the area of health care, it appears that collaboration will have to include all three partners with a stake in having the health-care system achieve its goals.

NOTES

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9

CONCLUSIONS: PROPOSALS FOR ADVANCING FEDERALISM, DEMOCRACY AND GOVERNANCE OF THE CANADIAN HEALTH SYSTEM

Duane Adams

It is apparent that national health policy is a pawn on a much larger federal/provincial/territorial (F/P/T) game board. There is a linkage between the development of a Canada-wide health policy and nearly all other areas of F/P/T interface — financial, economic, ideological, political, and jurisdictional. Federal/provincial tensions or conflicts in any of these fields affect the development of national health policy and its intergovernmental management.

The Canadian health system today is the product of over 40 years of history. This has included two federal/provincial collaborative initiatives, and a unilateral federally imposed consolidation of the legislation (*Canada Health Act*). On the two occasions when new federal/provincial agreements were reached collaboratively (the introduction of Canada-wide hospital insurance in 1957 and medicare in 1966), there were indeed serious points of intergovernmental contention — especially with the Governments of Quebec, Ontario, and to some extent, Alberta. Nevertheless, federal and provincial governments were able to work together successfully to overcome the difficulties that existed. As a result, health goals were advanced without any serious impairment to the health of the federation. The same cannot be said about the unilateral enactment of the *Canada Health Act* (CHA) in 1984. While this

measure may have been important in preserving Canada's public health insurance system, it has led at times to significant tensions in the federation, notwithstanding that all provinces have, on occasion, announced their support for its five broad principles.

More generally, the postwar history of health care in Canada has been marked by both cooperation and conflict among governments. Our case studies indicate, however, that the kind of collaboration that accompanied the introduction of hospital and medical insurance has been relatively rare, and that other attempts to improve the health-care system have been less cooperative and, in general, less successful, at least in part due to this lack of cooperation. Indeed, from some perspectives, it can be argued that the countrywide health system has not advanced at all since the introduction of medicare in 1966. Yet the long list (substantiated in the case studies) of public concerns — emerging and pent-up policy issues, new health needs and priorities — appear to require immediate government action. Furthermore, the near decade-long public disputes between orders of government about public issues in the health system, and the near absence of positive action by governments, has eroded public confidence in both the system and in the health policy performance of governments. Canadians accept that the *status quo* is no longer an option if the survival of the publicly insured health system is to be assured. If that system does not deliver the services demanded by Canadians, a system based on private insurance will emerge one way or another.

Since most solutions are dependent on governance decisions and action, the impasses must also be broken at the governmental level. This, of course, brings into play all the intergovernmental "linkage" issues, relationships, and contentions in the federation. In this regard, there seems to be only two major options to advance national health policy for the next generation:

- Fundamentally change the balance of power, jurisdiction, and capacity to deliver a Canada-wide health program; and
- Within the existing balance of intergovernmental power and jurisdiction, seek modifications to the intergovernmental governance arrangements, including a more clear differentiation of governmental roles, where the modifications offer possibilities for overcoming present stalemates, deficiencies, intergovernmental tensions, risks, and challenges.

Each of these options is discussed below.

CHANGE THE BALANCE OF POWER AND CONSTITUTIONAL JURISDICTION

In this option, there are two quite distinct ways to rebalance power and jurisdiction in the health system: either decentralize more power and tax capacity to provincial/territorial governments to manage the health system and establish some interprovincial mechanisms to deal with collective functions; or amend the constitution to give more power to the federal government to manage and pay for the health system.

The legal foundation of the Canada-wide health system is based on joint federal-provincial constitutional jurisdiction, with the provinces holding the legislative competence and hence the power to design and deliver health programs and the federal government possessing mainly its spending power, its general power of "peace, order and good government" and certain other associated laws (like drug patent law, for example) which were not targeted to health services delivery, but do have a general bearing on health programs. Since the 1960s, Quebec has often questioned the political legitimacy of the federal spending power and jurisdiction to participate in the field of social policy. From time to time, other provinces, like Alberta and Ontario, have asked that the federal government vacate the field of health to the provinces and turn over sufficient tax points to pay for health programs.[1]

Removing the federal government from its major role as a partner in the Canada-wide health-care system, however, appears to be undesirable. For one thing, from a policy perspective, our case studies suggest that many roles now played by the federal government are necessary to the effective and efficient functioning of a national health system (a system that is larger than just the insured components under the CHA). Therefore, if total responsibility for the health system (including maintenance of the Canada-wide characteristics of the program) were devolved to provinces, some new Canada-wide (non-federal), but very powerful governmental instruments would have to be developed to fulfill collectively, on behalf of all provinces and territories, what is now the federal role. Since the main points of dispute that the provinces have with the federal government have to do with Ottawa's financial contribution to the health system, and the potential impacts of Ottawa's other health policy decisions (e.g., national standards, enforcement of CHA principles, policy with respect to patents for drugs, health research, etc.) on provincial/territorial finances and provincial health policy (which are all matters of political choice), it is not

appropriate that an extra-governmental agency assume these responsibilities in a democratic federal state. Moreover, a voluntary approach to the enforcement of the essential features of a national health system (like the CHA principles) in such a diverse federal society as Canada appears implausible. This seems to suggest that the federal government needs to remain a substantial participant.

Second, from a political (as opposed to a policy) perspective, public opinion polls show Canadians are reluctant to trust one order of government alone with the task of preserving the health system. In brief, although some provinces periodically urge a federal withdrawal from its health financing role and the leverage over provincial governments which this affords, it is unrealistic to plan for the future on that basis.

The second possibility in the first option is to change the balance of power in favour of the federal government. If removing the federal government is a non-starter, as just argued, removing the provinces is an even more remote possibility. First, this would require a constitutional amendment that has no political possibility of being passed. Second, the federal government has never shown any interest in taking on the tough task of directly managing and delivering health care. Finally, while many countries throughout the world have a centralized health governance system, it is a fact that nearly every country with highly centralized health administration is attempting to decentralize it, consistent with the Canadian movement to "regionalize" the delivery of health services at the provincial level. From a "top down" model, all orders of governments have found great difficulty in stimulating change to their health systems, containing costs, sensitizing health programs to individuals' needs or accommodating cultural, linguistic, and economic differences of its peoples. A move to centralize health program governance in Canada would challenge the wisdom and experience of most of the world.

SEEK MODIFICATIONS TO EXISTING INTERGOVERNMENTAL GOVERNANCE ARRANGEMENTS

The lesson from the above discussion is simply that a completely disentangled regime is not a realistic option. This takes us to the second broad option above, namely, to somehow overcome the present stalemate and tensions by recognizing that there is a practical need for both orders of government to work effectively with one another from both a health policy and intergovernmental

perspective. To a considerable extent, this is what the Social Union Framework Agreement (SUFA) is all about.

The SUFA was signed on 4 February 1999 by the federal government and all the provinces as well as theYukon and the Northwest Territories, except the province of Quebec. For the most part, Quebec's refusal to sign does not reflect an opposition to the social policy issues or principles expressed in the document. In fact, Quebecers generally share the same fundamental views concerning social policy values and objectives as non-Quebecers. But the objective of the Quebec government was to obtain through this agreement broader restraint on Ottawa's spending powers in the social program field. The SUFA in its present form is unacceptable, even offensive, to the Quebec government because of its failure to ensure absolute provincial jurisdiction in the areas of health, education, and social services.[2]

Yet it is also noteworthy that the Government of Quebec participated in the SUFA talks from August 1998 forward, and that the PQ government, during the course of the negotiations, moved beyond traditional Quebec positions in acknowledging a possible role for the federal government. This chapter is not the place to discuss the Quebec position on SUFA in detail. Suffice it to say that it will be important, over time, for the federal and provincial governments to find a way of making it attractive for the Government of Quebec to eventually sign the agreement.[3]

The social union discussions have been a debate about principles, relationships, and processes. The agreement did not address the specific policy requirements of the sub-parts of the social sector, but rather it set a "relationship" framework around the developmental and implementation process for future policy solutions in the social subsectors. The Ministerial Council on Social Policy Renewal had expected that the subsectoral ministerial committees would advance plans to operationalize the Framework Agreement during the year 1999-2000. This would have offered a further opportunity to resolve some of the outstanding national health policy issues.

While it is hard for the public to know how much progress was being made at the health-subsector tables in the months that followed the signing of SUFA, we are aware of the September 2000 agreement. At that time, the first ministers, with the help of their F/P/T health ministers, announced their countrywide health reform plan, lubricated by a large increase in "new" (or depending on your viewpoint "restored") federal money. There is no federal/provincial consensus about the extent to which this first ministers' September 2000

agreement was related to the commitments of SUFA. Nevertheless, the tone and expectations for intergovernmental behaviour expressed by the September 2000 agreement are entirely consistent with SUFA. And as well, the agreement does require joint F/P/T work. Therefore, suggestions or options arising from our case studies might be of some assistance to the decisionmakers as they attempt to move these agreements forward.

Some of the commitments, statements of principle, intent, and direction in SUFA are instructive as quoted below:

- "The following agreement is based upon a mutual respect between orders of government and a willingness to work more closely together to meet the needs of Canadians."
- "…ensure appropriate opportunities for Canadians to have meaningful input into social policies and programs."
- "Ensure adequate, affordable, stable and sustainable funding for social programs."
- "Canada's Social Union can be strengthened by enhancing each government's transparency and accountability to its constituents."
- "Ensure effective mechanisms for Canadians to participate in developing social priorities and reviewing outcomes."
- Governments "agree to undertake joint planning … and collaborate on implementation of joint priorities when this would result in more effective and efficient service to Canadians."
- "For any new Canada-wide social initiative, arrangements made with one province/territory will be made available to all provinces/territories in a manner consistent with their diverse circumstances."
- "When the federal government uses conditional transfers … it should proceed in a cooperative manner that is respectful of the provincial and territorial governments and their priorities."
- Referring to dispute resolution, "provide for appropriate use of third parties for expert assistance and advice while ensuring democratic accountability for elected officials."
- And further regarding dispute resolution, "at the request of either party in a dispute, fact-finding or mediation reports will be made public."

These quotations from SUFA express the tone and general expectation of governments and presumably also offer a framework for acceptable options for advancement of the agreement. The SUFA seems to accept explicitly that a "collaborative" intergovernmental regime is necessary for the advancement of

the Canadian social union. But the findings of our case studies suggest less certainty, more conditionality about the choice of intergovernmental regimes in the health sector.

The case studies show that different intergovernmental regimes have been used for different activities within the health system. The hospital and medical *insurance* aspects of the program are a mixed regime, combining elements of federal unilateralism with significant collaboration; the development of the new Canadian blood system as well as the Canadian Health Surveillance system has used an F/P/T collaborative regime; the direct health service delivery to the majority of Canadians and the development of regional health governance structures are disentangled provincial initiatives (i.e., provinces have acted largely independently of the federal government); policy concerning federal contributions to the health system, interpretation, and enforcement of the CHA, and support of many health protection activities have been disentangled federal activities, and in some cases federal unilateral initiatives; physician manpower planning and controls have been collaborative interprovincial activities; regulation of the health professions has been a disentangled provincial responsibility exercised through health professional associations using a collaborative interprovincial liaison structure.

Whether or not the choice of intergovernmental regime was a conscious choice or an accident of history, the use of the mix of regimes worked reasonably well for the federation and its citizens until this past decade, although the use of federal spending power in the social program field has remained contentious for some provinces over a longer period. (Quebec has argued, for example, that the federal spending power capacity should not prevail over the constitutional division of program powers. If Ottawa has excess financial capacity, that excess should be transferred to the provinces that are short of financial capacity to support social programs within their constitutional jurisdiction.) Nevertheless, Canada-wide policy goals in terms of the CHA principles were met, although not modernized. Equity goals and fiscal redistribution occurred in the system to the benefit of society generally and the less prosperous provinces particularly. It is true that the regimes were less successful in advancing democratic values such as citizen consultation and involvement in health-system decision-making. Nor was there much public transparency or accountability for health governance decisions or health outcomes for the very large public investments made in the health system. But these deficiencies seemed relatively unimportant until the sustainability and future development of the health system came to be seriously questioned in the 1990s.

One broad conclusion drawn from the case studies is that, in general, there is a need for, and much to be gained by, better intergovernmental collaboration in several, but not all areas, of health policy. But to achieve this, it requires a change in attitude and behaviour of the players — from adversarial to collegial, with a prevalence of mutual respect. Collaborative intergovernmental activity implies that the sum of the whole collaborative activity is greater than the sum of the separate parts of the activity; it is not a zero-sum game being played out. If this concept is not recognized and appreciated by all the players, or if the positive benefit from collaboration is unlikely to materialize in a specific situation, then collaborative intergovernmental activity will not be productive.

The evidence in the case studies would support the use of a more collaborative intergovernmental regime in certain circumstances such as health program development issues with a countrywide impact (like national health surveillance), with new program initiatives (like expanding benefits to the public as in home care or Pharmacare), or F/P/T common political problems in the health system (like repairing the blood regime or restoring public confidence in the health system).

On the other hand, the case studies have concluded that a collaborative regime is more difficult, if not absolutely dysfunctional, when the issues at stake are, or can be made to appear, a "zero-sum" game between the provinces and Ottawa. Thus, in times of severe fiscal restraint, or in the face of serious ideological cleavage, collaboration will be very difficult if not impossible. Equally important to note is that in some instances, collaboration may not be desirable. One cost of collaboration is that it can be slow. The health system may need solutions faster than a collaborative intergovernmental regime can delivery them. Collaboration also entails political and financial transaction costs. Thus, where there is no genuine Canada-wide need to collaborate, it seems best that individual governments act within their own spheres of constitutional authority. SUFA also recognizes that there is a role for this kind of classical federalism.

From this analysis, one might conclude that insofar as the health system is concerned, conducting intergovernmental business in the federation has to be a more strategic activity, both with respect to what can be done and which intergovernmental process to use.

So, what are the major issues which are creating problems for the health system and which also need to be addressed intergovernmentally? From the case studies they appear to be:

- The need to restore public confidence in the health system in part by modernizing the goals and objectives of the system, enhancing transparency in decision-making and improving accountability for outcomes;
- The need to reduce intergovernmental public disputes and acrimony about national health policies, particularly, but not exclusively, with respect to the interpretation and enforcement of the *Canada Health Act* and the amount of federal financial contribution to the health system;
- The need to develop contemporary national health policy and programs to serve Canadians in the next generation;
- The need to create and advance Canada-wide health standards where public safety is at risk or where the health of Canada's population can be improved by standardization; and
- The need to negotiate a formula of federal fiscal contribution to the health system that assures the system's sustainability as well as its ongoing development.

Each of these issues is discussed further below.

THE RESTORATION OF PUBLIC CONFIDENCE IN THE HEALTH SYSTEM

Responsibility for public confidence in the health system is clearly shared intergovernmentally and must be addressed collaboratively amongst governments. Moreover, public opinion polls and the National Forum on Health have stated unequivocally that Canadians want both orders of governments involved in managing the health system. In practice today, both orders of government are held accountable for the system's performance and its difficulties.

Improving public confidence in the health system obviously requires many initiatives on many fronts. There is no quick fix for the confidence problem. All of the suggestions in this chapter taken together are designed to improve public confidence in the health system. One essential place to begin to rebuild this public confidence is in the intergovernmental management of the Canadian health system where that management is seen to be necessary and where it reasonably can be achieved. Many informed observers have remarked that the present national health "system" lacks many of the attributes of a recognizable system, and that this national array of relationships is not managed or governed at all. If one were to attempt to establish or improve the governance of these national relationships so as to begin to create "a health system," the

launching pad would be the definition of a clear set of national health goals and objectives with which the whole country could easily identify. Other than the five principles of medicare, Canada has no guiding goals or objectives for its national health system.

Other federations studied have some kind of national framework policy for health.[4] In some cases it is very general and in other cases, quite dense. In Canada, we do not have such a framework policy other than our five principles of medicare. Our case studies have concluded that however it is achieved, it is essential to develop national goals and objectives for the Canadian health system in order to provide an overarching sense of purpose and sense of direction for the system. Without such a framework of goals and objectives, but yet with a broad consensus on the importance of developing accountability measures for the system, there is no rational basis for deciding what these accountability measurements are or should be.

Moreover, all countries studied in this project face remarkably similar health challenges, whether they are federal or unitary states. This suggests that the fact of a country being federal in nature does not necessarily determine the issues that need attention. In the different federations, the broad approach to health policy appears to be more linked to the political history and culture of the country then the fact of its being federal.[5]

It will require national leadership, which does not necessarily mean exclusively federal leadership, to establish these goals and objectives. In this regard, it was suggested by one participant in a roundtable meeting convened to discuss the case studies contained in this volume, that there is already a lot of agreement among federal and provincial governments regarding the desired directions of the health-care system. What is needed now is momentum within governments to move this agenda forward, and momentum in turn requires federal/provincial collaboration and public support. The First Ministers' Conference and the Health Accord of September 2000 may be a point of departure for gathering this momentum.

All the case studies found that the governing mechanisms of the health system are not adequately transparent or sufficiently accountable (fundamental values for a well-functioning democracy), either collectively (through intergovernmental processes) or individually by provinces and territories. Alberta may be an exception to this general conclusion insofar as it is leading the country in developing health system public accountability measurements and reports. At the regional level, some improvements have been made to democratic processes within the governance of the health system (i.e., regional and

district management boards, elected boards, etc.), but it is too early to assess the impacts of these initiatives. The countrywide process is governed mainly by processes of executive federalism with little public input and relatively little expertise from the non-governmental research community, even within its advisory committees.

This lack of transparency and the dearth of objective and comprehensible public information on the health system are problematic in many ways. For example, tied to public confidence is a series of issues related to democratic values such as public participation in programs and decisions by governments; public transparency of governmental decisions and the decision-making process; objective information that allows the public to make informed judgements; public accountability for the outcomes of public expenditures; and the assurance of equity and fairness in the federation and its social programs. Addressing any or all of these matters requires excellent public information, transparency by the decisionmakers, and access by the public and stakeholders to the health-planning and decision-making processes.

While there are some advantages to a closed process with respect to the candor of discussion, and sometimes the negotiation that can take place amongst governments, the problem with a closed process is that it is not accountable to anyone except the governments represented at the table. Therefore, the governmental interests are of primary importance and these interests may not always be congruent with the majority Canadian interest in the health system.

While there is no denying that the Canadian public and all governments would like to see the very finest health system in Canada, the issues for all paying parties are "at what cost, who and how is it to be paid for, and what trade-offs in public and personal expenditure have to be made to finance an acceptable public health system?" Clearly there is divergence in their objectives. The Canadian public wants all potential health services free or at minimum direct cost to itself; the federal government wants its investment in health limited and politically profiled or acknowledged; the provincial and territorial governments want an affordable health system to their governments which also meets essential health needs and reasonable Canadian standards. These three sets of health objectives lead to different conclusions about what a national public health system should look like and how it should be financed.

There is a need to allow more public light into these policy development processes. Specifically, there may be benefits to the federation and the Canadian people if an external-to-government health oversight body were added to the Canadian health system's governance mechanism, even though most

governments are very sceptical and leery of these "arm's length" agencies. (Aside from the fact that these external-to-government agencies deplete the unilateral power of governments, such independent agencies, on the one hand, can tell the embarrassing truth about a situation, and on the other hand can totally ignore the governmental and political environment of the event they are observing.)

An independent oversight body should be seen though as one option in a range of possibilities, to enhance public participation, transparency, public accountability, and public confidence. It has been frequently noted that in the Canadian health system, there is an absence of an "honest broker." All the present influential participants have vested interests.

The SUFA and the September 2000 agreement seem to encourage a greater involvement of citizens in shaping the utilization of the health system and in becoming more knowledgeable in judging it (notably with respect to dispute resolution and third-party verification of facts, and through the much improved performance accountability reports to be made available by governments to their citizens). Meanwhile, citizen and stakeholder groups are demanding to be "engaged" in the health planning and decision-making processes, not simply "informed" or "consulted" about intended government plans or expected decisions. But governments are still learning how to most effectively involve citizens in the health decision-making process. No doubt some experimentation with citizen roles will need to take place. Some form of citizen involvement at the front-end of health planning may be effective, where the citizens are involved in establishing broad goals and objectives for the health system. In this domain, the average but informed citizen is not at any particular disadvantage relative to people who are informed about the technical sides of the health system. The role of citizens in Quebec's regional health authorities and other social spheres may be worth further study. The former Premier's Council on Health in Ontario is another example worth analyzing.

Another option for organizing this public involvement and the "honest broker" role is to create a Canadian Health Council as has been suggested in some of the case studies contained in this volume. In this instance, the citizen involvement might be selective or evolve to be somewhat more technically knowledgeable than being a simple reflection of public attitudes, needs, preferences and health priorities. This more sage role within the health system would be enhanced by the council's employment of a small number of permanent staff along with a mandate to address a defined list of activities on behalf of the public. While not intending to be exhaustive, some of the purposes for a

Canadian Health Council have been identified in the case studies; others have not. The suggested potential functions are:

1. to monitor the Canadian health system, seek public and expert advice as to health priorities for government attention, organize citizen participation in processes with other stakeholders to identify the goals for health system development, and regularly advise governments and Canadians about their findings;
2. to appraise specific Canada-wide health issues of immediate public concern, to develop on a timely basis practical options to address these public concerns and report on these issues and options to the public and all orders of governments;
3. to serve as a neutral fact-finding body for intergovernmental disputes concerning the CHA and other issues referred to it by governments, and serve as wanted by governments as a facilitator/mediator in the dispute resolution process;
4. to assume a leadership role in developing a national framework for public accountability consistent with the SUFA (especially to establish the purposes, policies, and agents for public accountability); to ensure that appraisal takes place, or independently assess the health system from time to time as to its performance, its progress toward any new national goals or objectives that might be established, its "reasonably comparable quality," its "fairness and equity," and its potential challenges;
5. to provide an annual report to the public about the performance of the health system and the emerging issues found in it;
6. as may be advisable, necessary or acceptable to governments, to facilitate, manage or deliver the "network" process for joint health planning (described later in this chapter) between orders of government, and other public and private stakeholders;
7. to take leadership for the development of a system of relationships that can deliver any new health standards that are needed by a national health system;
8. to take some defined responsibility to test innovative health service delivery and management concepts of national significance;
9. to facilitate or deliver the package of "accreditation" services to the Canadian health system (which are described later in this text); and
10. perhaps to serve as one possible vehicle to assemble and disseminate best-practice experiences from the Regional Health Authorities across Canada.

This option may be attractive to the Canadian public, but it will be viewed by governments very cautiously for fear that they will lose control of the health policy process, or that the Canadian Health Council might become biased, remote, and antagonistic toward government.

If the concept of a Canadian Health Council is to advance, undoubtedly there will need to be considerable support among orders of government and stakeholders within the public and private health sectors. Aside from defining its role correctly, there needs to be confidence that the council can in fact bring added value to the health system (not simply added frustration to governments). The structure, financing, and appointing of board members will have to be seen by both orders of government as well as the public, as independent from any particular order of government, balanced in terms of Canadian regional interests, and highly credible. To obtain such a credible council, one observer noted that it was expected that most governments will use "third parties" to assist them in formulating accountability measurements and reports which have been promised in the SUFA. As these third parties are selected and tried throughout the country, a council of third parties might very well emerge organically and necessarily as a result of the federal and provincial third parties beginning to work together.

Another approach to the selection of a Canadian Health Council is to copy (with some appropriate modifications) the experience of the fairly recently established Canada Health Services Research Foundation (CHSRF). While the precise history of the CHSRF formation does not need to be explained here, essentially CHSRF is a non-profit foundation established by letters patent from Industry Canada. Under its own bylaws, the board is independently self-perpetuating through its capacity to appoint new members with time-limited terms and to elect its own corporate officers.

Financing for the work of the foundation has several sources, both public and private. The initial funding derives from an endowment grant from the federal government which is then managed solely by the foundation and not tied in any way to the federal government. The careful financial management of this endowment investment provides a firm operating base for the foundation indefinitely. Additional funding can be accepted from other sources, public or private, that wish to partner with the work of the foundation or purchase work from it. The acceptance of this additional funding is totally at the discretion of the CHSRF board in order to assure that a conflict of interest does not arise between the purposes of the partner and the purposes and ethics of the foundation. In the case of the Canadian Health Council, an endowment could be created

in the same way, but might derive from all F/P/T governments on some negotiated formula.

Accountability of the CHSRF is to the public through its annual report, annual general meeting, and independently audited statements. There is also program accountability to any partners or research contractors for the work delivered under the auspices of the foundation.

Essential to the formation process is the appointment of an interim board charged with developing bylaws that address questions of the mandate of the foundation, the method and balance to acquire permanent, ongoing and regionally balanced board appointments, its public accountability, and other such important questions. There are a variety of methods for creating an interim board. One method would be to hold a founding convention of the principal governments and non-governmental stakeholders, although a less complicated and expensive method might be proposed. Using the third-party approach (described above) might be another option.

Beyond the Canadian Health Council suggestion, the Canadian Institute for Health Information (CIHI) is enhancing its Canada-wide comparative information and dissemination capacity about the health system. This information will be a foundation to the accountability commitments promised by the SUFA and restated by the first ministers' September 2000 health agreement. The proposed Canadian Health Council will need to draw heavily on this information source.

The very significant investment by the federal government over the past three or four years in health research, including health system and governance research through the Canadian Health Services Research Foundation (CHSRF), the wide dissemination of this research and the major efforts by CHSRF to increase uptake and application of the work in the health system is a vital initiative. The Social Sciences and Humanities Research Council (SSHRC), and the new Canadian Institutes of Health Research (CIHR), may be expected to contribute significant new insights into the health system. Their work too will be publicly available. Moreover, in commissioning new work, they will also be contributing to the training of new researchers to undertake this kind of research in the future. All of these and other initiatives will contribute eventually to improved public information and potentially better democratic participation in health system planning and decision-making.

With regard to the F/P/T conference system, while this system might find it helpful to increase public or expert representation on some of its advisory committees, it seems likely that the governments will want some forum

where they can discuss their business privately. If it is not this forum, then another one will be quietly created. Therefore, it should not be expected that much change will take place in the health conference system of ministers and deputy ministers. They must have an intergovernmental mechanism in which to do their work. To give the conferences the benefit of the advice of the Canadian Health Council, it would seem reasonable and likely that both the conferences of deputy ministers as well as that of the ministers of health would invite the council to meet with them during their meetings to update them on any new information, research findings or emerging public concerns.

If one conceptualizes the integrated impact of the new accountability capacity that is emerging or potentially could develop, the effect on governments and the health system could be quite substantial — probably achieving at least the floor (if not more) of what the SUFA had intended. The elements would look like this:

- The conferences of ministers and deputy ministers of health, meeting to discuss, negotiate, and decide intergovernmental framework policies for the health system;
- The Canadian Health Council, providing an independent and public assessment to F/P/T governments as well as to the Canadian public of the performance of the health system and its policy challenges, and perhaps managing or facilitating the development and testing of new policy and program initiatives through the voluntary joint planning "networks" system;
- The Canada Health Services Research Foundation, providing objective research evaluation of the key health system issues of the day, and nurturing of health officials on the uptake and use of this research information in their processes of decision-making;
- The new Canadian Institutes of Health Research will also incorporate a wide variety of themes in its research program (aside from biomedical and clinical research, other themes will include health services and systems, society, culture, environment, and health applications);
- The Canadian Institute for Health Information, creating the standardized Canadian health information database to allow Canada-wide comparative insight and evaluation to take place; and
- The Canadian Council on Health Service Accreditation (described later in this chapter) which, in collaboration with the F/P/T governments and health system officials, could potentially develop the essential health

safety and population-health improvement standards for the country while educating health delivery agents how to achieve these.

When and if this amount of public oversight of the health system materializes, the intergovernmental intent of "public accountability" will surely be met nationally, and there is, at a minimum, a legitimate informational base from which to discuss confidence issues in the health system.

FEDERAL/PROVINCIAL/TERRITORIAL GOVERNMENTAL DISPUTE RESOLUTION

Intergovernmental health disputes that have been examined in this project include those related to the CHA interpretation and enforcement and the extent of federal financing. There are of course other kinds of intergovernmental disputes in the health system. The conclusions of the case studies suggest the need for a mechanism to help resolve these various disputes (especially CHA disputes) in order to lower the dysfunctional intergovernmental acrimony that these disputes perpetrate. With regard to CHA and other legal disputes, we have considered four main approaches to dispute resolution: *status quo*, use of the courts, joint F/P/T interpretation of the CHA or other points of dispute, and a modified *status quo* arrangement of dispute settlement. It is important to note that neither the CHA nor SUFA provides for a hearing or resolution process for third-party complaints about the interpretation or enforcement of the CHA.

Status Quo

While rare, there are instances (some reported in the case studies and some others emerging in Canada) that provide an acceptable rationale for a national capacity to ensure enforcement of a federal/provincial/territorial agreement to sustain a national health program. Some may dispute that this enforcement capacity should rest unilaterally with the federal government. But it appears to us that for the moment there is no other viable intergovernmental instrument. These rare cases, however, have provoked major intergovernmental friction in Canada, usually adding to the tensions in the federation beyond the health issue at stake.

In the case of the CHA, since this is federal legislation, legally Parliament can decide what conditions it wishes to apply in exchange for making

fiscal transfers to the health system. The federal government must necessarily enforce these legal conditions. However, the effects of these conditions extend beyond the legal sphere. They also impact on the harmony of Canadian federalism, on the quality of our democracy, and on health policy as well. This suggests that the federal government should also be weighing these other and broader effects when it enforces the CHA. Balancing legal rights with these other considerations seems to have been difficult for the federal government. The meaning of many key words and clauses in the CHA are unclear in today's context, or they were never defined in the law initially (such as "medically necessary" health services). This allows considerable scope for interpreting what the law actually means and in what context it might apply. Both the provinces/territories and the federal government have a critical interest in the interpretation of this law as seemingly small issues of interpretation can have profound effects in practice on the spirit and intent of the foundation principles of the national health scheme. When disputes about "interpretation and enforcement" of the CHA have arisen, the intergovernmental rhetoric has frequently elevated the issue into a debate about "spirit and intent" rather than a debate about law.

Although disputes over the enforcement of the CHA are not frequent, when they do occur the facts of the case are often unclear to the public, the negotiations for a settlement are not transparent, the disputed issue is transformed by politicians into grand issues of intergovernmental principle, federalism or democracy. Public opinion coalesces around the transformed issue of grand principle more than the facts of the contested case. For the public, the debate about the actual point of intergovernmental dispute gets lost.

While the political rhetoric around CHA disputes may have been exaggerated and grandiose, the case studies have concluded that the *eventual* federal interpretation and enforcement of the CHA have historically been appropriate to the circumstances. Ottawa's role, though, has been contested. The case studies have also concluded that the power to enforce the national principles or framework standards of a national social program must ultimately rest with the federal government. Nevertheless, before any CHA enforcement stage is reached, there may be ways to moderate intergovernmental conflicts surrounding new provincial policy initiatives and their effects on the CHA. One example of a new approach is found in Alberta's Bill 11 (private clinics) controversy where Alberta submitted its proposed Bill to the federal government for review of CHA compliance before passing the legislation. Another approach to dispute avoidance is to clarify and define to the extent possible, using a federal/

provincial/territorial collaborative mode of intergovernmental behaviour, the contemporary meaning of some of the ambiguous words in the CHA.

Use of the Courts

The use of the courts is another option for dispute resolution. If the CHA were written more precisely, perhaps this would be a realistic option because the dispute would be a contest about the interpretation of law. As noted, the CHA disputes take on a larger dimension dealing with motive, spirit, and intent of the law itself. The disputes seem to take on the ideological and political positions of contesting governments as well as their solicitation of public opinion and support for their "trusteeship" of the health system. These are all political matters that cannot be placed before a court of law. In this context, court decisions will be unpredictable and perhaps too narrow to serve in the real interests of contesting governments or the public. (An example of this predicament is found in the Supreme Court's decision concerning the British Columbia case of the financial cap on Canada Assistance Plan payments. The court ruled that Ottawa could unilaterally adjust funding in federal/provincial cost-shared programs regardless of prior federal/provincial agreements concerning the federal contribution to these programs.[6]) Health disputes in this context are best resolved by political negotiation rather than court edict. This analysis does not preclude the possibility of a court challenge to a federal government's interpretation of the CHA, but rather that this is an unhelpful way of resolving what are really government policy matters and political choices.

Joint F/P/T Interpretation of the CHA

Provinces have asked for a joint interpretation mechanism, but the evidence suggests that health issues and disputes are a pawn in a larger intergovernmental political game and therefore there is no assurance that the decisions from a CHA joint interpretation mechanism would be to the advantage of the Canadian health system or to Canadians generally. Some provinces would clearly prefer a process of joint interpretation, whereas others may privately prefer that Ottawa maintain its interpretation and enforcement role as this enables a province to avoid conflict with a sister province that wishes to test the limits of the CHA while allowing Ottawa to take the brunt of the intergovernmental heat of any ensuing conflict. In any case, Ottawa has rejected joint interpretation.

The conundrum for governments concerning CHA enforcement is that in today's health system environment, no government seems to want to face a CHA enforcement contest. The provinces and territories do not want to admit that Ottawa should have the right to enforce a policy change on a social program within provincial constitutional jurisdiction. Ottawa would like provinces to share the responsibility of telling an offending province that it is out of line with at least the spirit and intent of the principles of the CHA. Provinces do not want to do this causing a breach with another province with which they may need an alliance on a more important issue. The Canadian public wants to have confidence in one or both orders of government to uphold the spirit and intent as well as the letter of the CHA law.

SUFA acknowledges this difference of opinion when it suggests joint "fact-finding" in the case of disputes, the "use of third parties for expert assistance," the possibility of making joint fact-finding reports public, non-adversarial ways to resolve disputes, and in a way that ensures "democratic accountability by elected officials." While provinces initially advanced a joint interpretation approach to the CHA at the time of the facility fees dispute, the proposal was superseded by the SUFA and subsequently the proposal seems to have died.

Joint F/P/T interpretation of the CHA might have been a possibility if the law were more precise in the first instant and if the intergovernmental disputes were really about technical interpretations of the Act. In reality there is an early stage in the current CHA dispute-resolution process, where the federal government and one or more provinces that are contending a technical point of interpretation, do meet (sometimes extensively) to try to work out a common understanding of a difference in interpretation or application of the Act. If this is achieved, there is never any public mention of the contention. Only those issues that cannot be resolved by collaborative work reach the public arena through the politicians. Joint interpretation, or perhaps collaborative dispute resolution, is already used and works to the extent possible.

Modified Status Quo

The case studies suggest that there has to be a final decisionmaker on the interpretation of the CHA. The SUFA has recognized this as well and has dealt with the parameters of settlement in some detail. It speaks to joint fact-finding, the desirability for third-party advice, expertise, and mediation. As well, public disclosure of fact-finding reports and third-party reports are acceptable, all this while "ensuring democratic accountability by elected officials."

If the SUFA dispute-resolution provisions are used in relation to the CHA, the issues at stake will become more transparent and the public will be better informed. The SUFA acknowledges that a third party might be useful to mediate a dispute. It also provides that such reports may be made public where either party requests it. In the end, if the federal government imposes an interpretation that is disputed by a province or territory, the public will at least be correctly informed about the reasons. It can then judge the decision at the polls.

To provide an option for governments to obtain third-party objective advice, current informed opinion reports that each government will choose its own third-party agency to assist with this work. This may be the only practical solution given the level of mistrust among governments. But our report suggests that a newly created Canadian Health Council is another option that could be used as a first step fact-finding and intergovernmental mediation body—whether or not it is staffed by uniquely chosen people, or whether it is staffed by the aggregation of third-party agencies from across Canada. Either option would be consistent with the SUFA commitment. The risk of using a Canadian Health Council for third-party consideration of disputed policy issues is that governments may in fact not want disputes settled objectively (or alternately outside the political arena). Governments may feel pressured into using a third-party agent if it exists, while they do not in fact want to use it. No doubt governments would then limit what they referred to the third-party agent for consideration. And that might well mean that nothing consequential is referred.

With regard to non-legal and non-fiscal health disputes, these will arise mainly over health policy and program development issues. Where desirable, these could also be referred to an external-to-government body like the Canadian Health Council or another expert panel for advice. Not only might these issues benefit from an external opinion, but the external body might also advantage the democratic process by eliciting public input into the issue without committing any government to a particular policy position that it then has to defend.

THE DEVELOPMENT OF CONTEMPORARY CANADA-WIDE HEALTH POLICY AND PROGRAMS

The case studies have concluded that there is an urgent need for the Canadian health system to establish contemporary and additional Canada-wide health goals and objectives. The CHA is necessary, but not sufficient for a modern Canadian health system. In their case studies, Adams and O'Reilly discuss many of the policy issues that need the collective attention of the governments.

Taken as a whole and to illustrate the point made here, a few of these policy issues are:

- That, if Canadians and their governments want to modernize or extend the range of Canada-wide insured health services, a new national framework policy is needed. The terms and conditions for the inclusion of additional health services in an insured package might well take different forms from those we cover now under the CHA. The benefit criteria might be consistent Canada-wide, but the impacts of the criteria might differ across the country. For example, a different insurance format might approximate an extended health benefits package that is consistent Canada-wide in application, but be tied to somewhat different criteria than benefits under the CHA. The criteria might consider age, income, utilization, patient financial participation, etc. In this hypothetical example, a benefit under a national pharmacare scheme might be consistent Canada-wide for a person 65 years of age or older, who possesses a minimum income only. Or, in another example, a Canada-wide benefit might be a floor financial contribution to a publicly run medical transportation service, with the province and patient deciding how to finance actual costs beyond the floor payment.

  The additional program benefits that might be considered could include: home care, pharmacare, ambulance, and other medical transportation services, community mental health services, aids to independent living, addiction services, wellness centres, and long-term or continuing care.
- That the absence of reference under the CHA to issues of quality of health services in the national system and the system's expected behaviour (and the behaviour of health workers), attitude, relevance, appropriateness, responsiveness, affordability and acceptability to Canadian needs addressing.
- That the roles and responsibilities of each order of government in areas of shared responsibility for health services or where there is identifiable overlap and duplication, need to be clarified.
- That clarification of the responsibility for funding and provision of the treaty-right health benefits to First Nations people, on and off reserve, needs urgent attention.
- That intergovernmental protocols are needed to assure Canadians reasonable comparability in the range of health services available across Canada and reasonably equitable consumer obligations (like patient charges other than for services under the CHA) given the different financial capacities and political ideologies of governments.

The listing of some of the policy issues and others contained in the case studies illustrate also that they all do not need the same degree of collective involvement by all the governments. Similarly, they do not all have the same priority, nor the same time frame or difficulty, for settlement. Many of the policy issues have horizontal linkages to other departments of government (both federally and provincially), and therefore require different players at the table if acceptable solutions are to be constructed. Furthermore, some issues are national/technical issues, while others are more of a national/framework character. Some policies are more challenging to provincial jurisdiction than others, while other issues would simply benefit from the efficiency and effectiveness of national collective action, really without threat to the principles of federalism or provincial jurisdiction.

Within Canada's constitutional structure, it is the provinces/territories that have the main responsibility for developing and delivering health programs. This does not mean, however, that policy goals can be easily met without the federal government. To the contrary, Ottawa has certain tools to contribute to the formulation and sometimes implementation of solutions to resolve certain national health system problems, for example, financial resources, national coordinating capacity, special expertise in some fields, international health networks, sometimes public opinion, a Canada-wide perspective, sometimes jurisdiction in a field linked to a health solution, and in some instances a legal framework to allow a resolution. In many instances of major health policy challenges, these tools are needed by the provinces as well as the health system itself to achieve solutions, although some provinces may be reluctant to admit this. The basic challenge is therefore to design an intergovernmental approach that does not lose sight of constitutional reality that assigns the management of the health system to the provinces, and yet is able to make use of the federal tools.

There is no single F/P/T or interprovincial/territorial advisory and evaluative mechanism to advise all governments, collectively or singularly, on policy options concerning health-service delivery issues that affect the whole country. While the F/P/T advisory structure for health ministers could potentially take on any health subject assigned to it, the subjects of assignment to the advisory structures are limited to those of "common intergovernmental interest" where constitutional jurisdictions are not seen to be threatened or invaded. These conditions have seriously limited the range of topics which have been reviewed by the advisory committees and therefore the range of common advice given to the ministers. This advisory structure simply does not deal with the

big health policy issues in the country. Moreover, the process of this structure is excruciatingly slow and generally cannot be relied on to deliver timely advice to all governments on subjects of profiled public concern.

Nor is the provincial/territorial advisory mechanism structured or staffed to deal with many contentious national issues of an interprovincial jurisdictional nature. (There is no permanent secretariat serving this advisory structure.) This structure is most frequently used to obtain interprovincial/territorial consensus on policy and strategy to address the federal minister of health and his policy positions. Even this limited purpose has not been hugely successful because of the diversity of provincial/territorial policy inclinations.

Since the current process of Canada-wide health policy development is virtually stuck and the SUFA promises joint planning, there really are only two options to advance policy solutions: attempt an intergovernmental joint planning venture, or give the development of policy options over to an external organization like the Canadian Health Council. While some governments will be reluctant to turn over important policy framework questions to an external-to-government organization, other governments may wish to place themselves at a distance from new policy options that emerge until the viability of those options is publicly scrutinized and perhaps tested. Whether joint planning is undertaken in a network internal to governments or managed through an external-to-government agency, joint planning and system experimentation is essential to the advancement of the Canadian health system.

An option to advance joint health planning and development, whether internal or external to government, is to create an F/P/T Health Planning and Development Opportunities Network. In this approach, ministers would collectively have to agree on the agenda and priority of intergovernmental policy issues or programs that they would like to see developed over perhaps a four-year time frame. Then the managers of the network process (internal or external) would have to select or accept the provinces and other stakeholders that need or wish to participate in a particular policy subject, and the degree of public involvement and transparency that is appropriate for exploring this particular policy issue. Several policy issues could be undertaken simultaneously across Canada using different provinces and stakeholders for different issues.

The experimental policy development networks could then come into play. Voluntary F/P/T bilateral and multilateral health policy development networks, horizontally inclusive of other public and private essential stakeholders would be used to develop program and policy solutions that could be tested in the networks' jurisdictions. If successful, these solutions would be offered to

other Canadian jurisdictions voluntarily. This approach is founded on the Canadian experience of provincial innovation and flexibility, local experimentation, and generalization of positive experience to the nation as a whole. In this instance, the innovation and test would be the capability of F/P/T jurisdictions to innovate together, rather than has been our history for a single province alone to innovate and then share its experience with the rest of the country.

Medicare, after all, was introduced across Canada after it was demonstrated to be a viable program in Saskatchewan and tested again in British Columbia. Other provinces eventually adopted the system. Developing collaborative policy networks remains logical. This more strategic approach allows for experimentation and more flexibility in the Canadian federation and within regions of the provinces. Voluntarily phasing in an initiative across Canada which has been intergovernmentally tested and found successful is more likely to be acceptable to governments than some attempt at a universal implementation from Ottawa. Moreover, this approach will limit political power struggles and contain damages to intergovernmental relationships.

Of course, the policy networks approach must be required to function within the commitments of the SUFA agreement. But policy developmental networks support SUFA initiatives to contribute to public accountability and transparency by acting as an effective mechanism for achieving and measuring results. If information is freely shared according to the expectations set by SUFA, Canadians will be able to participate in the development of health programs as progress on joint planning and development is presented. Consulting the public before programs are implemented Canada-wide is possible with the use of the proposed F/P/T Health Planning and Development Opportunities Network.

THE CREATION AND ADVANCEMENT OF CANADA-WIDE HEALTH STANDARDS

The Wilson case study (health surveillance system) illustrates the potential serious health risks to Canadians of delivering health services in a disentangled regime in a field of shared federal-provincial/territorial jurisdiction. The inefficiencies, gaps in programming, variable standards of practice and variable professional capacity across the jurisdictions, and the intergovernmental in-fighting, all leave the Canadian public with an unacceptable health risk.

Whether we are referring to principles (like the medicare principles), macro goals and objectives for the system as suggested in the Adams case

study, or detailed program standards as discussed in the Wilson chapter, the controversy over how to establish Canada-wide standards, and how and who should enforce them is an issue that brings to life all of the contentious constitutional jurisdictional and fiscal concerns in the federation.

There are two critical aspects of this standard-setting exercise: (i) if public accountability is to be improved (as has been promised by SUFA and the first ministers' September 2000 agreement), then a series of program goals or standards must be established against which to measure the system's achievement or performance at a point in time; and (ii) the choice of measurement instruments and data is critical if the conclusions to be drawn from the analysis are not to be misleading.

Perhaps in the fields of standards-setting and establishing new Canada-wide health policies and programs (discussed above), the need for a collaborative intergovernmental approach is most necessary; and also where more public input and transparency and external-to-government help is desirable. The SUFA agreement does not speak directly to national standards, but rather talks about objectives and principles of Canada-wide programs. The agreement does, however, commit to develop comparable outcome measures, over time, to measure progress on agreed objectives. This commitment implies that some sort of Canada-wide standards or indicators need to be developed to allow this form of comparable measurement.

The case studies have demonstrated that the health system has progressed reasonably well without detailed standards intergovernmentally enforced, with the exception of the CHA principles. There are, of course, strong educational and practice standards established by health professional bodies and colleges. In some technical health fields like the new Canadian Blood system, uniform standards have been created basically through a collaborative mechanism. It is hoped that this will hold true for the health surveillance system as well, although, at this point, the governments have decided not to develop national standards until they know how to enforce them and get by the jurisdictional challenges of this activity. In many other areas of health delivery policy and programming, approximately uniform standards and benefits occur through informal networks at the interprovincial level where in setting policy, one province does not want to be significantly out of line with the others. Of course while these interprovincial standards or program benefits are not secret, the comparisons are not highly publicized either.

Most governments traditionally have not wanted detailed standards intergovernmentally or provincially because the public statement of a standard

means that governments would have to pay to meet those standards, and might be subject to lawsuits by citizens if there were not the resources to do so. Defining nationally what is a "medically necessary" health service is subject to the same dilemma; a treatment or procedure that might be medically necessary for one person may not be for another. How does the state insure the procedure for one individual and not another? Where the definition of a "basket" of insured services has been offered in a few international jurisdictions, such as in Israel, it appears that citizens and practitioners all want to obtain the full basket regardless of essential need, but at enormous and eventually unsustainable cost to the state. There is no conspiracy by governments to intentionally suppress health standards; governments simply have limits as to what they can pay for at any point in time.

In Canada, further unilateral federal power to set and enforce national health standards will be rejected on constitutional grounds as well as on a practical political basis. The word "enforcement" has a negative implication and implies penalties that could be applied by one order of government on another. This is a difficult approach in a federated health system where health-service delivery is a provincial responsibility. Yet in some fields of health activity (health surveillance as one example only), countrywide standards are essential for the health and safety of Canadians. This is also the case where some standardization of medical practice and health-service delivery could improve the population health status of Canadians.

The SUFA and the September 2000 first ministers' agreement require that each participating government strengthen its accountability to its own constituents. It also commits to the "reasonable comparability" of levels of services and a balance between "jointly agreed objectives" and provincial design and delivery of new programs. While this general direction is a good starting point, evaluation of health programs on a more detailed basis that is geographically, culturally, and economically sensitive is required in order for improvements in specific local or regional health settings to take place.

An approach to local evaluation is the "accreditation" option. It is an educational and developmental approach, more suitable to an evolving health system and to independent jurisdictions. At the moment in Canada, accreditation is a voluntary engagement of service-delivery agents with a team of highly credible practitioners/appraisers for the purpose of assessing the performance of a health-delivery component (like a hospital), or the entire performance of a health region or health centre. Therefore the breadth of the review is determined in advance and does not need to be a "one size fits all" approach. The

benchmarks (or standards) for the appraisal are established by a national organization of health stakeholders/practitioners and the benchmarks are generally thought to be at the higher level of common practice in the health industry. But it should be stressed that there is nothing sacred about this method of adopting benchmarks or standards. If the country wanted a different method of establishing accreditation standards, then it could simply construct a different method.

The value of being "accredited" can also be variable. At one end of the spectrum of value, accreditation can mean that a health program or health region is being assured that its performance is in line with commonly accepted performance in the country. The health authority can do what it wishes with this information. Where the accreditation appraisal identifies shortfalls in performance, the accreditation report gives a sense of guidance for improvement and a timeline to achieve it on a voluntary basis.

At the other end of the spectrum of accreditation value, certain benefits or recognition can be attached to the accreditation status of a health program or authority. For example, medical schools and medical residency programs can only be attached to accredited health facilities. Or the accreditation status of health facilities or programs can be widely published to enhance or diminish the reputation of the program on the basis of its accreditation status. Or governments could decide to invest in new health programs only in accredited facilities or programs. Or non-accredited facilities might be targeted as the first for conversion or closure if there is a surplus of these facilities in a region. These are but a few examples of how the accreditation value system might be used to affect the behaviour of the organizational entity that is being appraised for accreditation.

What is important in this accreditation process is: (i) that there is a large consensus among health stakeholders and the general public that the benchmarks (standards) of the appraisal are realistic, fair, and appropriate to reflect the intent of the appraisal; (ii) that the measurement instruments are objective and can reflect the standards in unambiguous terms; (iii) that data and information systems exist to measure the achievements of the program or organizational entity being appraised; (iv) that the appraisers themselves are serving in the public's interest, not merely to satisfy vested interests in the system; and finally, the public use and profile of the accreditation report, and the attachment of benefits or penalties to the accreditation status of an organization by funding and other health service agencies, is determined in advance of accreditation being voluntarily undertaken by a health authority.

At present, we have in Canada the Canadian Council on Health Service Accreditation (CCHSA). This is a not-for-profit organization, independent from all governments whose mission, as they state, is "to promote excellence in the provision of quality health care and the efficient use of resources in health care organizations throughout Canada."[7] CCHSA recognizes that the ultimate beneficiaries of its work are the people of Canada. The council has the capacity to assess health governance regimes as well as clinical programs.

The CCHSA board consists mainly of representatives from health professional organizations like the Canadian Medical Association, the Canadian Nurses Association, the Canadian Hospital Association, the Canadian Association for Community Care, the Canadian College of Health Services Executives, the College of Family Physicians of Canada, and the Royal College of Physicians and Surgeons of Canada. In addition, the board includes two consumer representatives and a federal and provincial representative with observer status. Generally, accreditation activities of the council are paid for by the clients being appraised with some help from the governments that support this activity.

In recent years, the accreditation council has developed in order to enable the appraisal and accreditation of the health system as a whole within districts or regions (e.g., Saskatchewan) as opposed to accrediting individual programs; 1,451 health service organizations were accredited in 1998 including 70 complete health systems throughout all parts of the country.

While not suggesting that all the processes used currently by the accreditation council would be appropriate for the development and appraisal of all necessary national standards in the health system, the general approach seems to have merit and is consistent with the aims of the SUFA. It is also less adversarial than an intergovernmental approach for developing needed national health standards.

The accreditation approach to standards-setting has got to be relatively selective. To address the wide range of standards which might be necessary for the Canadian health system, it is an option to use the accreditation council as the leader for the exercise. It is recognized though, that the present accreditation council was not established to take on this vast task for the entire Canadian health system. If the council were thought to be the best building block from which to initiate this work, the organization would need to be strengthened considerably and perhaps some changes made to its governing board so as to reflect a greater public presence. Furthermore, the value of being accredited will be diminished in the public eye if existing health-provider monopolies are seen to control the process.

Both the conference of ministers of health and the proposed Canadian Health Council ought to be involved in determining the framework of a countrywide accreditation approach to standard-setting and achievement. These partners also need to decide what Canada-wide standards are to be developed and applied, and what value and public profile will be placed on the report of "accreditation status" in the health system.

Given the intergovernmental tensions which are generated by contemplation of uniform health standards and enforcement procedures in our national health system, the concept of accreditation is probably sufficient for advancing health standards in the health system in a non-threatening federalism mode for governments.

FEDERAL FISCAL CONTRIBUTIONS TO THE HEALTH SYSTEM

Federal money has been important to the construction of the national health system and it remains so. The evidence suggests that it is necessary first for the federal government to offer the financial capacity for provinces to join a Canada-wide initiative on a provincially affordable foundation. With this leverage, Ottawa may then be able to work with the provinces to secure agreement on the principles and character of the national system. And more recently, it has become important to support a health system transition to an affordable new plateau, presumably within the principles of the CHA.

The case studies in this volume were not an attempt to review fiscal federalism, nor were they in any way attempting to establish the appropriate balance of federal and provincial/territorial contributions to the health system. The case studies did assess, though, the crucial importance of federal contributions to the health system and the likely consequences if these were not sustained— or indeed e ven increased. The case studies have suggested that the impacts on the health system of the specific Canada Health and Social Transfer (CHST) cuts in 1996, on their own, may not have been devastating to provincial health systems. But the cumulative impact of federal reductions in its planned and actual contributions to the provinces since 1982, including the Established Programs Financing transfer reductions in 1990 and then the CHST in 1996, taken as a whole, have been more than the provinces or the health system could accommodate. By the year 2000, the accumulated impacts on the health system of cost restraint and reduction throughout the 1990s, coupled with the slowness of medical and management practices to improvements to

materialize, had precipitated real crises for provincial/territorial governments and for the health system itself. As expected, the impacts of this health issue have now begun to contaminate other provincial government programs and other intergovernmental relationships (e.g., provincial premiers' exchange about fiscal equalization grants).

Provinces have spread the effects of these cumulative cuts in federal transfers for social programs over many of their programs, not just their social programs. When the federal government implemented its CHST cuts to health and social transfer payments in 1996 to balance its own budget, provinces and territories had already initiated reforms to contain or defer health expenditure increases. The additional federal reductions in health transfer payments were absorbed by provinces mostly in fields other than health (highways and postsecondary education programs). From a financial perspective, since 1996 health programs have fared reasonably well relative to other provincial programs, although not to the extent that health programs have demanded. The greatest effect of governmental expenditure restraint on health programs, for the most part in most years in the 1990s, has been to control the rate of cost increases, not to reduce the financial base level of funding. (It is recognized that the financial experience of individual institutions and programs may not harmonize with this macro financial evidence.)

Nonetheless, and with the benefit of hindsight, it would appear that the federal funding cuts in 1996 had a politically and publicly galvanizing influence on the health system. The federal cut focused and mobilized the frustrations of provincial governments over federal cuts to its contributions to health and social programs since the early 1980s. Furthermore, the health system itself reacted to the cumulative effects of five years of provincial/territorial financial restraint, changes to the health system's governance, and the intensified changes required of medical practice. The federal fiscal policy (CHST) was perceived by provincial governments as evidence of self-serving federal fiscal unilateralism with important consequences on provincial/territorial governments' fiscal frameworks. As well, the CHST was used as further evidence of the federal government's unilateral breach and diminution of its historic funding partnership with provinces/territories for health-care financing— the very reason, say the provinces, for justifying a federal role in the health system at all.

Unable to cope with the rate of change, or in some cases to wait out change, many organizations within the health system used their reserve accounts, deficit financing, and delayed or deferred spending to meet their immediate provincial budget restraint targets. Adopting this approach, while

perhaps necessary in the short term, delayed and deferred internal change to the system that would have placed it on a more stable base for the future. The inability of the system to adapt to the required rate of change caused certain parts to jam (like waiting lists, elective surgery, emergency services, home care, etc.). In fact, transition and adaptation challenges have been facing the system, and the failure to deal with these challenges has had immediate implications, both for finances and health service. Many of these deferred and pent-up demands came together in 2000 to be characterized by provincial/territorial governments and the health system alike as "financial crises" which could not be met alone by provincial and territorial governments. With very optimistic federal fiscal forecasts, the pressure was on the federal government to infuse more federal money into the health system. Also, with a national election looming, the federal government agreed with the provinces and territories. Ottawa would provide a further $23.4 billion in new federal dollars over five years in return for an interprovincially constructed plan for Canada-wide health reform. This financial settlement has come to be known as the first ministers' September 2000 health agreement.

While in the short term there was no reasonable option to the infusion of more money into the health system, to close observers it is apparent that money alone will not handle the challenges and grievances found in the system today. Changes to medical practice, health system management, and public expectations are *the* vital elements of reform and adaptation in the health system. To make these changes is more important than the continuous infusion of more money if the future Canadian health system is to be viable and stable. But of course, the public's health care cannot be held for ransom while the medical and management changes are being made. That is why transition money is needed.

There are just a few findings from these case studies that should indicate a direction for future intergovernmental health fiscal policy:

1. Sustainable and predictable long-term federal money is essential to the maintenance of the present health system and its national principles. Without substantial federal money, the principles of CHA will come under attack and some provinces will be unable to afford to sustain (in relative terms) the principles.
2. Without substantial federal investment in the health system, the federal government cannot sustain its moral or political influence on the system.
3. Federal fiscal capacity is essential to see through some of the solutions and settlements that a twenty-first century health system needs.

4. Long-term federal sustainable and predictable funding is necessary, but how much depends on what other F/P/T settlements are made within the fiscal federalism framework.

The intergovernmental debate about fiscal transfers is not going to be resolved by talking about health transfers only. No one knows what the federal government is, or should be, transferring to the provinces for health. The real discussion is about provincial/territorial fiscal sustainability in light of substantially increasing costs against their constitutional responsibilities with their limited long-term fiscal capacity to meet these obligations.

Since this fiscal federalism battle will continue in the years ahead, it would be helpful it the public understood the fiscal situation regarding the health programs in order to reduce the health "pawn" factor in the intergovernmental debate. There can be no informed public or private debate about these contributions until the current amount of federal contribution is clarified. The way the CHST payment is calculated now does not identify how much of the federal transfer is for health program purposes. At the provincial level, there is no identification of what amount or proportion of the transfer is allocated to health programs; and further, the value of tax points transferred from the federal to provincial governments in 1977 is usually lost in the health financing debate. No one in the country knows for certain how much federal money is supporting the health system. Both orders of government have used this ambiguity to their own advantage with the Canadian public from time to time so that they can bully each other. The ambiguity has not served the Canadian public well, however.[8]

A case can be made that some method has to be found to identify this money other than burying it in the CHST transfer which also includes money for social assistance and postsecondary education. One method is to separate the health transfer from the CHST and establish a unique transfer for health programs. The downside of this option for provincial/territorial governments is that they would have less overt flexibility in the allocation of either the health transfer, or the remaining social assistance and postsecondary education transfer to programs other than that for which the transfer was intended. An alternative is for the federal government to notionally allocate the CHST among its three purposes. While this approach would not require provinces to spend for the earmarked purposes, provincial/territorial governments would be under more public scrutiny to account for the dollars as they were intended to be spent and also would be in the position of having to justify their own proportional contributions to these programs more explicitly.

When discussing this idea at a roundtable of senior health practitioners and academics in September 2000, there was considerable support for the idea that the federal contribution to health in the CHST should either be notionally or actually separated in the federal transfer payment. It was noted though that some program initiatives like early childhood development overlap between the components of the CHST, but measured in dollar volume these overlaps are small.

What our case studies suggest, however, is that a substantial federal cash contribution is required for the maintenance and improvement of the current Canada-wide system of public health insurance. They also suggest that it is highly desirable that this substantial federal contribution be arrived at in a collaborative manner as seems to have been done in the September 2000 health agreement. Finally, they suggest a firm commitment to stability in the federal contribution. In this regard, the SUFA requirements of stability and predictability in funding are, to us, the bare minimum standard required to help build the necessary trust. These criteria imply that there will be an agreed realistic cost escalator in the transfer payment formula to address stability in the health system when the F/P/T September 2000 funding agreement expires.

CONCLUSION

It may seem to some readers that more dramatic changes to governance arrangements might have been proposed by this study to resolve intergovernmental conflicts in the Canadian health system. Indeed it is recognized that some critics might accuse this study of assuming a rather bureaucratic approach to reform and that adopting the proposals of this study might simply contribute to bureaucratic overload in the governance system.

Nevertheless, the case studies have not revealed profoundly different intergovernmental approaches from the existing ones for achieving a reasonable balance between the goals of advancing health policy, enhancing democratic values, and respecting the federal principle. The case studies do, though, offer an abundance of evidence that the health governance system we have now needs some repair work in the interests of federalism, the Canadian public, and future Canada-wide health policy. Any modifications to the present governance system will likely be of little value unless they are backed by strong and continuing political support of the first ministers. To achieve this support implies at least a modicum of intergovernmental goodwill. That in itself may be a substantial challenge, although a significant stride forward was made by

the first ministers in September 2000 with the settlement of their health agreement which will bring $23.4 billion new federal transfer money to the health industry over five years.

The infusion of this large new federal contribution into the health system seems to indicate that the federal government has finally awakened to several of the conclusions noted in our case studies, an important one being that significant federal money in the health system is essential, not only to sustain the health system but to lubricate the processes and relationships needed to undertake effectively intergovernmental business in our Canadian federation.

NOTES

[1]Barbara Cameron, *Rethinking the Social Union: National Identities and Social Citizenship* (Ottawa: Canadian Centre for Policy Alternatives, 1997).

[2]Kathy O'Hara, with the collaboration of Sarah Cox, *Securing the Social Union: Next Steps* (Ottawa: Canadian Policy Research Networks Inc.,1997), p. 9.

[3]Alain Noël states "Canada now marches on as if Quebec did not exist or did not matter. The Social Union Framework is a case in point. As with the Canadian Constitution, Quebec will be bound by an agreement it did not demand and did not approve. No matter how the Quebec government uses the situation to act autonomously, the outcome has more to do with domination than with freedom," in *Without Quebec: Collaborative Federalism with a Footnote*, paper presented at the Social Union Forum, Regina, Saskatchewan, 4 February 1999. The SUFA, therefore, represents a step backward with respect to relations between Quebec and the rest of Canada. It may also serve as a warning sign that the patience to resolve the long-standing conflict does not exist.

See also, the Andre Burelle and Claude Ryan exchange on Quebec and the Social Union, translated and reproduced in *Inroads* 9(2000):124-33.

[4]The federations studied for this project included Australia, Belgium, Germany, and the United States.

[5]This finding is contained in the project's companion volume of international health system comparisons, edited by Keith Banting, to be published in 2001 by the Institute of Intergovernmental Relations, Queen's University through McGill-Queen's University Press.

[6]See, *Re: Canada Assistance Plan.* Supreme Court of Canada Reports, Vol.2, 1991, p.525. Also, Peter W. Hogg, *Constitutional Law of Canada,* Student Edition (Toronto: Carswell, 1998), ch.6.

[7]Canadian Council on Health Services Accreditation, *1998 Annual Report* (Ottawa: Canadian Council on Health Services Accreditation, 1999).

[8]It seems that the federal tax transfer should "count" more for some purposes and less for others. It should count more when people attempt to compare the current federal transfer to the amounts Ottawa was transferring in the 1960s and 1970s. It should count for less when one is trying to understand the actual tax burdens the two orders of government impose today in order to finance current health-care programs.