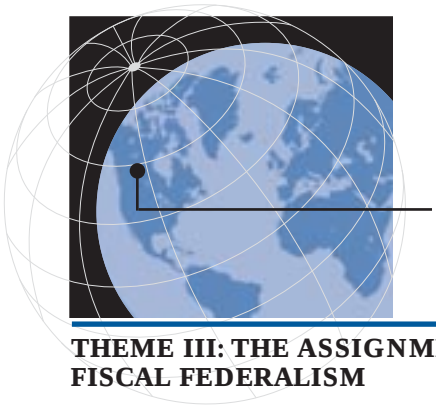

Canada's health system – a challenge for fiscal federalism

A cherished system more than three decades old requires a high degree of co-operation between orders of government.

THEME III: THE ASSIGNMENT OF RESPONSIBILITIES AND FISCAL FEDERALISM

BY *HARVEY LAZAR*

A large majority of Canadians are strongly attached to their countrywide system of universal publicly administered and publicly insured hospital and medical services. But they are also concerned that it may become fiscally unsustainable due to rising public expectations, the proliferation of expensive new technologies, and an aging population. There are further worries that the timeliness and quality of care has begun to deteriorate.

The tools of fiscal federalism were instrumental in the creation of the health care system in earlier decades. Even as Canadians debate the future of Medicare today, questions arise about how these mechanisms can again be utilized to preserve and strengthen the health system to which they are so attached.

Birth of the system

Canada's 1867 constitution assigns to provincial governments much of the legislative authority to regulate health care services. During World War II, while planning for the post-war peace and reconstruction, the Government of Canada became committed to a Canada-wide system of health insurance. Given the constitutional division of authority between federal and provincial governments, the federal government recognized that it could only advance its plan if provinces were willing to implement it. To secure provincial support, Ottawa offered the carrot of cost sharing.

By the mid-1950s, a majority of provinces were anxious for federal cost sharing and legislation was enacted in 1957. The federal government would cover half the eligible operating costs of provincial acute bed hospitals. To qualify for federal funds, the provinces had to provide universal coverage, public administration, public insurance, and portability.

By 1961, all provinces had joined. In 1966, similar legislation was enacted in respect of physicians' services and by 1970 all provinces had joined in. Federal-provincial agreement on the use of conditional shared-cost grants thus enabled a Canada-wide system of hospital and medical insurance to be created.

Deficits and debt

Political priorities then began to change. By the mid-1970s, there was anxiety at the federal level that too much of its budget was being driven by provincial spending decisions, thanks to the cost sharing mechanisms for health and other programs. This concern then merged with a larger concern about annual deficits and rising debt. As for the provinces, they had come to dislike the intrusiveness of federal cost sharing and the fact that it could distort the provincial resource allocation process.

The outcome was a prolonged federal-provincial negotiation and a series of major amendments to the fiscal arrangements. First, block funding replaced cost sharing. In the first half of the 1970s, Ottawa had been operating four major shared cost transfer programs with the provinces – for hospital services, medical care, post-secondary education, and social assistance/services. In 1977, the first three were combined into a single block fund. In 1996 the fourth program was added, making a single large transfer for all four purposes.

Block funding meant that Ottawa's transfer payments to the provinces were no longer linked directly to levels of provincial spending. And with that link broken, the federal government no longer had reason to question and audit provincial health expenses. And any distortion of provincial resource allocation was ended.

Second, Ottawa only paid for half of the new block transfer through cash. The remainder was in the form of transfer of income tax room. Ottawa lowered its income taxes, allowing provinces to raise their tax rates by an equivalent amount without increasing the overall burden on taxpayers. The federal government accompanied this "tax room transfer" with associated equalization payments so that the per capita benefit of the tax points was as large in the poorest provinces as it was in the richest.

As for the *amount* of the total transfer to the provinces in 1977, it was roughly what it had been expected to be under the previous cost sharing formula, with the cash portion legislated to increase at a rate linked to the growth of the economy. The 1977 fiscal arrangements represented a wide measure of federal provincial consensus if not formal agreement.

Single transfer, 30% cut

By the early 1980s Ottawa's fiscal situation was deteriorating badly and had become considerably worse than that of the provinces. When the provinces showed no willingness to agree to amendments to the federal block funding formula, the federal government acted on its own, making a series of largely unilateral reductions in the planned rate of increase in the cash transfer beginning in 1982. This process culminated in a 1995 federal budget decision that its cash payment to the provinces for the new single block transfer would be cut by over 30 percent relative to previously planned levels beginning in 1996.

Whereas cash transfers had equaled about 25 percent of eligible provincial hospital and medical expenses in 1977, by 1997 they had fallen in value to about ten percent of total provincial health care

expenses. In part, this decline was because of the fiscal cutbacks Ottawa had imposed. And in part, it was due to the fact that provincial health costs had continued to grow rapidly, including in areas that had previously not been subject to federal cost sharing, such as prescription drugs and home care.

The 1995 federal budget also did not include legal commitments about whether and when the reduced cash outlays would again begin to escalate. Provinces were thus left to plan their health care reform efforts without any certainty about future federal payments.

Enforcing principles?

The other important change related to the countrywide conditions. After cost sharing ended in 1977, it became more difficult for the federal government to enforce the principles associated with hospital and medical insurance. When some provinces allowed physicians and hospitals to impose patient charges beyond the standard fees that provincial governments paid them, the federal Parliament enacted the *Canada Health Act* in 1984. This legislation consolidated the principles that had previously been imbedded in the federal hospital and medical care legislation and it added a principle related to access. It also authorized the federal government to penalize provinces financially if the provincial authorities did not enforce these principles. While the provinces moved generally to comply with the legislation, some resented the legislation, especially as the federal share of provincial health costs continued to decline.

From one perspective, the tools of fiscal federalism were successfully used in the 1977-1995 period. They helped the federal government to cope with overall fiscal pressures without undermining the broad principles that governed Canada-wide health insurance. But a big price was paid for these successes in the form of strains in federal-provincial relations.

The current context

By the mid-1990s, these strains had come to be among the most contentious issues in federal-provincial relations. They included:

- A disconnect between the very modest amount of federal cash going into provincial health care and the amount of policy influence Ottawa was attempting to exert on provincial governments.
- Provincial objections to the way in which the federal government was interpreting and enforcing the provisions of the *Canada Health Act,* with Ottawa acting as prosecutor and judge.
- The idea of Canada-wide health care as a partnership between provincial and federal governments and Ottawa's unwillingness to provide certainty to the provinces regarding the basis on which the block transfers would in future grow.
- The fact that a large and growing share of provincial health costs were occurring in areas that are not part of the Canada-wide insurance system, including prescription pharmaceuticals and home care.
- The disconnect between the idea of countrywide health care as a program of federal-provincial cooperation and the more unilateral federal approach to related fiscal decisions that began in the 1980s.

Since then, the federal fiscal position has improved dramatically. The federal government has increased substantially the amount of its cash contribution. While there is much dispute as to what share of provincial health care costs are now accounted for by the Canada Health and Social Transfer (CHST) cash, a reasonable 'middle of the road' estimate is 15 percent.

Second, the federal government has enacted legislation that indicates the magnitude of the increases in the CHST until 2006.

Third, the effective freedom of the federal government to unilaterally interpret and enforce the provisions of the *Canada Health Act* has been reduced recently through federal-provincial agreement to allow for third party intervention in the event of a dispute. Reports from these third parties, while not binding on the federal government, will be made public. And in September 2000, federal and provincial governments agreed on a Health Accord that may turn out to be a stepping-stone to needed health care reform.

Looking forward

As of the middle of 2002, intergovernmental tensions remain high, in part because provincial health care costs continue to mount, crowding out other important provincial programs. Provinces continue to demand that Ottawa restore former funding levels for health and that, once restored, the federal commitment should increase in a predictable manner that reflects cost pressures on the provinces.

On a variety of grounds, the federal government questions provincial numbers (much of the dispute relating to whether the tax transfer of 1977 should still be counted as a federal contribution). In any case, it is most unlikely that Ottawa will take further action until it has the report of the Commission on the Future of Health Care in Canada, a body it appointed in 2001. That report is expected toward the end of 2002.

The Commission is likely to be guided by values and principles in its final report, not mechanisms. But it is also likely to have to reach once again for the tools of fiscal federalism to translate some of its goals into actions. From the viewpoint of the ability of Canada's system of fiscal federalism to respond to the new challenges, both in health care and intergovernmental relations, key issues include:

- Whether to move toward a single block transfer for health only rather than having a multi-purpose fund.
- Whether to expand the scope of the *Canada Health Act* to include uncovered health services and, if so, how to finance them.
- Whether to increase, maintain, or decrease the conditionality of the federal transfers.
- How to respond to the provincial demands for increased federal funding with a predictable escalator.
- Whether to develop proposals for a fiscal decision-making mechanism that is more collaborative.
- How to improve further the dispute resolution mechanisms between federal and provincial governments.

How the Commission will answer these questions remains to be seen. The toolkit of fiscal federalism can adapt to a wide range of answers. It contains a highly flexible set of instruments for responding to ongoing change pressures.