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# MEDICARE: HOW TO KEEP AND IMPROVE IT, ESPECIALLY FOR CHILDREN

***Summary***

The argument of this paper is that good, equitable health care in Canada requires new federal action soon. The proposal has two distinct, but related, parts.

One part is a set of new measures to enhance the well-being of children. It is recognized, however, that the provinces cannot be expected to collaborate in new programs unless the federal government also restores a significant part of the funding it has cut from medicare. Nor will they again put faith in the old kind of promise of cost-sharing, on which the federal government has been able to renege with impunity.

The other part of the proposal therefore is that the federal government should now commit itself to provide the proportion of existing medicare costs attributable to children under the age of ten. Significant new programs for children would then be practicable.

***Where we are***

For the past 20 years, medicare has been sustained by the public will. Most people had come quickly to like it. They may find some faults but in fundamentals they want it at least to stay as it was set up nearly 30 years ago: tax-financed, providing comprehensive physician and hospital care according to need, without charge to the recipient.

For this medicare, we owe no thanks to the present generation of federal politicians. It survives despite them. Though they pose, because of its popularity, as the defenders of medicare, in fact they have destroyed the financial basis on which their predecessors created it. That political betrayal is the root cause of the tension that, despite the public will, now pervades medicare.

It is true that the quality of some medicare services in some places has been reduced. It is also true that within it there are still important, unresolved issues about which differing opinions are strongly held. How can it provide more preventive care, as distinct from the treatment of illness? How is medical practice best organized, doctors paid? How can primary care and specialist treatment be integrated more cost-effectively? What is the efficient role of hospitals and of other institutional care? Can home care be more adequately supported? How can the greatly needed improvement in health information systems be secured? Should medicare be extended – as was originally intended – to comprehensive coverage of drug costs, dental and eye care? Alternatively, should it be contracted through user fees and a larger element of privatization?

The last question is what remains of the ideological opposition to medicare that, in the controversy over its introduction, was voiced most aggressively by Premier Manning of Alberta – the father of the

Reform party's Manning.

Significantly, however, medicare is too popular for any serious politician now to attack it directly. Those who want a 'second tier' of private practice and hospitals are compelled to argue that the effect somehow would be to improve the public service. In fact, resources would necessarily be diverted from it. The Canadian Medical Association has recognized this issue by setting aside, for the time being at least, the views of those of its members who want two-tier medicine. Instead, it is pressing the federal government to provide more money for medicare. If the Canadian Medical Association fails in this attempt, the two-tier demand will come to the forefront, with support from some provincial governments.

### *The fifty to fifteen betrayal*

The doctors have chosen the right target. Even if money in total were not the main problem – if deficiencies in medicare could be overcome by internal reorganization – constructive reform would require the political impetus of federal action, through new ideas with new money.

That is so because the federal government itself has made an anachronism of its existing legislation for medicare. Its refusal to admit this, seemingly even to itself, does not affect the plain fact. It is necessary to recall only briefly the history of medicare.

In an area of provincial jurisdiction, Parliament legislated – constitutionally, could only legislate – the terms on which federal revenues would be provided to the provinces: the famous 'principles' of medicare. If the provinces established health care plans conforming to the principles, Ottawa would reimburse them for half of the costs incurred. That was the offer of 30 years ago. It was how the federal government brought about what is effectively national medicare: ten provincial plans, not identical in detail but close enough to provide Canadians with much the same tax-financed health care wherever they live and however they move across the country.

The Pearson government used the same cost-sharing inducement to secure a large expansion of provincial programs for social assistance/social services and postsecondary education. While the program criteria were loose in the first case and nil in the second, the practical effect was not only great improvement in the two services but also a considerable degree of consistency across the country.

But these cost-sharing measures had not been in place for ten years before the federal government began to renege on the financial commitment with which it had induced the provinces into the programs. With its Established Program Financing (EPF) legislation of 1977, the Trudeau government abandoned 50 percent sharing for medicare and postsecondary education. Federal taxation was replaced largely by provincial taxation, supplemented by a federal transfer according to a formula not related to the provinces' actual expenditures and designed so that the transfer would diminish over time.

The Mulroney government continued this retreat from federal commitments. With its 'cap on CAP' it extended the withdrawal of 50 percent sharing to the third major area, social assistance and social services. The Chrétien government has brought the process to its logical conclusion. All that is left of federal involvement – the Canada Health and Social Transfer (CHST) – is a relatively small block grant arbitrarily fixed by Ottawa without reference to the health and social costs incurred by the provinces. It is at present $12.5 billion.

In 1994-95 (the last year for which full figures are available), provincial spending on what would have been the three shared programs was $79 billion. There have since been some cuts and some increases, for little net change. If the initial federal share had been maintained, total spending certainly would be somewhat larger. But even with that consideration set aside, the contrast between the promise and the CHST is stark. The contribution of federal taxes to health and social programs would have been about $40 billion. It is $12.5 billion. It is not the original 50 percent but only 15 percent.

In the past, federal authorities would have claimed that this calculation is unfair. Through EPF, Ottawa reduced its income taxes so that the provinces could raise theirs. The Finance Department proclaimed these 'tax points' to be part of its contribution. That was always a misrepresentation. A transfer is money that the federal government provides to the provinces out of its taxes, not theirs. With the replacement of EPF by the CHST, even the

Finance Department has had to give up pretending otherwise. The federal contribution to the cost of the provincial programs is now 15 percent, period. It will be less as costs rise, or when the feds decide to spend their money differently.

***The provinces' resentment***

Despite recent cuts, Canadian health care still stands up well in international comparisons. Talk of a crisis *within* medicare is, as yet, exaggerated. What is true is that the way medicare now operates is unstable. Despite the public will, the political foundation of medicare is too insecure for it to continue much longer as it has been; a turning point in the federal-provincial relations about medicare is at hand. The consequences for health and equity in Canada will come later, but shaped by the politics of today.

Ottawa led the provinces as a whole into medicare, and let them down. Provincial politicians and bureaucrats resent a program that demands far more of their tax revenues than they anticipated. Technology, demography and the power of transnational drug companies will go on driving the costs higher. But the provinces have been trapped; medicare is too popular for abandonment or for reduction except by a series of cuts sufficiently spread for no one of them to produce political disaster.

The other formerly cost-shared programs, on which the provinces have equally been let down, are more vulnerable. Social assistance can be cut sharply without offending most voters, indeed with the approval of many. Higher university fees generate more articulate protests, but not of a kind likely to fell a government.

Health is different, and also there is here an additional reason for resenting the political pain it at present involves. This goes back to the way medicare was started. In the 1950s many people wanted medicare, the Liberals among them led by Paul Martin senior. Many of his cabinet colleagues were opposed or doubtful. The compromise was hospital insurance. It was a long step towards medicare. But it produced a readily foreseeable distortion that is still plaguing provincial governments.

When people could go to hospital free but still had to pay for treatment outside, obviously they became more inclined to go to hospital. Hospitals responded by widening their services, expanding their capacity and keeping patients for long recovery periods. Federal cost-sharing made the response easy.

This force operated for a decade before general medicare began. Over-provision of expensive hospital services, relative to other health care, became embedded. To correct the distortion is among the first

ways in which provinces have had to cope with financial stringency. Inevitably, however, closing, downsizing and consolidating hospitals provoke strenuous objections. Some provinces have handled the changes well, while others have not. But in all cases, it is unfair that the political unpopularity has fallen on them, hardly at all on the federal government.

I make this comment with a clear conscience because, at the time it was proposed, I criticized hospital insurance as the first step to medicare. Politically, there had to be two steps. But there was a better way to take the first one.

The Income Tax Act then provided that medical expenses over three percent of net income could be deducted in arriving at taxable income; and for this purpose medical expenses were (and remain) very broadly defined. The deduction has since been changed to a non-refundable tax credit, which makes it less regressive than it was. But it still can be a considerable relief to people with potentially large tax bills, though of little or no help to seriously ill people with low incomes who have little or no taxes to be offset.

My suggestion, at the time hospital insurance was proposed, was that there was a simpler and fairer way to protect people from disastrous medical expenses of whatever kind. Instead of tax reduction, the federal government should reimburse people for family medical expenses of more than three percent of income. In today's jargon, I would have written about a refundable tax credit. This approach would have been more equitable than hospital insurance, and would not have had its distorting effect on medical practice.

Admittedly, this proposal had its own problems. Control of its costs would have required a schedule of allowable expenses, difficult to negotiate with physicians and hospital administrations even though public opinion then would have been strongly with the government.

The arrangement would not, of course, have been medicare – for several reasons, most particularly because it would not have met the fundamental principle that treatment be provided without charge at the time of need. No doubt doctors and hospitals, if not insurance companies and banks, soon would have developed schemes of bridge financing to cover the gap in time between major expense and refund. But it is the nature of such schemes that they work for some people, not for others. I think we could have been sure of moving on, at least as quickly as we did from hospital insurance, to fuller medicare – though perhaps with some differences from, even some advantages over, the detail as we have known it.

My point, however, is not to explore might-have-beens. It is to illustrate the danger of compromise arrangements of the kind hospital insurance was. If the federal government is to take a new initiative in health care – as, if its election talk were to be taken seriously, it would – it should ensure that its intervention does not again distort medical practice and create new problems for provincial administration.

### *Joint process: necessary but dangerous*

The provinces are too aware of public opinion to make a frontal assault on the Canada Health Act. They point out, accurately, that the Act "narrowly focuses on insured physician and hospital services."[1] It is "unacceptable" that, while reducing health funding, the federal government imposes "unilateral interpretations" of the Act, backed by "financial penalties" on the provinces. Instead, there should be a federal-provincial "process" through which "the parameters of the Canada Health Act can be clarified,

refined and interpreted." The process would involve: first, federal-provincial discussions "to establish a baseline understanding" of what the Act means today; second, "continued consultation to ensure that interpretation continues to adapt in step with the evolving health system;" and third, a federal-provincial "structure for interpreting the Act to deal with those instances where disagreement arises over issues of interpretation."

All this is reasonable. Given the paucity of federal funding, it is hard to see Ottawa maintaining the refusal of joint process that it has so far professed. Indeed, a government as anxious as the present one to conciliate the provinces – to show Quebec that federalism works, in the current favourite phrase – may in the end accept pretty much what the provinces ask.

The trouble is that, while joint federal-provincial structures look like – and in some respects are – good federalism, they confuse accountability. A decision is not made by one government, responsible to its electorate. It emerges from mysterious negotiations. Together, the various sets of politicians can appear on TV patting each other's backs for their achievement in the collaborative solving of a difficult problem. Separately, each can explain to critics that the decision was not of its making but what it had to accept for agreement. The confusion of responsibility dulls the retribution at the polls that an unpopular decision would earn for one government alone.

It should be said that such confusion is not necessarily against the public interest. It may enable weak governments to withstand special interests. That was true in the creation of medicare and the Canada Pension Plan. If the provinces had been acting alone, it is unlikely that some would then have faced down the insurance industry and other business interests opposed to public health and pensions. Joint responsibility made the democratic will more effective.

But in other circumstances, joint responsibility can blunt the democratic will. The provinces' demands now pose that danger for medicare. Clarifying, refining and interpreting the 'parameters' of medicare principles are code words. For some provincial politicians – not, of course, all – such jargon signifies what they dare not put bluntly: the dilution of medicare.

Medicare already has been weakened to varying degrees in different provinces. In their view, they are driven to unpopular decisions by federal downloading. Can Ottawa prohibit what it has made necessary for them? If the provinces' proposal is accepted, Ottawa's weight in the joint process may be little more than the 15 percent of its funding share. The effective pressure will come from the provinces that want to modify medicare; it will be all the stronger because of the Chrétien government's established disposition to contract its responsibilities and cede authority to the provinces.

I am not suggesting a frontal attack, which would fail. There will be no sudden collapse of medicare. The provinces will proceed 'clarification' by clarification, 'refinement' by refinement, continually pointing to the impoverishment of Ottawa's funding. The outcome will be compromise after compromise, with Ottawa always making the concessions. Each will be billed as a minor modification, but they will accumulate to be a major erosion of the principles of medicare. Its extent probably will vary province by province, reflecting differences in ideology as well as in finances. What Ottawa has hitherto secured – enough consistency of provincial programs to give effectively national medicare – will be lost.

Such predictions will be dismissed by those who think that the CHST is sufficient to maintain federal control of the principles of medicare. These people are dealing in wishes, not reality. This is not, however, to say that the threat to medicare is unavoidable. It is not to say that Ottawa should – or indeed can – deny the provinces a larger role in determining medicare policy. It is to say that a joint process

will endanger national medicare unless it is accompanied by other measures that restore federal weight in a genuinely collaborative process.

The federal-provincial relations of medicare are confrontational. They are not how Ottawa spin-doctors want to portray them. With the deficit going or gone, fiscal downloading is out; a new era of collaborative federalism is promptly proclaimed. We may hope that there are indeed some policy areas where a little federal money will work wonders. But in medicare, Ottawa is caught by its own propaganda. The federal government cannot reveal its nakedness by shedding its cloak as the defender of medicare. A defender needs an enemy. Who but the provinces? They have to be kept at bay by federal legislation and the threat of financial penalties. The reaction of provincial health ministers and officials, struggling with their departments of finance for funds, is to grind their teeth in frustration as the feds grandly hint at pharmacare.

Collaboration will replace confrontation only if federal politicians recognize that they themselves are also the enemy. It is the massive cutting of federal funding that has created the necessity or the excuse – the emphasis varies with the ideology of provincial governments – for reductions in health and social programs. The provinces cannot be asked to accept new programs − pharmacare or any other, however desirable, however shared – while the federal government retains its present degree of downloading of existing programs. The maintenance and improvement of medicare depend on a reinjection of federal funds. And not in trivial amounts. No one expects to go back to the 50 percent share. But the step back must be significant.

This is not to pre-judge how far medicare needs more money in total. It does need more money, but that involves a different set of issues. The prior point is that, whatever the total, more of it should again be federal. It is the provinces' prerogative to decide, within the medicare principles, how far extra federal funding is utilized to improve medicare and how far it can better serve other provincial priorities. What is sure, given the popularity of medicare, is that more federal funding for it will ensure, politically, that the range and quality of health services will not further deteriorate, but at lease will be restored.

### *Cost-sharing is dead*

But how is federal funding to be provided? Not by the old kind of cost-sharing. It served well in its day. Federal politicians of the 1950s and 1960s were remarkable for their willingness to impose their taxes in order to transfer revenue for the provinces to spend on social programs. But the generosity reflected postwar circumstances. Strong economic growth made revenues exceptionally buoyant. Canadians were eager for the kind of social protections that European states built so quickly after the war. Above all, there was a strong psychological hangover from the wartime centralization of government: Ottawa expected, and was expected, to take national responsibility in a way it had not done since Sir John A. Macdonald failed to get the kind of federalism he wanted.

These circumstances are long behind us, and federal generosity has ebbed accordingly. Provinces became more assertive; finances tightened; as the social programs became established, federal credit for initiating them faded in the public mind. Ottawa politicians developed a new determination to spend their taxes for purposes identified with them. Pierre Trudeau said that there would never be another medicare. Social programs have borne the brunt of the Chrétien government's expenditure-cutting, not primarily because they are social but even more because they are provincial.

This course will not be reversed in the foreseeable future. Indeed, even if federal politicians were to

undergo a miraculous reconversion, provincial politicians would not be caught again; they would not let themselves be drawn into program commitments by cost-sharing that probably would not endure.

***Selective, locked-in funding***

The politics of federalism now are clear. If Ottawa is to put more money into medicare, or any social program, it cannot again entail sharing the costs of a broad program. It will have to be direct funding of specific activities with which the federal government is clearly identified; for which it gets the political credit; and, by the same token, on which the provinces can rely in the sense that, if the activities were cut, the political pain would fall clearly on the federal government.

If this principle is accepted, there is ample scope for health and social activities to which it can appropriately be applied. Within health care, the largest gaps are in the preventive care that is neglected in the Canada Health Act. And preventive care is more effective the earlier in life it is provided. There is growing recognition of the extent to which the child shapes the person, in health, understanding, socialization and skills; and recognition too that the disadvantages of the parents are visited on the children, that many of those who grow up in deprived homes never afterwards get an adequate chance to over-come the handicaps with which they start adult life. Increasing polarization of incomes and diminished social services will enlarge this underclass that our society traps, generation by generation, in poor jobs or none.

My proposal therefore is that federal social policy should concentrate on children. This requires much more than health care. But early education and the rest will not do much for disadvantaged children who are in poor health. I would like to give priority to a wide range of programs for children and youth, not only health services with preventive emphasis but other social services and, above all, kindergarten universally available from an early age. But there would be justified objection to federal initiation of such programs while existing medicare is so poorly funded from Ottawa. Provision of new services, however federally funded, is a provincial prerogative. They are possible only with genuine federal-provincial collaboration. And for that the requisite is more federal funding of present medicare.

The first part of my two-part proposal therefore is that the federal government should undertake to reimburse the provinces fully – 100 percent – for the portion of the costs of their existing medicare systems that is attributable to children. The attributed costs would begin with maternity care. The cut-off age, defining children for this purpose, can be debated; I would suggest ten.

It would not be practicable to make the attribution by continuous current accounting. Even with modern information technology, that would be irksome. It would also open the way to pressures to inflate costs. The proposal therefore is that there should be, in each province, an initial joint review to establish the percentage of medicare costs (in physician fees, hospital services and overheads) that were attributable, over the previous 12-month period, to children under age ten. The federal government then would commit itself to funding, in full, this proportion of the province's medicare costs year by year.

Children under ten are at present about 14 percent of the population. Medical costs are, of course, heaviest for older people. They are also relatively heavy for babies and infants, but not particularly so for older children. At present there are not, to my knowledge, statistics providing a precise breakdown of national medicare costs by age. However, a reasonable preliminary estimate is that full funding to age ten would at present require around $6 to $7 billion a year. That is new federal money, an addition to the $7.5 billion of the CHST that can be regarded as medicare's share in the programs that the CHST has

replaced.

This first part of the proposal would not, in itself, provide services special to children. The extra federal money would go into medicare as a whole, to lessen financial stringency and to make improved health care possible for all patients. The reason for identifying this funding with one category of patients is that it would be politically locked in; provinces would not have to fear being let down again. The feds may betray them, but not the nation's children.

The same result could be achieved by alternative forms of identified funding. The federal government could, for example, pay the medicare costs attributable to cancer, or heart diseases, or whatever. But that would be administratively more complex; it also would risk distorting medical practice, in something of the way hospital insurance did. Since the costs of treating various illnesses can change considerably, with new technology and practice modifications, it would give the provinces less security of funding. Identification with the young age group is in every way more satisfactory, though even that cannot ensure long-term stability in the federal share of funding. The provinces no doubt will point out that, as the population ages (and unless immigration is increased and heavily concentrated on young families and children), the share of medicare costs rightly attributable to the under-tens will gradually shrink. Federal legislation should therefore provide that, if periodic reviews show that this is happening, the committed federal share of medicare funding will be maintained by raising the cut-off age — eventually, if necessary, as far as all pre-teens.

***For the children***

This first part of the proposal will maintain and improve medicare for people of all ages. By doing that, it makes the second part of the proposal practicable: that is, federal-provincial collaboration in the institution of further programs for children. The provinces would provide the services, directly or through community groups where that is practicable, according to standards agreed in detail with the federal government. Ottawa would fund the services, 100 percent.

The emphasis of these programs would be on preventive care. They should include nutritional supplements, nurse home visits, counselling and regular medical, eye and dental examinations. They would go beyond existing medicare for adults to provide coverage for prescribed drugs, dental treatment, eyeglasses and special aids for children with special needs. Other desirable inclusions are the treatment of learning disabilities and professional home care required after hospitalization. The list of constructive services, now provided in limited ways or hardly at all, is long. They are constructive not only in the sense that they would enhance the chances of useful adult life, especially for poorer children; they are an investment in human capital necessary for the future strength of the national economy; they would reduce the health and social costs later incurred for adults.

Such programs are not unprecedented. The federal Community Action Program for Children funds community groups that deliver some of the suggested services for children at risk. But, its present scale is small indeed. My proposal is, in effect, that the scope of services provided should be greatly broadened and that they should be made generally available with the methods of delivery adopted to suit the various services.

It fits the temper of post-deficit times that measures of this nature are now being discussed not only by social activists but also among officials. This does not mean, however, that such items will get onto an early agenda. When it comes to political decision-making, the provinces will not agree to give new

services precedence over fixing up the finances of medicare. We can be more optimistic if, as I am suggesting, a comprehensive policy links the two, providing new financing for existing medicare along with the preventive health care and related services that are so clearly needed for children.

The linkage does not imply that the cut-off age for the new services must be the same as the ten suggested for the costing of existing medicare. In some cases it might well be extended, eventually if not initially, all the way to school-leaving. Many of the services could best be provided in school; preventive health care will be most effective if we move, as we should, to universally available kindergarten from an early age – that is, 'quality' child care. Meantime, however, services to younger children can be provided in clinics and doctors' offices as well as homes.

The provinces would provide the children's services, directly or through authorized nonprofit agencies. The federal government would reimburse the provinces for their full costs, directly or perhaps in some cases through voucher systems. Again it must be emphasized that, for federal politicians, full funding, unlike cost-sharing, gives identification and political credit. For provincial politicians it gives, unlike past cost-sharing, security; no federal government could endure the politics of abandoning commitments to the nation's children.

***The costs***

The children and the provinces would be secure. At risk would be the taxpayers. Full federal funding defies the nostrum that who provides a service should be who has to find the money for it; then, but only then, the provider will be careful.

Sensible as it is, in practice the nostrum is necessarily honoured in breach as well as observance. Business is rife with cross-subsidies, stronger units propping up weaker units, consolidated company accounts concealing from shareholders how their money has been moved around. We enjoy anything near a common level of local services only because provinces fund their poorer municipalities. Federally, transfers to the poorer provinces are essential.

In theory, transfers could be made secure by constitutional amendment. The sovereignty of Parliament has already been limited by the Charter. It could be further circumscribed by providing that, once one Parliament has approved a federal-provincial agreement, a future Parliament may not alter its terms unless the provinces consent. Cost-sharing, 50 percent or whatever, would then be secure for the provinces.

There are two problems. First, this is not a time for constitutional change. Second, and permanently, federal politicians would not gain the political visibility they want from the use of their taxes. They would be compelled to maintain arrangements as unsatisfactory to them as the old cost-sharing programs on which they reneged. In practice, they would not start again on the same path. The federal government's power to secure consistent social programs across the country would atrophy.

We therefore have to consider whether the accountability nostrum can be safely set aside, whether 100 percent federal funding of the suggested new programs can be reconciled with provincial care in administration. The scope, standards, costing principles – of, for example, the program of nutritional supplements – would have to be fully agreed and open to modification with experience. This is difficult work, but entirely possible if collaboration is close and trusting.

Here, the provinces' demand for joint process in the interpretation of the Canada Health Act would become helpful. I have argued that by itself, in the present state of federal funding, joint process would risk the erosion of medicare. But the package I am suggesting would make a profound change. Funding of medicare for children would restore federal influence and set a style for collaboration in place of confrontation.

In these new circumstances, joint process would not create the risks it does now. It could be accepted and provide a precedent for negotiating the terms of new children's programs. Such programs would not stand alone. They would be parts, some small but all conspicuous, of each province's health and social system. Most would be administered in much the same way, with the same people in charge, as programs using purely provincial dollars. The provinces would have every motive to make them work successfully for the benefit of their children. It would not be difficult to ensure that these programs are administered as effectively as other provincial programs.

What, then, would the new, fully-funded children's programs cost the federal treasury? There can be no precise answer in advance of negotiations and detailed estimates by federal and provincial officials. Not all that I have suggested could be put in place quickly. The scope of some programs could be tailored to fit the funds available. However, a ball-park figure is necessary. Good, equitable services, providing care that sets children on the path to healthy useful lives, will not come cheap. The federal government would be foolish to claim to be launching a major initiative unless it is prepared to commit, within two or three years, expenditures of the order of $3 or $4 billion annually.

With the funding of children's existing medicare, this makes a combined cost for the health policy package of around $10 billion a year. No Minister of Finance would be expected to provide that in one installment. Two years of economic growth (if the Bank of Canada does not contrive to kill it) will be needed to add so much to federal revenues. Higher tax rates cannot be seriously considered. And while revenues at existing rates could be – in my view, should be – substantially increased by ending the many tax advantages now provided to richer Canadians, many of the gains from constructive tax reform would take some years to develop.

In short, the proposal of this paper is not for taking in one bite. One of its merits, however, is that it lends itself to implementation in stages. As far as possible, the staging should reflect the fact that the earliest years are the most decisive; the programs are more urgent the younger their beneficiaries. However, such timing − like many other features of the plan − could be settled only in federal-provincial negotiations. To allow three or four years for complete implementation would be reasonable. What is critical is that the federal commitment to move to full funding of health care for children should be public, specific and firm. People and provinces, health and social practitioners and institutions, then can confidently plan how to manage increasing resources to best advantage.

### *After the CHST*

The follow-up financial issue is, what happens to the CHST? It was the desperate device of a government determined finally to extricate itself from cost-sharing. The CHST was the price of obtaining extraction without provoking revolution. It has no place in a rational fiscal structure for federalism.

A federal government has two financial roles in relation to provincial spending. First, it can offset the unequal resources of provinces by block grants to the poorer provinces: so-called equalization. Second,

it can contribute to specific, major programs in all provinces, because it is nationally important that those programs provide comparable services to all Canadians; medicare is the classic case.

The CHST, as a block grant paid to all provinces, serves neither of these purposes. Nevertheless, the best answer to the question is: for the present, nothing; the CHST should continue for a while as it is. It is still new. Mr. Martin introduced it with much fanfare as a constructive reform; it was part of getting national finances under control, and at the same time it gave the provinces more control of their finances. In practice, what was new was that, along with the savings for the federal treasury, it became easier for the provinces to cut welfare programs. But the dust is too thick to have settled yet. The time for house-cleaning will come later.

Then – and it ought not to be much later – the CHST would best be replaced in part by strengthened equalization and in part by federal contributions to social improvements that the provinces would otherwise be impelled to undertake alone. Quality child care (or, as I prefer to say, universally available kindergarten) is one of the strongest claimants; another is the consolidation and improvement of income supports and services for the disabled, irrespective of the cause of disability.

For the present, however, the provinces need the CHST for their budgets as they are. To require them to adjust to another shock from Ottawa would not advance collaborative federalism.

### *National unity*

With that proviso, it is hard to see how nine provinces could do other than cooperate in the proposed package. It offers them a large increase in federal funds for medicare and, with incorporation of their joint process proposal, takes the tension out of their relationship with Ottawa. The new programs for children would be too popularly appealing, would fit too well with current moods, to be easily rejected. However, the conditions required to secure efficient administration would be considered irksome and it would therefore be necessary to insist that the two parts of the proposal are a package. The funding of existing medicare for children would be available only if the provinces agreed to collaborate in the new programs.

As a bonus, the provinces might be clever enough to use federal collaboration to their advantage in dealing with some of the unresolved medicare issues noted in the first section of this paper. The most conspicuous is the remuneration of doctors. Medicare could not have been started, in the circumstances of the time, on any basis but fee-for-service. Its defects, however, were always apparent and have increased as fee schedules have become outdated by changes in procedures and technology. But the tensions within the health professions and administration result chiefly in agreement to resist change; provincial searches for reform have been largely stymied. Health departments could well be glad to use negotiations with Ottawa as a lever to introduce some of the experiments in the reorganization of practice and pay that they know to be needed.

However, while we can be fairly confident of a positive response from nine provinces, Quebec with a PQ government may be different, unique if not distinct. If that is so, national unity will not be helped by trying to appease Quebec with special arrangements. A sovereignist government cannot be allowed to impair the development of Canadian health and social policy. It could well be that PQ rejection of the programs for children would do as much as anything to strengthen the federalist cause in Quebec.

Whatever the unfolding of this issue, relief from the budget deficit brings difficult choices for the

Chrétien government. The 'fiscal dividend' is limited and the ways in which it can be well used are many. The temptation is to embrace a variety of politically rewarding purposes. The consequence would be to spread extra spending too thin to do much good anywhere. Wisdom calls for setting a few first priorities, not general areas such as 'children,' 'health' and 'education' but the specific programs that will be most effective in such areas.

Wisdom also calls for long sight, for recognition that, in an environment of growing technical complexity and increasing social stress, the future of our democratic society will be shaped by the investment we make now in the well-being of our youth. With the growing polarization of work and income, more and more of our children face entrapment in circumstances in which their abilities will never develop for their own and society's benefit. Good health care is a primary tool for preventing such entrapment.

The proposed program would not only serve this crucial purpose. It would restore vitality to the most valued of our nation-wide services, medicare as a whole. It would be the federal action that best responds to the concerns and purposes shared by Canadians across the country. It merits a large and early claim on the fiscal dividend.

**Endnote**

1. All the quotations in this paragraph are from the December 1995 document issued by the provinces' Ministerial Council on Social Policy Reform and Renewal.

***Tom Kent***

***December 1997***

*Tom Kent was active in shaping the policies of the Liberal party during its 1957-63 opposition years and, as Policy Secretary to the Prime Minister and a Deputy Minister, equally active in the implementation of those policies - including medicare - by the Pearson government. He is now associated with the School of Policy Studies of Queen's University.*