



Three Choices for the Future of Medicare

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In August 2000, the Caledon Institute of Social Policy published a policy memorandum to the Prime Minister on what Tom Kent felt should be done about medicare [Kent 2000]. Two years later, Kent followed up with *Medicare: It's Decision Time*, urging the federal government to act before it was too late [Kent 2002]. Kent's plea also was directed to the federal Commission on the Future of Health Care in Canada chaired by Roy Romanow, then just three months away from reporting. Kent feared the possibility of the Romanow Commission making "soft" recommendations offering a "range of options" that would let the Canadian government off the hook [Kent 2002: 4]. Kent urged a strong report that would "define, firmly and clearly, how to strengthen medicare by modernizing it" and force a hard decision on the future direction of the system [Kent 2002: 5].

When the Romanow Commission delivered its report in November 2002, it made hard recommendations on transfer funding, the Canada Health Act, governance and federal leadership. It urged transformative changes in primary care, home care, Aboriginal health, prescription drug utilization and health human resources essential to improving quality, access and the sustainability of the public health care system. The report also concluded that a tax-funded, single-payer, universal system was more equitable *and* more efficient than the alternatives. It argued that the introduction of patient-pay mechanisms such as user fees or medical savings accounts would result in higher total health care costs – even if governments would gain a temporary advantage on their bottom line by off-loading part of the financing burden onto patients.

During the Commission's existence, very influential voices – a dissenting minority of Canadians – challenged the efficiency and

effectiveness of a single-payer, publicly administered health care system. However, the overwhelming weight of evidence adduced through the Commission's consultations and research demonstrated the advantages of Canadian medicare – the set of medically necessary hospital and physician services covered under the Canada Health Act.¹ This Act requires the provinces to operate single-payer, publicly administered health plans for hospital and physician services without user fees, in return for federal transfers to help pay their cost.

The Commission's deliberative consultations demonstrated the clear commitment by the vast majority of Canadians to the values and principles at the foundation of such a system, including universality and equity of access [Maxwell et al. 2002, 2003]. In the immediate aftermath of the Romanow report, presumably struck by the strength of public opinion, the dissenters muted their concerns about the desirability of a single-payer, universal system for hospital and physician services as defined under the Canada Health Act, even while continuing to encourage private-for-profit delivery within the existing publicly administered medicare system.

Where are we today and how did we get here?

More recently, however, the dissenting minority has resumed its attack on Canadian medicare. Some want the Canada Health Act changed so that user fees could be introduced, while others argue in favour of a system of variable premiums to be introduced by the provinces and/or the federal government. Some want a return to the past where medicare benefits would be restricted to the very poor, while

others want Ottawa to remove itself from medicare so that provinces can experiment without the ‘constraints’ of the Canada Health Act. In fact, Premier Klein recently stated that Alberta may be prepared to break with the Canada Health Act completely – despite his earlier and explicit commitment to the universality, accessibility, portability, comprehensiveness and public administration principles of the Canada Health Act, in the February 2003 First Ministers’ agreement on health care.²

On the surface, the 2003 agreement appeared to implement the bulk of the Romanow Commission’s recommendations concerning transfer funding and governance. The substance and timing of the Health Accord – so quick following the Romanow report – seemed to signal federal direction and leadership as well as a clear consensus among all the provinces and territories.

But appearances are misleading. Although most Canadians were ready and the political timing ostensibly seemed right, no bold blueprint for the future of medicare emerged from the meeting.

The substance of the Accord actually reflected an extremely limited consensus among the Premiers and the Prime Minister – much less an agreed upon vision and direction for the future of medicare. The weak compromise that emerged out of this closed-door meeting obscured what were in fact sharply competing views on the future of medicare.

To be sure, some progress was made. Existing provincial initiatives in primary health care, home care and prescription drug coverage were fortified. A tip of the hat was given to improving the state of advanced diagnostics and information technology, including electronic

health records. Encouragement was given to public reporting on health system performance and health outcomes. A commitment was made to create a national Health Council by May, although subsequent opposition from Alberta would produce a narrow mandate for the Council and delay its establishment until November 2003, ultimately without the participation of Alberta and Québec.

However, even this limited progress was purchased at a high price – an increase in federal cash transfers to the provinces, including an immediate \$2.1 billion top-up, and a \$16 billion investment in a five-year Health Reform Fund, enriched by a further \$2 billion, one-time top-up the following year. It was the price that Ottawa felt it had to pay for a few months of peace again.

The money may be enough to avoid medicare becoming the major issue for the federal Liberal government in the coming election campaign. But it did not lever transformative change for medicare.

It did not establish a new transfer funding mechanism that would create a clearer accountability relationship between Ottawa and the provinces, much less allow Canadians to know with any precision the level of the federal contribution.³ It did not result in a modernization and strengthening of the Canada Health Act that would have permitted a carefully calibrated and fiscally responsible extension of insured services beyond hospitals and physicians. It did not lay down a national platform for home care services throughout Canada.⁴ It did not begin addressing the fragmentation of Aboriginal health services and funding. And it did not tie fundamental changes in drug prescription and utilization behaviours and patterns to any extension of public coverage, despite the fragile fiscal sustainability of all current provincial drug plans.

These would have been transformational changes in both governance and health care policy.

So despite Tom Kent's warnings, the Romanow Commission's clear recommendations in these areas and the general public's thirst for change, Canadians are still waiting for a decision on fundamental direction from both orders of government. Deep down, they know that unless their governments arrive at a workable consensus for change, the Canadian brand of medicare is not likely to survive for long. Although accustomed to a certain level of intergovernmental tension – it goes with the territory in our diverse federation – Canadians nonetheless understand that the past decade has been anything but normal when it comes to medicare.

Recent federal-provincial relations and the damage done, 1994-2000

From 1994 until 2000, I participated in almost every meeting of Premiers and First Ministers, as well as numerous federal-provincial meetings of Ministers and officials. As Deputy Minister of Intergovernmental Affairs and later as Deputy Minister to the Premier and Cabinet Secretary for the government of Saskatchewan, I represented a 'middle' province that traditionally has pursued a meeting point between the more centralist tendencies within the federal government and the more decentralist provinces. From this position, I observed how health care eventually became hostage to a crass struggle over money and power and, at critical points, a much more profound clash between contending visions of the country.

At bottom, however, these titanic clashes between Ottawa and the provinces had precious little to do with medicare itself. As former federal Minister of National Health and Welfare, Monique Bégin, so aptly put it, the crisis that emerged was more a crisis in governance than a crisis in medicare [Bégin 2002]. The origins of this crisis lie in the unanticipated consequences of decisions made by both orders of government. One part of the story involves provincial health reforms and cost constraint efforts that squeezed health funding in the early 1990s, resulting in the general public perceiving substantive provincial health reforms as a cover for mere budget cutting. The other part entails the federal government's unilateral decision to change the nature and amount of transfer funding for health care through a series of unilateral reductions in funding by the Mulroney government in the 1980s and early 1990s, and the introduction of the Canada Health and Social Transfer and across-the-board transfer cuts by the Chrétien government in the mid-1990s.

By 1992, many provinces were initiating real health reforms on the ground in an effort to improve the continuity and coordination of illness care through organizational changes such as regionalization, while placing more emphasis on wellness and prevention. At the same time, however, the provinces put the brakes on health spending to an extent that was unmatched among OECD countries. Measured in constant (1997) dollars, the growth in total public sector health expenditures declined from 4.2 percent in 1991-92 to 1.7 percent the next year, then registered negative growth for four consecutive years: -0.7 percent in 1993-94, -0.2 percent in 1994-95, -0.9 percent in 1995-96 and -0.5 percent in 1996-97.

Then, almost as suddenly, in response to voters angered by long wait lists and deteriorating quality that they perceived to result from the cuts, provincial governments began to pour money back into health care. Real growth in public sector health expenditures ballooned up from 3.0 percent in 1997-98 to 6.2 percent in 1998-99, 6.5 percent in 1999-2000, 6.0 percent in 2000-01 and 6.8 percent in 2001-02. Overall, health care spending went from feast in the 1980s to famine in the early 1990s and then back to feast by the late 1990s [Commission on the Future of Health Care in Canada 2002: Appendix E].⁵

While substantive provincial health reforms combined with stop-go financing were changing medicare on the ground, the introduction of the Canada Health and Social Transfer in the mid-1990s was fundamentally altering the country's fiscal and social policy environment [Yalnizyan 2004]. In terms of public health care alone, it produced three major changes.

First, the Canada Health and Social Transfer (CHST) reduced cash transfers to the provinces just as they were ending their fiscal squeeze on health care expenditures. This meant that the provinces would be drawing on their own revenues in their health spending ramp-up. Second, the CHST eliminated the escalator formula that previously had tied growth in federal cash transfers to growth in the economy. This meant that annual increases would henceforth be subject to episodic, highly charged and unpredictable negotiations between the provinces and Ottawa. Third, the CHST allowed provincial governments to blame the federal government for the dislocation caused by their own reforms as well as cutbacks in health care spending.

Despite the fact that the Canada Health and Social Transfer cuts also affected post-

secondary education and social assistance/services, the Premiers insisted on referring to the CHST as 'health funding.' Initially frustrated by the public's lack of sympathy or understanding for their plight, the provinces began to describe their own difficulties in health care (in part caused by their own stop-go financing) as a crisis that could only be fixed through more money from the federal treasury. However erroneous in terms of timing, this was a logic that was easily understood, and the public began to blame the federal government for the deterioration – both perceived and real – in medicare. The Premiers had finally hit on a winning formula to shift at least some blame onto Ottawa.

This blame-shifting became apparent with the signing of the Social Union Framework Agreement (SUFA) in February 1999. When the First Ministers sat down together at 24 Sussex Drive, the ostensible purpose was to finalize and sign a protocol regulating the conduct of both orders of government in terms of social policy. With the exception of Quebec, which chose not to sign, this was done.

In reality, however, the meeting was all about health care funding. The dynamic was simple – even crude. From the provincial perspective, expenditures – driven by health care – were climbing faster than revenues; a quick transfer shot from Ottawa would make the problem go away for a little while. This was valuable for those Premiers about to call elections, particularly Premier Harris of Ontario who suddenly dropped all his objections to the Social Union Framework Agreement, abruptly ending his alliance with Premier Lucien Bouchard of Quebec. From the federal government's perspective, the provinces would agree to a less decentralizing Social Union Framework Agreement in exchange for more cash – the kind of bargain permitted by the

Canada Health and Social Transfer mechanism in which increases were now entirely at the discretion of the federal government.⁶ The extra money from Ottawa might also alleviate Canadians' growing concern about the commitment of the federal government to medicare.

Unfortunately for both sides, the fix was temporary. A combination of promised tax cuts and rising health expenditures pushed many provinces into deficit territory, and all blamed Ottawa for under-funding health care in an effort to shift blame. At the Annual Premiers' Conference in the summer of 1999, the provinces demanded more money but the Prime Minister refused, disappointed that the earlier February agreement had not bought more credit and time. Just before the release of the next federal Budget, the Premiers sent an open letter to the Prime Minister demanding "an immediate rescue of Canada's failing health care system" [Crites 2002: 398]. Although rescue did not come in the subsequent 2000 federal Budget, the general public was, after a four-year lag, finally associating the earlier Canada Health and Social Transfer cuts to the perceived crisis in health care. With Ottawa now seen to be as culpable as the provinces, the intergovernmental struggle for the hearts and minds of Canadians began in earnest.

The provinces charged Ottawa with underfunding health care based on a historic 50/50 cost sharing formula, blithely ignoring the impact of a massive transfer of federal tax points to the provinces in 1977. The federal government responded with some misleadingly "clever fiscal arithmetic" of its own, overstating its contribution to provincial social programming including medicare [St-Hilaire and Lazar 2003: 66]. Counter-attacking in August with a report called *Understanding Canada's Health Care Costs*, the Premiers called for a

cash increase equal to what had been cut with the introduction of the Canada Health and Social Transfer in 1995 [Provincial and Territorial Ministers of Health 2000].

The arguments used by both sides as ammunition in this war – misleading at best, dishonest at worst – simply served to confuse and confound the Canadian public. Further adding to the public's growing anxiety, three provinces – Quebec, Alberta and Saskatchewan – set up external committees that summer to advise them on health care reform and financing, leaving open the question of whether at least one report might end up recommending a fundamental break from the basic principles of the Canada Health Act.

With the so-called health care crisis drumbeat growing louder, Prime Minister Chrétien called a meeting of First Ministers to focus on health care reform and funding for September 11, 2000. The war of words had escalated to the point that the stakes were enormous for both sides. Opening a window for a fall election, Chrétien went into the meeting prepared to increase cash transfers by a considerable amount if the provinces would sign onto an accord linking this money to new investment in medical and advanced diagnostic equipment as well as primary care reform. The provinces went into the meeting expecting a federal cash injection equal to what had been pulled out in the original Canada Health and Social Transfer cuts. Though substantial, the federal offer fell short of expectations, and the fragile unity of the Premiers fractured.

The division among the Premiers was about both money and principle. On money, some believed that continuing the attack on Ottawa while boycotting the conditional federal offer would force the federal government to give

cash with no strings attached. On principle, some wanted an unconditional transfer – perhaps in the form of a transfer of federal tax points to the provinces – while others continued to believe that Ottawa should play some role in setting the national dimensions of the health care system, and were therefore prepared to sign onto an accountability framework.

These conflicting views came to a head very early in the morning. Explaining that Ontario officials had met the night before with officials from Quebec, Nova Scotia, New Brunswick and Prince Edward Island (Manitoba's role was less clear), Ontario's Premier proposed a much more decentralist approach in which the provinces would have maximum latitude to allocate any additional federal money for health care. Vigorous debate followed as Premiers who knew nothing about the secret discussions the night before fumed.

Taken by surprise, Chrétien temporarily adjourned the meeting in the hope that the provinces left out of the decentralist gambit would pressure Ontario and its allies back to the table with a response more acceptable to Ottawa. At this, Premier Harris of Ontario threatened to leave the meeting permanently. After some acrimonious debate and a further series of private meetings among Premiers and their officials as well as the Prime Minister and some of his key officials, the Premiers of Ontario and Quebec along with the three Maritime Premiers eventually dropped their alternative text, accepting a slightly amended version of the original agreement. In the end, even the decentralist Premiers found the federal cash too difficult to turn down. Nonetheless, the September 2000 agreement was achieved at the high cost of further damaging relations between Ottawa and the provinces, as well as creating deep suspicions and mistrust among the provinces themselves.

As with the February 1999 SUFA deal, the September 2000 agreement turned out to be another temporary fix. Almost immediately afterwards, the provinces most opposed to the agreement began dragging their collective feet on the collaborative work outlined in the Accord and soon started up the familiar drumbeat for more money (with fewer strings attached) from Ottawa. While the September Accord may have allowed the federal Liberals to portray themselves as the defenders of medicare, it did not remove health care as the major irritant in the federal-provincial relationship.

From Romanow to the present

Ottawa's now perpetual battle with the provinces over health care funding convinced Chrétien of the need to try to find a more permanent solution in the spring of 2001. He appointed a veteran of the recent federal-provincial wars and a close colleague from earlier constitutional battles, Roy Romanow, as the chair of a new Commission on the Future of Health Care in Canada. As the recently retired Premier of Saskatchewan, Romanow understood the provincial perspective, but also had consistently advocated a more meaningful federal role in social policy [Romanow 1998].

While agreeing on the arm's length nature of the study and consequent recommendations, Chrétien insisted on a November 2002 deadline for its final report – long enough to avoid having to commit any further federal money for 2002, but short enough potentially to implement some of the recommendations within the current term of his government. With the general public, health care providers and the provinces all demanding action, few cared that this eighteen-

month deadline was substantially shorter than normally allotted royal commissions: Indeed, it amounted to one-half the time taken by the Hall Commission on Health Care in the early 1960s. Despite this, Romanow insisted on his Commission initiating a major program of research projects as well as conducting the most ambitious, sophisticated and multi-layered series of consultations ever undertaken by a royal commission.⁷

To manage the Commission's relationship with the provinces and territories and to facilitate their participation in the consultations, an intergovernmental unit was established.⁸

This initiative reflected Romanow's own view that, although the provinces did not have exclusive jurisdiction over medicare, they nonetheless had the primary responsibility for health care organization and delivery. As such, a royal commission concerning the future of health care in Canada had to be a national – rather than an exclusively federal – enterprise. To emphasize its independence from the federal government, the Commission ran its operations from Saskatchewan rather than Ottawa – the first federal royal commission to do so.

At a minimum, these gestures prevented the Commission from being dismissed by a majority of provinces and territories as just more federal ammunition in the intergovernmental war. Perhaps not surprisingly, however, Premiers were much more focused on how the Commission might provide some advantage in their own immediate struggle with the Prime Minister. Speaking and meeting with Premiers directly, Romanow was consistently being pressured to reveal his recommendations – particularly those concerning federal funding – well before the final report.

Delivered in November 2002, the recommendations in the Romanow Commission's final report were a curse and a blessing for both orders of government. From the provinces' perspective, the report endorsed their argument that the federal government should live up to its historic funding obligations, which would mean a significant increase in transfers from Ottawa to the provinces. But the Commission also said that federal transfers should be targeted for transformational change and directly attached to funding conditions within a modernized Canada Health Act. For the decentralist Premiers, this recommendation involved a degree of federal partnership (beyond funding) that they found difficult to swallow. From Ottawa's perspective, considerable weight was given to the federal role through legislation and conditional transfers, though at the price of exposing the historic decline in federal transfers and the need to bolster the amount of transfers to the provinces.

Moreover, the Romanow report exposed the weaknesses in the arguments on health funding and governance put forward by both sides during their recent battles. It also demanded that Ottawa and the provinces meet as soon as possible to reach a consensus, repair the damage done, and come forward with a long-term action plan to improve public health care in Canada.

In the immediate aftermath of the report's release, much of the Canadian media focused on the increase to the federal cash transfer recommended by Romanow. But the media largely ignored the fundamental governance changes and the national health reform agenda that the Commission put forward as pre-conditions to any new investment in medicare by Ottawa.⁹

In some quarters, the report was crudely interpreted to be simply a call for more (federal) money to be pumped into medicare.

The Premiers themselves focused on the money and soon coined a phrase – ‘the Romanow gap’ – to dramatize the difference between the Commission’s recommendation on federal funding and what Ottawa was actually transferring to the provinces. Contrary to the Romanow report’s insistence on restricting the federal share to *Canada Health Act* expenditures, the Premiers inflated the size of the gap by including all provincial and territorial health expenditures including prescription drug plans, home care and long term care in their calculation. Predictably, the federal government responded in kind by throwing into its calculation of the federal contribution a number of non-medicare expenditures and transfers.

Thus deployed as a weapon in the ongoing federal-provincial struggle, the so-called Romanow gap now serves only to create more confusion for the Canadian public. In the February 2003 agreement, the federal government partially filled the Romanow gap. The Premiers took what they could, but made it clear they were disappointed with the quantum of money and would soon be back for more.

Three options for the future

In these circumstances, there are three main options in terms of the future of medicare. One is to continue with the status quo, with Ottawa achieving temporary truces with the provinces through transferring billions of federal dollars politically calibrated to be the minimum necessary to keep Premiers temporarily at bay, while exerting limited or no leadership on the

future direction and governance of the system. The second is for the federal government to get completely out of the medicare business, perhaps with a final transfer of tax points, allowing the provinces maximum freedom and maneuverability in running their respective health plans. The third is for Ottawa to get back in the game in a new and more vigorous way, working with the provinces to establish a new direction for medicare better suited to the needs and pressures of the new century. Each of these options will be examined briefly.

1. The status quo: death by stealth

The federal-provincial story told above reveals why the status quo is really death by stealth for medicare. Clearly, there are structural incentives that encourage the Premiers to use health care as a weapon against Ottawa to get additional cash in ‘health’ transfers – money that can, in reality, be used for almost any purpose including tax cuts and deficit control. The constant demand by the provinces for more cash will continue because the reforms announced in the First Ministers’ agreement of February 2003 do not change these structural incentives; neither does the extra \$2 billion one-time cash transfer confirmed in their meeting in January 2004.

The status quo also will allow the current debate over the sustainability of health care to fester, further undermining public confidence in the future viability of medicare.

During the past few years, there has been a concerted campaign by an array of interests opposed to a universal system of medicare to convince Canadians that they no longer can afford the current system. The campaign has been given a real boost by First Ministers who have con-

sistently used health care as a hostage in their larger struggle over taxation and fiscal resources.

The sustainability argument has claimed credence in the rapid growth of health care costs since 1997. Less commented on is the fact that since 1997 most governments also have introduced significant tax cuts. Given the unpopularity of raising taxes, these tax cuts constitute a quasi-permanent reduction in the revenue stream needed for public services such as medicare in the future. It is also little understood that both public and private health care costs have grown slightly faster than the rate of economic growth (and therefore government revenues) for at least the past half century. Since 1977, annual health care expenditures have been growing about 0.8 percent faster than the gross national product of the country [Lazar, St-Hilaire and Tremblay 2004: 172]. This fact alone does not constitute a sustainability crisis. But the reasons for this phenomenon need to be understood.

First, health care is a leading sector in the economies of advanced industrial nations, and leading sectors by definition grow faster than most other sectors of the economy. According to economist William Nordhaus, health care spending – both public and private – has added as much to the growth of the American economy as all other consumer spending combined [Nordhaus 2002]. The conventional wisdom is to speak of private health care spending as a dynamic investment in the economy and public health care spending as a static consumption of existing resources. The truth is that both types of expenditure are investments that stimulate the economy, but both are also costs to Canadians as investors, consumers or taxpayers.

The second important point is that health care has all the attributes of what economists call a ‘superior good.’ This term means that we tend

to spend progressively more on health care as our incomes go up. We do so collectively through the taxes we pay for public health care services, and as individuals privately paying for services not covered under our public plans. Indeed, higher income is the single most important determinant of higher levels of public and private health spending for all countries [Gerdtham and Jönsson 2000].

This brings us to the question of why current health expenditures are growing faster than the historic average. Two theories have been advanced. One is that we are simply in a period of catch-up after the cutbacks, layoffs and under-funding of the early 1990s that produced growth rates well below the historic average [Tuohy 2002]. The other is that this is a permanent ratcheting-up of health care expenditures for which we must now make new private funding arrangements to relieve the pressure on public resources – although little hard evidence is advanced to explain why the growth trajectory for health care costs has fundamentally changed [Boothe and Carson 2003]. These explanations will be confirmed or denied over the next five years. But right now, we know that simply shifting costs from the public purse to individual pockets is more likely to exacerbate, than to solve, the problem of the total costs for health care faced by Canadians – to say nothing of the new accessibility problems that would be created by such a shift.

Canadians spent just over \$120 billion on health care in 2003 or about \$3,840 for each man, woman and child [Canadian Institute for Health Information 2003]. Paid for through taxes, insurance premiums and out-of-pocket, this amount equals about one-tenth of the Canadian economy. It is worth looking more closely at the public and private components of this expenditure.

Health care expenditures fall into four categories. Medicare services under the Canada Health Act (CHA) come to just over 42 percent of the total. Prescription drug plans and home, continuing, and institutional care as well as other non-CHA services provided by the provinces and territories amount to about 25 percent. Direct federal expenditures on Aboriginal health, public health and other items constitute 5 percent of the total. The private component (non-medicare health services paid by patients, private insurance plans and employee benefit plans) makes up just over 27 percent of the total.

Of these components, provincial expenditures on non-medicare services and private expenditures have been growing much faster than medicare expenditures not only since 1997, but since medicare was introduced in the 1960s. Therefore, it is illogical to argue that simply reducing the basket of CHA services, thereby shifting health costs from the public purse to individual pocketbooks or targeted public programs, would reduce overall health costs. On the contrary, it is more likely to do the opposite given the proven administrative efficiencies of single-payer insurance systems over the alternatives [Woolhandler et al. 2003]. One way or another, Canadians will pay these costs either through a system that provides access to ‘medically necessary services’ based on need or through a system where access is based on ability to pay.

The solution to the ‘sustainability problem’ offered by the opponents of medicare – that of shifting costs from the public purse to private pockets – is simple but illusory from an economic policy standpoint [Evans 2004]. It is also highly inequitable from a social policy standpoint. And it is neither bold nor innovative – ‘out of the box’ – thinking since it generally involves old nostrums such as user fees,

co-payments and health premiums (occasionally dressed up in modern garb such as medical saving accounts) that were the norm prior to the introduction of universal medicare.

Nonetheless, sustainability continues to be equated with the growth in medicare costs – with little or no thought given to the growth in non-medicare costs, whether in the public or the private sector. Proponents of introducing more private health care rarely discuss rising health care costs in this sector, but cost-shifting in this way will lead to higher personal costs for Canadians. It will also lead to cost escalation in non-universal, non single-payer provincial programs (such as the majority of provincial drug plans) which, in turn, will contribute to further cost-shifting from the provinces to individual Canadians as they try to prevent other priority programs and services such as education from being crowded out.

If we want to see the future in this scenario, we need look no further than the United States where public health care is non-universal and non single-payer, and where Americans bear a much higher burden of personal health care costs. In the US, per capita total health costs are almost double those in Canada; per capita *public* health care costs are actually higher than in Canada; and population health outcomes are among the lowest in the OECD. Is health care more fiscally sustainable in the United States than in Canada? Clearly not.

And for those who believe that the United States is so unique a case that it should never be compared to Canada, I would point to the example of Switzerland, which has the most expensive health system in the world after the US. The Swiss private health insurance system is an anomaly among the predominantly publicly insured systems of Western Europe, and its

higher costs are a product of the inevitably higher costs associated with multi-payer insurance systems.

2. Tax transfer: death by execution

One alternative to the status quo is to accept the decentralist provinces' argument that health care is exclusive provincial jurisdiction. This approach would remove Ottawa's influence over medicare by eliminating the Canada Health Act and cash transfers.¹⁰

There are at least two reasons why a future federal government might wish to leave medicare entirely in the hands of the provinces.

While federal cost-sharing originally ensured that provincially administered, single-payer systems for hospital and physician care services were adopted by all jurisdictions (including the minority that would have preferred targeted, means-based programs), it could be argued that the federal spending power in health care has outlived its early usefulness. According to this argument, medicare is here to stay as an 'established program' and provincial governments, irrespective of their ideological proclivities, will be prevented by their own voters from subverting or eliminating the national dimensions of the system.

Of course, there are no guarantees. In fact, it is unlikely that all provinces would continue to uphold the medicare principles of public administration, universality, accessibility, comprehensiveness and portability in the absence of transfer funding and the Canada Health Act. There would be little incentive to do so. Even now, the principle of portability is not being upheld by Quebec within Canada and

by five provinces for out-of-country services [Flood and Choudhry 2004]. And even now, the Alberta government threatens to break with the Canada Health Act by introducing user fees that are inconsistent with the principle of accessibility.

There is another possible argument in favour of the federal government vacating the field. Ottawa might decide that medicare is no longer worth the candle – that the influence the government of Canada buys through billions of dollars in transfers is just too minimal and the political cost in terms of intergovernmental squabbling just too high.

Indeed, provinces have been demanding greater flexibility for decades, and the tax transfer deal worked out between Prime Minister Trudeau and the Premiers in 1977 was partly in response to their demand for greater freedom. This freedom was offered through a historic transformation of roughly 50/50 cost-sharing of provincial hospital and physician costs to what eventually was intended to be a 25 percent permanent federal tax transfer to the provinces in combination with a 25 percent cash transfer.¹¹ Has the time now come for Ottawa to move the remaining cash transfer into a final transfer of tax room to the provinces, and forget about the national dimensions of medicare? Transferring the Goods and Services Tax (GST) to the provinces, for example, would give them a sufficiently robust revenue source to fund medicare well into the future [Rode and Rushton 2004].

If nothing else, such a change would produce clarity. Henceforth, the provinces would be solely responsible for medicare – so no more accusations about Ottawa treading on provincial jurisdiction and no more blaming the federal government for the performance of provincial health plans. No more painful meetings

between federal and provincial health ministers, except perhaps on items that clearly involve federal jurisdiction (First Nations and Inuit health care, drug safety and regulation, and public health).

However appealing this solution may seem to some, there is evidence that a majority of Canadians would find it unacceptable [Mendelsohn 2001]. There are some very good reasons why most people feel this way. With this option, Canadians no longer would be guaranteed the basic contours of a health care system that most regard as a keystone of their national identity. Without federal cash, and the consequent ability of the federal government to withdraw it, the Canada Health Act would be a dead letter law.

Canadians could only accept a tax transfer option if it came with a guarantee. This could only be achieved in one way – by entrenching the current five principles of the Canada Health Act as a right of citizenship in the constitution. Presumably, no federal government would offer a transfer of tax points to the provinces without first getting unanimous agreement from the provinces to support such an amendment to the Charter of Rights and Freedoms. The courts rather than governments would then be entrusted with the responsibility of protecting and preserving the national dimensions of medicare, and governments could not change the medicare pact without a further constitutional amendment.

Even assuming a constitutional amendment to be politically feasible – and this is a very dubious assumption – it may not be desirable for a number of reasons. Canadians would lose their ability to shape the future basic direction of the health care system acting through democratically elected governments at both levels. With the permanent loss of its spending power on health

care, the federal government would be unable to set the broad framework for any expansion of the public health care system as it did with hospitalization in the late 1950s and primary physician care in the late 1960s. Finally, Canadians would lose the equalization effect of accessing a national revenue base as well as provincial revenues to fund the system, making it even more difficult for poorer provinces with thinner tax bases to deliver health services roughly comparable to those funded and delivered by wealthier provinces.

3. Ottawa as a real partner in medicare

There is a real alternative to the options discussed above and to the demise of medicare as Canadians have come to know it. This would be for both orders of government to agree upon a new medicare pact that draws upon the more positive features of a cost-sharing regime but sheds some of its more negative aspects. Such a pact would be built upon a recommitment to the founding principles of medicare as well as an agreement on its future direction.

In terms of funding, the federal government could create a purely cash-based transfer to the provinces and territories for medicare expenditures. In line with what the public has long accepted as a fair share, this would be 50/50 cost sharing. But the federal government made a tax point transfer to the provinces in 1977, so the more appropriate federal contribution is now 25 percent. This new federal cash transfer should be calculated on the basis of a national average, with provinces receiving a per capita share to avoid any potential skewing of provincial resource allocation simply to lever federal dollars.

While federal contributions and provincial medicare expenditures would be transparent and made available to the public and governments, there would be no need for federal monitoring or micro-managing of provincial expenditures. At the same time, the federal government would share in some of the fiscal risks of medicare by virtue of its permanent 25 percent stake that would make future contributions more predictable. To add to this predictability, an escalator formula could be introduced within the context of a permanent 25 percent contribution target. However, the Canadian public and governments must understand that the provinces should get no more and no less from Ottawa than the 25 percent. This formula would remove the incentive for Premiers to make regular demands on the Prime Minister for more health care money.

In terms of governance, an agreement among First Ministers concerning principles and direction would give Ottawa the moral legitimacy to modernize the Canada Health Act. The discretionary penalty provisions underpinning the five principles that have been so ineffective (as well as irritating to the provinces precisely because of the discretion given to the Minister of Health) could be replaced by the mandatory “dollar-for-dollar” penalties that have worked so well in eliminating user fees and extra billing. Some targeted home care services could be added to the basket of insured services and form part of the federal cash transfer to the provinces in order to encourage some transformational changes in health care on the ground.

At the same time, it would be understood that the provinces should be entirely responsible for administering their own single-payer systems within the principles of the Canada Health Act. The provinces have had decades of experience

in managing their respective systems and know best how to implement reform, including changes that will ensure that all Canadians have timely access to high quality services in the most cost effective manner. The national dimensions encompassed by the Canada Health Act are not a barrier to innovative organization and delivery of medicare. In fact, provinces and provincially delegated organizations such as regional health authorities should be encouraged to experiment as much as they choose within the very broad framework principles of the Canada Health Act, rather than be subject to any delivery model designed in Ottawa. This is the federal balance in medicare that can, and should, be achieved in the months ahead.

Despite the corrosive intergovernmental disputes of the last few years, public support for the Canadian model of medicare remains high. Moreover, Canadians want their elected representatives at both the federal and provincial levels to work together in renovating their medicare house for the 21st century. Their vision is of a country that is a sharing community, one that works actively to reduce regional disparities in terms of access to quality health care services [Banting and Boadway 2004]. Such a vision requires a meaningful federal role in medicare.

The meeting of the Prime Minister and the Premiers in June 2004 will be pivotal. It will provide an opportunity to put the damage caused by federal-provincial fighting over health care transfers behind us and agree upon the national dimensions of medicare. The issue is of such importance to Canadians that they should know exactly what their governments are negotiating and the decisions they ultimately make. This is reason enough to televise the proceedings and let some light into a process that has been hidden in the shadows for too long.

On the tactical front, there may never be a better time to attempt such a change. In 2003, new governments were elected in Quebec and Ontario. We now may have two Premiers more willing to work on using a strengthened federation to address some deep-seated federal-provincial problems in medicare. We have a Prime Minister who believes that universal medicare is one of Canada's greatest achievements [Martin 2003]. While stating that the Romanow report was "a milestone in the development" of health care policy in Canada, the Prime Minister also has made it clear to the Premiers that he will not "talk about the Romanow gap" unless they deal with it in the context of "the report in its entirety" [Hansard, Feb. 3, 2004: 41].

Further federal transfer cash should flow only *after* both orders of government agree on the national dimensions of public health care in Canada, a modernized Canada Health Act, and the federal government as a real partner in the medicare enterprise. Without such a role, it is difficult to see why Ottawa should continue transferring billions of dollars to the provinces for health care.

Conclusion

Historically, the federal role in medicare has made a profound difference to all Canadians. Universal public health care insurance would not exist without the federal spending power or the various pieces of legislation setting out the transfer conditions, from the Hospital Insurance and Diagnostic Services Act of 1957 and the Medical Care Act of 1966 to the Canada Health Act of 1984. While Saskatchewan got the ball rolling by introducing hospitalization in 1947 and medicare in 1962, national medicare could not have achieved its policy framework con-

sistency nor funding stability without the federal government.

As important to remember, medicare would not exist without brave and visionary acts of personal leadership from Premier Tommy Douglas and Prime Minister Lester B. Pearson. And it cannot be maintained and improved without both provincial and federal nation-builders. Despite his difficulties as a minority leader and his perceived failings as a strong leader of cabinet, Pearson will always be remembered as a great Prime Minister because he insisted on implementing national medicare in the face of stiff opposition from organized medicine, the business elite and many within his own party. He also strove to find the optimal balance between broad national principles and funding conditions on the one hand, and the breathing room required for the provinces and territories to administer and deliver as effectively and efficiently as possible 13 individual medicare plans on the other hand.¹²

The time has come to remake the social compact concerning medicare. 'Muddling through' will be a disaster for the country. The debate over health care transfer funding will continue to poison federal-provincial relations, forcing other urgent matters into the background, even while it contaminates Ottawa's ability to have a collaborative and constructive relationship with the provinces and territories. This can only lead to further political crowding-out of other important issues demanding federal-provincial collaboration.

Provinces also face enormous challenges on their respective home fronts. Public health care is taking up more and more spending space in provincial expenditure plans. This crowding-out of other program spending is creating considerable hardship for provinces,

most of which are either skirting deficits or once again running deficits. They are desperately looking for quick solutions to slow down the growth of health care expenditures. Some provinces may be tempted to push health care costs out of the public purse and onto individuals if they lose faith in their political ability to improve the efficiency and effectiveness of their public health care plans.

National leadership provided by First Ministers could boost confidence. More importantly, it could clarify the national dimensions of medicare and produce a national game plan for a set of transformative reforms that would make the system much more sustainable in the future.

Medicare is too important to continue to be held ransom by both orders of government in an increasingly sterile debate over fiscal transfers. For most Canadians, medicare is an integral part of their citizenship and identity. They want their First Ministers to quit playing the blame game and instead to work at improving medicare on the ground, including reducing waiting times and improving the quality of care. At the same time, they want both orders of government to come up with a common game plan that will address growing costs and ensure the sustainability of medicare for the future. Most want the principle of 'access based on need' preserved.

For a vocal minority, however, nothing less than greater privatization and decentralization, attractively dressed up as patient choice, is required to fix medicare in Canada. Though well financed, visible and powerful, we should always remember that this view is a minority view, and should not be allowed to dictate what the majority of Canadians actually want for themselves and future generations.

Endnotes

1. The Commission's consultations included 12 all-day regional citizens' dialogue sessions involving almost 500 randomly selected Canadians, televised forums, nine expert workshops, three regional forums, partnered dialogue sessions on individual health policy issues and an internet consultation workbook as well as the more traditional public hearings. The Commission's research included a series of expert roundtables on public-private partnerships (London, UK), co-payments and related options (Paris), health system cost-drivers (Washington, DC) and financing options (Toronto); three major research projects; and 40 externally commissioned researched papers. Many of the latter have recently been published by the University of Toronto Press in a three volume series entitled *The Romanow Papers* edited by Gregory P. Marchildon, Pierre-Gerlier Forest and Tom McIntosh.

2. *Canadian Press*, Feb. 20, 2004. Perhaps the most serious threat to medicare, however, comes from a case currently before the Supreme Court of Canada brought by Dr. Jacques Chaoulli and George Zeliotis that is challenging the legal basis of the single-payer system in Quebec (and therefore all provinces). A long-time advocate of two-tier health care, Chaoulli has been joined on the main constitutional issue by Senator Michael Kirby and some fellow Senators who argue that the rights of Canadians under section 7 of the Charter of Rights and Freedoms are violated if timely access to publicly funded health care is denied through wait lists and they are prohibited at the same time from seeking private health care. The case will be heard in June 2004 and could have momentous consequences for the manner in which medicare has been administered since the 1960s.

3. This is so despite the appearance of creating a dedicated transfer. The Canada Health Transfer referred to in the February 2003 Accord is simply the health portion of the CHST, mixing tax with cash transfers in the same confusing manner. In addition, the transfer can be used for any health or related expenditure, not merely medicare expenditures as defined under the Canada Health Act.

4. It did suggest a move towards home care norms by September 30, 2003, although little progress was made by that date or afterwards.

5. Total (public and private) health expenditures per capita (in constant 1997 dollars) tell a similar if less dramatic story. From 1990 until 2003, total health expenditures grew an average of 2.3 percent per year, which is very close to the overall 2.5 percent annual growth rate from 1975 until 2003. But if you split this 13-year period into two, then you discover an annual growth rate of 0.4 percent from 1990 to 1996 and 3.6 percent from 1997 to 2003. See Canadian Institute for Health Information, *National Health Expenditure Trends, 1975-2003*.

6. Although two separate communiqués were issued from this meeting – one on SUFA – and one on health fund funding in order to allow Quebec to avoid signing SUFA on principle while gaining the benefit of the health funding, the other provinces understood that more federal cash for health was conditional on the SUFA agreement.

7. See Appendix C on the external research program (pp. 301-307) and Appendix B (pp. 271-299) on the structure of the consultation processes in the Romanow Commission's final report, *Building on Values: The Future of Health Care in Canada*.

8. This unit also was responsible for the Commission's relationship with the major national Aboriginal organizations.

9. The French-language media in Quebec concentrated on the broader constitutional and federal-provincial implications of Romanow's recommendations.

10. For analyses as to why the constitutional argument concerning exclusive provincial jurisdiction is faulty, see the chapters by André Braën and Howard Leeson in T. McIntosh, P.G. Forest and G. Marchildon eds. *The Governance of Health Care in Canada*.

11. There has been much huffing and puffing about whether shared cost programming for medicare was ever 50/50, but this was the explicit assumption under the Hospital Insurance and Diagnostic Services Act (1957) and the Medical Care Act (1966). Moreover, the empirical evidence supports a rough 50/50 split for provincial hospitalization and medicare expenditures (but clearly not for total provincial health expenditures) during the era of cost-sharing. Established Program Financing (1977) introduced additional complications in terms of an imputed amount for the tax transfer and the

mixing of hospitalization and medicare expenditures with all other health expenditures as well as post-secondary education.

12. There is an argument, however, that federal direct services to special groups including First Nations (on reserve), Inuit, veterans and members of the RCMP and Armed forces constitute a 14th medicare system which would be the sixth largest in Canada based upon expenditures.

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