

Sacred Trust

or

POLITICAL FOOTBALL?

A CITIZEN'S GUIDE TO CANADIAN HEALTH CARE

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PREFACE

I thought about writing a Guide on health care some time ago but other priorities intervened. When I heard CBC Radio's Michael Enright talking to Roy Romanow about his report on the future of health care a few weeks ago, I felt it was time to stop procrastinating.

Health care is the single most important issue for Canadians, and because it would clearly be an election issue, I decided to take a stab at demystifying it for the general reader. There are many scholars specializing in health policy whose credentials in the field are far more impressive than mine. My modest contribution is to shed some light on the political dimensions of this very important public policy because political decisions will decide its fate.

To say the subject is complex is an understatement, and once I began, I realized how daunting the task is. I must confess to feeling uncomfortable about boiling down reams of information into a short booklet. It doesn't do justice to a complex, multi-faceted topic but I hope it will inspire some of you to pursue the matter further.

Given the short time frame, it isn't possible to distribute hard copies widely; some have been printed but the bulk will be disseminated electronically. The web address is <http://members.shaw.ca/dpbarrie> and I encourage readers to download and pass it on to anyone who might be interested.

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Introduction

Citizens...see themselves as owners, investors and stakeholders. They expect to be engaged in deciding how health care choices are made.

(Mary Pat Mackinnon, 2004)¹

It would be impossible to exaggerate how highly Canadians value the public health care system. Poll after poll puts health care at the top of the agenda but anxiety about its future is increasing because government cutbacks have resulted in long waiting lists. An air of crisis is hanging over the system, one that was the envy of the world until a decade ago. The foregoing quote suggests a new sense of ownership that Canadians feel about health care.

As health care is a major issue in the current federal election, I offer this quick guide to Canadians as they try to make sense of the claims and counter-claims about its merits and its sustainability. This brief look at an extremely complex issue can only scratch the surface, setting out in very broad terms some background and the economic arguments for and against the role of for-profit medicine. The focus will then shift to the politics of health care. There are many more areas that could be dealt with but time and space do not permit anything more than a sort of appetizer to spark your interest. With some basic information it will be easier to have a healthy public debate on this topic during the election. I'd like to emphasize that this is not a partisan interjection into the election campaign, but rather an exercise in public education.

In the interests of brevity and accessibility, I will try to tread the fine line between an academic paper and an informal presentation of facts, arguments and analysis. The use of footnotes will be limited but authors will be cited parenthetically and keyed to the bibliography. A list of suggested readings will appear at the end.

¹ The quote is from a speech delivered by Mackinnon, Director of the Public Involvement at the think tank, Canadian Policy Networks Inc. which organized the national citizens' dialogue on behalf of the Romanow Commission.

Health Care: A Brief Overview

The Canadian health care system was born in Saskatchewan. Premier Tommy Douglas, who led the first social democratic government in North America in 1944, initiated the first universal hospital insurance scheme on the continent in 1947. The Co-operative Commonwealth Federation (CCF) government's initiative was watched with interest and several other provinces began to provide some health services for their citizens. In 1961, the CCF government expanded the universal public insurance plan to cover medical care as well. This met with fierce opposition from the medical profession and resulted in a doctors' strike. However the government was determined to press ahead with its plan and there was a successful resolution to the dispute. From that moment the population of Saskatchewan had universal, comprehensive medical coverage, another first on the continent. Gradually the idea spread and other provinces expanded medical coverage, but it took federal action for a plan to come into effect across the country.

Universal hospital insurance (via the **Hospital and Diagnostic Services Act**) on a national basis was not introduced until 1961. This was a public and compulsory scheme covering hospital stays, a way-station on the road to comprehensive medical care. Companion legislation, the **Medical Care Act**, was passed in 1966 and gradually all the provinces agreed to the basic principles in exchange for partial funding from Ottawa. A national public health care system was in place by 1971.

Some provinces collect modest premiums from their populations, but the bulk of the money for medicare (I will use this term interchangeably with health care) comes out of general tax revenue. In 1984 the **Canada Health Act** (CHA) consolidated previous legislation relating to hospitalization and medical insurance. The Act enshrines the five principles which must be upheld by the provinces. These are: public administration, comprehensiveness, accessibility, universality and portability. This means that in order to be eligible for federal money, the system has to be administered publicly, to cover all medically necessary services, and be available to the entire population even if they travel to another province. These principles began to erode in the late 70s as doctors began to extra-bill their patients and some hospitals began to levy user-fees. As we shall see below, the additional charges were partly a result of new funding arrangements between Ottawa and the provinces. However, Monique Begin, then federal Minister of Health in the Trudeau government, felt action was needed to nip in the bud the practice of extra charges.

Despite fierce opposition from provincial governments and the medical profession, the federal government pressed ahead with the CHA. The Act provided for penalties if a province allowed extra billing, a dollar for dollar deduction from transfer payments for every dollar a patient paid. Despite provincial objections to what was regarded as federal intrusion into their jurisdiction, the CHA was strongly supported by Canadian citizens. Within the last decade or so, in an attempt to reduce its burgeoning deficit Ottawa cut back on transfers to the provinces for health care and other programs. As a result, the

provinces reduced their spending on health care. In the wake of these cutbacks, the system began to deteriorate as provinces closed entire hospitals or shut hospital beds across the country resulting in dangerously long waiting lists for some procedures. It is against this backdrop that one must look at some of the recommendations for change. These include calls for the introduction of private health care to relieve some of the stress in the system. The next section looks at the case for moving towards a mixture of public and for-profit medicine in Canada.

The Economic Arguments

There is a growing body of evidence that for-profit health care is more expensive, less efficient and less effective than publicly funded or not-for-profit health care.² Yet these facts are not widely known. Nor do people know that economists have come to the conclusion that standard economic models do not apply to health care, that it is considered an example of market failure. When shopping for appliances or vehicles, a consumer has an opportunity to weigh price, quality and performance. Consumer guides can be utilized to help in the decision-making process. Health care does not fit into this mould - it is in a category of its own.

The most important difference is that illness is not a choice. Due to circumstances beyond their control people become ill.³ When they do they are in no position to “shop around” for medical attention. Even if one assumes that an individual has the time to do some comparison shopping, the required information is not available. It is not possible to do a Google search to track down the most competent doctor or surgeon.

Another difficulty is what Richard Plain (2000:16) calls the “asymmetry of information.” He points out that the asymmetry of information between medical practitioner and patient destroys the “level playing field” assumptions underlying perfectly competitive markets. These assume that a patient has perfect knowledge and is capable of making informed choices. However patients do not have the ability to assess the quality of the medical advice they receive and few seek a second opinion even if they are afraid the physician is more concerned about personal gain than their interests.

Thus, unlike a consumer debating whether to buy a Saab or a Subaru, patients have no yardstick by which to judge their doctors. The patient's lack of expertise forces vulnerable individuals to trust that their medical practitioner will advise the best course of action. The latter, being a gatekeeper to usage of medical care, has the power to decide the appropriate level of care required. Unlike consumers of other products, patients cannot walk into a hospital and demand a new hip or a CAT scan, buy prescription medication

² Studies by Plain (2000), The Consumers' Association of Canada (1999), Rachlis and Kushner (1994), Evans, Barer, et. al. (2000) and Woolhandler and Himmelstein (1997 and 1993) to name a few, raise questions about for-profit care.

³ Arguably, people who eat and drink to excess, smoke heavily and “do” drugs are deliberately courting ill health. However, many people who do all of the above live to a ripe old age with no apparent health problems. Others who do not smoke, exercise regularly and practise what one might describe as “gastronomic celibacy” are struck down early in life due to some genetic weakness!

or book a procedure without their doctors' recommendation. Medical practitioners are assumed to behave ethically and in the best interests of their patients and we have no reason to question their motives. There is a much higher ethical standard expected of a doctor than of a used car dealer. When a medical practitioner becomes a medical entrepreneur, there is potential for a conflict of interest.

The current debate over health care revolves around whether Canada should move to a mix of private, for-profit and public health care in order to address the problems of access and sustainability. The argument is often made that because runaway costs are causing the system to deteriorate (although many health experts disagree) reforms are necessary. Critics argue that the private sector will bring the price down, provide service more efficiently and improve quality because of competitiveness. Criticism of the system is couched in terms of choice versus a monopoly. Opponents of Canada's largely public system⁴ argue that patients should be able to choose from a range of alternatives and that the government monopoly, at best, harks back to an era when we depended too much on government, or at worst, exemplifies a socialized system like those of the former communist states which delivered universally sub-standard services to their citizens.

The Evidence

There is a great deal of evidence that can be cited, but I will mention four that highlight the advantages of not-for-profit care (Cited in Rachlis, 2004:294-297):

- A 2003 article in the **New England Journal of Medicine** by Harvard Medical School physicians S. Woolhandler, T. Campbell and S.U. Himmelstein found that the U.S. system spends 3 ½ times what it costs in Canada for administration because resources are devoted to screening out sick people ineligible for insurance, denying claims and fighting appeals.
- A 2002 study led by Dr. P.J. Devereaux, a McMaster University cardiologist was published in the **Canadian Medical Association Journal**. It looked at studies comparing mortality rates in for-profit and non-profit hospitals. They discovered that the mortality rate in for-profit hospitals was 2% higher for adults and 10% higher for infants than in non-profit facilities. The researchers estimated that if all Canadian hospitals were converted to for-profit status, there would be 2200 deaths per year as a result. The likely cause: fewer staff and/or less well-trained staff.
- A 2002 paper by Devereaux's group published in the **Journal of the American Medical Association** looked at for-profit and non-profit dialysis care in the U.S. They found that the mortality rate was 8% higher in for-profit facilities and that they had fewer and less well-trained staff. In addition, patients were dialyzed for less time and with lower doses

⁴ Just to clarify: Canada has a publicly funded, single-payer system which pays for approximately 70% of medical expenditures. The rest is paid for out of the patient's pocket e.g. for medications and procedures not defined as "medically necessary". The definition varies in different provinces. Doctors are independent professionals who are paid by provincial governments. This leads to the misleading statement that we already have two-tier medicine.

of key medications. It's estimated that there are 2500 premature deaths annually in such for-profit clinics in the U.S.

- Another 1999 study by Woolhandler and Himmelstein addressed the issue of quality of care. Published in the **Journal of the American Medical Association**, their research found that for-profit health maintenance organizations (HMOs) rated lower on all 14 quality indicators. They estimated an increase of almost 6000 breast cancer deaths a year if all HMOs were for-profit (Cited in Rachlis, 2000).

With respect to efficiency, a single-payer system obviously requires less administration than one in which several hospitals and several insurance companies are involved. There are other reasons why one would expect for-profit hospitals to be more expensive. Taft and Steward (2000:63) list six reasons why private hospitals would be more expensive than their public counterparts:

- Investors expect profits annually
- Management personnel must devote time to activities other than their "core business" to defend against takeovers, corporate filings and securities requirements and bill collections
- Incentives and stock options drive up costs
- There is excessive equipment and facilities are under-used because providers must compete with each other
- Expensive marketing campaigns are required
- Private facilities must pay income taxes and property taxes.

Another point that must be made is that governments can get much more favourable terms than a private investor when they have to borrow money. Consequently, it would be much more economical for taxpayers if governments financed hospital construction directly.

Before 1971 when Canada established comprehensive public health care insurance, we were spending the same as the U.S. on a per capita basis. By the late 80s, the gap had widened considerably with Americans spending \$450 per capita more than we do (Fierlbeck, 200:221).

In addition, Canada spends about 9 percent of GNP on health care annually compared to 14 percent in the U.S. In the face of such evidence, it is obvious that there is more at work than a simple cost/benefit analysis. What clouds the debate is the collision of two viewpoints: On the one hand, there are people who strongly believe that the private sector is superior to any public organization. On the other, there are many people who are philosophically opposed to reducing health care to the status of a commodity. The economic case for privatization is weak but the information presented above is not known to a majority of the population. The battle is therefore waged in the political arena and it is to this aspect of the debate we now turn.

The Politics of Health Care

There are two reasons why health care is political: Firstly, public policy is (ideally) anchored in what people value and if there is to be a change, people have to be convinced that change is necessary. The campaign to convince them of this need is intensely political. Secondly, medicare is paid for through the public purse and 14 different governments are involved.

As Canadians cling tenaciously to a health care model that, despite its many problems, still delivers high quality care, even opponents have backed off from recommending that a parallel private system be established. The debate has shifted ground and the argument being made is that the CHA doesn't apply to delivery: Why can't we expand the role of private providers who will contract with governments to provide services? The studies mentioned above demonstrate some of the consequences of for-profit medicine, but there are other factors to take into consideration.

The proposal to allow private delivery while retaining a single payer system is superficially attractive. However, there are a number of problems that might result from such a move:

- Medical professionals are already in short supply and if there is competition for their services, it is quite likely that it will exacerbate the problem. If these individuals practise in public facilities as well as private practices, there will be an irresistible temptation to steer patients to the latter to avoid the waiting list. This happens routinely in the two-tier systems in Britain and Australia.
- Private contractors will "cherry pick" the procedures they wish to perform, choosing those that are quick and easy and leaving the more complicated, expensive ones to be done in public facilities.
- Specialized units would typically not be equipped to deal with medical emergencies. Patients who run into trouble would therefore, be shipped off to public hospitals with fully equipped emergency facilities. The taxpayer will have to pick up the tab.
- In order to ensure that we are getting value for money, governments will have to monitor and oversee facilities to ensure compliance with regulations. At a time when deregulation is the norm, it is unrealistic to expect governments to commit the resources necessary for adequate oversight of perhaps dozens of private health care clinics. The cost of monitoring would likely cancel out any savings.
- The degree of transparency can be severely curtailed on grounds of commercial confidentiality. Private organizations are not anxious to open their books to public scrutiny.
- There are NAFTA and WTO implications when something like health care, provided as a social service by governments, is opened up to competition.

For these reasons and others we need to proceed cautiously before we seriously consider contracting out on a wider scale.

Moulding Public Opinion

As mentioned in the introduction, the Canadian health care system is an icon, and any politician who recommends moving towards the dreaded “American-style, two-tier system” will be regarded as a heretic. A large part of public support flows from the undeniable practical advantage of being relieved of the financial burden caused by illness. In other words, while many Canadians may be philosophically pre-disposed to the current system, others support it because they have ample evidence that it has served them well. However, self-interest is not the only motivating factor; there are many other reasons why Canadians cherish their health care system.

Living next to a super-power is not necessarily good for the collective ego; unfavourable comparisons sometimes cause Canadians to feel inferior. With respect to health care however, Canadians see that in the United States, where government insurance covers only the elderly and the poor, 40 million people have no coverage at all and many millions have inadequate coverage. This statistic shocks Canadians, whose entire population of 30 million has access to publicly-funded medicare. Health care therefore distinguishes us from Americans, causing an unaccustomed feeling of superiority. But the system is also a symbol of what it means to be a Canadian, crystallizing in one program the fundamental values that Canadians hold dear. These values mark Canada as a compassionate society that strives for social justice through collective action. As many of the programs that signal this commitment have been drastically cut back, if not eliminated, the only emblem that is left is health care.

Some critics scoff at the idea that the Canadian identity should rest on such a slender base, that it is such a sensitive topic politicians must tiptoe around it. **Globe & Mail** columnist Jeffrey Simpson recently pointed out that none of the party leaders, including Conservative Stephen Harper, will engage in a meaningful debate about reform (May 15, 2004). Another **Globe** columnist, Lysiane Gagnon, is also impatient with Canadian attitudes. In a column she wrote four years ago she complained that medicare has acquired a quasi-spiritual dimension as a major part of the Canadian identity: “In the eyes of many Canadians, medicare is what separates Canadians from the United States. Medicare feeds the self-righteous tendencies of Canadians. It allows them to think of themselves as morally superior to Americans” (2000:16). Her column was titled “What do you do with a Sacred Trust?” and she laments the fact that we do not suffer critics of public health care gladly: “The hapless critic is accused of promoting a selfish and brutal two-tier, American style regime...Ah, but what can you do with a sacred trust? All you can do is sit down, shut up and honour it” (2000:16).

Gagnon mentions the sacred trust sarcastically, but she is not far wrong in her assessment regarding the esteem in which the program is held. It would seem therefore that the most fruitful way to proceed if you want to propose drastic reforms would be to puncture the trust citizens have in the medicare system.

We have all heard stories about people who didn't receive timely treatment due to long

waiting lists for diagnostic tests, specialists and surgery. These stories fuel calls for major reforms and are exploited in a sophisticated campaign to dent people's faith in the health system. The campaign is proving lucrative for consulting firms.

Fully aware that Canadians are wary of for-profit medicine, companies like Ernst & Young are exercising their considerable skills on behalf of clients (Fuller, 1998:233). Their advice is to proceed cautiously, bidding for contracts to provide "non-core" services (laundry, dietary and cleaning services for example) as a first step towards "an integrated system of health care with the full participation of the for-profit sector." In the longer term the strategy is "effective management of public perceptions hostile to private sector participation in health care" (Fuller, 1998:233). The "management of public perceptions" (a telling phrase) could proceed through a carefully crafted public relations campaign to "educate" the public on the virtues of the private sector and the deficiencies of the public monopoly. Ernst & Young also advocates lobbying to change public policies that use non-financial criteria to measure success: measures like quality, health outcomes and universal accessibility would yield to assessments made on financial grounds alone (Fuller, 1998: 233). American public relations firms regard medicare as "one of the largest unopened oysters in the Canadian economy" (Armstrong, et al. 2000).⁵

During the last few years there have been assaults on the viability and sustainability of the Canadian system illustrating that the management of public perceptions is well under way.

Politicians are alert to the sensitivity of the medicare issue and they therefore tread carefully in this minefield of public expectations. Not surprisingly, both federal and provincial governments proclaim their commitment to the principles of the **Canada Health Act**. When they discuss problems in the system, their remarks are couched in terms of affordability and sustainability. The murky fiscal relationship between the two levels of government is the starting point for inter-governmental skirmishing.

According to constitutional authorities health is not a single matter, since it was not assigned exclusively to one level of government. The constitution only makes specific reference to hospitals and the primary responsibility for health care is inferred from provincial jurisdiction over matters of a "local nature". Over the years, the courts have ruled that provincial jurisdiction over health care also flows from provincial regulation of medical professions and the insurance industry. Nevertheless, there is room for a federal role as well: actions that threaten public health are dealt with via criminal law which falls within federal jurisdiction. Ottawa is also responsible for segments of the population like First Nations, members of the armed forces and inmates in federal institutions (Banting, et al., 2002). Recent experiences with SARS and the West Nile Virus demonstrate that it makes sense to adopt a national approach to newly-emerging health problems. The

⁵ Because health care is a growth industry, Canadian providers are anxious to crack open oysters elsewhere. While this would generate much revenue, it also renders us more vulnerable to foreign companies that want to enter the Canadian market.

role might need to expand as new health threats surface.

Over the last four decades the federal government has played a central role through its “spending power” which although controversial, allows it to spend money as it sees fit even in areas of provincial jurisdiction.⁶ Equalization payments to “have not” provinces which were entrenched in the constitution in 1982, strengthen Ottawa’s role. These payments are not made by wealthy provinces, but come out of federal general revenue. The goal is to ensure that less fortunate provinces have the financial means to provide their citizens with services comparable to those in wealthier provinces. Equalization payments thus oblige Ottawa to ensure a measure of equity in the country.

The federal government has always contributed some revenue to the provinces to enable them to discharge their various constitutional responsibilities. The amount of the federal contribution to health care is a bone of contention and both levels of government have taken to the airwaves and newspapers to make their case. Former Ontario Premier Mike Harris spent a lot of money on an advertising campaign to complain that Ottawa contributed only 11 cents on the dollar to Ontario’s health expenditures. The federal government countered with the argument that the figure is closer to 35 cents. More recently provincial governments launched a joint media campaign to make similar complaints.

The question that arises repeatedly is whether Ottawa has the moral and political authority to enforce the **Canada Health Act** if its financial commitment has declined drastically. It isn’t possible to understand the merits of the arguments without some background on fiscal arrangements. The merits of the arguments are more easily understood when some background on fiscal arrangements is provided

Funding Arrangements

Federal-provincial financing is an arcane and specialized field which few people venture into, but as money is the source of much federal-provincial squabbling, it is very important to have a basic understanding of how medicare is funded.

As mentioned above, the constitution confers primary responsibility for health care on the provinces but the federal government has played a role through legislation and the power of the purse. The cost of providing a universally accessible, comprehensive system would have been beyond the financial capacity of most provinces. Without the carrot of federal revenue, Canada would not have the system we enjoy today. Ottawa provided powerful incentives to the provinces by offering funding conditional on provincial agreement to abide by the principles spelled out by the federal government. Initially roughly half the cost of hospital insurance and physician services was borne by Ottawa. The federal government also matched funding for hospital construction.

The medicare system enjoyed widespread popular support but the consensus among

⁶ In the U.S. and Australia the federal government routinely resorts to the “power of the purse” to fund its programs in areas of state jurisdiction.

governments began to break down in the 70s. The faltering economy resulted in shrinking government revenues and the federal government began to re-think funding arrangements. Both levels of government were dissatisfied so the system was altered in 1977.

From the federal perspective, the problem was that it could not predict its financial commitment, nor could it control its outlay to the provinces. In addition, there was some concern that as a result of receiving “50 cent dollars” the provinces were not being very frugal.⁷ The provinces were dissatisfied because provincial priorities were being distorted. Ottawa was making an offer the provinces couldn't refuse, but hospital construction might not have been as urgent as say, infrastructure. Yet it would have been politically unwise to refuse the funding being offered. Federal intrusion into areas of provincial jurisdiction was also a concern.

In 1977 Ottawa unveiled the Established Programs Financing (EPF) formula. This changed how health care and post-secondary education (PSE) were funded.

Instead of sending a cheque to the provinces, Ottawa split its contribution into cash and the transfer of tax points. Very simply, Ottawa made “tax room” for the provinces, by surrendering some of its revenue to them. Each tax point represents 1% of the federal government's take from personal income tax (PIT) or corporate tax raised in a province. (This is eye-glazing stuff, but please bear with me because it's important!) In 1977 Ottawa transferred 13.5 tax points of PIT and 1 tax point of corporate tax to the provinces. Taxpayers didn't notice because their taxes remained unchanged. I should emphasize that we are not talking small change here; the value of one tax point could be over \$100 million depending on the affluence of the province concerned. The value of tax point revenue for Ontario is over \$5 billion annually and it grows with the economy.

Supporters applauded the greater flexibility EPF offered provincial governments. However, critics identified major problems, pointing out that although the federal government “deems that about two-thirds of the EPF transfer was to support health care and one-third was for PSE, the flexibility of the arrangements allowed each province to treat these revenues in the same way as any other [provincial] general revenues and allocate resources as it saw fit” (Maslove, 1994:59).

In other words, billions of dollars flow into provincial coffers courtesy of Ottawa but the latter does not get credit for this and consequently it loses leverage with the provinces. Furthermore, the federal government hopes that the funds will be spent for the two programs, but has no mechanism to verify this. The next problem is that, having surrendered tax points, it isn't possible to claw them back.

The issue of tax point revenue has been at the heart of the federal-provincial dispute over money. Ottawa calculates its contribution based on tax point transfers plus the cash transfer it makes annually. The provinces recognize only the cash portion as the federal contribution.

⁷ As the wealthy provinces were able to spend much more, they were receiving much larger federal payments. The arrangement was therefore inequitable in addition to its other short-comings.

The crux of the dispute is whether tax point revenues can still be counted as Ottawa's contribution to health care or whether they were one-time grants that are now provincial revenue. The confusing part of this dispute is that both sides can claim to be right! The provinces now consider the tax transfer to be their revenue and the federal government regards it as federal money that flows into provincial treasuries for health care and PSE.

Provincial Complaints

Given that health care constitutes about 1/3 of provincial budgets, the provinces correctly argue that it's important that funding be stable and predictable. However, between 1982 and 1995, Ottawa unilaterally made changes to its EPF obligations that transferred a greater share of the burden of these programs to the provinces. In 1995 Finance Minister Paul Martin phased out EPF beginning in 1996, and folded it into a new block grant system, the **Canada Health and Social Transfer**, which also covers welfare payments (Jackson and Jackson, 1998:220). This unilateral action angered the provinces and broke the trust that is so important to ensure inter-governmental harmony. A much broader problem is that medicare has evolved in the last four decades to encompass much more than hospitals and physicians' services. Home care, palliative services, long term care and drug costs are all adding to the financial burden borne by provincial governments. In addition, costly diagnostic equipment is consuming millions of dollars in health care budgets. The provinces thus feel that Ottawa should open the purse strings but resent being told which areas to target.

Federal Complaints

The Chretien government's position was that deficit and debt reduction were a high priority when transfer payments were cut. Since then the deficit has been eliminated and there are budget surpluses. The provinces have attempted, and to a certain extent, have succeeded in prising some additional revenue from Ottawa. They also complain about the "vertical fiscal imbalance" - the federal government's ability to raise much more revenue than the provinces.

Ottawa seems to be rethinking the way in which it funds programs like health care as the lack of visibility and the perennial complaints of the premiers put it on the defensive. Towards the end of his term, Jean Chretien adopted a more assertive attitude towards the provinces accusing them of cutting taxes (thus foregoing revenue) while crying out for funding from the national government. One could argue that the "have" provinces could have made up the shortfall from their own revenue sources. Chretien decided Ottawa should get more "bang for its buck" and informed the premiers that his government would not provide funding without a quid pro quo.

In September 2000, the Chretien government provided \$1 billion for much-needed medical equipment. It was assumed that it would pay for MRIs, CT scanners, etc. but half the money sat in trust funds, some was unaccounted for, and New Brunswick bought lawn tractors and ice-makers with it. The Ontario government channelled funds into investor-owned firms to buy diagnostic equipment that could be used after hours to generate a profit (Yalnizyan: 2002).

The provinces resent intrusion into their jurisdictional territory so when the Chretien government proposed setting up a national home care plan, the idea received a chilly reception.

The Search for Reform

Public concern about the state of medicare prompted the Chretien government to appoint former Saskatchewan Premier Roy Romanow to head the Commission on the Future of Health Care in Canada. The Commission concluded that the system is sustainable, should be funded more generously by Ottawa and should be expanded. Home care and a plan for catastrophic drug coverage were identified as priorities. Romanow also expressed concern about the lack of accountability and transparency in the system. A National Health Council composed of health professionals, economists and government officials was suggested.⁸ A further recommendation was that the federal cash contribution should have a floor of 25% with an “escalator” clause to cover automatic increases.

The Romanow Commission was only one of several studies on the future of health care. Space doesn't allow for a discussion of the others but they can be found at the sites identified at the end of this Guide.

Before the 2004 election was called, Paul Martin scheduled a July meeting with the Premiers to discuss health care. In the first few days of the election campaign he identified this as a top priority and pledged \$9 billion in additional funding over the next decade. There has been criticism of the plan because it isn't clear if this is new money or recycled funds from the Chretien era. The Premiers' response has been scepticism and a reminder that they wouldn't welcome money that comes with strings attached. The Quebec government flatly rejects the notion of national standards.

The situation as it stands is that federal and provincial camps are still squabbling over the health file and the prospect for collaboration and cooperation appears bleak. Despite additional money being pumped into the system, there is little discernible improvement and public anxiety remains high.⁹

⁸ The Council was finally established in December 2003 and has met three times since. Participants hope to identify priorities and make the system more transparent and accountable to Canadians. Quebec has its own equivalent but Alberta refused to participate (Yahoo! News).

⁹ It should be emphasized that when we talk of a crisis in the system we have to remember that Canadians are still well served by their health care system when their problems are of an urgent nature. Saul argues that the fear-mongering by politicians is a deliberate strategy to accentuate the problems so a new “vision” of medicare can be unveiled, one that is not universal (Saul, 1999:4).

Conclusion

Canada's public health system is indeed highly-cherished. As the discussion above has illustrated, there's plenty of evidence that a single-payer, non-profit system can deliver quality health care. Critics try to discredit it by labeling it unsustainable, an unhealthy monopoly and an anachronism. Aware that "two-tier, American-style" health care sets off alarm bells in Canada, opponents of public health care have changed their tactics. They now recommend European models which don't carry negative baggage and they seize every opportunity to point out deficiencies in public health care. This systematic campaign to "manage public perceptions" is an ongoing one designed to change public attitudes as well as public policy. Those who will make the major decisions on the future of medicare aren't all of one mind but most troubling, is the sour relationship between Ottawa and the provinces.

Friction in inter-governmental relations is not new and there are irritants in numerous areas. But squabbling is unproductive and, although this might sound trite, collaboration and cooperation are absolutely essential if we are to address problems.

The top priority should be to ensure the delivery of quality care to Canadians. While Ottawa can be faulted for cutting back on funding in the last decade and for taking unilateral action in the past, there are hopeful signs that things might be changing. Canadians now have a heightened awareness of the importance of accountability. Therefore, provincial refusal to acknowledge let alone account for the billions of federal dollars that flow into health care (including tax transfers) will in future, be greeted with suspicion. Participants in the National Citizens' Dialogue felt that an Auditor General for Health should be appointed, someone who is independent of both levels of government. They were also critical of federal-provincial "bickering which they see as adding cost and delaying decisions without improving services" (Mackinnon, 2004).

Many observers have noted that throwing more money at the problem won't necessarily solve it and I agree. Until we are able to follow the dollars we won't have a real fix on whether funding is adequate.

Not all the provinces have the means to finance medicare so it may be time to carve out a legitimate role for the federal government to play. The question turns on whether we see this country as a group of ten provinces with tenuous links to each other or a group of diverse provinces which share a strong sense of kinship. Depending on which model we subscribe to, the dimensions of the community within which we feel sharing and redistribution should take place will differ (Banting, et al., 2002). Except perhaps in Quebec, health care isn't a regional issue. The commitment to it and the values it enshrines, cross regional, class and ethnic lines.

The public health system truly unifies this country. That is why I felt it was important to put together this Guide. I hope it will provide Canadians with the tools to understand and perhaps, become advocates for the system. I regret it has to be so brief, but I've laid the table with an appetizer, the rest of the meal is up to each one of you!

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Suggested Readings

Studies on health care that have been done by governments can be found at these web addresses:

Commission on the Future of Health Care in Canada (Romanow Commission): http://www.hc-sc.gc.ca/english/pdf/care/romanow_e.pdf.

Saskatchewan Commission on Medicare (Fike Commission), **Caring for Medicare: Sustaining a Quality System**: http://www.health.gov.sk.ca/mc_dp_commission_on_medicare-bw.pdf

Premier's Commission on Future Health Care for Albertans (Mazankowski Report) www.health.gov.ab.ca/

Quebec' Clair Commission report is available at www.cessss.gouv.qc.ca/intro_ns.htm

Other sources that might be of interest are:

The Canadian Centre for Policy Alternatives which has a number of studies on health care in addition to those I have already mentioned. Their website is: <http://www.policyalternatives.ca/middle.html>.

The Canadian Policy Research Network Inc. cited above also has other works on health care. [Http://www.cprn.org](http://www.cprn.org).

The Fraser Institute has studies and they can be consulted at <http://www.fraserinstitute.ca>

Raisa B. Deber has written extensively on health care. A Google search will provide several titles.