

# ASSESSING THE SOCIAL UNION FRAMEWORK AGREEMENT / ÉVALUER L'ENTENTE-CADRE SUR L'UNION SOCIALE

*In February, the IRPP and the Saskatchewan Institute of Public Policy sponsored a major conference on the Social Union Framework Agreement, or SUFA, which came into being a year earlier. Participants analysed the agreement from several different perspectives. In this and the next issue of Policy Options we present summaries of selected presentations.*

*Au mois de février, l'IRPP et le Saskatchewan Institute of Public Policy ont parrainé une importante conférence sur l'Entente-cadre sur l'union sociale, qui avait vu le jour un an auparavant. Les participants y ont analysé l'entente sous plusieurs angles différents. Nous présentons, dans le présent et le prochain numéro d'Options Politiques, les résumés de communications choisies.*

## The Social Union and Health Care

Antonia Maioni

**T**he *Social Union Framework Agreement (SUFA)* has done little to change the politics of health reform in Canada. It has been business as usual in the spectacle of warring factions as provincial premiers and the federal government face off in the battle over fiscal transfers. In fact, with rapidly escalating talk of “crisis” in the health care system, intergovernmental tensions seem to be worsening. The *SUFA* has not fundamentally changed the political debate, nor has it reduced the tendency to use health care as a political football between levels of government, particularly in the gamesmanship over fiscal transfers. It certainly hasn't prevented federal-provincial spitting matches over the *Canada Health Act*. If people were expecting it to play the pacifying role of Moses wielding the Ten Commandments as a deterrent to the disobedient, they will be disappointed.

The *SUFA* has allowed federal and provincial governments a measure of political maneuvering room in health reform, but it has done little to encourage a focus on the real political debate over two unresolved but crucial issues on the health agenda: Who should make the rules in health care? And what should the rules look like? Whether the federal government has a role to play in the health care sec-

tor is the major issue in the first debate, while what the boundaries will be between the public sector and private markets in provincial health care systems dominates the second.

**T**he *SUFA* was heralded as a “new era of flexible federalism.” But on paper, it is redolent of the spirit of “cooperative” federalism of the 1950s and 1960s. The hospital and medical insurance programs developed across Canada during that era were a high-water mark of federalism's power to shape effective social reform. Canadian federalism has become much less cooperative since then. Changes in health care funding, from initial cost-sharing arrangements to EPF block grants to the CHST “super” grant, were implemented largely without provincial agreement. Technically speaking, the federal government can deploy its spending power however it sees fit. But in terms of the politics of intergovernmental relations, the federal government has not been playing by mutually accepted rules, leading to the feeling among some provinces that federalism has become unilateral rather than cooperative in practice. The refusal of most provinces to participate in the National Forum on Health was evidence of the prolonged tension between levels of government on the issue of health reform. The NFH itself reported that although the federal government must ensure the integrity of the Canadian health system, there should be more institution-

alized cooperation between governments, as well as an end to federal imposition of change on the provinces.

The *SUFA* does not fully reflect the interprovincial processes that led to its development. It was, in part, the perception by provincial governments of unilateral gamesmanship in social policy by the federal government that spurred provincial leaders (including Quebec) to discuss forging a new "social union." At the 1995 Annual Premier's Conference, the premiers took a leadership role in social policy reform, calling for federal-provincial discussions to aid in the interpretation of the *Canada Health Act* and to find ways to guarantee a predictable funding base for health services. At their August 1998 Saskatoon conference, it seemed the provinces (again including Quebec) had come to an historic entente about how to adapt intergovernmental processes to reflect provincial interests and needs. This entente, with its provisions for opting out of federal social spending programs, was not incorporated into the *SUFA*, however — a decision that cost the process both Quebec's support and any resolution of where the jurisdictional boundaries in health care lie.

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Power struggles over jurisdiction in health policy are fundamentally struggles over the nature of the health care system itself, and over what kinds of alternatives can be envisaged or realized. The federal government's interpretation of *SUFA* tends to assume that such alternatives are necessarily limited, and that the existing Canadian model of public, universal health care delivery and financing will hold. There are limits on change, of course. The policy choices that shaped public hospital and medical insurance in Canada led to distinct paths in the development of the provincial health care systems and continued divergence from the American experience. The *Canada Health Act* also limits change insofar as it constrains provincial health reform decisions, which it does both through financial incentives, and through the more intangible, but nonetheless real, moral authority it attempts to exert as the protector of Canadians' health benefits.

This does not mean that Canadian health system is not subject to profound change or that the *Canada Health Act* is set in stone. In the past decade, attempts at rapid change in many provincial health care systems, combined with fiscal

constraints that forced many governments to cut public expenditures, have led to distinct shifts in the debate over health reform. Ten years ago, polls showed that Canadians were extremely satisfied with their health system, indeed were proud of it, particularly when compared to the United States. More recent polls reveal less confidence and greater uneasiness as well as increased openness to other alternatives. Privatization in health care, once a taboo in political discourse, is now a focal point of discussion in the media and within many political circles.

What is striking about health care, unlike many other social policy areas, is the presence of myriad possible policy alternatives — many beyond the scope of government involvement, some explicitly related to market profitability, most backed by powerful interests. Although the Canadian health care model has so far resisted the widespread use of market incentives or private alternatives, both our proximity to the US and the example of managed care and market-based incentives that have been exported to health care systems around the world are influences that should not be underestimated.

The *SUFA* allows the federal government to occupy considerable political space in health care and retain leverage in trying to constrain the array of alternatives on the health policy agenda. It does not, however, engage either governments or citizens in a reassessment of some of the real challenges facing the health system. The federal government continues to defend the status quo in health care, upholding the *Canada Health Act* and engaging in the familiar fiscal carrot-and-stick routine with the provinces. Using the *CHA* as a firewall against change and the *SUFA* as a hedge against conflict is not a tenable position, however, for it is based on the increasingly dubious assumptions that consensus opinion still supports the Canadian health model and that, if the consensus weakens, the model can nevertheless be imposed on recalcitrant provinces.

With or without the federal government playing the role of a "hegemon" or enforcer, widespread consensus on health "norms" should not be taken for granted. There is at least room for debate on whether the *CHA* principles are truly national norms which provincial governments, professional stakeholders, and even individual citizens support completely or will continue to support under different conditions in the future.

**I**n terms of health policy, the Social Union agreement builds on existing intergovernmental procedures for consultation, co-operation and decision-making, and has some potential to extend collaborative policy-making and establish mechanisms for sustainable funding and dispute resolution. When considered through the prism of the real world of health politics, however, the agreement is more problematic. The real effect of the Social Union on policy outcomes is limited by the political con-

flict embedded in the framework agreement and by unresolved issues surrounding health reform. The *Social Union Framework Agreement* does not resolve the enduring struggle about who should make the rules in the health sector nor does it address fundamental questions about what rules should govern the Canadian health system in the 21st century.

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## Du neuf avec du vieux ? L'union sociale et la santé

Pierre-Gerlier Forest

**I**l y a des domaines de l'activité gouvernementale dans lesquels l'Entente-cadre sur l'union sociale représente un progrès réel. Ce n'est pas le cas dans le domaine de la santé ou, du moins, ce n'est pas encore le cas, pour de multiples raisons. Je vais tenter d'en signaler quelques-unes dans ce texte, en insistant sur le partage des responsabilités entre le gouvernement fédéral et les gouvernements provinciaux et territoriaux.

Toutefois, mon intention n'est pas de reprendre l'argumentation traditionnelle sur le caractère intangible des compétences provinciales. Je pense au contraire que le rôle du gouvernement fédéral en matière de santé est primordial. Ma seule réserve, qui se fonde sur les faits pratiques de la politique de santé autant que sur l'analyse du fédéralisme canadien, consiste à dire que le rôle du gouvernement central ne peut pas résider dans la gestion du système de soins, l'administration des hôpitaux et l'organisation des services médicaux. C'est la santé de la population, au sens large du terme, qui devrait être au centre des interventions fédérales — dans le langage des spécialistes : un *rôle de santé publique*. En fait, si le gouvernement fédéral manque à ses obligations en ce domaine, le bien commun est introuvable ou menacé; en règle habituelle, les provinces n'ont ni les moyens ni les appétences pour y concourir, comme elles l'ont trop souvent démontré lors des dernières crises de financement ou de réorganisation.

**P**our commencer, il n'est sans doute pas inutile de rappeler que la collaboration et la concertation en matière de santé s'inscrivent dans une longue tradition. L'union sociale se contente de formaliser et de rendre visible un

dense réseau de relations intergouvernementales, soutenu par un système complexe de comités et de groupes de travail, associant des représentants des différents gouvernements, des experts et des professionnels de la santé.

À l'intérieur même de ces comités et de ces groupes, parce qu'on était loin des regards des médias et du public, les méthodes politiques utilisées n'avaient pas grand chose à voir avec les comportements qui s'affichent habituellement sur la scène fédérale-provinciale, comme on l'a encore récemment vu avec la réaction de l'Alberta, de l'Ontario ou du Québec aux propositions du ministre canadien de la Santé. En fait, sans que personne n'ait besoin d'y laisser ses principes ou son âme, ce sont la négociation et le compromis, plutôt que l'affrontement et la vocifération, qui ont caractérisé la recherche de solutions aux différents problèmes d'ajustement rencontrés dans la gestion du système canadien de santé.

Est-ce faire preuve de pessimisme que de croire que l'Entente-cadre sur l'union sociale met en danger le bon fonctionnement de ce système ? Peut-être, mais il faut aussi admettre que nous n'aurons pas gagné au change si la visibilité et la transparence, qui sont de bons principes, ne servent qu'à mieux couvrir des querelles politiques d'un autre ordre et d'un autre niveau. S'il fallait en plus que le ministère fédéral de la Santé, sous prétexte de responsabilités nouvelles et reconnues, se mêle de développer sa propre bureaucratie de services, dans un régime de santé déjà trop administré, ce serait vraiment le pire de deux mondes : paralysie politique au niveau des décideurs, prisonniers de la logique des affrontements constitutionnels, et présence multipliée des fonctionnaires sur le terrain, sans que de nouvelles ressources pour la prestation des services de santé ne soient vraiment libérées. Dans les deux cas, nous nous éloignerions de l'esprit et de la lettre de l'organisation fédérale de l'État canadien.

Les normes qui figurent dans l'actuelle *Loi canadienne sur la santé (LCS)* sont contraignantes, certes, mais elles n'empêchent pas les provinces de poursuivre leurs propres intérêts. C'est tout ignorer du système de santé canadien, de son histoire et de ses règles de financement que d'affirmer le contraire. Quant au gouvernement fédéral, il est difficile de comprendre comment il pourrait vouloir se mêler d'administration et de prestation des soins aux dépens des responsabilités qui sont les siennes, et qui le sont pour toutes les meilleures raisons du monde.

**A**dmettons que l'union sociale serait viable si le rôle des partenaires était bien défini et si les finalités poursuivies étaient claires — il y a des postulats plus risqués... Dans ce cadre, on ne doit pas trop s'inquiéter du rôle des provinces, dont l'identité est si étroitement liée aux programmes sociaux qu'il est difficile d'imaginer qu'elles pourraient négliger leurs responsabilités en ces matières. Ce