

# A FIX FOR A GENERATION?

France St-Hilaire and Harvey Lazar

Far from being “a fix for a generation,” as Paul Martin suggested during the recent federal election campaign, the federal government’s proposals for this month’s health care summit with the provinces fall far short of creating conditions for renewing the federal-provincial partnership, write France St-Hilaire and Harvey Lazar. “As things stand now, a disproportionate share of the financial and political risk inherent in the public health care enterprise is borne by the provinces.” The reason recent health accords have not put an end to federal-provincial squabbling over money or helped the reform process is that they failed to provide lasting solutions to this problem. “What is called for is some kind of peace treaty rather than just another temporary and ineffective ceasefire.” A new fiscal pact needs to be negotiated based on four key principles: transparency, risk sharing, predictability and collaboration. It must also include a firm commitment by all parties to then keep fiscal arrangements off the table for an extended period, 10 years or longer.

Loin de constituer le « redressement pour une génération » annoncé par Paul Martin en campagne électorale, les propositions fédérales en vue du sommet sur la santé de ce mois-ci ne sauraient créer les conditions d’un renouvellement du partenariat fédéral-provincial, notent France St-Hilaire et Harvey Lazar. « À l’heure actuelle, estiment les auteurs, les provinces assument une part disproportionnée des risques financiers et politiques inhérents à la gestion publique des soins de santé. » N’ayant proposé aucune solution durable à ce problème, les récents accords sur la santé n’ont pu mettre fin aux querelles fédérales-provinciales sur le financement, pas plus qu’ils n’ont contribué au processus de réforme. On devrait en conséquence viser « une sorte de traité de paix au lieu de convenir d’une énième entente de cessez-le-feu, aussi provisoire qu’inefficace ». Il faut donc négocier un nouveau pacte fiscal qui repose sur les quatre principes de transparence, de partage des risques, de prévisibilité et de collaboration. Suite à cette négociation, tous les gouvernements seraient tenus de prendre un engagement ferme de ne pas réouvrir le dossier des transferts fiscaux pour la santé pour une période d’au moins 10 ans.



Since becoming prime minister, Paul Martin has been quite adamant that health care would be the number one priority of his government. His plan for better health care — the central plank of the Liberal election platform — was presented as a blueprint “to fix medicare for a generation.” These proposals, which presumably will be on the agenda at the First Ministers’ Meeting from September 13 to 15, are quite ambitious.

The object is to “deliver real, measurable progress” by:

- ensuring stable, predictable long-term funding (\$3 billion over the next two years plus automatic increases in the future);
- implementing a National Waiting Times Reduction Strategy — the “Five in Five” plan (\$4 billion);
- reforming primary care;
- creating a National Home Care Program (\$2 billion over five years);

- developing a national strategy for prescription drug care by 2006; and
- respecting the *Canada Health Act*.

This latest prescription for health care, however, failed to generate much enthusiasm or optimism. This is not surprising, since the new plan comes on the heels of two major federal-provincial “accords” on health renewal in the last four years. The first two health accords laid out essentially the same priorities and plan of action for reform, and provided a lot more funding — \$48 billion over an eight-year period (2000-2008) compared with \$9 billion over five years. But with each new round, the stated goals become more ambitious, the delivery commitments more precise and the funding more targeted and conditional.

For instance, the goal of the “Five in Five” plan is to significantly reduce waiting times based on national targets over the next five years in five key treatment areas (cancer,

heart, diagnostic imaging, joint replacements and sight restoration). And to receive new money for home care, provinces will have to pass legislation on the provision of at least a minimum basket of home care services. Yet as the Liberal election document acknowledges, progress on previously set goals such as 24/7 access to primary care and the provision of home care services has been quite slow. Undaunted by this, the docu-

tors as a way to bring pressure to bear on them to deliver the goods.

The problem with this strategy is that it has not worked in the past and it is not likely to be any more effective this time around. The 2000 and 2003 health accords were more or less unilaterally imposed by the federal government. On both occasions, Ottawa extracted the provinces' commitment to health care reforms in return for substantial increases in federal funding. But provincial

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ment pledges that a Liberal government will "work with the provinces to *restart* the process of *expanding* the public system on a national basis."

There is a common thread running through each of these three action plans for health care reform. In each case, the underlying message is that: (1) the basic structure of the system is sound and only parts of it need fixing — that is, there is no question of revisiting the *Canada Health Act*; and (2) that there is a consensus on *what* needs to be done and *how* to do it. Moreover, since health care is under provincial jurisdiction, the federal government's role is to assume leadership and prod the provinces into action by giving them more money, telling them what it should be spent on, and making them more accountable to the public through monitoring and reporting on progress achieved.

"Buying change" is the basic idea. Clearly, the strategy is to get the provinces to commit to certain measurable outcomes and deadlines (e.g., benchmark waiting times for specific treatments, percentage of residents with access to 24/7 primary care or catastrophic drug insurance coverage), and to have them report to the public annually on changes in these indica-

agreement, motivated primarily by the need to secure much-needed revenue, was half-hearted. To call these "accords" was a bit of a misnomer.

**T**he reality is that recent increases in federal health transfers to the provinces have not brought an end to the fiscal stalemate that has poisoned federal-provincial relations since the federal cutbacks of the mid-1990s. The provinces still maintain that Ottawa is not contributing enough to ensure the sustainability of our public health care system in its current form, let alone to dictate new reform directions such as expanded coverage for home care and drug insurance. With health spending increasing at a much faster rate than revenues, the provinces argue that health care is gobbling up an ever-increasing share of their budgets and is the major reason for their deteriorating fiscal balances. Most provinces have fallen back into deficit in the past few years and they see recurrent surpluses at the federal level as evidence of fiscal imbalance in the federation. These arguments have of course been strongly contested by Ottawa and others who point to the significant tax cuts implemented by the provinces in recent years. As each side continues to

shift the blame to the other, tough decisions are postponed, needed reforms are implemented in half measures, and real progress remains elusive.

The similarities and differences in the federal and provincial approaches to health care reform are evident when we compare the "Premiers' Action Plan for Better Health Care," released in July by the Council of the Federation, to the federal Liberal policy document cited above. Among their reform priorities, premiers highlighted reduced waiting times, improved access to community-based care (including primary care, home care, and mental health), investing in medical diagnostic services, and ensuring access to appropriate and cost-effective prescription

drugs. In effect this list is quite similar to the federal priorities noted above. The premiers also agreed on the importance of reporting to their publics using "comparable [performance] indicators where possible and appropriate," which suggests some convergence on accountability measures. So the problem is not a matter of agreeing on priorities.

The provincial proposals, however, also revealed important differences between their position and Ottawa's that will need serious discussion. In particular, premiers called for

- a National Pharmacare Program, for which the federal government would assume full financial responsibility and be accountable for outcomes (along with provisions for Quebec to opt out with compensation);
- an increase in federal base cash funding under the Canada Health Transfer to 25 percent of total provincial health care spending beginning in 2004-05 — the federal government should then maintain its cash transfer at least at that level;
- additional ongoing federal dollars for any new initiatives agreed to at the September First Ministers' Meeting to

cover the associated costs; and

- assurances that new health care funding will not come at the expense of funding for other social programs and Equalization (moreover the premiers make suggestions for further strengthening Equalization in the near term).

All of these demands entail additional financial outlays by the federal government, thus reinforcing the idea that some of the main points of disagreement between the two orders of government are fiscal. But fiscal differences can be negotiated. A more worrisome area of dispute, however, relates to the degree of freedom provinces are to have in addressing reform priorities. Ottawa appears intent on obtaining a “national” strategy for home care, prescription drugs and waiting times. In contrast, the provinces’ action plan stresses the need to respect each government’s jurisdiction and provide each province and territory the flexibility and capacity to adapt and “deliver the health care services that best meet the evolving needs and priorities of their residents.” (Although the document is silent on what this might imply for controversial issues such as the role of for-profit private sector organizations in service delivery, a topic on which premiers likely hold divergent views.) This philosophical difference may be the harder nut to crack.

In the work we did for the Romanow Commission two years ago, we came to the conclusion that longstanding federal-provincial conflicts over health care funding had created an intergovernmental dynamic that is detrimental not only to the cause of health care reform but also to the proper functioning of the federation. And while we found some evidence of fiscal imbalance favouring Ottawa, we argued that another form of imbalance was also at play in health care. It is the

imbalance that exists between the policy influence that federal government is trying to exert and what it is contributing as a partner in this area.

As things stand now, a disproportionate share of the financial and political risk inherent in the public health care enterprise is borne by the provinces. The reason recent health accords have not succeeded in resolving the federal-provincial impasse and in promoting reform is because they have not provided lasting solutions to this problem. The prime minister is quite right that we need a fix for a gen-

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In our report we concluded that the only way to escape this counterproductive dynamic is for the federal and provincial governments to jointly establish the principles and guidelines that will dictate their future relationship on health care. In other words, what is called for is some kind of peace treaty rather than just another tempo-

rary and ineffective ceasefire. The idea would be to negotiate and legislate a new fiscal deal. Part of this deal would include a firm commitment by all parties to then keep fiscal arrangements off the table for an extended period (10 years or longer). The 2003 Health Accord was an important missed opportunity in this regard. And the Martin plan, as it currently stands, also falls far short of the mark in several respects.

Canadians have indicated time and again that they want and expect both levels of government to be involved in and to cooperate on health care. Our report laid out different models and scenarios for renewing the federal-provincial health care partnership. But all of them revolved around four key requirements: transparency, risk sharing, predictability and collaboration.

**T**ransparency should be paramount in any new fiscal arrangements for health. The new Canada Health Transfer is a definite improvement over previous CHST arrangements, and we applaud the federal government for taking that step. It is now possible to identify clearly the amounts allocated by Ottawa for health care. Transparency would be further enhanced, however, if the federal government decided to drop the value of the

1977 tax point transfer from its calculations of transfer costs. This would certainly make sense in the context of negotiating long-term fiscal arrangements for health care with the provinces that established a new clear benchmark for federal cash funding.

**R**isk sharing is really the core issue. The only way that our national health care system could be established decades ago was through a genuine partnership agreement between the two orders of government based on cost-sharing. The magnitude of the



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Provincial premiers and territorial leaders on July 29 at Niagara-on-the-Lake. To fix medicare, they proposed that, along with an increase in the federal base cash funding, Ottawa assume full financial responsibility and be accountable for the outcome of a national pharmacare program.

project was too great and the uncertainties and expectations too high for the provinces to proceed alone. The countrywide dimensions of the system could not have been put in place otherwise. Risk sharing was inherent in these arrangements. Over time cost sharing proved problematic and was replaced with block funding. The new negotiated arrangements were supposed to provide stable funding with about half to come from the 1977 tax transfer and the rest in cash. But beginning in 1982, a series of unilateral federal spending restraint measures gradually eroded the federal cash share of health care costs from about 25 percent to a low of 11 percent in 1998.

In our report we argued that a new federal-provincial consensus needed to be reached as to what would constitute a “fair share” for the federal cash contribution — a share large enough to justify a federal presence at the policy table. We concluded that the new

benchmark should be set at between 20 and 25 percent of provincial health care costs, depending on a number of factors. This benchmark would then determine the base amount of health transfer from which new fiscal arrangements would proceed. This would be like re-setting the 1977 fiscal clock to 2004 — recapturing the spirit of what was intended at that time.

In the present context, a 25 percent share now seems to us to be appropriate. And this 25 percent figure should be applied to total provincial/territorial health spending, not just hospital and medical services (as suggested by references to the Romanow gap). The reason for this is twofold. First, had provinces not been investing in other areas such as home care and modern pharmaceuticals, hospital and medical services would have been costlier. Provinces should not be penalized for making these appropriate choices. Second, the value of the tax points transferred to

the provinces in 1977 has not kept up with the rate of increase in health care costs. From a fiscal viewpoint, provinces have “lost” on that front and it seems to us inappropriate that they be shortchanged on the cash side as well.

Even with the large transfer increases announced in recent years, the fact is that Ottawa will only cover 18 to 19 percent of provincial health costs over the next four fiscal years (this excludes the amounts promised during the recent federal election campaign and not yet implemented). For this year alone, this represents a funding gap of close to \$5 billion. This is assuming that health care costs for existing services continue to grow at the same rate as in recent years. And it does not take into account the additional costs involved in setting up and running new national homecare and pharmacare programs and reducing waiting times.

This is where risk sharing comes in. In many ways, provincial governments currently face as many uncertainties in health care spending as they did when they first established the system. The cost pressures are well known, from new diagnostic technologies and medical advances to addressing the needs and expectations of better-informed and aging populations. The idea that provinces should embark on new national health care programs with the federal government only offering the equivalent of seed money and no guarantees of sharing uncertain future costs, as the federal plan proposes, is simply beyond reason. Quebec's recent experience with pharmacare and \$5-per-day daycare certainly illustrates both the fiscal and political risks involved.

What is needed is fair, long-term and predictable federal funding. In order for the provinces to get on with the long-range planning and reforms necessary to ensure the sustainability of the health care system, they need to know with some certainty what kind of contribution they can count on from Ottawa. Five-year horizons are simply too short when MRI equipment, new treatment facilities and the future supply of doctors and nurses are at stake.

Recent federal health transfer initiatives, however, have tended to be "à la carte" with time-limited, earmarked funds for primary care, home care and now waiting times. Base funding is being explicitly linked to traditional CHA expenditures (hospitals and physicians). Yet most experts would agree that the health care system needs to be managed and reformed as a cohesive whole since changes implemented in one segment inevitably affect the others. Informed decisions about resource allocation can therefore only be made at the provincial level. Ottawa may wish to be seen to pick and chose which activities it supports, but the reality is that — short of going back to formal cost-sharing arrangements and the problems of micro-management

and fiscal responsibility that entails — federal dollars flow through provinces' general revenues. To pretend otherwise is somewhat of a charade, notwithstanding the need for better accountability on the part of the provinces.

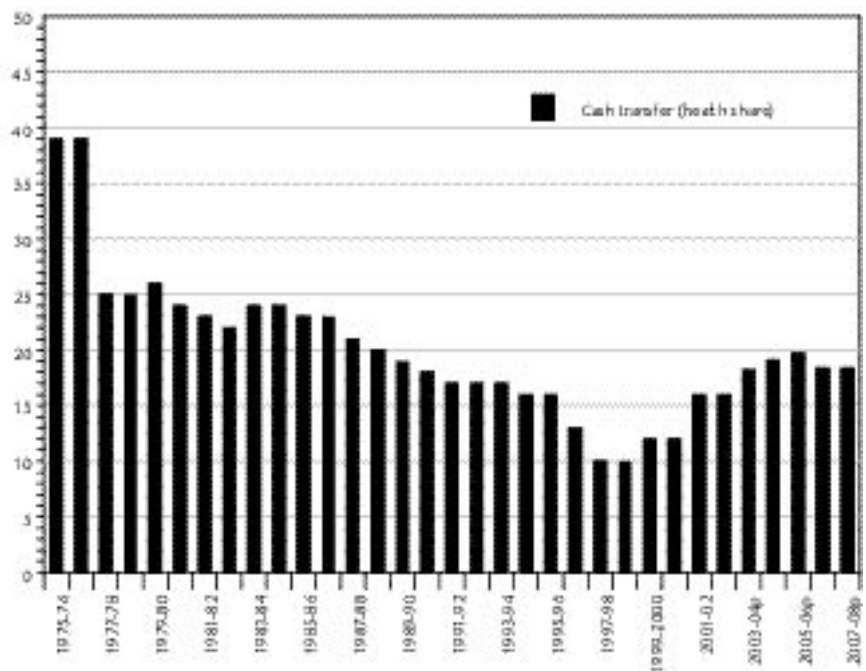
Putting in place a growth formula (i.e., an automatic escalator) is the best way to ensure stable and predictable federal funding while avoiding the pitfalls of cost sharing. The escalator should apply to a comprehensive health transfer and not just to "base funding." The choice of a growth index would also have to be negotiated, but funding could be linked to GDP growth, federal revenues or a composite index of health care costs that cannot be arbitrarily manipulated.

This negotiation process would represent an important opportunity for governments to finally discuss openly the issue of fiscal sustainability. For instance, after the hard-won deficit battle of the 1990s, it would be logical for Ottawa to argue that it

will not commit to increase health transfers at a faster rate than the growth in its revenues. As long as this was the new fiscal deal formally endorsed by all parties, then the provinces would have a clear idea of what to expect and could manage their own budgets accordingly. In fact, this could also become their benchmark for fiscal sustainability. It would then be legitimate and responsible for them to find ways (on both the revenue and the spending sides of the ledger) to respect this constraint and to demand some flexibility from Ottawa in doing so, within certain broadly defined and agreed-to parameters. This type of dialogue would be a lot more conducive to real progress than the sterile debates of recent years as to who best defends the principles of the *Canada Health Act*.

Achieving a new deal on health care will require moving toward a more collaborative form of intergovernmental partnership. The model of federal-

FIGURE 1. FEDERAL COST-SHARING OF PROVINCIAL SPENDING ON HEALTH CARE



Source: Reproduced in part from Armine Yalnizyan, "The Health Care Budget: Did It Resolve the 'Crisis'?", in Charles M. Beach and Thomas A. Wilson (eds.), *The 2003 Federal Budget: Conflicting Tensions* (Kingston: John Deutsch Institute, Queen's University, 2004), p. 243. Projected estimates for 2003-04 to 2007-08 are based on the authors' calculations and include recent health transfer increases announced up to the 2004 federal budget. Provincial spending on health is projected to grow at the average annual rate of growth for 1998-2003 based on CIHI data (7.35%).

provincial fiscal relations that enabled the establishment of medicare decades ago was characterized by tough negotiations but with a determination to reach agreement. Returning to the earlier model or finding an alternative that gives provinces more influence over outcomes is bound to be more constructive than the unilateral stance adopted by Ottawa since the early 1980s.

Canada is not alone in facing growing pressures on its public health care system. Looking at other countries' experiences, two observations stand out. The first is that, based on comparable indicators of health resources (numbers of physicians, nurses, diagnostic equipment, etc.) and outcomes (e.g., life expectancy), Canada is a relatively high spender that has less to show for its investment than many other countries. Second, research shows that there is no silver bullet or ideal health care model that could be imported or emulated to provide a quick fix to the problem. Finding custom-made solutions will require more than tinkering at the margin of the existing structure with a few add-ons. This in turn will call for an environment conducive to experimentation and innovation, something that is most likely to occur in a well-functioning federal system.

**T**he communiqué issued by the premiers following their July meeting listed a series of innovations and reforms taking place in the different regions of the country stressing the variety of solutions being explored and the fact that each province is at a different stage in the process. In this regard, Ottawa has been right in pressing the provinces to undertake meaningful public reporting based on comparable and agreed performance indicators. Indeed, this is the only way for them to compare best practices and for the Canadian public to judge the outcome of their efforts. Yet, to varying degrees, provinces have been dragging their feet on reporting and most Canadians are still waiting to see real improvements "on the ground."

The provinces are the jurisdictions that must be held responsible for implementing needed health care reforms. For them to be successful, however, two changes are needed. First, a new federal-provincial fiscal pact must be achieved and accepted by all parties as a lasting arrangement. For as long as there is a "federal fiscal off-ramp" for the provinces — the possibility of mounting another political campaign demanding that Ottawa pay a larger share of health care costs — they will find it easier to put off making the hard choices and implementing the difficult changes.

Second, if provinces are to be the jurisdiction accountable for results, they must be given the freedom to decide what needs to be done. And this means that the federal government must re-think its recent approach of adding new layers of conditions to its health transfers. Considering that Canada has democratically elected provincial governments that range from strongly market-oriented to social democratic, we should expect that the innovations will differ from one province to another. What *is* needed, however, is federal-provincial agreement on the broad objectives and parameters of health care reform and the common performance indicators required in order to assess whether those objectives are being reached.

In practice, it is our sense that unless this flexibility and capacity to adapt and experiment is provided to the provinces, whatever new fiscal arrangements are reached will not be lasting. That is, if provinces are effectively prevented from undertaking innovations because of the threat of federal fiscal sanctions, they will once again be reluctant signatories and at the first opportunity ignore their commitments. As a federation, we must learn to welcome diversity in the search for solutions to tough problems, not fear it.

In this context it is not clear that the premiers' proposal for a federally run national pharmacare program would lead to better outcomes. It could be an effective way of ensuring uniform standards of coverage across the country

and of shifting some of the anticipated cost pressures (and risks) to the federal government. From an efficiency standpoint, however, there are many reasons why the health care system should be seamless, with one order of government making sure the pieces fit together. Were Ottawa to assume responsibility for a national drug insurance plan, this could open up a new avenue for distortionary cost shifting between governments (e.g., provinces trying to shift drug costs they now cover in hospitals to the federal government), as has happened in the past with other programs such as UI and disability pensions. Moreover, it could have the effect of blurring the lines of accountability even further.

There is much at stake in the upcoming federal-provincial negotiations on health care. And there are legitimate differences of opinion among governments regarding not only the best approaches to health care reform, but also the management of the federation. These differences need to be worked through. This will require considerable effort and persistence. For these reasons, we do not anticipate the mid-September First Ministers' Meeting will in itself result in a lasting fiscal deal on health care — a fix for a generation. The agenda is just too big to allow all the issues to be resolved with that kind of speed. Perhaps what our governments should strive for is a consensus on the basic outline and parameters of an agreement and a clear plan for a series of subsequent meetings, with the express purpose of reaching a genuine and lasting health accord. While not a quick fix, such an outcome would be part and parcel of the return by governments to a style of negotiation that eschews hasty "take it or leave it" ultimatums. The mid-September meeting will signal to Canadians whether our leaders are up to the task.

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