Health care, federalism and the new Social Union

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Abstract

The Social Union framework agreement and the Health Accord provide examples of the close relationship that exists between federalism and the delivery of health care. These recent agreements represent a move from a federal–unilateral style of federalism to a more collaborative model. This shift will potentially affect federal funding for health care, interpretation of the Canada Health Act and the development of new health care initiatives. The primary advantage of the new collaborative model is protection of jurisdictional autonomy. Its primary disadvantages are blurring of accountability and potential for exclusion of the public from decision-making.

Review

Synthèse

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The Canadian Social Union is a term referring to the network of social programs provided by this country and the method by which provincial and federal responsibility for administering them is distributed. The Social Union occupies a central role in the Canadian identity. It "reflects and gives expression to the fundamental values of Canadians — equality, respect for diversity, fairness, individual dignity and responsibility, and mutual aid and our responsibilities for one another."[1] Ottawa and the provinces have been involved in negotiations on the nature of the Social Union, culminating in the signing of the Social Union framework agreement in February 1999. This agreement demonstrated the close relationship between how power is distributed among levels of government in this country and how social programs are delivered. At their core, the Social Union talks were about federalism, specifically what form of federalism is best suited for the delivery of social programs in this country. Health care, as arguably the most popular Canadian social program, played a key role in the outcome of these talks. This article describes the different forms of federalism that have existed in Canada, their relationship to health care, their advantages and disadvantages, and the impact of the Social Union framework agreement on federal–provincial relations.

Forms of federalism that have existed in Canada

Federalism is a method of dividing governmental powers in an attempt to balance the advantages of shared rule with the advantages of regional self-government.[2] Several different forms of federalism have operated in Canadian health and social policy. One system of classifying these is based upon the degree of interdependence between the federal government and the provinces with respect to policy implementation. Interdependence refers to the reliance of one level of government on decisions made at another level. Where interdependence exists, it is further characterized by the degree of hierarchy in the relationship (i.e., how much power one level of government can exert on the other to ensure that its objectives are achieved). Three main forms of federalism have been used by Ottawa: disentangled federalism, federal unilateralism and collaborative federalism. A fourth form of federalism, interprovincial collaboration, has recently been proposed[3] (Table 1).

In a disentangled model of federalism there is very little interdependence between the 2 levels of government. Each level has a clearly defined constitutional role, and each operates within "watertight" compartments. Disentangled federalism was the original form of federalism that operated in health care, because health care was, constitutionally, a provincial domain with little federal involvement.[4,5] In a federal–unilateral model there is considerable interdependence between the levels of government. The relationship is hierarchical, with the federal government having

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the ability to coerce the provinces into administering programs in a certain manner. The development of public hospital and medical insurance represented a move toward a federal–unilateral relationship. The federal government agreed to match provincial spending on these programs dollar for dollar if certain standards were met, a system that created a new interdependence between the two levels of government.[6,7] Ottawa's attachment of conditions to its funding made the relationship hierarchical. In a collaborative model there is interdependence between the 2 levels of government but no coercion on the part of the federal government. Instead, agreements are reached by discussion and consensus. In contrast, there is no interdependence in an interprovincial collaborative model. In this model, provinces work together to arrive at agreements on how programs will be delivered, and the federal government is, to a large extent, excluded.

Since the introduction of national medical insurance in 1966, the relationship between Ottawa and the provinces has remained primarily a federal–unilateral one with some alterations in the degree of hierarchy. The Established Programs Financing Act[8] of 1977 represented a move toward a less hierarchical relationship because it changed the system from a cost-sharing model of funding (in which the federal government matched provincial spending dollar for dollar) to a model in which the federal government provided fixed block grants for health care and education, which were adjusted to growth in gross domestic product. The block grants gave the provinces more freedom in how they could administer health care programs.[8,9] However, the introduction of the Canada Health Act[10] in 1984 represented a return to a more hierarchical relationship, as Ottawa restated the conditions for grants and outlined financial penalties if these conditions were not met.[10,11] The Canada Health and Social Transfer (CHST), established in 1995, further demonstrated the hierarchical nature of the federal–provincial relationship in health care as Ottawa unilaterally reduced transfers by $6 billion while still insisting on compliance with the Canada Health Act.[12,13]

To summarize, health care in Canada has evolved from a decentralized federal model to a federal–unilateral model. However, problems have developed with the current model, primarily related to Ottawa's insistence on national standards as it reduces funding to the provinces. This situation, coupled with provincial demands for more autonomy, primarily in Quebec and the west, has resulted in pressure to re-evaluate the current relationship.

Assessing different forms of federalism in health care

With the introduction of the CHST, Ottawa agreed to consult with the provinces to develop a set of shared principals that would govern the future allocation of CHST funds.[14] The choices being considered were a return to disentangled federalism, a continuation of the current federal–unilateral relationship or development of a new style

Table 1: Assessment of forms of federalism

Disentangled federalism
Example: Health care after Confederation
Definition: Federal and provincial governments work independently with little interaction
Strengths: Jurisdictional autonomy, potential for provincial experimentation
Weaknesses: Difficult to establish national programs and national standards

Interprovincial collaboration
Example: None in health care
Definition: Provinces work collaboratively, with limited federal involvement, to attain policy goals
Strengths: Jurisdictional autonomy, potential for provincial experimentation
Weaknesses: No guarantee of collaboration in absence of federal leadership, absence of national standards

Federal unilateralism
Examples: Hospital and medical insurance, Canada Health Act
Definition: Federal government directs provincial policy, usually through conditional funding
Strengths: Most effective for national programs and associated benefits (economies of scale, reduced overlap and duplication)
Weaknesses: Infringes on jurisdictional autonomy

Collaborative federalism
Example: Social Union framework agreement
Definition: Federal and provincial governments work collaboratively to attain policy goals (no coercion on the part of the federal government).
Strengths: Allows for national programs while protecting jurisdictional autonomy
Weaknesses: Potential for excluding the public, requires effective dispute resolution mechanism, blurs accountability

of relationship: collaborative federalism or the recently proposed interprovincial collaborative model.

Each of the forms of federalism that Ottawa was considering has advantages and disadvantages (Table 1). The original disentangled model provides for jurisdictional autonomy and clear accountability for policy decisions, advantages that allowed for the provincial experimentation that led to hospital and medical insurance. However, this model impeded the formation of national programs and the development of national standards, which required cooperation between the 2 levels of government. The federal–unilateral model is more conducive to the establishment of national programs, as was demonstrated by the introduction of national medical and hospital care. Its major disadvantage is the violation of provincial jurisdiction and the potential animosity that may result. Also, while national programs allow for national standards and have advantages of economy of scale, they do not allow for the experimentation that may occur when there are several different provincial programs.

At the federal level it was believed that collaborative federalism could provide a solution to some of the problems with the federal–unilateral model. Collaborative federalism has the same advantage as the federal–unilateral model in that it allows for the development of national programs. Although national standards would be harder to enforce under a collaborative model, the respect for jurisdictional boundaries would likely result in more intergovernmental cooperation than under a federal–unilateral model. The main difficulty with the collaborative model is reliance upon negotiations between elected officials and the failure to include the public in the process. However, it is important to note that even under the other models of federalism there is limited public involvement in decision-making because of the centralized nature of parliamentary government. Another potential disadvantage of collaborative federalism is lack of accountability and transparency, which is due to the possibility of blaming the other level of government for failures in policy.[15]

The interprovincial collaborative model has recently been proposed as a new model of federalism.[16] This model suggests that Ottawa return social programs to the provinces by providing unconditional funding. The provinces would then enter into agreements among themselves for maintaining standards. There is no guarantee that such agreements would be established, but the argument has been made that Canadians' commitment to these programs would ensure that this aspect of the model would be put into place.[16] There are also concerns about the likelihood of provincial cooperation in the absence of federal leadership.[17]

The Social Union framework agreement

The development of the new Social Union framework agreement represents a partial resolution to the debate at the federal and provincial levels over which form of federalism should be adopted. The objectives of this framework were to develop a set of principles to guide social policy, to develop collaborative approaches to the use of federal spending power, to develop mechanisms for settling disputes, to clarify rules for intergovernmental cooperation, and to clarify roles and responsibilities in health and social policy. With respect to health care, the provinces had initially asked for a return to a more disentangled model of federalism in which they would not have to participate in national health care to receive federal funding, as long as they instituted a similar program. Ottawa, on the other hand, wanted to maintain the current relationship, citing strong public support for the Canada Health Act.

A final agreement was signed by all provinces except Quebec on Feb. 4, 1999. The main components of this agreement that will affect health care are a reaffirmation of the principles of the Canada Health Act, a promise to consult with the provinces and territories 1 year in advance of changes to transfer payments, commitments to work collaboratively with the provinces in the development of new programs and to not introduce new initiatives without the agreement of a majority of the provinces, and a commitment to a collaborative mechanism for resolving disputes.[1] Closely tied to this agreement is the Health Accord, the guarantee on the part of the provinces to adhere to the principles of the Canada Health Act and to use any additional federal funding for health care from CHST transfers for health care programs. In addition, the provinces agreed to make available information on their respective health care systems. Following the announcement of these agreements Ottawa released its 1999 budget, in which it committed to increase health care spending by $11.5 billion over the next 5 years.

Commentary

The Social Union framework agreement signifies a movement toward a more collaborative style of federalism in the field of health care. The main features of this new relationship are the commitment to obtain provincial agreement before introducing new programs and the agreement on a collaborative mechanism for settling disputes. In many ways, however, the relationship remains a federal–unilateral one. There is no guarantee that Ottawa will not reduce transfers in the future, although it will have to announce them 1 year in advance. The provinces still face financial penalties if they fail to adhere to the Canada Health Act. In addition, the federal government will now be more closely monitoring provincial health systems. The provinces appeared willing to compromise on their original demands for increased autonomy in exchange for additional federal transfer payments. Difficulties that may arise from the present relationship include an inability to resolve disputes over reductions in transfers and perceptions at the federal level of provincial violations of the Canada Health Act. In

addition, the nature of the collaborative process appears to exclude both the public and health care providers from the decision-making process.

The framework agreement and the Health Accord can be considered an endorsement of a "national" health care system, with a reaffirmation of national standards and the principles of the Canada Health Act. The main advantage of a movement to a more collaborative relationship is the potential for a break in the impasses that have existed between federal and provincial leaders with respect to the development of new health care initiatives. The first major test for the framework agreement and the Health Accord will be in the development of national pharmacare and home care initiatives. Until now, development of these programs has been impeded by provincial distrust of Ottawa related to reductions in CHST transfers. The provinces are concerned that the federal government would initially agree to share costs in these programs and later reduce its contributions, as it did for medical and hospital insurance. The successful development of these programs will be evidence of whether the new style of federal–provincial interaction has had a constructive effect on the delivery of health services.

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