

An Assessment of the Health Council of Canada

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In December 2003, the federal minister of health announced the setting up of an independent, non-profit organization called the “Health Council.”¹ This new body would be responsible for both monitoring and making annual public reports on the implementation of a health care accord agreed upon by Canada’s first ministers ten months earlier. The council would communicate to the general public through ministers of health at the federal, provincial and territorial levels, and be composed of representatives from both orders of government as well as health care experts and members of the interested public. The operation of the council would be reviewed in the fourth year of its five-year mandate and first ministers would determine the fate of the council on completion of the review. To be successful, the minister said, the council would have to be both independent and objective in the carrying out of its responsibilities.² A few months later, at the end of January, the council held its first set of meetings at which time the immediate intentions of the new body were outlined. The council, as instructed, would follow progress on the implementation of the accord. The accord had made available new funding to the provinces for selected areas in health care, so the job of the council was to ensure in one way or another that these monies were spent appropriately. The chair of the council, a respected observer of the Canadian health care system, also said that the council would produce a comprehensive annual report on health care and release interim reports on key health care issues. The chair added that the council would also try to determine the “best practices” in the process of health care

¹ The new structure is often called the “Health Council of Canada,” but in publications of the federal government it is referred to as the “Health Council.” The exclusion of “Canada” may just be an oversight or a desire to ensure that the council is not seen as an agency of the federal government.

² Health Canada, “Framework for Health Council”, December 2003. Available at www.hc-sc.gc.ca/english/media/releases/2003/2003_97bk1.htm.

renewal and note areas where improvements might be made.³ In the following March, the council held its second set of meetings. At these meetings, the council began addressing the priority areas outlined in the accord, which included home care, catastrophic drug coverage, human health resources, and primary health care. To facilitate this work, members of the council were assigned to various working groups for the purpose of laying out detailed plans. The chair of the council also made it clear that the first priority of the council would be to focus on waiting times for medically-required care, and had arranged for the council to hear a talk on how the British health system tackled the waiting problem.⁴

At first glance, the Health Council appears as a welcome development in the ongoing attempt to correct problems in the Canadian health care system. The council seeks to ensure that important new funding for health care is directed to those areas that have been designated as key to ensuring that Canadians have timely access to the best possible care. It also attempts, through its reports, to provide the Canadian public with a better understanding of the operation of medicare, an important objective in light of the increasing demand for greater accountability in political life. The fact that the council has already had two sets of meetings indicates a body eager to carry on with its assigned task, and its focus on waiting doubtlessly resonates with many users of the Canadian health care system. Yet, notwithstanding all of these seemingly positive aspects of the council, there are questions about this new entity. The council promises to provide annual reports on the Canadian health care system, yet already such reports appear to be

³ Canada News Wire, "New Health Council Sets Direction and Organization," 30 January 2004. Available at www.newswire.ca/en/releases/archive/January2004...

⁴ Canada News Wire, "Health Council Sets Priorities on Accord Themes," 26 March 2004. Available at www.newswire.ca/en/releases/archive/March2004...

available to Canadians and additional work could be done to meet the demands of the 2003 accord for information on additional indicators. Supporters of the council might counter that reports of the council will be different because of the focus on policy implications, but again a plausible response is possible: there is a great deal of policy advice already available and adjustments could easily be made to make this advice more sensitive to short-run interests of governments. The council thus might seem redundant and an unnecessary administrative complication in a country already replete with health-care research and policy units. A further concern is the claim of the council to provide a disinterested view on health care reforms contained in the 2003 accord. As will be shown, the impetus for the council rests partly in the belief that the intergovernmental process affecting health care has become too politicized, making it difficult to discover the truths about the efficacy of proposed reforms and the overall operation of medicare. But there are real differences over the most appropriate changes for the Canadian health care system and the conflict represents in part a reflection of honest disagreements about health care in Canada. Ironically, an attempt to ‘de-politicize’ health care may do the opposite and endeavor to speak truths where few exist. The most important question is one that addresses the impact of the council on federal-provincial relations. The governments of Quebec and Alberta have refused to participate directly in the activities of the Health Council, a development which suggests that the council offends some sensibilities in the area of federal-provincial relations and health care. Key to fixing the problems with medicare will be workable relations between the two orders of government, so any action which may produce friction between Ottawa and the provinces requires our attention.

Path to the Council

The immediate origins of the Health Council lie in the publication, in late 2002, of two reports on the Canadian health care system.⁵ In October, the Senate Standing Committee on Social Affairs, Science and Technology released the final volume of its extensive examination of health services in Canada. The Senate committee observed, among other things, that many were unhappy with how the two orders of government were handling health care in the country. “Canadians are tired of the endless finger-pointing and blame-shifting that have been recurring features of intergovernmental relations in the health care field,” read the report.⁶ With this situation, Canadians were without “access to a reliable and non-partisan assessment of the true state of the health care system.”⁷ In light of this analysis, the Senate committee recommended the establishment of an independent and permanent body that would report annually to the Canadian people on the both the condition of medicare and the health status of residents in Canada. It would also advise the federal government on the allocation of new funds to health care. A month later, the Commission on the Future of Health Care in Canada, which the federal government has set up in April 2001, released its final report. In the report, the Commission, like the Senate, felt that relations between the two orders of government fell well short of what was required to deal with the challenges of health care reform. It conceded that disagreement and conflict can result in outcomes that serve the interests of the country, but such was not the case now:

⁵ As will be argued later, the Health Council is part of the continuing federal-provincial relationship relating to fiscal transfers and health care – in other words, the council is rooted in developments that began with the introduction of medicare and the accompanying fiscal arrangements.

⁶ Senate of Canada, Standing Committee on Social Affairs, Science, and Technology, *The Health of Canadians – The Federal Role: Volume Six: Recommendations for Reform*, 12. Available at www.parl.gc.ca.

⁷ *Ibid.*, 11.

The current intergovernmental mechanisms for addressing health issues have become increasingly dysfunctional and characterized by fractious debate between federal and provincial and territorial governments over who is responsible for what and whether each party is paying its fair share.⁸

The Commission recommended the establishment of a structure called the “Health Council of Canada” that would serve to limit the political bickering over health care and “provide a foundation for a more constructive and innovative partnership” between the two orders of government.⁹ Initially, the proposed council, which would be a creation of federal, provincial and territorial governments, would set out common health care indicators and measure the performance of health care plans. It would also establish performance benchmarks and report on activities directed towards improving access, quality of care, and outcomes of health care systems. In this first stage, the proposed council would essentially provide a good picture of how well medicare was performing and suggest areas for improvement. In the long term, the council would move beyond data collection and analysis and “provide ongoing advice and co-ordination in transforming primary health care, developing national strategies for Canada’s health workforce, and resolving disputes under a modernized *Canada Health Act*.”¹⁰ In effect, the council would attempt to insert itself in the central decision-making processes affecting health care. “Ultimately, the Council should be a collaborative mechanism that can drive reform and speed up the modernization of the health care system,” wrote the

⁸ Commission on the Future of Health Care in Canada, *Building on Values: The Future of Health Care in Canada – Final Report, November 2002*, 47.

⁹ *Ibid.*

¹⁰ *Ibid.*, 53.

author of the report, “by ‘de-politicizing’ and streamlining some aspects of the existing intergovernmental process.”¹¹

In February 2003, two months after the release of the Commission report, the first ministers met to discuss health care. The two reports, especially the work of the more high-profile commission, had an effect at the meeting. Both reports had urged additional spending on health care, and the first ministers agreed that an additional \$34.8 billion would be transferred from Ottawa to the provinces over the next five years. Much of the new money would be targeted for primary health care, home care, and catastrophic drug coverage. Additional money would be allocated to a Diagnostic/Medical Equipment Fund to help improve access to diagnostic services, and other funds would be used to facilitate greater progress towards development of electronic health records. Additional priorities in the areas of human health resources, technology assessment, research, and health promotion would also receive some support. To assist in the carrying out of the provisions of the agreement and also to ensure that Canadians have a more direct role in the reform process, the accord included a section that provided for a national health council. The council, composed of representatives of government, the public, and the health care community, would make available reports to the public on the implementation of the accord, with special attention being paid to the “accountability and transparency” sections of the accord.¹² To some extent, the proposed council fell short of the recommendations of the Senate Committee and the Commission on the Future of Health Care in Canada. Both saw the council assuming a larger role in the provision of advice in relation to the reforming of the health care system. The council of the First Ministers

¹¹ Ibid., 55.

¹² Canadian Intergovernmental Conference Secretariat, *2003 First Ministers’ Accord on Health Care Renewal*, February 5, 2003, 8.

appeared to be restricted to a reporting role. However, the emphasis on ‘accountability,’ which referred largely to the degree to which the provinces targeted the new monies in the designated way, seemingly provided the council with an opportunity to comment on progress in changing medicare. In other words, the provisions in the accord presented some openings for the newly formed body.

In the accord, the First Ministers directed that the new Health Council be in operation within the space of three months. During this period, the orders of government would confirm the mandate of the council and determine its basic structure and operational processes. But the proposed council ran into trouble. Indeed, even before the first ministers meeting, reservations had been expressed about a health council. Some of the premiers feared that such a council would result in more bureaucracy, and they also complained of a new accountability mechanism that would track the spending of new monies by provinces.¹³ Moreover, Quebec had already indicated it would not be a part of the council; it would have its own health council (though admittedly it would try to work in tandem with the Health Council). These and other concerns continued to be expressed after the meeting of the first ministers. One of the other concerns was that the difficulty of securing reform even with new money. The assumption underlying the Health Council seemed to be that careful monitoring of new funds would almost guarantee the stipulated changes. But some of the most significant players in the health care system were opposed to the reforms. Primary health reform, for instance, required physicians to make fundamental adjustments in the organization of their practices; not surprisingly, some physicians resisted this change. Advocates of the council championed the new agency on

¹³ Robert Fife, “Premiers Want Cash Without Any Strings,” *National Post*, 28 January 2003, A6; John Ibbitson, “Ottawa Insists on Medicare Monitor,” *Globe and Mail*, 30 January 2003, A1.

the grounds that it would address the “intellectual and imaginative shortfall” in the making of health policy,¹⁴ but the problems with resistant health professions suggested that the greater shortfall was one of political power.¹⁵ An additional concern was that the council, with its emphasis on indicators and performance measures, amounted to a “command and control” system that took little heed of differences in the provincial and territorial health plans: “...Ottawa is forcing the provinces to accept centralized outcomes and establishing a dangerous precedent by federalizing health-care delivery.”¹⁶

Those designing the new health council failed to meet the May deadline, and there were signs that council was even in greater trouble than at the time of its proposal three months earlier. To be sure, there had been some progress – a preliminary framework for the council had been agreed upon in early June – but large obstacles were looming on the horizon. The premiers were unhappy with the amount of new federal funding under the 2003 accord and pressed Ottawa for more funding (about \$3 billion more over the next two years). If this not was forthcoming, then the premiers might be unable to find agreement on the council. The federal response to the SARS and ‘Mad Cow’ events also angered the affected provinces – more financial support should have been made available.¹⁷ Problems with the proposed council itself also continued to plague planning for the new body. At the annual premiers conference in July, the premiers almost split over the council. Provinces such as Saskatchewan and Manitoba supported the council

¹⁴ Allan Sniderman and Gerard Veilleux, “Therapy for What Ails Us,” *Globe and Mail*, 31 January 2003, A13.

¹⁵ John Ibbitson, “Federalizing Health Care on the Cheap,” *Globe and Mail*, 6 February 2003, Online edition.

¹⁶ *Ibid.*

¹⁷ Brian Laghi, “Health Council Delayed Due to SARS, Mad Cow,” *Globe and Mail*, 12 June 2003.

on the grounds that it could identify the best practices and contribute to a better health care system in Canada; other provinces, primarily Alberta and to a lesser extent Ontario, felt that the council represented a serious intrusion into an area of provincial jurisdiction.¹⁸ In particular, these latter provinces feared that the council would be used to deny funding to provinces that allowed practices which Ottawa disliked (e.g. greater private participation in the delivery of health care).¹⁹ In the end, the premiers agreed to continue their support for the council while noting that more work was needed to ensure that the council was “affordable, with an appropriate mandate and non bureaucratic in nature.”²⁰ The premiers also stated that they were willing to discuss the council with the new prime minister – suggesting that the provinces might wait until the departure of Prime Minister Chretien in order to get a better deal from the new power-holders in Ottawa. Interestingly, at this point the premiers also put forward the proposal for a “Council of the Federation.”²¹ Though not directly related to the discussions over health care and the health council, the proposed Council of the Federation emphasized the ability of provinces to use inter-provincial agreements to secure national programs. The Health Council was based on the notion that only national institutions are capable of effecting national programs, but the new provincial body suggested otherwise.

In August, the federal minister of health expressed her frustration with the failure to set up the health council and urged the provinces to meet their promise to support the

¹⁸ Murray Campbell, “Summit Wraps Up on Familiar Note,” *Globe and Mail*, 12 July 2003, A8; John Ivison, “Eves, Klein Hold Noses on Health Council,” *National Post*, 12 July 2003, A4.

¹⁹ Richard Foot, “Premiers Unity Crumbles on Health Care,” *National Post*, 12 July 2003, A1, A4.

²⁰ Canadian Intergovernmental Conference Secretariat, “Health Care Remains Premiers’ Number One Priority,” *News Release* 11 July 2003. Available at www.scics.gc.ca/info03/850092016_e.html.

²¹ Canadian Intergovernmental Conference Secretariat, “Premiers Announce Plan to Build a New Era of Constructive and Cooperative Federalism,” *News Release*, 10 July 2003, Available at www.scics.gc.ca/info03/850092006_e.html; Murray Campbell, “Premiers Council Gets a Boost, But Will It Fly?” *Globe and Mail*, 12 July 2003, A8.

council. At the same time, there were reports that the prime minister wanted the council in place before he left office, which was expected to take place in early 2004; more important, he was willing to implement the body without the support of all the provinces and territories.²² A month later, at the meeting of the health ministers, the federal health minister succeeded in getting agreement from her provincial counterparts to start the process of nominating members to the council; but this was still no guarantee that the council itself would receive the approval of all provinces.²³ A few weeks later, the federal minister of health announced agreement on a 27 member Health Council of Canada, with 13 spots reserved for government representatives and another 13 for those from outside government. The chair of the council would be the final member. Though gladdened by signs of agreement, supporters of the council lamented the large size of the council – they had wished for something half this size. They also feared for the independence of the council in light of the fact that all members would be nominees of one government or another.²⁴

In spite of the ministerial announcement, the deal was not done quite yet. Some of the provinces still resisted a final agreement and hoped for something more from the soon-to-be prime minister of Canada. In November, the premiers met with Mr. Martin, and out of these discussions seemingly emerged a consensus on the Health Council (with the understanding Quebec would have its own council). But it was not to be. The premier of Alberta denied any agreement and said that the council had to be specifically limited to monitoring provincial spending of new federal funds on the three major areas outlined in

²² Mark Kennedy, "Health Council Needed Now," *National Post*, 14 August 2003, A4.

²³ Brian Laghi, "Ministers Take Step Toward Health Council," *Globe and Mail*, 5 September 2003, A6.

²⁴ Dennis Bueckert, "Ottawa, Provinces Agree on National Health Council," *London Free Press*, 26 September 2003, A5.

the 2003 accord (primary health care, home care, catastrophic drug insurance). The premier still felt that the council, if not properly restricted, would inevitably attempt to tell provinces how to run their health plans. He added, almost incidentally, that “the average Canadian doesn’t know, nor does he or she care, about a health council.”²⁵ What they do care about, he said, was their hip replacement or cancer treatment.

By now, the federal minister of health had lost her patience with the premier of Alberta. Ottawa and the other provinces (save Quebec) would proceed with a health council for Canada: “We understand [the] premier’s concerns, but the rest of us feel it is time to move forward.”²⁶ A few weeks later, in early December, she released details on the structure and operation of the Health Council:

- The mandate of the council would revolve around the First Ministers’ Accord of 2003. The council would monitor the carrying out of the accord, especially in relation to the accountability and transparency elements of the agreement. The council would also produce annual reports on the implementation of the accord. In pursuing its mandate, the council would rely on government reports, federal-provincial advisory bodies, and health information agencies.
- The council would report to Canadians through the federal, provincial, and territorial ministers of health. The latter would be given notice of the intent of the council’s intent to release a public report and would be offered an opportunity to provide comments on the report before being issued. The council, however, would be “responsible for determining the content of its final reports.”²⁷
- The council would consist of 27 members. Thirteen members would be from each of the relevant government jurisdictions (excluding Quebec) and another thirteen would be either health care experts or representatives of the interested public. The final member would be chair of the council. Each jurisdiction would be responsible for naming its representative and putting forward nominees for the

²⁵ Jim Brown and Dennis Bueckert, “Health Council to Go Ahead Without Albertra,” CNEWS Canada. Available at <http://cnews.ca/CNEWS/Canada/2003/11/19/262...>

²⁶ Canadian Press, “Feds to Move Ahead on Health Council,” *London Free Press*, 20 November 2003, A8.

²⁷ “Framework for Health Council,” Health Canada, December 2003. Available at www.hc-sc.gc.ca/english/media/releases/2003/2003_97bk1.htm

expert/public positions on the council. A nominating committee composed of federal, provincial, and territorial ministers of health would select the 13 expert/public members; all ministers of health would participate in the selection of the chair. All 27 members would serve on a part-time basis, and a full-time staff would support council members.

- The council would be set up as a non-profit corporation and its members would be the federal, provincial and territorial ministers of health. The federal government would be responsible for the funding of the council. The council would be assessed in the fourth year of its five-year mandate and first ministers would decide the future role of the council with the completion of the assessment.
- Both Quebec and Alberta would not participate in the activities of the council, but the council would “collaborate with Quebec’s Council on Health and Welfare.”²⁸

Questions

The establishment of the Health Council elicits a number of queries about the new organization. Of course, it is too early to determine whether the council will contribute to the attempt to provide for better health care in Canada; but it is not too early to address some of the questions that emerge in an examination of the council’s terms of reference and the process that led to its creation. Some of the questions are minor and deal mostly with the internal operations and structure of the council. The size of the council seems too large – many believe that council membership should be limited to about 15.²⁹ The appointment process, which relies on the actions of government ministers, appears to conflict with the desire for a truly independent body,³⁰ and the same sentiment arises when it is appreciated that ministers of health are given an opportunity to comment on

²⁸ Ibid.

²⁹ See, for example, the summary of proposed models for the Health Council in *Report of the Invitational Workshop on a Health Council*, Faculty of Law, University Toronto, March 21, 2003.

³⁰ The Canadian Health Council, a group dedicated to maintaining the principles of medicare, has expressed this concern. See Dennis Bueckert, “Ottawa, Provinces Agree to National Health Council,” *London Free Press*, 26 September 2003, A5.

council reports before their publication. Even the first meetings of the council may lead to some uneasiness, for the focus on waiting times mirrors the priority of the new government of Paul Martin.³¹ But for the most part these are minor concerns. There are, however, those which require greater consideration.

One of the larger questions deals with the need for a new agency to provide reports on the performance and spending of provincial health plans. Currently, there exist a number of bodies at the national (e.g. Canadian Institute for Health Information) and provincial levels (e.g., Institute for Clinical Evaluative Sciences in Ontario), and in the universities (e.g., Manitoba Centre for Health Policy, Centre for Health Economics and Policy Analysis at McMaster) which spend a great deal of time examining the Canadian health care system. It might be argued that one of these bodies or perhaps a combination of them would be able to carry out the reporting duties of the Health Council. Supporters of the council doubtless would counter that these bodies are involved largely with data collection and that what is required is a structure which analyses the data and offers policy advice; indeed the terms of reference for the council imply this by directing the council to work closely with the Canadian Institute for Health Information (CIHI) – presumably, the latter would provide the data, the former would do the analysis. But it is difficult to make a distinction between the collection and analysis of data, and often research bodies do both. For instance, the work of CIHI includes an appreciation of the policy implication of its findings,³² and other national research bodies

³¹ The chair of the Health Council himself has observed that the council and the prime minister are one on the need to address waiting times. See Dennis Bueckert, “Medical Waits Likely to Top Agenda for New National Health Council.” Available at www.canada.com/components/printstory/printstory.asp?id=6a.

³² Interestingly, CIHI was once considered for a council-like role in early 1999 when Ottawa was about to reverse its past practices of reducing health care transfers and make available new monies to the provinces. See Mark Kennedy, “Watchdog for Health May Emerge from Closed-Door Talks,” *National Post* 25 January 1999, A4.

address health policy issues.³³ The same combining of data collection and analysis can be found in research bodies at the provincial level and in the universities.

Also relevant to the question of the need for a new body is the “Comparable Health Indicators” project. In September 2000, the first ministers agreed on the desirability of a common set of indicators which could be used to measure health outcomes, the quality of health services, and the health status of residents in all provinces and territories. In response to this directive, the country’s health ministers established the Performance Indicators Reporting Committee whose purpose is “to develop and drive the overall process to achieve agreement on comparable reporting by federal, provincial, and territorial governments.”³⁴ The committee has achieved some success and the result has been the publication of performance reports by all jurisdictions using comparable indicators. Some believe that the reports have little value³⁵, and inherent in the argument for the Health Council appears to be the belief that the performance reports fail to inform Canadians about the operation of their health care system. Yet, the reports offer a great deal of information on measures which many believe are important to assessing the effectiveness of a health care system (e.g. infant mortality rates, self-reported health measures, changes in life-expectancy for various illnesses, and wait times for key diagnostic and treatment services), and the length of the reports (often over 100 pages) is probably more than enough for any interested citizen.³⁶ Interestingly, the 2003 accord mentions these reports and urges work on comparable indicators to include additional

³³ For instance, the Canadian Health Services Research Foundation has a publication series (called “Mythbusters”) tackling most of the most interesting issues in health care, and the authors are not afraid to offer policy advice on these issues. Available at http://www.chsrf.ca/mythbusters/index_e.php

³⁴ Canadian Institute of Health Information, “Performance Indicators Reporting Committee General Briefing Notes,” 1. Available at <http://secure.cihiweb>.

³⁵ See, for example, Editorial, “A National Health Council Whose Time Has Arrived,” *Globe and Mail*, 1 February 2003, A18.

³⁶ The reports are available at http://secure.cihi.ca/cihiweb/dispPage.jsp?cw_page=pirc_e

measures relating directly to areas targeted for funding. This suggests that the performance indicators project could help ensure the faithful implementation of the accord and ensure that Canadians are properly informed of the workings of the Canadian health care system. But in the next paragraph the accord states that a new agency is needed to report on the carrying out of the accord.

For a final consideration in relation to the question of the need for the Health Council, it is possible that provinces will follow Quebec's lead and set up their own health councils. In the case of Quebec, the intention is for its agency to "collaborate" with the Health Council³⁷, but clearly Quebec will be more autonomous in its relations with the council than the other provinces and territories. The other provinces may eventually find this arrangement attractive and elect to set up a body parallel to the Health Council. If this comes to fruition, the need for the national body may be put into question. Already, Ontario has drafted legislation that provides for the establishment of the "Ontario Health Quality Council." Members of the council will include representatives from government, the public, and the health policy community, and its purpose will be "to monitor and report to the people of Ontario" on the performance of the Ontario health care system and "to support continuous quality improvement."³⁸ The new Ontario council appears as an echo of its counterpart at the national level, which effectively places Ontario in the same position as Quebec in its relation to the Health Council.

A second question arises from the claim that the council represents an opportunity to provide disinterested advice on health care reform. A major argument of the

³⁷ Health Canada, "Framework for Health Council," December 2003.

³⁸ Legislative Assembly of Ontario, Bill 8 2003. Available at www.ontla.on.ca/38_Parliament/Session1/b008_e.htm

Commission on the Future of Health Care in Canada for a health council had been the politicization of the debate on health care and the consequent need for an “effective and impartial mechanism for the collection and analysis of data on the performance of the health care system.”³⁹ The chair of the Health Council also emphasizes this point and promises that the council can “be a trusted source of policy advice outside the field of intergovernmental conflict.”⁴⁰ But this emphasis on impartiality and trust appears to assume that there are certain truths about health care reforms and that the council will be able to convey these truths. Yet some of the aforementioned conflict stems from valid differences of opinion about the desired direction of health care reform. The chair of the council claims, for example, that there is much agreement among reformers on the value of primary health care services,⁴¹ yet differences over the value of primary care can arise. In Ontario, primary care reform relies on a near collaborative relationship between family physicians and nurse practitioners, but studies reveal some difficulties in establishing this essential relationship. Many GPs in Ontario are either uninterested or uncertain about working with nurses who provide some services typically associated with medical doctors, and evaluations of pilot projects reveal the challenges of incorporating providers other than physicians into primary care centers.⁴² The fact that some of the resistance to

³⁹ Commission on the Future of Health Care in Canada, *Building on Values: The Future of Health Care in Canada*, 54

⁴⁰ Greg Bonnell, “Michael Decter Named Head of Health Council; Alberta’s Seat Remains Vacant.” 9 December 2003. Available at http://mediresource.sympatico.ca/health_new_detail.as...

⁴¹ Dennis Bueckert, “Medical Waits Likely to Top Agenda for New National Council,” Canada.comNews, 26 January 2004. Available at www.canada.com/components/printstory/printstory.asp?id=6a

⁴² See Ontario Ministry of Health and Long Term Care, *Report on the Integration of Primary Health Care Nurse Practitioners into the Province of Ontario*, June 2003. Available at www.health.gov.on.ca/english/public/pub/ministry_reports/nurseprac03/nurseprac03_mn.html; Ontario Ministry of Health and Long Term Care, *Evaluation of Primary Care Reform Pilots in Ontario, Phase 2 – Final Report, October 31, 2001*. Available at http://www.ontariofamilyhealthnetwork.gov.on.ca/english/pilot/summary_2.html

primary health care may be political in nature – physicians want to maintain present forms of practice – does not detract from the reality that primary health care reform is not uniformly embraced. There is also disagreement about some of the other reforms as well – a catastrophic drug plan may or may not be affordable, health prevention services may or may not be effective, home care may or may not substitute for other more expensive forms of care.⁴³ And then we come to the matter of user fees and private suppliers of health care services. The orientation of the Health Council is towards the provision of advice necessary to sustain the present structure of medicare, which tends to rule out greater private sector participation in the publicly funded health care system and appears to do the same for direct patient fees. There is a great deal of research to support this stance, yet there are also studies that paint a different picture.⁴⁴ Moreover, some provincial governments are electing to use more private parties in the provision of health care services.⁴⁵ Interestingly, this difference of opinion was captured in statements made by the present federal minister of health, who one day late last April conceded that greater private participation in medicare might work and then the next day offered a contrary opinion (a change of mind that admittedly also reflected political pressure).⁴⁶ Clearly, then, there appear to be differences over the value of private sector involvement

⁴³ For example, The Canada Health Services Research Foundation has produced a short paper in its “Mythbusters” series which reveals uncertainties about the cost-effectiveness of health prevention. Available at http://www.chsrf.ca/mythbusters/index_e.php

⁴⁴ For the debate on this issue, see Robert Evans et al., *Private Highway, One-Way Street: The Decline and Fall of Canadian Medicare?* Available at chspr.ubc.ca; Robert G. Evans, Morris L. Barer, and Greg L. Stoddart, “User Fees for Health Care: Why a Bad Idea Keeps Coming Back (Or, What’s Health Got to Do With It?),” *Canadian Journal of Aging* 14:2 (1995); David Gratzer, *Code Blue: Reviving Canada’s Health Care System* (Toronto: ECW Press, 1999), and Nadeem Esmail and Michael Walker, *How Good is Canadian Health Care? 2004 Report* (Vancouver: The Fraser Institute, 2004)

⁴⁵ A good case study here is the new McGuinty government of Ontario. It promised to end privatization in the Ontario health care system, but now finds itself dependent on private suppliers of diagnostic testing. See April Lindgren, “Ontario Re-Considers Private-Clinic Closure,” *National Post* 29 April 2004, A4.

⁴⁶ Campbell Clark and Brian Laghi, “Pettigrew Clarifies Health-Care Statements,” *Globe and Mail*, 29 April 2004, A4.

in medicare, and it may seem inappropriate to rely on a body inclined to one of the positions in the debate to provide ‘trusted advice’ on this matter.⁴⁷ There is also the issue of governments committed to these practices in principle. Even if research conclusively shows that user fees and private providers fail to improve the functioning of health care systems, it may be that certain public authorities will want to proceed with them because of an ideological predisposition towards smaller government. No amount of impartial or trusted advice can be used to prove a value wrong, yet some fear that the orientation of the Health Council will lead to an attempt to accomplish this end. The refusal of Alberta to become a member of the council appears to stem in part from this fear.

A final question – the most important of the three – concerns the effect of the council on intergovernmental relations and the federal-provincial fiscal arrangements for health care. In some minds, the council is consistent with what some call “collaborative federalism,” a term which refers in most cases to the view of “Canada as a partnership between two equal, autonomous and interdependent orders of government that jointly decide national policy.”⁴⁸ Through its membership and its mandate, the council tries to capture the essence of collaborative federalism and make the health care system a product of both federal and provincial efforts (and others). Certainly, the Senate report and the study of the Commission on the Future of Health Care saw the council this way, and the federal government and some of the provinces see it similarly.⁴⁹ But the refusal of

⁴⁷ This difference also appears to be evident in polling done on attitudes about medicare and its privatization. See Matthew Mendelsohn, *Canadians’ Thoughts on Their Health Care System: Preserving the Canadian Model Through Innovation*, June 2002. Report for the Commission on the Future of Health Care in Canada.

⁴⁸ David Cameron and Richard Simeon, “Intergovernmental Relations in Canada: The Emergence of Collaborative Federalism,” *Publius: The Journal of Federalism*, 33:2 (Spring 2002), 49

⁴⁹ A related sentiment is that the council is not really a partnership of governments but rather is a “national body” reporting to Canadians. See Michael Decter, “The Health Council of Canada: A Speculation on a Constructive Agenda,” *Hospital Quarterly* 6:4 (2003), 30.

Alberta and Quebec to sit on the health council suggests the need for a closer look at the implications of the council for federalism.

As shown earlier, the proponents of the council view it as a kind of antidote to the dysfunctional nature of intergovernmental relations in health care. The past years have allegedly seen nothing but conflict and disagreement when it comes to dealing with medicare. But another picture of relations in health care is possible. In 1995, the federal government made severe cuts to intergovernmental transfers largely directed at health care, an action that helped reduce the federal deficit but also damaged the legitimacy of Ottawa in the making of health policy (and in fact this process had started with smaller cuts to transfers in years preceding 1995). Accordingly, the role of the federal government in health care diminished and the provinces assumed greater control over health, and inter-provincial relations also took on more importance. But the weak fiscal position of the federal government soon disappeared and by the turn of the century Ottawa found itself able to play a greater role in health care. In 1999, the federal government made available new monies to the provinces and did the same thing a year later. However, the provinces were essentially left with the job of allocating most of the new federal funding.⁵⁰ In the 2003 accord, the federal government again made available new monies, but this time specified more explicitly where it would like the money spent. Equally important, it stipulated that a new mechanism, a health council, be established to monitor the implementation of the provisions of the accord. Notwithstanding the near

⁵⁰ Admittedly, promises were made in 1999 to spend all new federal money on health care and not on non-health areas, and a few targeted funds were set in the 2000 accord. For details on the 1999 increase, see Department of Finance, *The Budget Plan 1999* (Ottawa: Her Majesty the Queen in Right of Canada, 1999), ch. 4. For the 2000 accord, see Canadian Intergovernmental Conference Secretariat, *First Ministers' Meeting: Communique on Health*, September 11, 2000. Available at www.scics.gc.ca/cinfo00/8000380004_e.html.

unanimous provincial acceptance of the council, the new funding and the council can be seen as a rejection of collaborative federalism and the emergence of what some call “unilateral federalism.”⁵¹ Under this type of federalism, the federal government uses both old and new devices – money, accountability mechanisms, and new structures and programs – to assert greater leadership in various fields of social policy. In the area of health care, it has set up a new structure, the Health Council, to help ensure that the health objectives of the federal government are met through successfully targeted new funding. As with most unilateral attempts to assume more control, it will most likely generate resistance. Already, Alberta and Quebec have served notice with their rejection of the Health Council that they will oppose the federal government. History suggests that other provinces, especially more powerful ones (Ontario, BC) will not be far behind. Ultimately, the council may encourage the very thing it was meant to reduce, namely federal-provincial conflict.

Some may, of course, object to this reading of federal-provincial relations in health care.⁵² They may see the council as a helpful addition to the attempt on the part of all governments to fix medicare, or they may think that they can dissociate the council from the larger discussion about the character of federal-provincial relations and accompanying fiscal arrangements. Before he became chair of the council, Michael Decter wrote that the council would “need to leave the grand debates of ideology to others and focus on the practical challenge of getting Canadians the health care they need

⁵¹ See Gerard Boismenu and Peter Graefe, “A New Federal Tool Belt: Attempts to ReBuild Social Policy Leadership,” *Canadian Public Policy – Analyse de Politiques*, 30:1 (2004).

⁵² See, for example, Gregory P. Marchildon, *Three Choices for the Future of Medicare* (Ottawa: Caledon Institute of Social Policy, April 2004).

and want.”⁵³ But the chair surely must realize how central targeted funds and the council are to the ‘grand debates’ about the formulation of health policy in this country. In 1977, the federal government and the provinces agreed to replace cost-sharing funding for health care and postsecondary education with block grants, a change that made it more difficult for Ottawa to control how its money would be spent (but would give it more control over its spending). Seven years later, it introduced the *Canada Health Act* with the hope of giving greater ‘conditionality’ to federal funding for health care. But the generality of the conditions – the five principles or criteria of medicare – made it difficult for the federal government to achieve its aims, so eventually it needed something more precise (but only after dealing with its fiscal problem). Returning to the old cost-sharing mechanism was out of the question – it had already been rejected years earlier, plus both orders of government found little favor with it. Moreover, Ottawa could hardly re-direct expenditure of existing federal funds by the provinces, but it could gain control of use of new transfers. What might work was targeted funding – the federal government could withhold new monies unless they were spent in specified areas. But what was needed was an enforcement mechanism. In earlier days, cost sharing with its auditing of provincial books to ensure eligibility for federal funding had been the mechanism of enforcement. Now, it would be up to a council to monitor the spending of the provinces and territories. As Boismenu and Graefe say, the old cost-sharing mechanism had lost its support and new devices had to be found to provide for federal leadership:

⁵³ Decter, “The Health Council of Canada,” 30.

... the federal government has had to impose much more subtle controls on the provinces in exchange for new federal money. The vocabulary now centres on 'reporting' and having provinces submit reports on where money is spent, and on mutually agreed upon performance measures.⁵⁴

Though the authors are not explicitly referring to the health council and the 2003 accord, it captures the dynamics of present relations between the two orders of government in the area of health care.⁵⁵

Even if the council sours relations between Ottawa and the provinces, the new body may still seem warranted if it achieves positive effects. But it has already been suggested that are enough existing entities to do one aspect of the council's job, which is to develop performance measures and report on the state of the Canadian health care system. As for the monitoring of provincial spending and progress on targeted reforms, there is reason to believe that the benefits will not be worth the conflict. The 2003 accord wants the provinces to spend new federal funds on specified areas, but already the provinces are concentrating on many of these areas. At the first ministers meeting which led to the 2003 accord, the premiers presented a draft accord. The federal government rejected the draft, but it contained suggestions for reform that resembled many of those in the agreed-upon accord.⁵⁶ Moreover, the council and the accord commit the same error which helped precipitate the demise of the cost-sharing arrangements: they assume that the provincial and territorial health plans are basically the same and hence should receive the same treatment. As suggested above, many of the provinces are moving in the same

⁵⁴ Boismenu and Graefe, "A New Federal Tool Belt: Attempts to ReBuild Social Policy Leadership," 77.

⁵⁵ Where Boismenu and Graefe may be wrong is suggesting clear differences between old and new devices of federal control. Morris Barer, a respected expert in health care, states that the council "has to be similar to an audit office," which would make the council quite similar to practices under the old cost-sharing arrangements. See Gloria Galloway, "Health Council Shrinking From Romanow's Concept," *Globe and Mail*, 12 July 2003, A8.

⁵⁶ Premiers Council on Canadian Health Awareness, *Improving Health Care to Canadians*, February 3, 2003. Available at www.premiersforhealth.ca.

direction with health reform, but there are differences that record varying preferences at the provincial and territorial level. But the council and the targeted funding appear to ignore this reality and in so doing slight the federal nature of the country and the desire to allow for some differentiation.

Conclusion

The Health Council is an ambitious attempt to help put health care renewal in Canada on the right track. Also, its aim to make government health plans more accountable and to give individual Canadians greater say in the formulation of health policy is also to be applauded. But this paper has indicated that there are some questions and concerns about the council. Perhaps it would have been wiser to establish a body to act as a kind of moral advocate for reform of the Canadian health care system. The council could have been used to publicize the cause of reform without being too specific about initiatives and without acting as a monitor of the performance and spending of provincial health plans. The model to emulate here may be the *Canada Health Act*, whose influence rests not in its alleged enforcement of the principles of medicare but rather in its symbolic effect - for many Canadians, the act stands for the country's commitment to a publicly-funded health care system which provides access for all to medically required care. The Health Council might have aspired to the same lofty status in the area of health care renewal.⁵⁷

In the end, it may not matter what we think of the Health Council. The council is

⁵⁷ Of course, the *Canada Health Act* has generated much federal-provincial conflict, but now all governments in Canada subscribe at a minimum to the spirit of the legislation.

tied to the 2003 accord, but already the government of Paul Martin has new designs for health care. The prime minister wants to set out a ten-year plan for medicare and intends to seek agreement with premiers in the summer.⁵⁸ Events may eclipse the council.

⁵⁸ Brian Laghi, "PM Seeks 10-Year Plan to Preserve Medicare," *Globe and Mail*, 25 March 2004.