Federal-Provincial Fiscal Relations and Health Care: Will Targeted Funds Work?

Paul Barker
Brescia University College
1285 Western Road, London, Ontario, N6G 1H2
pfbarker@uwo.ca

Paper presented at the annual meeting of the Canadian Political Science Association
The University of Western Ontario, June 2005

A number of well-known fiscal instruments – conditional grants, cost-matching agreements, block grants, and tax point transfers – have been used in various combinations to support federal-provincial fiscal arrangements in the area of health care in Canada. However, in recent reports and agreements on health care a new fiscal instrument has assumed some prominence. The "designated transfer" or "targeted fund" has been at the centre of federal-provincial accords on health care signed in the past few years, and it can also be found in some of the major recommendations of the Romanow Commission on health care.[1] The targeted fund involves a non-matching transfer of monies from the federal government to the provinces with the stipulation that these monies are spent on specified areas of health care; it also sets out in most cases a deadline for taking actions consistent with the purposes of the fund. Accompanying the grant often is a general accountability requirement that the recipient governments provide public reports on both the performance of their plans and progress achieved in the specified areas (and in most instances other independent bodies are asked to do the same of provincial actions).

The intent of the targeted fund is to offer greater funding for areas deemed important to the renewal of the Canadian health care system. Medicare is at a crucial point in its development, so it seems natural that different ways of transferring federal money to provincial health plans should emerge. There is, however, some uncertainty about the efficacy of the new fiscal instrument. Given its appearance in major health care accords, some apparently believe that the fund will shape the behaviour of recipients of

[1] The two names for the new fiscal instrument are suggested and used in See Michael Mendelson, *Accountability Versus Conditionality: the Future of the Canada Social Transfer* (Ottawa: Caledon Institute of Social Policy, December 2003) and Terrence Sullivan and Colleen M. Flood, "Chretien's prescription for medicare: a green poultice in lieu of accountability," *Canadian Medical Association Journal* 170:3, 3 February 2004.

the grant in the desired direction – the fund will be employed to provide more financial support for such areas as primary health care, diagnostic services, and home care. But others are less sure and fear that the fund amounts to an unconditional grant and hence the provinces will allocate very few additional dollars to the targeted services. Still others have invoked the grant while appreciating that its use might require some supplementary arrangements. This uncertainty over the targeted grant combined with the importance of successfully reforming the Canadian health care system suggests a need to look more closely at this new element in federal-provincial fiscal relations. In so doing, this paper uses the theory of intergovernmental grants, a body of thought developed to give insights into the effects and appropriateness of various fiscal instruments employed in a federal state.

Background

Federal-provincial fiscal arrangements in Canada have relied upon various types of fiscal instruments to assist in the financing of health services. Initially, in the late 1950s and the 1960s, conditional, cost-matching cash grants were employed to establish both hospital and physician programs. The cost-matching quality of the grants was intended to provide the provinces with an incentive to spend more on hospitals and doctors. The theory of intergovernmental grants – developed to provide direction on the proper use of grants – offered support for the use of such an instrument; the theory claimed that the cost-matching grant has the effect of lowering the price of the designated program and thus provided an incentive for the recipient government to allocate more to

this area.[2] A review at these initial arrangements for health care suggests that the matching effect was less than commonly believed, but the grant nevertheless had the desired effect.[3] The conditions accompanying the cost-matching grant came to be known as the five principles of medicare – universality, comprehensiveness, accessibility, portability and non-profit administration – and they had the aim of shaping the operation of the provincial health plans in an manner consistent with the wishes of the federal government. A failure to satisfy these conditions would result in the withdrawal of federal funding. As with the matching element, the conditions appeared to have the intended effect, for the provincial health plans broadly reflected these conditions.

In the late 1970s, conditional block grants and tax points replaced the cost-matching arrangement. The latter part of the new arrangement was straightforward. The federal government would make available additional tax room for the provinces – effectively an unconditional grant that could be spent in any way. But the conditional block grants were a little more complicated. Under this new agreement, federal cash transfers directed at health would be determined by a base amount increased by the rate of growth in the economy. The matching element had disappeared, but the conditions remained and they offered a means of monitoring the quality of provincial health plans. Subsequent developments, specifically the emergence of direct patient fees, indicated that the conditions needed to be expanded to include a more precise stipulation for extra-billing by doctors and hospital user fees. What emerged, in 1984 under the *Canada*

---

[2] The theory is outlined in a number of publications. See, for example, Harvey Rosen et al., *Public Finance in Canada, 2nd ed.* (Toronto: McGraw-Hill Ryerson, 2003), ch. 9.

[3] Constantine Kapsalis, "Block-Funding and Provincial Spending on Social Programs," *Canadian Tax Journal* 30:2 (March/April 1982). But see Peter C. Coyte and Stuart Landon, "Cost-sharing versus block-funding in a federal system: a demand systems approach." *Canadian Journal of Economics* 28:4 (November 1990).

Health Act, was a kind of cost-matching arrangement in reverse in which federal funds would be reduced by one dollar for every dollar of extra-billing and user fees. In the late 1980s and early 1990s, the federal government made some unilateral adjustments to the block funding arrangement that limited the rate of increase in the cash grants, and eventually it eliminated the escalator clause altogether (while at the same time reducing the total amount of funds available for health care, postsecondary education, and social services). Without the escalator, any upward movement in transfers would have to be provided for in specific agreements between the two levels of government.[4]

All in all, then, up to the end of the 1990s, arrangements had depended on a variety of fiscal instruments to achieve two related purposes. One was to increase the revenue of the provinces and the other was to provide an incentive for the provinces to spend more on the basic components of a health care system (physician and hospital care). In the terminology of the theory of intergovernmental grants, the fiscal arrangements had both an income effect and a substitution (or price) effect. The former effect simply placed additional monies in the hands of the provinces and assumed that some of this money would be spent on health care. The latter effect, through cost-matching arrangements, manipulated relative prices of government programs to provide the provinces with an incentive to spend on health care. The conditions, in theory, also swayed the provinces to spend the grants in one way rather than in another.

In September 2000, the two orders of government signed a health accord that saw the emergence of a new fiscal instrument, namely the targeted fund.[5] The bulk of the

---

[4] See A. Maioni and M. Smith, "Health Care and Canadian Federalism," in F. Rocher and M. Smith, eds., *New Trends in Canadian Federalism, 2nd ed.* (Peterborough: Broadview Press, 2003).

[5] The February 1999 health accord represented a transition to the targeted fund, for the provinces committed themselves formally to spending the new monies on health care in general.

monies provided for under the accord took the form of conditional block grants, but a small portion ($2.3 billion of over five years) was targeted at medical equipment, health information technology, and primary health care.[6] Two years later, the Romanow Commission made recommendations that relied on targeted funds for the making of important reforms to medicare.[7] A few months later, in February 2003, the first ministers followed up on the Romanow report with another agreement that used the targeted fund to achieve some of their major purposes. The accord allocated $16 billion over five years to a "Health Reform Transfer" directed at primary health care, home care, and catastrophic drugs.[8] Targeted funds were also made available for a diagnostic/medical equipment fund, electronic patient records, and other smaller initiatives (e.g., patient safety).[9] The most recent federal-provincial agreement for health care, signed in September 2004, also depends on targeted funds. It provides $4.5 billion over the next six years for a "Wait Times Reduction Transfer"; additional monies are also provided for medical equipment, home care, and catastrophic drugs.[10] In all of these developments, the targeted fund took the form of a non-matching grant that was to be used for a particular purpose. Also, to ensure accountability in relation to the targeted funds, it was expected that the provinces (and in most cases independent bodies as well) would publish reports on the performance of their plans to give some idea of whether the targeted funds

---

[6] Canadian Intergovernmental Conference Secretariat, *News Release – Funding Commitment of the Government of Canada, September 11, 2000.* Available at www.scics.gc.ca/cinfo00/80003806_e.html

[7] Commission on the Future of Health Care in Canada, *Building on Values: the Future of Health Care in Canada* (Saskatoon: Commission on the Future of Health Care in Canada, 2002), 71-72.

[8] *Federal-Provincial Fiscal Arrangements Act, Ch. F-8, s. 24.6* at http://laws.justice.gc.ca/en/f-8/text.html

[9] Canadian Intergovernmental Conference Secretariat, *Backgrounder 2003 First Ministers Health Accord* February 4-5, 2003. Available at http://www.scics.gc.ca/pdf/800039004_e.pdf.

[10] *New Federal Investments on Health Commitments on 10-Year Action Plan on Health and A 10-Year Plan to Strengthen Health Care.* Available at http://pm.gc.ca/eng/news.asp?category=1&id=260. See also Statutes of Canada 2005, *An Act to Amend the Federal-Provincial Fiscal Arrangements Act and to enact an act respecting the provision of funding for diagnostic and medical equipment*, ch. 11.

were having the desired effect. Also, some of the agreements (but not the accompanying laws) laid out a timetable for achieving the aims of the targeted funds.

Traditionally, the federal government had used broad conditions and price manipulations to secure their preferences, but with the more recent agreements a new way of achieving these preferences had emerged. Specific areas would be designated for funding, deadlines would be set, and public reports would confirm whether the monies had been properly spent. The question was whether the new fiscal instrument would be effective and what might be done if the instrument proved wanting.

Analysis

The emergence of the targeted fund has elicited various views about its probable impact. With its reliance on the fund, the federal government appears to believe that the grant monies can be successfully used to increase provincial and territorial spending on the targeted areas. But it is not clear how the funds will achieve their aims. The theory of intergovernmental grants suggests that the targeted fund is little different from an unconditional grant (assuming with reason that the amount of the targeted fund is less than the funds already being spent on the targeted area). Figure 1 shows how this may be the case (see end of paper). The x-axis measures the quantity spent by government on the targeted area (s) and the y-axis on all other areas (or a tax cut), and the budget constraint line AB represents the various combinations of x and y that government could purchase with its total revenues at fixed prices. Point P represents the optimal combination of x and y (using indifference curve analysis) which produces OE and OF quantities of the

targeted and non-targeted areas respectively. The effect of the targeted fund (which is equal in size to AC) is to create a new budget constraint line ACD and new optimal point at P1. The quantities of the targeted area now increases from OE to OG and the non-targeted areas from OF to OH. As can be seen, the targeted grant has the effect of increasing the quantity demanded of the targeted area, but not the by the amount of the targeted grant (AC >EG). What happens is that recipient effectively places all the targeted money within the targeted area (which ensures compliance with the grantor) but then removes some of the existing revenue spent on the targeted area and places it with the non-targeted funds. The actual amounts for each area will be determined by the income elasticity of the demand for both the targeted and non-targeted areas. The theoretical expectation – given the various areas of interest for government – is that the elasticity for the targeted area will be far below necessary to consume all of the targeted money. The end result is that the targeted fund has the same effect as an unconditional grant: it places additional funds with the recipient government, which can use this in a manner consistent with its preferences (as measured through income elasticity).

In plain terms, the targeted fund gives the recipient governments additional funds that can be employed according to their needs and not those of the donor government. This grant arrangement requires that the recipient government spend the money on the targeted area, but the recipient can easily comply with this requirement and still spend according to its needs as long as the existing expenditures on the targeted area are equal or greater than the targeted fund itself. In this situation, the recipient effectively places the new monies into the targeted area but at the same withdraws existing money out of

the targeted area in order to service other needs.[11] Without specifying additional requirements associated with the use of the grant (which will be discussed later), the federal government is quite helpless in its attempt to see the targeted fund to be used as wished – namely to ensure that the entire targeted fund is spent on the targeted area. (Moreover, even if the targeted fund were greater in size than existing expenditures on the targeted, it would require careful monitoring to guarantee compliance with the terms of the fund – something that is difficult to do, as well be shown.) To be sure, the targeted grants in the health accords have been accompanied by commitments to publish performance reports on provincial plans, but such reports focus on the overall performance of provincial plans and do not represent an explicit attempt to track the targeted money – at least up to the point. Most of the agreements also outline a timetable for actions connected to the targeted funds (e.g., establishing standards for wait times for high priority surgical procedures by the end of 2005), but these deadlines are not set in law[12] and there appears to be no real way of enforcing them through the withholding of federal funds. Lastly, the legal framework accompanying the most recent health accord provide for parliamentary review and third-party trust arrangements to increase the chances of provincial compliance, but the absence, again, of any real enforcement mechanism and the sheer difficulty of determining whether the new funds truly represent an additional investment in the targeted areas limit the utility of these particular efforts.

The Romanow Commission recognized the problem with targeted grants. In its report, the Commission listed areas of health care targeted for additional funding. It was

---

[11] See Michael Mendelson, *Accountability Versus Conditionality: the Future of the Canada Social Transfer*.

[12] See, for example, *An Act to Amend the Federal-Provincial Fiscal Arrangements Act and to enact an act respecting the provision of funding for diagnostic and medical equipment*, ch. 11.

quick to note that the grants did not amount to a "blank cheque" and that the provinces had to "shape their health budgets in the immediate future to reflect the agreed-upon priorities, matching or exceeding federal support for these priorities."[13] The reference to matching suggested one way in which the federal government might achieve its purposes with the targeted fund. Though the commission urges the provinces to match federal targeted grants, the more useful employment of matching grants might be for the federal government itself to match the spending of provinces on the desired area. And here the theory of intergovernmental grants would be supportive. Figure 2 provides the analysis for a cost-matching grant. As with Figure 1, there is an initial budget constraint line of AB and spending of OE on the targeted area and OF on the non-targeted area. The effect of the matching grant for the targeted area is to half the price for this area (assuming dollar for dollar matching) and to create a new budget line of AC. The optimal point shifts from P to P1, but in this case spending on the targeted area is greater than under the targeted-grant arrangement because of the price reduction. The prediction of the theory of intergovernmental grants is that this price effect (price elasticity of the demand for targeted services) will generate a substantial increase in spending on the targeted area (an income effect also takes place for both targeted and other areas). However, it is unlikely that either level of government would accept matching grants based on previous experience. As shown, matching grants were used initially in the development of medicare, but both orders of government grew to dislike this particular fiscal instrument. The federal government felt, correctly, that it had little control over spending in this area – it had to match provincial spending on hospital and physician care. For their part, the provinces believed that the availability of matching grants distorted their preferences.

[13] Commission on the Future of Health Care in Canada, *Building on Values*, 71.

The need for federal audits of provincial spending to ensure provinces were spending on the desired area also left a bad taste in the mouths of provincial governments.

In light of the seeming weakness of targeted funds, it has been suggested that it be would be better to put in place conditional grants for the major elements of health care renewal.[14] For example, the targeted grant for home care might be replaced with a conditional arrangement that includes medicare-like principles. But again it is not clear how this would make any difference. Supporters of this position assume that such grants have been successful in the past in forcing provinces to spend federal funds on the desired areas. But the theory of intergovernmental grants predicts that the effect of conditional grants will be no different from than that of targeted grants outlined in Figure 1. As with the targeted funds, the recipient government can simply place the conditional grants into the required area and then draw out monies freed up by the new grant. It might be argued that the conditions (or criteria) contained in the conditional grant provide a standard against which the actions of the provincial governments could be judged, but many students of Canadian fiscal federalism contend that the conditions are too general to act in this manner.[15] For example, the condition of 'comprehensiveness' in the medicare arrangements provides the federal government with little real influence in dealing with the provinces. The same applies to portability and even in some situations to the prohibitions on direct patient charges. But why did the provinces nevertheless build their health plans to resemble the conditions specified by the government? One possible answer is that provincial preferences were similar to federal ones. However,

---

[14] Terrence Sullivan and Colleen M. Flood, "Chretien's prescription for medicare: a green poultice in lieu of accountability," *Canadian Medical Association Journal* 170:3, 3 February 2004.

[15] For example, see Peter M. Leslie, "The Fiscal Crisis of Canadian Federalism," in Peter M. Leslie, Kenneth Norrie, and Irene K. Ip, eds., *A Partnership in Trouble: Renegotiating Fiscal Federalism* (Toronto: C.D. Howe Institute, 1993), 29-30.

there is no reason to believe that this pertains today in relation to the areas targeted by the federal government, though there are some signs that the provinces are sympathetic to some elements found in the targeted funds.

So it seems that we are back at the same point: the targeted funds seemingly fall short of achieving their aims. What might be done to alleviate this unsettling situation?[16] As mentioned earlier, some additional actions might be taken to give some support to the targeted fund. One possible action is to engage in careful monitoring of the spending of recipient governments. The Canadian Institute for Health Information (CIHI) is an independent body responsible for collecting and analyzing information on health care. In the most recent accord, CIHI is directed to "report on progress on wait times across jurisdictions,"[17] but perhaps this role could be expanded to include tracking provincial spending on designated areas. In the past, such a role for the CIHI has been proposed.[18] But the agency might be reluctant to undertake a task that may put it at odds with the provinces and compromise its reputation as an entity capable of a disinterested assessment of health information. Perhaps a more acceptable arrangement would be monitoring by the newly established Heath Council of Canada. Indeed, the mandate of the council is to monitor implementation of the 2003 accord and to report on the 2004 accord, and with its membership – which includes representatives of most of the provincial governments – the council might be viewed favourably by the provinces (though likely not Alberta or Quebec, who refused to join the council). The first report of the Health Council suggests a little movement in this direction, but a more aggressive

---

[16] Incidentally, it should be clear by now that this paper takes no position on the appropriateness of the targeted funds; its interest lies only in determining the workability of the funds.

[17] *A 10-Year Plan to Strengthen Health Care*, p. 3.

[18] See Mark Kennedy, "Watchdog for Health May Emerge from Closed-Door Talks," *National Post* 25 January 1999, A4. The idea here was the agency could performs audits of provincial spending.

stance would be needed for truly effective monitoring.[19] Another possibility, relying on the theory of intergovernmental grants, is to set up a targeted grant with an explicit maintenance requirement. Under this type of arrangement, the donor government states that existing spending on the targeted area has to be maintained and the targeted funds must be added to this amount.[20] Figure 3 shows how this kind of arrangement works. As with the other figures, there is an initial budget constraint line AB and OE spent on the targeted area. The effect of the maintenance stipulation is to create a new budget line APP1D, which reflects the stipulation that current spending on the targeted area must be kept at OE. With the new budget line, the optimal decision of the recipient government is to place all additional spending on the targeted area (so PP1=EG). At first glance, this seems to be an obvious solution to the problem under consideration, and there is research (based on the American experience with fiscal transfers) which suggests that the maintenance provision can have the desired effect.[21] But evidence also suggests that maintenance arrangements can be difficult to implement. Recipient governments – provincial governments in our case – may be unwilling to accept them and gaining access to the required information may be equally difficult.[22] This latter problem could affect attempts to use such agencies as CIHI and the Health Council of Canada to track the spending activities of provincial governments.

---

[19] See Health Council of Canada, *Health Care Renewal in Canada: Accelerating Change*, January 2005.

[20] For more details on this, see Lee S. Friedman, *The Microeconomics of Public Policy Analysis* (Princeton: Princeton University Press, 2002), 142-45.

[21] Craig Volden, "Asymmetric Effects of Intergovernmental Grants: Analysis and Implications for U.S. Welfare Policy," *Publius* 29:3 (Summer 1999), 52; Shama Gamkhar and Shao-Chee Sim, "The Impact of Federal Alcohol and Drug Abuse Block Grants on State and Local Government Substance Abuse Program Expenditures: The Role of Federal Oversight," *Journal of Health Politics, Policy and Law* 26:6 (December 2001).

[22] Gamkhar and Sim, "The Impact of Federal Alcohol and Drug Abuse Block Grants on State and Local Government Substance Abuse Program Expenditures: The Role of Federal Oversight."

Testing of the theory of intergovernmental grants leads to another possibility for the implementation of workable targeted grants. As noted, the theory predicts that targeted funds will do no better than basic unconditional grants in ensuring the expenditure of designated funds on the targeted areas. Without any kind of matching arrangement, the funds will simply disappear into the consolidated revenue fund with very little chance that much of the money will be spent on the designated areas. However, the theory at times has tested poorly on this proposition. Research (again, largely American) shows that targeted funds tend to get spent on the targeted areas despite the absence of a matching effect or other adjustments such as maintenance requirements. There is, it seems, in the world of intergovernmental grants a 'flypaper effect' – a grant "sticks where it hits."[23] Estimates of increases on spending in the designated area range from 25 to almost 100 per cent – in the latter case, the entire grant gets spent on the targeted area.[24] Many reasons have been put forward to explain this effect. One is confusion on the part of voters who mistakenly believe that the targeted grant has affected prices at the margin and who exert political pressure to ensure that governments take advantage of the price discount. Another more political explanation is that actors in the policy process (e.g., bureaucrats, interest groups, politicians) use the presence of targeted funds as leverage to support additional funding in those areas. An arguably richer and more intriguing explanation relates to the alleged fungibility of money or the notion that 'money has no labels' and can be used for any purpose. In his

---

[23] James R. Hines, Jr. and Richard H. Thaler, "The Flypaper Effect," *Journal of Economic Perspectives* 9:4 (Fall 1995), 218.

[24] See, for example, James R. Hines, Jr. and Richard H. Thaler, "The Flypaper Effect" and Stephen J. Bailey and Stephen Connolly, "The flypaper effect: identifying areas for future research," *Public Choice* 95 (1998). Admittedly, the few studies of Canadian federal-provincial fiscal arrangements fail to locate a flypaper effect, but this could be due to the nature of the arrangement under consideration (Equalization program). See T. Snodden, "Budgetary shocks and revenue adjustment: How governments respond to unexpected fiscal shocks," *Economics of Governance* 5 (2004).

analysis of targeted funds, Mendelson relies on this quality of money using an example relating to household behaviour. He asks the reader to assume that an individual spends $100 weekly on groceries, $10 of which goes to the purchase of milk. He then proposes that the individual is given an additional $5 to spend on milk and predicts that no additional milk will be bought. To be sure, the individual may literally use the gift of $5 on milk, but this amount simply substitutes for another $5 that is allocated elsewhere. For Mendelson, money indeed has no labels – it just goes into a big pot to be spent according to the preferences of the individual and not those of the donor. But we have all received gifts with stipulations and sometime we do spend it on the specified area. In the holiday season, many of us have been beneficiaries of monetary gifts that carry the condition that they be spent on clothes or some other designated areas. And indeed we do just that – contrary to Mendelson, individuals are swayed by labels. The argument here is that the same may happen in government, and indeed the evidence points to this. As stated earlier, the explanation for this outcome may be just pure power politics, but it may also be the tendency of individuals, families, and even governments to assign precise purposes to money to which a label has been attached. It may be irrational, but there is now a large literature that demonstrates that people commonly betray maxims of rational thinking because of the way the human mind functions.[25]

The implication of the flypaper effect is that targeted funds may work because they tap into a human vulnerability to labels. The hypothetical rational decision –maker in government places the targeted funds into the consolidated revenue fund, to be used in a manner which respects the preferences of the recipient government. But the actual

[25] The leaders in this field of cognitive psychology are the late Amos Tversky and Daniel Kahneman. See their seminal paper "Judgment under Uncertainty: Heuristics and Biases," *Science* September 27, 1974.

decision-maker may act differently and fall prey to labels – even those attached to money. Interestingly, there is evidence of the flypaper effect in recent actions of provincial governments and their use of funds made available through the health accords. The four western provinces have proposed a waiting time strategy, an action consistent with the September 2004 health accord.[26] In Ontario, the provincial government has targeted new money for cutting wait times for surgical procedures pinpointed by the most recent health care agreement.[27] Ontario has also made "announcements of mostly federal money the province is passing on, such as for diagnostic medical equipment." [28] The same province has also aggressively pursued primary health care, and put additional monies into home care – another priority of the health care accords.[29] Granted, there is also evidence that conflicts with the flypaper effect,[30] and one could always argue that even in the above examples some substitution is taking place. Nonetheless, a great deal of activity appears to be taking place in relation to the targeted activities (though admittedly more research is needed to confirm this point).

There is a final point to take into consideration, namely the power of public opinion. What the targeted funds do – one might argue – is to remind voters of their preferences for health care and to place pressure on government to act accordingly; in other words, governments spend the targeted funds on the targeted areas because that is what the electorate wants to happen. A similar explanation could be used to explain the

---

[26] Robert Matas, "Patients waiting-time plan ready in the West." *Globe and Mail* 15 October 2004, A9.
[27] Margaret Philip, "Ontario to slice year off waiting times," *Globe and Mail* 18 November 2004, A9.
[28] Rob Ferguson, "Taps open on spending announcements,' *Toronto Star* 19 February 2005, F1.
[29] Murray Campbell, "Liberals steam ahead on health-care reform." *Globe and Mail* 20 January 2005, A7. The recent Ontario budget also contains evidence of compliance with the targeted funds. See Ontario, Department of Finance, *2005 Ontario Budget: Budget Papers* (Toronto: Queen's Printer for Ontario, 2005), 20-22.
[30] Terrence Sullivan and Colleen M. Flood, "Chretien's prescription for medicare: a green poultice in lieu of accountability and Maude Barlow, *Profit is not the Cure: A Citizen's Guide to Saving Medicare* (Toronto: McClelland and Stewart, 2002), 83-85.

success of the traditional fiscal arrangements for health care. What have made these arrangements successful are not the conditional grants themselves and the monetary penalty for failing to observe them; rather, the key has been public support for activities inherent in the grants. It is not the conditionality itself that acts here, but instead political pressure. Alberta, for instance, has flirted a couple of times with the idea of introducing patient fees of one kind or another, but has backed off because of the political pressure. Premier Klein can handle quite easily the fiscal penalty associated with violating the *Canada Health Act*, but he cannot handle the lost votes. Seen in this light, targeted funds are not really fiscal instruments; rather, they are political devices used by the federal government to speak over the heads of provincial governments and directly to provincial electorates. With their concrete or precise nature, targeted grants can attract a great deal of publicity – certainly more so than the medicare conditions and their generally vague quality – and in this sense they may be seen as effective ways for the federal government to secure its preferences in the area of health care.

Conclusion

On the face of it, the targeted grant in relation to health care (or any issue) is really no more than an unconditional grant. It transfers additional monies without any evident means to guide its expenditure. The performance reports included in the health accords are meant to provide for some accountability in the way the provinces spend the federal monies, but they are usually not sufficiently precise to carry out such a role. Matching grants might be substituted for the targeted grant, but there is little support for

this fiscal instrument. Additional administrative strictures might be implemented to make the targeted grant more effective – monitoring by the Health Council of Canada or maintenance-of spending-stipulations – but these too seem unsatisfactory, and the required actions associated with the funds (e.g. deadlines) are difficult to enforce and can seemingly be ignored without any fear of loss of funding. But all is not lost. The flypaper effect suggests that supporters of the targeted grants may be pleasantly surprised, and even if this effect fails there is always the belief of the Canadian people in the renewal of medicare. At first glance, it seems that it may be necessary to recommend some kind of change to the targeted grant arrangements, but a closer examination suggests that they might work out. The policy advice forthcoming from this paper is that the federal government should be patient. If the flypaper effect does not get the funds put into the right place, then the Canadian people may be able to do the job.[31]

[31] And the advice for the researcher in federal-provincial fiscal relations is to give greater attention to the flypaper effect

Figure 1

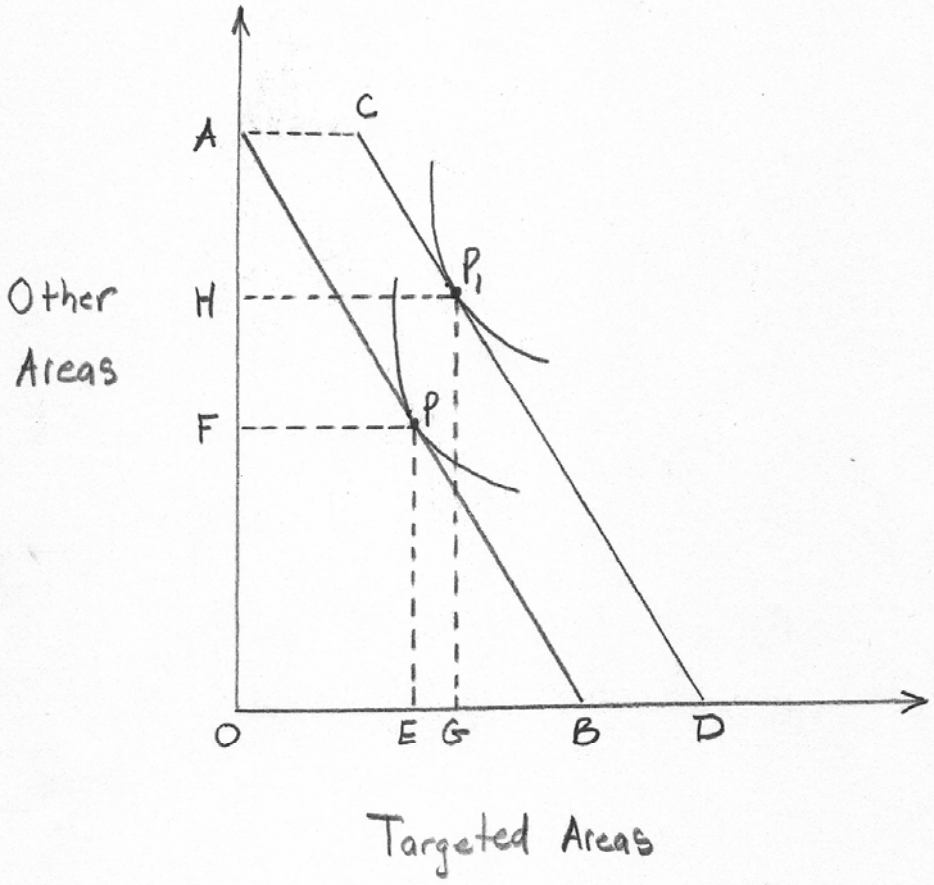

Figure 2

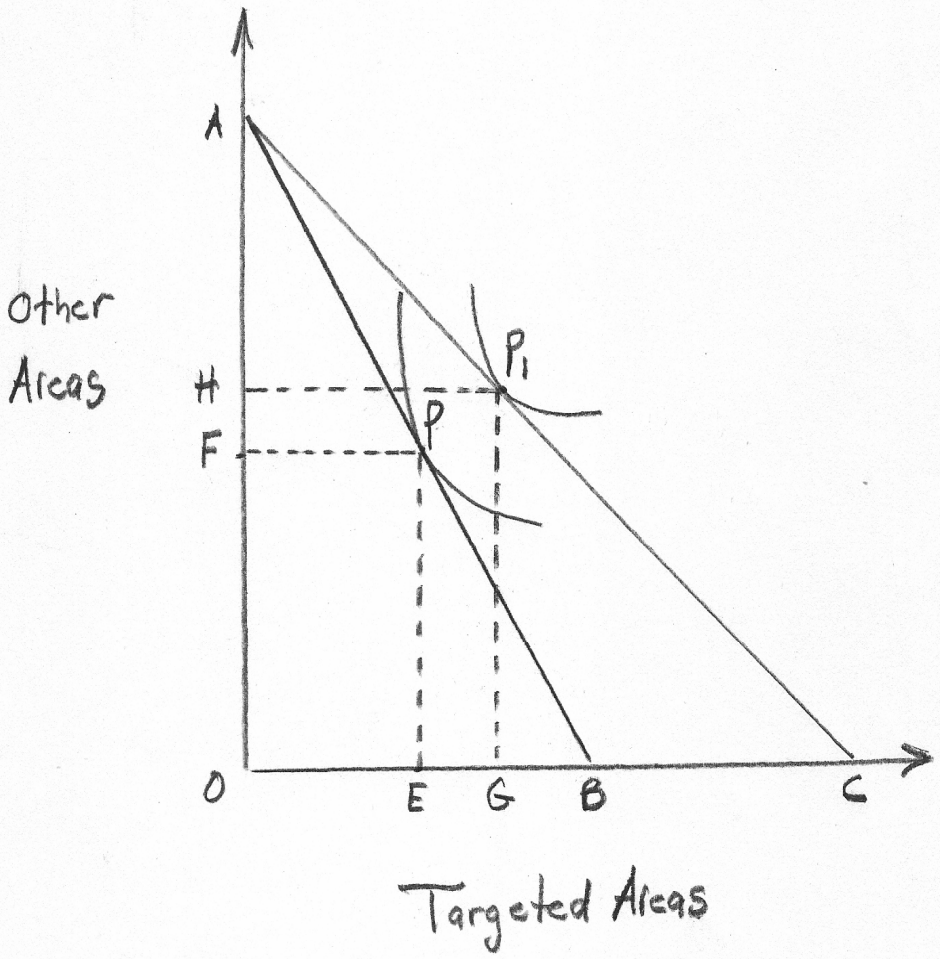

Figure 3