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In the thirteenth edition of Federalism-e our mandate was to produce an annual volume of undergraduate papers related to various issues within the study of federalism such as political theory, multi-level governance,

Canadian Federal Spending Powers: The Impact on Health Care Delivery

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Introduction

National public health care has increasingly become a politically contentious concern for Canadian citizens since its establishment. The role of Canadian federalism and intergovernmental relations has been a major contributor to the controversy surrounding the funding, the development, and the outcome of health care policy. While federalism has been attributed to the expansion of health care in Canada, it has also been criticized for lacking efficiency and harbouring intergovernmental power struggles. Although the Constitution Act of 1867 outlines that provinces are responsible for health care in their jurisdiction, in practice there is actually an unclear division of powers between the two levels of government (Maioni 2002). Health care is an industry that is constantly transforming, but the framework of Canadian federalism is not proficient enough to keep up with these much needed changes. As a result, citizens may not be receiving the best health care available, and are caught in the tug of war between the provinces and the federal government.

In this paper, I argue that federal spending powers are intervening in provincial jurisdictions, through policies like the Canada Health Act (CHA) and the Established Programs Financing Act (EPF), and limiting provincial experimentation for innovative health care delivery. The federal framework is hindering interprovincial diversity and the provincial autonomy that essentially founded Canadian public health care. In the following sections, I will focus on Canadian intergovernmental relations and its effect on Medicare in terms of fiscal federalism, efficiency of policymaking, and the impact on citizens. Moreover, I will also address the future of health care in Canada with respect to federalism.

Origin of Public Health Care in Canada

The prevalence for national health insurance system and government intervention did not arise until the Second World War and the Great Depression, when Canadian citizens were severely devastated by social and economic fragility (Bakvis, Baier and Brown 2009). Since the Second World War, the federal government played a more expansive role to develop social welfare. During the late 1940s, the province of Saskatchewan was able to successfully introduce the first model of public healthcare to its citizens through the Saskatchewan Hospitalization Act, a hospital insurance program (Wong 2005). Subsequently, this inspired the diffusion of public healthcare to other provinces in which the federal government played a key role as -provincial cooperative efforts in health care , according to Maioni (2002). Accordingly, the federal government introduced the Hospital Insurance and Diagnostic Services Act (HIDS) in 1957, and the Medical Care Insurance Act (Medicare) in 1966. These laws mandated that the federal government would subsidize 50% of provincial health expenditures through direct cash transfers, and that each province must adopt a health insurance policy by 1971 (Bakvis and Skogstad 2008, Wong 2005). The decentralized federal state encouraged the national expansion of health care, since provinces could experiment with policies while receiving federal support. This - comprised of harmonious intergovernmental relationships, shared-cost federalism and flexible federal spending powers (Maioni 2002, Wong 2005).

Federal and Provincial Roles in Health Care

Canada is a relatively decentralized federal state that grants sovereignty to both orders of government within their respective jurisdictions. According to the Constitutional Act of 1867 (CA 1867), subsection 92(7) states that provinces are primarily responsible for health care and obtain the authorization to legislate in and charities [excluding marine hospi . Moreover, section 92(16) also grants the provincial enerally all matters of a merely local or private nature in the p (Bakvis and Skogstad 2008, Rocher and Smith 2002). While the federal government does not have a direct role in the matters of health care, they do have constitutional responsibilities outlined in Section 91(1) in regards to public health and the general welfare of people in the territories and under special classes. Moreover, Section 91(3) states that the federal government obtains the money by any mode or system of t . Consequently, Ottawa has increasingly taken advantage of this by using its federal spending powers to gain political leverage, thus

In actuality, the provinces and territories are so politically, sociologically, and geographically diverse that Canada does not have a true national public health care system. Instead, Medicare is comprised of an amalgamation of 13 unique models of provincial and territorial health policies that are unified by overarching federal principles of Canadian health standards formed by the federal government (Wong 2005). Given the realities of the complexity of health care, the division of powers outlined in the CA 1867 are still ambiguous; and there will certainly be many federal-provincial jurisdictional overlaps. It is these unassigned, fluid responsibilities, that have been arenas of major political contestation and power struggles. Moreover, the unclear lines of responsibility lower the efficiency and promptness of health care provision to citizens.

Fiscal Federalism

The funding for Canadian health care is overseen by the two primary levels of government, federal and provincial, in a relationship called fiscal federalism. Fiscal federalism in health policy refers to the intergovernmental processes of taxation and expenditures that allow the provinces to adequately fulfill their constitutional requirement of health care delivery. This process is mainly carried out through the allocation of funds via federal spending powers, which is generally the Federal spending powers include two kinds of payment schemes: cash payments (typically shared cost programs and block grants) and tax points (Maioni 2002).

Federal Spending Powers

During the establishment of health care, the federal spending powers were predominantly presented through 50:50 shared cost programs of the 1958 HIDS Act and the 1967 Medical Care Insurance Act. However, the federal government was not able to control their expenditures through the cost-sharing formula and, in turn, replaced that scheme with the EPF Act in 1977. The EPF Act reduced Ottaw commitment to match provincial health expenditures, implementing block grants and permanent transfers of tax points; thus, allowing provinces to directly collect a percentage of federal tax revenues. Initially, the provinces saw this act as a means of increasing political autonomy and acquiring financial independence through greater taxation powers, as well as reducing federal oversight on health policies. Unfortunately,

Intergovernmental relationships in regards to health care funding have been characterized by power struggles and assertions of political autonomy. The federal government has assumed entitlement to use its spending powers by setting federally construed health standards over provinces, which have raised numerous political and constitutional concerns (Rocher and Smith 2002). Since the 1977 EPF Act, the federal government has drastically decreased funding for health programs. Cash payments and tax points from the federal government totalled 27.5% of total provincial health spending in 2001-2, which is a significant reduction from the initial 50% in the postwar era (Wong 2005). The various changes made to the transfer payment system offer uncertainty to the provincial governments, and hinder their ability to make important long term health care plans. Since long term planning is an essential strategy for optimal health care delivery, citizens may be receiving the short

On the other hand, Rocher and Smith (2002) argue that multiple veto points may provide numerous accessible opportunities for policy change, especially for social forces who seek to influence health policy. At the same time, one must consider all other institutional factors present in Canadian federalism as dynamics like executive federalism may not even be swayed by interest groups. Thus, institutional structures play an important role in policy making and have a noteworthy impact on citizens and their health care system.

The Future of Medicare in Canada

As we have seen, Canadian federalism brought positive and negative effects to the health care system. While the decentralized federal framework embraced interprovincial diversity to establish health care, it also set limitations on provincial autonomy through national standards of the CHA. How can Canadian federalism contribute to the progression of the health system and move forward from past setbacks to provide excellent care for citizens?

The intergovernmental tensions that have arisen from fiscal disagreements are evidence that there is a need for mechanisms to mediate intergovernmental conflicts. In 1999, the federal and provincial governments (with the exception of Quebec) introduced of the Social Union Framework Agreement (SUFA), which acknowledges the requirement for more transparency and consultation in intergovernmental policymaking to eliminate federal-provincial disparities (Bakvis, Baier and Brown 2009, Fierlbeck 2002, Maioni 2002).

In 2002, a report from the Commission on the Future of Health Care in Canada, known as the Romanow Report, suggested numerous changes, such as a $15 billion dollar injection, in order to sustain the Medicare in Canada. It was uncertain if the report would have any policy impact, but the federal government immediately responded with the commitment of $30 billion towards health care for the next ten years (Wong 2005). This is quite a sizeable contribution as Wong (2005) affirms that -2 amounted to $74. . Accordingly, the quick federal response to the Romanow Report indicates an effort towards recovery from ongoing intergovernmental tensions, but also a promising outlook for the future health of Canadian citizens.

Conclusion

In the past decade, Canadian federalism has made positive and negative contributions to public health care. The decentralized federal framework allowed for provincial policy experimentation, while intergovernmental relationships supported policy expansion. In contrast, the complexity of intergovernmental relationships and the unclear delineation between the roles for both orders of government have caused considerable delays in health care delivery. The controversies of fiscal federalism and fiscal imbalances continue to pose questions about the need for more transparency and accountability [(p)807916 3e12(y)-54

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Although these

confederations may skew the conceptual framework of a federal system, this is only a slight deviance from the core argument that the individual is ultimately subjugated to the will of his nation. As Tocqueville has noted in his work *Democracy in America*, this sort of hierarchy of loyalties eventually culminates into the tyrannical rule of the majority, and given the top down structure of the American federal system, the indiv
to his state and finally to his nation.

individual would dare use it against his national community. In terms of the formulation of legislation, it appears that America is has no real way to escape the tyrannical rule imposed upon it by way of democratic despotism. Despite this, the individual still believes that nationalism simply provides a strong vehicle, through which his or her interest may be pursued. Personal interests will rarely triumph in issues considered to be of national interest, as the nation invariably has more power than the individual just on the fact that majority, which is embodied by the nation, is far stronger than its constituents. Given the popularized forms of patriotism, nationalism in itself is often seen as a form of emancipation, but in reality it continues to subordinate the individual to the federal state.

The American feder

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The Call for Senate Reform: An Implausible Demand

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From shortly before Confederation in 1871, to the present day, the western

really hard to introduce the Triple E format. For example, an elected Senate:

Specifically after the 2004 federal elections (i.e. the height of the Sponsorship Scandal), the BQ recorded a high of fifty-four seats in the province of Quebec. This is the highest number of seats the BQ ever held. (This amount of seats was also seen in 1993).

As these figures demonstrate, support for a separatist political party only went up after the misfortune of another party. Once enough time passes, people will start to forget about the Sponsorship Scandal and people will once again start to support political parties other than the separatist parties. This was seen in the 2011 federal elections. As it has already been mentioned, the BQ only obtained seven seats in the last election. Clearly, citizens of Quebec do not merely vote for a separatist party because they want to separate. Quebecers will vote for whichever party they hate the least.

Yet another way to put Senate reform back on the agenda was discussed in

Boychuk, Gerard W., and Debora L. Vannijnatten. "The Canadian "West" as a Public Policy Space?: Public Policies in Western Canadian Provinces from a National and Cross-National Perspective."

Climate Change

Climate change results from human development. In their First Assessment Report, released in 1990, the Intergovernmental Panel on Climate Change (IPCC) which is an international scientific research body explained the phenomenon. They say human actives result in the increased atmospheric concentrations of green house gas (GHG) emissions, which cause the earth to warm beyond what it would otherwise (IPCC 1990b, 52). While water vapor and ozone are most responsible for the greenhouse effect

While Quebec has been actively engaged in a global conversation about climate change policy, the Conservatives have largely been absent. DDEP Minister

next action plan (2012

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