"A TORTUOUS HISTORY:"
FEDERAL – PROVINCIAL RELATIONS AND THE FUTURE OF MEDICARE

by

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Abstract

By examining the historical development of Canada’s health insurance program this thesis demonstrates that the federal government played a significant role in establishing a national policy. Consequently, the federal government is obligated to promote, direct and contribute reasonable levels of funding to ensure the maintenance and stability of the program. However, through a series of negotiations and directives throughout the 1980s and 1990s the federal government has reneged on its financial contributions. In recent years the provinces have correctly asserted that federal financial commitments have dwindled and undermined the sustainability of our national health care program. This thesis examines how these funding cuts have been achieved as well as public and provincial reactions to shifting funding responsibilities and the overall effect on the health care system.
# TABLE OF CONTENTS

Abstract ii  
Table of Contents iii  
List of Tables iv  
List of Figures v  
Introduction 1  
Chapter One Establishing and Ideal: Building the Canadian Health Care System 15  
Chapter Two Negotiating Funding 43  
Chapter Three Compromising the System 64  
Conclusion "Building on Canadian Values." The Precarious Future of Medicare 93  
Bibliography 104
List of Tables

Table I

Federal Established Programs and Financing Act Contributions To the Province of British Columbia 81

Table II

Summary of Federal Established Programs Financing... Contributions To British Columbia 85
List of Figures

Figure A

Health (Financial Management System Basis) 82
Introduction

Universal health care in Canada has been shrouded in controversy and debate since the institution of Hospital Insurance in 1957 and Medicare in 1968. Indeed, just three years after Medicare’s inception, critic and author, Jack McLeod wrote,

...the existing health delivery system is increasingly recognized as being obsolete and the danger is that health insurance schemes may lock us into paying for an extremely inefficient and costly system... we have committed ourselves to public payment for health services which are beyond the present public means to control and ... health remains unorganized, unplanned and fragmented....

However, despite the rhetoric of continued crisis, characterized by evolving developmental pressures, conflicting political agendas and funding disputes, universal health care remains the country’s most revered social program and, in many quarters, symbolizes Canadian aspirations of social justice and equality.

For most Canadians the health care dilemma is played out and understood almost exclusively as a localized issue. Hospital closures and doctor shortages are framed as immediate and local concerns that are divorced from the broader pressures created by shifting federal-provincial fiscal arrangements. This thesis broadens the discussion by concentrating on the health care system and specifically examines ongoing changes to fiscal policy and the consequences for our national health care program. Author Robert W. Gordon believes polices and the adaptations associated with a specific policy are the result of numerous “tiny contingent practices” representing a “universal historic force”.

In Canada, federal funding commitments were established, but through a series of policy

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1 Quoted in Gwendolyn Gray, Federalism and Health Policy: The Development of Health Systems in Canada and Australia (Buffalo: University of Toronto Press, 1996), 106.
adjustments implemented over time the federal position has been radically altered. By examining fiscal arrangements including cost-sharing, the Established Programs and Financing Act (EPF), and the most recent Canada Health and Social Transfer (CHST), I will detail the federal government’s attempt to decentralize and reduce its financial commitment to social programs, particularly Medicare. As each decision was rendered and adjustments were enacted to fiscal policy, choices appearing rational at the time, the federal government became increasingly detached from its original commitment to the national health insurance program.

To explain the rationale behind evolving funding arrangements, this thesis will be centered on the relationship between the federal government and British Columbia. This specific relationship will provide the means to chart the shifting political and ideological perspectives of both the provincial and federal governments while, at the same time, allowing for a precise and detailed portrayal of provincial sentiment concerning federal spending power in health care. Certainly, it would be disingenuous to suggest that the assertions and agendas of the various provincial governments in British Columbia are representative of the entirety of federal -provincial relations on health care funding throughout Canada but, it is arguable that the British Columbian experience does illuminate a fiscal history of the current financing pressures experienced across the country. Although this thesis will argue that the federal government has sought to reduce its financial commitment to Medicare through changes in the federal - provincial funding structure, the object is not to place blame on either level of government for the current

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3 The term “federal” will be used in discussing relations between the two levels of government, rather than “dominion,” because it is consistent with the notion of fiscal federalism which underlies the emphasis on health care transfer arrangements.
"crisis" or to identify possible reforms in health care delivery. Rather the intent is to
draw upon evidence concerning federal expenditures, analyze the policies that have
influenced the flow of federal money and exhibit how this historical trend creates
pressure for reform, but limits the range of current policy options.4 The province and the
nation have not arrived at this current crossroad through happenstance; commitments
were made, revisited, and probable consequences were fully appreciated. It is only with
an informed historical perspective on these commitments and their legacy that the
contemporary debate can precede beyond posturing and recriminations towards
reconciliation of current fiscal concerns and declining social policy commitments.

In the waning years of the twentieth century the aura of crisis enveloping
Canada's health care system seemingly thickened with the implementation of the Canada
Health and Social Transfer in 1995. In line with previous policy agendas, federal
transfers for health care, education, and welfare, were combined into a single block of
funding that effectively reduced the federal commitment by $6.2 billion.5 Not
surprisingly, the change was greeted with provincial howls of protest. The core of the
complaint was simple: many provinces argued that they were being saddled with
increased responsibility for programs originally designed to be shared between the two
levels of government. This latest response is in part the product of growing fiscal
pressures on the provinces as they attempt to control expenditures and contain debt while
maintaining services. Overall, federal fiscal restraint has illuminated the health care crisis

4 Jacob S. Hacker, "The Historical Logic of National Health Insurance: Structure and Sequence in the
(Spring 1998), 57-130. In his study Hacker argues that "by pushing policy development down a particular
historic path, a policy passed at time T1 may significantly constrain the range of possible options at T2.
and Canadian health care “reform” has become the topic of the hour as increasing pressures for privatization brew in the provinces in the wake of budget reforms and the relevance of national standards becomes increasingly problematic.

Like all things political and jurisdictional in Canada, strained federal-provincial relations are a direct result of the 1867 British North America [BNA] Act that outlined areas of authority between the dominion and provincial governments. While the provinces retained jurisdiction in matters of a “local and private nature,” including health care, the federal government secured broad taxation powers and assumed responsibility for an undefined range of “national interests.” For the most part, during the early part of the twentieth century the provinces initiated health policies by developing or supporting insurance systems and providing assisted coverage for low-income earners. However, as social policies emerged many provincial governments began to request federal funding support for rapidly expanding programs. Education, health, income assistance and unemployment were areas viewed as national in scope and, in the minds of many politicians and Canadians, worthy of federal involvement. Correspondingly, increased action in social policy was rationalized by post-war Keynesian economic theory emphasising the correlation between a healthy and stable society and increased economic productivity. As a result, a more complicated and cooperative arrangement developed between the two levels of government as national policies emerged, rendering the independent roles of government laid out in the BNA Act impossible to sustain, as a whole.

At the 1945 Dominion-Provincial Conference on Reconstruction, the federal government introduced the “Green Book” outlining broad proposals to facilitate
employment and enterprise, provide protection against individual risks including unemployment, sickness and old age and offered financial assistance to the provinces.\(^6\)

Although the proposals were essentially shelved during the ensuing years of negotiation on a broad range of programs, including health care, the conference nonetheless highlighted the incorporation of social policies as matters of national interest. Indeed, according to Prime Minister Mackenzie King’s opening statement,

> The enemies we shall have to overcome will be on our own soil. They will make their presence known in the guise of sickness, unemployment and want. It is to plan for a united campaign in Canada against these enemies of progress and human well being that we have come together at this time...\(^7\)

Although speculation remains whether King sought to encourage collaborative efforts between the two levels of government, subsequent dominion-provincial conferences eventually created a complex, evolving symbiotic relationship.\(^8\) Hobbled in their taxation powers, the provinces received federal financial support which, in turn, provided the federal government with leverage to implement and influence nation-wide policies in areas deemed to be within provincial jurisdiction.

After a decade of discussion, the Hospital Insurance and Diagnostic Services Act was introduced in 1956 as the first cost-shared health program. Its quick acceptance by the provinces and widespread popular support would later justify establishing a comprehensive health insurance scheme embodied by the Medical Insurance Act in 1968,

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\(^6\) Entitled the Green Book, the federal government’s proposals at the 1945 Dominion-Provincial conference introduced a broad range of social policy options. These proposals will be further discussed in Chapter 1.


\(^8\) David Slater argues that although the King Liberals introduced the Green Book Proposals, they were not fully committed to ensuring the implementation of new and expensive social policies. See David Slater, “The White Book, The Green Book and the 1945-46 Dominion Provincial Conference on Rebuilding,” in Greg Donaghy ed., *Uncertain Horizons: Canadians and their World in 1945* (Ottawa, Canadian Committee for the History of Second World War, 1997), 333.
a conditional cost-shared program providing basic universal health care for Canadians. Specifically, in the act federal government agreed to match fifty percent of provincial costs for insured services, provided that provincial programs met the criteria of universality, comprehensiveness, portability and were publicly administered.

By the mid-century it was clear that issues regarding the health and welfare of Canadians had exceeded provincial boundaries. In what would be his final year of his Prime Ministership, Lester B. Pearson defended the interactive function of federal funding. According to Pearson:

The governments of the provinces believe that their powers of taxation are too limited; the federal government believes that provincial taxing powers are virtually as great as its own. The governments of some provinces do not believe the Parliament of Canada should not use spending power in the way that it has, but in fact the use of this power has been responsible for much of Canada's economic and social progress. There have been demands for wholesale transfers of taxing and spending power from the Parliament of Canada; the federal government has replied that transfers to the provinces of powers of such magnitude would make it impossible to discharge its responsibility for the whole country (Pearson, 1968). Clearly, Pearson viewed federal financial participation as the foundation of a national health care program. In the end, despite the federal move into provincial jurisdiction and confrontation over tax bases and program control, the establishment of Medicare symbolized cooperative federalism. It remains one of the few programs where both levels of government strived to establish sound social policy through a reasonably harmonious exchange of ideas, enquiry and investment.

However, within a decade pressures for greater fiscal restraint and responsibility began to undermine the foundations of the national health care program forcing federal funding. 

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9 Lester B. Pearson, *Federalism for the Future* [The White Paper] (Ottawa: Supply Services, 1968), 162. [Authors emphasis]
policies towards decentralization. The connection between health care and a healthy economy diminished as the upward trend in provincial social spending was increasingly viewed as detrimental to the national economy. The 1970 Economic Council Economic Annual Review argued that “if the rate of increase of the past five years (1964-1969) were to continue unabated, these two areas of activity (health and education) alone would absorb the entire national product before the year 2000.”

Although the argument was flawed, since spending as a percentage of the gross national product only grew marginally in the 1960s and stabilized around seven percent during the 1970s, both levels of government nonetheless supported changes to the funding formula. This willingness to restructure was rooted in two distinct but related issues. Under the cost sharing formula there was little incentive for the provinces to control expenditures while Ottawa guaranteed to cover fifty percent of all insured costs. Not surprisingly the federal obligation increased at an alarming rate producing rising and unpredictable federal budget expenditures. At the same time the provinces complained that insured services under the cost sharing formula primarily targeted acute care in hospitals, arguably inhibiting the establishment of less costly preventative and out patient services. As a solution, block funding seemingly answered both federal and provincial concerns. On one hand the new funding structure allowed the provinces greater autonomy in determining provincial priorities for health care spending while, on the other, federal funding stabilized with the implementation of a predictable financing formula.

Unveiled in 1977, the new funding formula attracted what now appears to be far sighted criticism. Specifically, Medicare historian Malcolm Taylor warned,

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10 Taylor, 423.
As these words are being written, the Canadian health insurance system, whose tortuous history generated so much federal provincial conflict is being dramatically altered by the passage of the Established Programs and Financing Act [EPF]. In a sense the new arrangements mark the end of a national program as the format of the conditional grant in aid is abandoned.

In essence, while the new funding formula alleviated some concerns, some onlookers felt that the EPF signalled a decentralized role for a federal government slowly withdrawing from shaping health policies and increasingly concerned about national economic policies centred on deficit reduction. These issues were eventually given voice at the expense of social programs. Under the EFP, transfers included a fixed per capita grant based on 1975-76 expenditures adjusted annually according to the rate of growth of the GNP. The grant consisted of two elements: a cash component in concert with tax points for the provinces. While provinces were concerned that the EPF would result in lower transfers, the opposite was true for the first four years of the program. Despite these initial results, there was continued apprehension, as indicated by Taylor, that the EPF Act could ultimately undermine the universal health care system when influenced by the emerging economic ideology of fiscal restraint. Three issues were of particular concern. First, although the provinces remained answerable to the four principles of universality, portability, public administration, and comprehensiveness, the absence of legislated enforcement mechanisms meant that federal funding was no longer tied to the maintenance of these standards. Second, since funds were no longer earmarked for specific health care delivery programs, the monies were effectively considered part of general provincial revenues, and consequently could be dedicated to other spending priorities. Finally, the EPF was not guided by legislation guaranteeing continual federal

\[11 \text{Ibid., 487.}\]
funding for health care and post secondary education, although expenditure cuts and structural changes to the program would require three years notice to the provinces. Essentially the EPF acted as a "critical juncture" in the ongoing historical progression of health care financing in that a seemingly rational and uneventful adjustment to policy "resulted in large eventual consequences."^{12}

By the 1980s the fears of a decentralized federal role were coming to fruition. Owing to the unconditional nature of EPF funding, user fees and extra billing emerged, as did accusations that health dollars were being siphoned into other programs. These problems were further exacerbated by a decade of declining federal transfers under the EPF program. To meet the emergent concerns over extra billing, the federal government instituted the Canada Health Act in 1984 reintroducing conditional funding through the use of fiscal levers. The act defined more precisely the conditions of federal payments, adding accessibility to the previous four national standards, and tied extra billing to dollar for dollar reductions in cash transfer payments. As a result of the historical conflict between jurisdiction and funding authority, the federal government may have had little choice but to impose fiscal levers to uphold the views and values of Canadians. The Canada Health Act, once again, allowed the federal government to enforce national standards, but the return to conditional funding did not include a legislated commitment for continued federal financial support. Thus, in the years following the act, substantial funding reductions were introduced. These developments lent themselves to a series of questions. Can Canadians expect the provinces to maintain national standards with increasing limited funds? If we desire a continued commitment to these principles what

^{12} Hacker. 77. A critical juncture is defined as a crucial period of transition that shapes political and economic development for decades to come.
should the federal role be in assuring and providing a niche for adherence? Should there be federal initiatives to encourage reform within these standards? Or should Canadians accept limited federal spending commitments and work towards reform within the emerging framework? No single study can hope to provide conclusive answers, but this thesis seeks to broaden the mindset for reform beyond local issues.

While Ottawa maintained its claim of protecting national standards, the provinces carried the increasing burden of reduced federal monies under the EPF. In 1982 basic cash allotments—a base line figure granted to all provinces regardless of their own tax revenues—was replaced with a formula that calculated the allotment in relation to revenue. The result was that the provinces with large tax revenues received a proportionate reduction in the cash allotment. Three years later the federal government introduced a series of EPF reductions through an adjustment of the financing formula in relation to GNP. This escalator, the means of connecting EFP financing to the rate of growth in the economy, was reduced by two percent in 1986/87, and an additional percent in 1989 and, one year later in 1990, was frozen at zero for five years. Given inflation, the zero growth in EPF payments translated into reduced transfers for the provinces where the costs of health care continued to rise. The consequences were mirrored in the Health Action Lobby claim that reductions during the period from 1986-87 to 1995-96 resulted in a shortfall of $30 billion dollars in respect to health related transfers to the provinces.¹³

¹³ Health Action Lobby, A Prescription for Medicare (Ottawa: HEAL, 1995).
Changes in the EFP formula are indicative of the evolving federal role in social policy. Writing in the 1970s, political analyst, William Livingston argued that "the essence of federalism lies not in the institutional or constitutional structure but in society itself. Federal government is a device by which the federal qualities of society are articulated and protected." But in a 1995 author Jean Denis Frechette claimed just the opposite, that the federal economic role was no longer compatible with the social ideals of the past. According to Frechette,

...now more than ever it is the economy that must dictate how federal transfer payments are financed...the federal government would seem to be feeling more and more trapped by its policy of imposing national standards... In the coming years economic rationality will have to win out over constitutional concerns. If the central government wants to reduce transfer payments, it will have to rethink standards that have become incompatible with economic reality and make them more flexible.  

Indeed the emerging ideology has engendered a shift in how the federal role has been perceived. In the 1940s, the dominant liberal tradition suggested that a stable economy was achieved via a healthy and productive society, whereas in the 1990s the very means of contributing to a healthy populace was portrayed as detrimental to economic growth.

The financing policy has been significantly reshaped over the last three decades. In the process the federal government has diminished its financial commitment to health care, compromised national standards, and shifted increasing responsibly for health care to the provinces. The funding retractions entrenched in the past policies have been driven by economic, political and social concerns and are highly unlikely to be restored to previous levels. Despite some concessions to the provinces in the year 2000, continued

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14 Quoted in Gray, 7.
pressures for fiscal restraint at all levels of government are going to force the provinces and the nation to examine reform options, some of which may deviate from the very principles that guide the program.

This thesis will highlight the evolution of funding arrangements for health care with an emphasis on the federal role. Both the cash and tax point elements of the transfer will be addressed, although an emphasis on the cash value will dominate since it is the portion of the transfer specifically tied to health funding and enforces compliance with national standards. Tax points are considered part of general revenues and thus provincial governments are not committed to allocating this portion of the transfer to health or post-secondary education. As a result, the residual cash becomes an essential mechanism through which the federal government can influence health policies. Further, while I will discuss the actual transfers British Columbia received, and how reductions in these transfers may influence the spending capacity of the province, the thesis will not address how the British Columbia government manages health care dollars.

Chapter one discusses the British North America Act of 1867 and how jurisdictional and funding powers allocated in the act continue to influence federal-provincial relations. The Hospital Insurance and Diagnostic Services Act (1957) and Medical Care Act (1968) will also be sketched to document the extent to which both levels of government supported the development of a national health policy. The chapter will close by outlining the cost-sharing arrangements that applied to both programs. Chapter two will analyze the pressures contributing to the move from cost-sharing to block funding, describe the new funding formula, suggest some problems inherent in the new arrangement and how the EPF marked a decentralized role for the federal
government. This chapter will also address the paradigm shift, first evident at the federal level, where economic priorities emphasised deficit reduction and cost efficiency. As a result, managing transfer payments became a major source of cost reduction. Here it will also be argued that while the Canadian public continued to support the ideals of health insurance programs they were excluded from understanding the inner workings of the transfer payment system. In chapter three changes to the funding arrangement from 1982 to 1995 will be explained with specific tables outlining federal transfers to the province of British Columbia. The chapter will address how the diminishing federal fiscal commitment has shifted greater responsibility onto the provinces and ultimately jeopardizes the commitment to national standards as provincial governments seek reforms beyond the limitations of the Canada Health Act in order to reduce costs and control expenditures. Further reactions from the province to the Canada Health and Social Transfer will highlight their demands for a more interactive federal funding role in the field of health care. The conclusion will briefly address the impending pressures for reform and recommendations regarding a federal commitment outlined in the Romanow Commission released in 2002. Given that health care continues to dominate the social agenda, public perceptions regarding health care and its financing will also be addressed throughout the discussion.

Ultimately, this thesis examines the federal role and approach to transfer payments in the field of health care. Federal-provincial relations will be framed within a B.C. context, but will not address specific provincial reforms, policies or initiatives. Through detailing the historical development of fiscal policy we will witness the declining federal financial commitment to health care, resulting in shifting responsibility
to the provinces. Framed in this manner this thesis will contribute to a general understanding of how transfers functioned and evolved, and detail how continual minor policy adjustments compound overtime to yield broad and serious consequences.
Universal health care in Canada was the result of myriad social and political forces, shaped by ideas and initiatives coinciding at critical period in the country's history. By the mid twentieth century the welfare state had become increasingly prominent in matters once considered to be private. Under the British North America Act, and a generation of judicial interpretation, provincial and local governments expanded their influence in the areas of health, education and welfare.\(^1\) Mounting pressure from the provinces in concert with a shifting of governance eventually solidified a federal commitment to a nation wide health insurance program. This chapter briefly surveys the evolution of health insurance policy, beginning with early British Columbia and expanding to later national initiatives. Framed within this context the central role of intergovernmental relations in shaping the original cost sharing arrangements for Hospital and Medical Care insurance will be highlighted. The road to universal health care was both long and complex and it is clear that neither the Hospital Insurance and Diagnostic Services Act (1958) or the Medicare Care Act (1968) would have evolved without the cooperative and concerted efforts of both levels of government.

The delineation of powers outlined in the British North America Act of 1867 recognized and entrenched the areas of responsibility between the provinces and the newly established Dominion government. In pre-confederation Canada limited forms of

social welfare were delivered through non-profit, voluntary organizations as well as municipalities guided by traditional poor laws. Given the undeveloped nature of social policy, any suggestion that the Dominion have authority to legislate in these areas would have been inconsistent with the Dominion’s initial goal of facilitating economic prosperity across the nation. At the time of Confederation, Dominion and Provincial government objectives emphasised economic development, infrastructure and trade. For the most part social policies, of the type that would emerge in the twentieth century, were non-existent. Thanks to changing public attitudes, the role of the state had become increasingly prominent in matters previously dealt with by extended family structure or by institutions devoted to the indigent.

Notwithstanding the delineation of powers outlined in the British North America Act of 1867, specific jurisdictional authority was subjected to interpretation and debate as issues involving program initiation, taxation powers and financing responsibilities emerged. Writing in 1950 historian Elizabeth Wallace noted that

when the framers of the British North America Act distributed powers between the Dominion and the Provinces with the intention of conferring on the former all the great subjects of legislation, the exiguous responsibility for health and welfare... were considered local and private, and thus properly to come within the provincial sphere. The Act did not impose any obligations to provide welfare services upon either the Dominion or the Provinces, but simply allocated, with less precision than its framers had hoped to achieve, the various spheres of jurisdiction, any subsequent action being permissive not mandatory.... The fathers of confederation clearly thought they were assigning the provinces the unimportant and inexpensive function of government, among which education, hospitals, charities and municipal institutions were then reasonably numbered.2

As time would reveal, these “obligations” would be viewed as essential, increasing in

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both importance and expense.

Accordingly, under Section 92 of the BNA Act the provinces were allocated “all matters of a local or private nature,” including exclusive power for the “establishment, maintenance, and management of hospitals, asylums, charities, eleemosynary institutions in and for the province other than marine hospitals.” Section 91 assigned exclusive powers to the dominion. They were also designated additional authority to “make laws for the Peace, Order and Good Government of Canada” securing a central role for the dominion in establishing policies of national interest.

“Matters of a local and private nature” included the most significant categories of modern social policy—education, health and welfare. As these envelopes grew at provincial expense, a fiscal commitment the fathers of confederation could have scarcely predicted, a federal presence in provincial jurisdictions came to be justified on the basis of “national interests.” At Confederation these interests were primarily economic in nature, however when social distress compromised capitalist production the lines of jurisdictional authority became blurred. According to Antonia Maioni, “Canada represents the ‘liberal’ model of welfare state development that emphasises individual initiative and opportunity, where social policy is more residual in nature and associated with the role of the market.” For example, during the 1930s the country experienced staggering unemployment rates. Dominion involvement, through grants to the provinces, could in part be justified as investment in the work force and ultimately the economy. Limited to direct taxation, some provinces welcomed a degree of “federal intrusion,” in the form of financing, arguing that the federal government had a broader tax base to

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support growing social policies. The implications of this view will be addressed in the following chapter.

In the post confederation era provincial governments were gradually enticed to deliver health care services, expanding the role of scientific medicine, access to care, and ultimately public expectations regarding personal and social health and wellness. In the late nineteenth century social and economic conditions had altered so radically that provision of health and welfare services became a significant component of political and social movements. The influence of industrialization contributed to rapid urbanization, shifting social relationships, and unstable economic patterns. As in all parts of Canada, private institutions, extended family, and municipalities provided limited social welfare services. However, Megan J. Davies has argued that in British Columbia, late settlement patterns in the west meant that municipal health and welfare service in the province were "embryonic" and its "charitable organizations limited." In fact the narrow nature of social welfare in British Columbia was exacerbated by the fact that unlike other Canadian provinces it was not guided by traditional poor laws. Rather, limited social welfare provisions were directed by a clause in the Municipal Act stating that "it shall be the duty of every city and district municipality ... to make suitable provisions for the poor and destitute." According to Harry Cassidy "the obligation did not mean much in the early days of municipal history, partly because demands for relief were small and partly


because there was no provincial machinery to guarantee that the local authorities would take it seriously." As a result, the consequences of industrialization meant the need for social support mechanisms outstripped the capacity of traditional methods. Rapid population growth brought fiscal and delivery pressures that small, localized institutions were incapable of meeting. In British Columbia the population increased from 98,000 in 1891 to nearly 700,000 in 1931. Further, these population increases combined with urbanization and industrialization contributed to a whole host of public health concerns, including contagious diseases and sanitary issues, that were beyond the capabilities of traditional providers where training and funding was essential to service delivery. In addition, the boom and bust cycle of economic activity that characterized the province made it extremely difficult for localized organizations to deliver services during periods of excessive demand. As a consequence, the province became increasingly involved in a variety of social welfare issues.

Unable to deal with the expanding health concerns flowing from rapid urbanization, the municipalities turned to the province for assistance. Specifically, in response to a small pox epidemic and a cholera outbreak, the provincial government demonstrated a willingness to invest in the health care field by instituting the Public Health Act of 1892. The act established a Provincial Board of Health and designated municipal councils as local boards to address health concerns regarding sanitary conditions and communicable diseases. Gradually, the province expanded services and

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7 Ibid., 38.
8 Ibid., 41. Cassidy discusses the expansion of public health services in the province of British Columbia from 1890s to early 1930s.
it financial commitment to the public health program. In the early part of the twentieth century the province legislated and expanded the Public Health Code on a variety of fronts including Tuberculosis (1901), Sanitary Inspection and Regulation (1904), Food Inspection (1906), Medical Examination of School Children (1910), and Sanitary Conditions in Work Camps (1911). Initially, the team of public health officers delivering the program remained minimal, but during the post war period the province committed to funding and training additional public health nurses and expanding public health initiatives.\(^9\) In a 1928 address to the Canadian Public Health Association, Dr. Esson Young claimed that World War I “marked the awakening of the public conscience” and consequently the expansion of provincially operated public health programs. He claimed that prior to the war “the voices of public health authorities were crying in the wilderness. The public was not concerned. Epidemics were considered visitations from providence.” However, when nearly one third of Canadian Army recruits were rejected as unfit for military service, a healthy populace became a crucial component in promoting and protecting the nation. According to Monica Green “the war had shown that general health measures had prevented outbreaks of disease, as well as demonstrated the benefits of good health and medical care. The public was now in the mood to accept advice in health matters, and at the same time health authorities had broadened their scope to include general health protection, advice and preventative health measures.”\(^10\)

The economic emphasis on raw resource extraction in the west meant the provincial population was widely dispersed and often isolated. Cassidy argued that the

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\(^9\) For information on the establishment and expansion of public health nursing in the province see: Monica Green, *Through the Years with Public Health Nursing* (Ottawa: Canadian Public Health Association, 1983).

\(^10\) Green, 8.
provinces were enticed into areas of public health given the "incomplete coverage and relative weakness of the municipal system." In 1941 a quarter of the population resided in "unorganized territory." Further most municipalities were small, and consequently limited in revenue generating powers. In 1941, only 22 of 61 cities and districts had more than 5,000 people. Retaining jurisdiction over unorganized territory, the province was increasingly compelled to provide care for the infirmed and sick through subsidies and grants to hospitals, physicians and private agencies offering care to individuals outside municipalities. Sporadic settlement patterns coupled with specific public health concerns also contributed to the expansion of health institutions throughout the province. For example, in 1907 the province issued grants to establish and maintain the Tranquille Sanitorium in Kamloops for tuberculosis patients. The facility, which also acted as a base for a travelling diagnostic clinic, was supported and later purchased by the province in 1921.

The province exhibited other commitments to the public health front in implementing the Disease Control Act of 1919. Aided by Dominion grants, the province also established free treatment clinics in Vancouver and Victoria and, in the course of the next decade, the province also struck various agreements with hospitals to process public health laboratory work. Given the high volume of work, the province opened its own lab in Vancouver in 1931. Four years later the Medical Services Branch was established continuing work in areas of public health including tuberculosis, venereal diseases, sanitation and compilation of vital stats. Margaret Andrews argued provincial efforts to

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11 Davies, 60.
12 Cassidy, 39.
13 Ibid., 78.
expand and promote public health services coincided, and perhaps facilitated, a growing public awareness regarding the capabilities of scientific medicine. "In the four decades prior to 1920 there was an increasing variety of medical products available: new types of surgery, new diagnostic aids, new drugs, new immunization agents – all of which significantly increased doctors’ ability to cure and prevent ill health." According to Andrews, increasing public health and education programs including "wartime health measures and receipt of medical treatment under workers compensation laws all tended to increase consumer acceptance of medical products and treatments in the early part of the century."

With greater public acceptance of medical practice the public increasingly developed expectations pertaining to types of services they deemed necessary. However, Megan Davies points out that provincial commitment to public health during the 1920s and 1930s was not base solely on humanitarian rational. "Positive Public Health,’ a buzzword of B.C.’s public health professionals in the 1930s fit well with the... broader shift in public health away from the concept of ‘dirt’ to an interest in personal hygiene. The state would provide each individual with the education and services necessary to attain good health; individuals then had an obligation to be healthy and productive citizens.... thoughts about public health ... were therefore more concerned with fiscal

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15 Ibid. Note: the Workers Compensations Act was implemented in the Province of British Columbia in 1916.
management and bureaucratic efficiency than with humanitarianism."^{16} Despite the province's positive investment in public health, which was not intended to meet private health needs, increasing numbers of individuals were unable to afford necessary hospital and physician care.

Active participation by the provincial government in public health contributed to British Columbia's unique interest in establishing a health insurance program. The Liberals felt such an endeavour might help to quell the turbulent industrial relations that plagued the province. The end of World War I had marked the return of workers and veterans eager for social policies. Historian David Naylor noted that "with 6,255 native sons dead in the war and more than 13,000 wounded returning to the province, some improvement to domestic conditions seemed called for as a gesture of gratitude for sacrifices made in Europe."^{17} Further, throughout the interior police frequently engaged in battle with striking miners and loggers demanding improved working conditions, increased wages and benefits.^{18} The growth of a discontent working class also contributed to the rise of social democratic, labor and socialist political affiliations. Indeed, as early as 1916 an assortment of left-of-center candidates gained a foothold in provincial politics and, in so doing, pressed the Liberals to investigate extensive social reforms.^{19}

In reaction to escalating public and political pressures in 1919, Liberal J.W. Mackintosh raised the issue of public insurance in the legislature. The queries eventually led to the appointment of an unproductive B.C. Welfare Commission to investigate mothers' pensions, maternity benefits, state health insurance and public health nursing

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^{16} Davies, 66.
^{18} Ibid.
^{19} Ibid.
arrangements. While the report claimed "evidence ran strongly in favour of legislation on all fronts," the section pertaining to health insurance was never officially acknowledged or published.\(^{20}\) While mother pensions were introduced in 1921, the reining Liberals acknowledged that the issue of health insurance required greater investigation and an extensive investment beyond the fiscal capabilities of the province.\(^{21}\) While other social programs developed and expanded, such as old age pensions, workers compensation and public health, a health insurance scheme for the province remained on hold.

The depression of the 1930s further illuminated the inadequacies of traditional welfare mechanisms mobilizing a social agenda calling for government intervention in unemployment, health, welfare and education. Megan Davies argues that the presence of young, progressive, reform minded public servants, including George Wier, Esson Young and Harry Cassidy, fostered the expansion of public health front despite the economic downturn.\(^{22}\) But the economic collapse of 1929 brought sharp rises in unemployment and left many citizens unable to obtain basic necessities. An epidemic of national proportions, federal aid became essential for financially drained municipalities and provincial governments across the country. Continued pressure to alleviate social conditions, magnified by economic depression, led to a new Royal Commission in 1932 on State Health Insurance and Maternity Benefits. The Commission recommended a compulsory health insurance plan for all employed persons below a fixed level of income, with voluntary admission available to all other persons, paving the way for subsequent

\(^{20}\) Ibid. 44. Also see Allan Irving, "The Doctors Versus the Experts: Harry Morris Cassidy and the British Columbia Health Insurance Dispute of the 1930s", *BC Studies*, no.78 (Summer 1988).

\(^{21}\) Cassidy, 46. Cassidy discusses the allowances for Mothers’ Pensions.

\(^{22}\) Davies, 66.
legislation. Looking back from the vantage point of 1945, provincial director of social welfare Harry Cassidy claimed the report was indicative of the changing political climate. "Clearly the time had come for a provincial government to turn from the easy going frontier politics of roads and bridges, construction contracts and patronage and the spoils of the office to the politics of social welfare in order to retain the confidence of the people."^24

Given the recommendations of the report and political pressures to expand social policy commitments the Liberals once again added health insurance to their agenda. Labour movements in the province had a strong and successful history and were a critical component in shaping political platforms. The growing middle class tended to support expanding social policies and consequently emerging left wing political groups that espoused such goals. In British Columbia the newly formed, socially attuned, Canadian Commonwealth Federation, which had established a strong following in Saskatchewan, was preparing to run in the 1933 election. Political competition served to ensure the Liberals would continue to support progressive social policies in an effort to maintain the working class vote and political supremacy.^25

With a victory behind them the Liberals pursued their ambitious endeavour to establish public health insurance in the province. Initially, they requested federal loans to help subsidize the plan, but were turned away. Claiming such a program was beyond their jurisdiction, R.B. Bennett’s Conservative government left the provincial Liberals under Premier Dufferin Pattullo to forge ahead with a draft health insurance bill in

^23 Cassidy, 64.
^24 Ibid.
^25 Ibid.

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1935.26 Davies described Pattullo as a progressive “reformist” that supported the development of health and social welfare, promoting “an active interventionist state under the direction of experts.” Given strong political motivation the B.C. Health Insurance Act received royal assent on 1 April 1936, providing compulsory coverage of wage earners receiving less than $150 per month. Given that indigent populations were often covered under existing provincial – municipal arrangements, the act targeted low income earners as those most likely to experience financial hardship during a medical crisis. Insured persons and dependants were provided medical benefits covering doctor services, hospitals, partial drug costs, and necessary x-ray and diagnostic services. Coverage would be funded through contributions from wage earners and employers, with government aid limited to administration and coverage of indigents.27 Despite popular public support, financial considerations, political vulnerability and opposition from the B.C. Medical Association (BCMA), the B.C. Manufactures Association, the Chambers of Commerce and Board of Trade prevented implementation of the bill. Initially, provincial physicians were receptive to some form of health insurance for compassionate reasons, coupled by the reality that high unemployment rates and unpaid bills were affecting their bottom line. Margaret Andrews confirms that during the 1920s “doctors in the province clearly supported the establishment of a provincial health insurance system on the

26 The federal government was particularly adamant about maintaining jurisdictional boundaries in the early 1930s owing to a recent ruling of the Privy Council. In 1928 the House of Commons requested a Standing Committee on Industrial and International Relations to investigate unemployment, sickness and disability insurance. In their findings the committee recommended further study into a national health insurance program. As a result, the Employment and Social Insurance Act was passed in 1935 incorporating an Administrative Commission to develop various forms of social insurance for enactment by the government, including health insurance. However, the Act was appealed by both the Canadian Supreme Court and the Privy Council ruling it unconstitutional based on jurisdictional authority. See J. Harvey Perry, A Fiscal History of Canada: The Post-War Years (Canadian Tax Foundation, Paper No. 85, 1989).

27 Cassidy, 91.
understanding that it would cover much of the treatment they had been providing without pay.\textsuperscript{28} Although the provincial government had worked closely with the Canadian Medical Association (CMA) in developing the Act, the BCMA continued to express concerns over third party intervention and capitation forms of remuneration and argue that set income ceilings prevented doctors from directly billing financially secure patients.\textsuperscript{29} But most concerning was the fact that the act failed to cover the unemployed and indigent population. When physicians were questioned “Are you prepared to work with the Health Insurance Act as it now stands? Only 13 of 633 respondents supported the plan.\textsuperscript{30} Meanwhile the business community complained increased payroll taxes would drive up prices allowing eastern competitors an unfair advantage.\textsuperscript{31} On going controversy and debate coincided with party concerns over the upcoming election resulting in an indefinite postponement of the bill. However, in an effort to attract voter attention and gain a sense of public support regarding the policy, the liberals polled British Columbians during the 1937 election. Voters were asked “Are you in favour of a comprehensive Health Insurance Plan progressively applied?” Fifty-nine percent of voters supported such a plan.\textsuperscript{32} Given established support it is clear the public desired some form of health insurance.

Given the province’s inability to overcome opposition on the health insurance

\textsuperscript{28} Andrews, 132. A 1934 government survey of British Columbia physicians showed that 29\% of patients in 1929 did not pay for medical attendance they received.

\textsuperscript{29} For an extensive discussion on the attitudes of both the CMA and BCMA towards the health insurance in Canada see, David Naylor, \textit{Private Practice and Public Payment} (Montreal and Kingston: McGill – Queen’s University Press, 1986). For a discussion specific to BCMA objections during the 1930s debate see pp. 76-83.

\textsuperscript{30} Andrews, 141.

\textsuperscript{31} Naylor. Note: Payroll taxes were not to exceed 2\% of the total payroll and employees were capped at 3\% of their wages for maximum contributes to the program.

\textsuperscript{32} \textit{Ibid.}, 86.
front, in 1940 the BCMA unveiled the Medical Services Associated Plan, a non-profit, physician sponsored health insurance plan with membership limited to groups of ten or more employees. Rates consisted of an initial registration fee of $1.50 supplemented by monthly dues of $1.15 for individuals or $2.38 for dependants. Doctors were reimbursed through a fee schedule negotiated with the College of Physicians and Surgeons. The program operated on a similar basis as Blue Cross and a variety of other health insurance schemes emerging in the province and elsewhere. In establishing their own plan doctors were able maintain the autonomy they desired to protect while ensuring patients would receive and pay for necessary services. Further, the relative success of the program entrenched physician opposition to government involvement in areas of health insurance.

A provincial Royal Commission in 1947 inquiring into health and accident insurance associations found that the majority of insurance options were beneficial for clients. But the commission also reported several negative aspects of privately operated plans including fraud, poor management and most importantly, on membership restrictions that excluded a vast majority of the public. Based in part on public hearings, the report concluded that

... throughout the Province it would seem apparent that the public generally are desirous of having some form of health insurance inaugurated either by the Provincial or Dominion Government on a contributory basis, and [one] cannot see any reason why this should not be

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34 See Howard C. Shillington, *The Road to Medicare in Canada* (Toronto: Del Graphics, 1972) for a discussion on private, for profit, health insurance plans in Canada. While these plans were beneficial they were limited in that they were only available to individuals with the ability to pay for coverage.
accomplished, and particular in respect to hospitalization, under a similar plan to that recently embarked upon by the Province of Saskatchewan.\footnote{Ibid., DD9.}

Despite the relative success of private schemes, it was clear that the public still viewed government involvement as essential in order to provide broad and comprehensive coverage to the population.

Despite setbacks during the 1930s the Liberals continued to support a provincial health insurance policy. According to D. Turnbull, Health and Welfare Minister in 1950, "the provinces were increasingly being approached for help by financially drained hospitals and municipalities." Byron Johnson, provincial Minister of Health in 1947 viewed health insurance as a solution to the problem. In the spring of 1948 the legislature passed an "Act to Provide for the Establishment of Hospital Insurance and Financial Aid to Hospitals" to be followed by the implementation of a health insurance program.\footnote{A. Douglas Turnbull, "Memoir: Early Years of Hospital Insurance in British Columbia," \textit{BC Studies} (76) (1987-1988): 58-81.} In January 1949, British Columbia became the second province in Canada to implement a non-profit, comprehensive, public hospital insurance plan.\footnote{Saskatchewan was the first province to establish a comprehensive health plan. For a discussion on the technical and programming difficulties associated with the British Columbia Hospital Insurance Service see A. Douglas Turnbull.} The Hospital Insurance Services Act provided public ward accommodations and hospital services including operations, x-rays, laboratory procedures, anaesthetics, dressings and certain prescribed drugs.\footnote{British Columbia, "Hospital Insurance for Everyone! A Guide to the Provincial Government Hospital Insurance Plan," (Victoria: Ministry of Health and Welfare, 1948).} The provincial government financed the plan through premiums and contributions. In an effort to fulfill the comprehensive mandate the program required registration of the entire population, which proved to be an administrative nightmare.

Specifically, persons subscribing to "approved," non-profit, insurance agencies could be
exempted from the provincial plans and their files were passed on to the requested insurer. Individuals remaining with a “non-approved” carrier were required to pay the designated premiums and remain registered in more than one plan. Social assistance recipients were exempted from premiums.\footnote{Ibid.}

Initially support for the plan was limited, a consequence of complicated administrative procedures, high premiums, and competition from existing insurance agencies. In 1952, the new W.A.C. Bennett Social Credit government sought to revamp the program by abandoning the six month waiting period and lowering premiums while instituting a dollar per day user charge covering services without limit. Two years later premiums for hospital insurance were abolished, compensated by an increase of the social services tax from three to five percent. The combined effort attracted over 30,000 new subscribers.\footnote{Malcolm G. Taylor, \textit{Health Insurance and Canadian Public Policy: The Seven Decisions that Created the Canadian Health Insurance System} (Montreal: McGill Queens, 1987), 168. Also see Howard C. Shillington, \textit{The Road to Medicare in Canada} (Toronto: DEL Graphics, 1972) for further discussion on non-profit, prepayment, physician-sponsored plans.} By the 1950s roughly ninety percent of the provincial population had coverage through either private or public plans.

While British Columbia struggled with the complexities of a suitable health insurance scheme, the federal government continued to investigate whether health concerns should be viewed as national in scope. In 1940 the Royal Commission on Dominion-Provincial Relations (Rowell-Sirois Report), in line with the traditional interpretation of the BNA Act, sought to preserve provincial jurisdiction but recommended increased federal financial commitments. “The commission’s plan seeks to ensure to every province a real and not illusionary autonomy by guaranteeing to it free
from conditions and control, the revenues necessary to perform those functions which relate closely to its social and cultural development." Accordingly the commissioners did not recommend health policies and insurance programs as initiatives viable for federal financial support. Specifically, "an enduring and deep rooted social malaise, which requires the mobilization of efforts on a nation wide scale to deal with it, is beyond the power of the Dominion unless it is compromised in the enumerated heads of Section 91. Generally the power to deal with these pressing social questions rests with the provinces." Furthermore, centralization would jeopardize regional differences and national unity. Specifically, from the Commissioners' perspective the "Mere importance of a service does not justify its assumption by the Dominion."

At the same time the commission recommended far reaching changes in federal-provincial fiscal relationships to foster greater coordination and alleviate some of the hardships experienced during the depression. Overall, the commission recognized a new division of government responsibilities wherein revenue exchange would foster emerging national objectives. Recommendations included establishing a national unemployment relief program, transferring the direct tax field to federal jurisdiction and establishing a national adjustment grant to reduce regional disparities. The majority of the provinces, including British Columbia, opposed the findings voicing concerns over the transfer of taxation powers while the wealthier provinces rejected possible financial losses incurred through the adjustment grant system. Thus the report failed to generate significant

43 Ibid.
44 Ibid.
45 Taylor, 10.
changes, but foreshadowed the future of federal-provincial relations. The sphere of national interests was growing and would, in time, be mirrored by a corresponding fiscal presence.

Only two years later an internal federal task force, the Advisory Committee on Health Insurance, drew up the first blueprint for a national health insurance plan. The commissioners argued that public opinion demanded a national program structured within the existing constitution, where responsibilities for administering and providing health care would remain in provincial jurisdiction. Furthermore the plan would be compulsory, embrace the entire population, and foster preventative programs. Because a constitutional amendment was not an option, Grants in Aid were suggested to promote the nationwide expansion of health services. The task force findings were passed to a select special committee of Parliament for further examination. The committee supported the proposal recommending a national program funded through taxation and grants, an initiative added to the agenda of the upcoming post war conference on reconstruction.

Health insurance proposals also gained momentum, thanks to Leonard Marsh’s 1943 report on Social Security for Canada favouring an extensive social safety net and the collective pooling of risks in response to the changing economic realities, brought on by massive industrialization, urbanization, and shifting social conditions. Marsh claimed, “in modern economic life there are certain hazards and contingencies which have to be met, some of them completely unpredictable, some of them uncertain as to time but others reasonably to be anticipated. They may be met in hit-or-miss fashion …; but we know from experience that, these problems or needs are always present at some place in the

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46 Ibid. 18.
community or among the population.\textsuperscript{47} This perspective recognized an emerging national conscience where the welfare of individuals signified the development, advancement and prosperity of the state. Under the previous classic liberal view of society, private markets were pre-eminent and government had a limited role in altering production and the distribution of income, goods and services. This philosophy was countered by a new outlook favouring government intervention guided by a responsibility to protect and compensate their citizens.

Marsh's views coincided with emerging economic theories, the most popular of which was modeled by British economist John Maynard Keynes. He claimed that high levels of employment, reasonable price stability and increased standards of living could be achieved through the manipulation of taxation and expenditures. Increased capital investment on various programs, combined with reduced taxation rates, would ultimately stimulate the economy, even if this meant incurring a deficit. In periods of economic prosperity surpluses were to be used to control and reduce debt accumulation. The theory justified an interventionist role of government and seemingly worked with the ebb and flow of the economy throughout the post-war years.\textsuperscript{48}

Theory, however, was not the sole motivator of Liberal support for national health policies. In a letter to Prime Minister Mackenzie King in 1943, Ian Mackenzie, national Minister of Health reiterated his electoral concerns about the future of the Liberal party. He commented, "What of the rise of socialism all across Canada? It was for years a

\textsuperscript{47} Quoted in Armstrong, 54.

\textsuperscript{48} Robert and Doreen Jackson, \textit{Politics in Canada: Culture, Institutions, Behaviour and Public Policy}, 5\textsuperscript{th} ed. (Toronto: Prentice Hall, 2001), 521. Jackson noted that although "successive federal governments intervened to boost aggregate demand as an incentive to economic growth, they rarely followed Keynes' prescriptions of expenditure cut backs and tax hikes to deflate the economy in time of expansion and inflation."
British Columbia and Saskatchewan freak but now it is definitely a national political menace.\footnote{Quoted in Taylor, 35.} Begrudgingly receptive to public demands, the federal Liberals joined all other federal parties to include health insurance proposals in their campaign platforms in stiff competition for public support. A Gallup poll conducted in 1944 asked if individuals would approve or disapprove of a National Health Plan where a flat monthly payment of complete medical and hospital care by the federal government? Eighty percent approved; five years later support had risen to 83 percent.\footnote{Naylor, 158.}

During the 1945 Dominion-Provincial Conference on Reconstruction the federal government proposed financial participation in a comprehensive health insurance plan, offering to meet 60% of estimated costs as well as responsibility for old age pensions and unemployment assistance.\footnote{Canada, Health, Welfare and Labour: Reference Book for Dominion-Provincial Conference on Reconstruction, (Ottawa: 1945). Note: the “60%” contribution was capped at $12.96 per person. If government spent excessively their contribution could recede below the sixty percent mark.} However, in an effort to retain substantial tax sources acquired during the Wartime Tax Agreements, financial and administrative participation was contingent on provincial relinquishment of personal income and corporate tax fields, succession duties and several minor taxation fields.\footnote{The influence on intergovernmental tax arrangements on negotiations regarding social policies will be clarified and elaborated in the concluding portions of the chapter.} Following three days of deliberations control over taxation and financing continued to divide the two levels of government. In the end the three prairie provinces agreed to accept the entire deal. All the provinces were willing to cede personal and corporate taxes, but only six were willing to abandon succession duties. Unwilling to compromise the meeting was called; the proposals were shelved, foretelling of the continual set backs the program would endure.

In a political manoeuvre demonstrating a federal commitment to health care, the
previously contemplated Grants in Aid program was implemented supplying financial contributions for a variety of public health programs, training, education and hospital construction.\textsuperscript{53} Introduced in 1948, the grants fostered impressive new growth in the availability of health services, acting as a catalyst for developing health insurance programs.

Clearly, in the first half of the twentieth century provincial politicians exhibited a concerted effort to expand the social policy field on a variety of fronts regardless of the Dominion's unwillingness to commit. In Cassidy's view British Columbia was patiently waiting for a "comprehensive outline of a national system of social security ... [in order] to clear the way for really effective work on the provincial and local level."\textsuperscript{54} While the province continued to expand social services, public and political pressures spurred on federal involvement.

By the 1950s the establishment of a national health insurance program or, at minimum, a national hospital insurance scheme, had become a political necessity for three distinct reasons. Both levels of government had, to varying degrees, committed to expanding health services and inquiring into national insurance schemes. Second, public opinion had consistently demanded action on the policy front. Finally, the governing federal Liberals were becoming increasingly wary of growing support of the Canadian Commonwealth Federation and the Conservatives who were both committed to a national hospital insurance plan. Consequently, in 1956 at a Federal-Provincial Conference the

\textsuperscript{53} Federal Grants in Aid to the provinces increased from 7.8 million in 1948-49 to 50.3 million 1962-63. During the period 1948-62 British Columbia was eligible to receive 50 million in grants, but actually applied and received 39.9 million. In 1972 the Grant in Aid program was terminated. See: Paul A.R. Hobson and France St. Hilaire, Reforming Federal Provincial Relations: Towards Sustainable Federalism (Institute For Research on Public Policy, 1993), 39.

\textsuperscript{54} Cassidy, 12.
Liberal government extended the grant in aid program to provinces enacting legislation for operation of hospital insurance programs. A year later the introduction of the Hospital Insurance and Diagnostic Services Act followed, passing with a unanimous Commons vote. Under the Act the federal government would pay a fraction of defined sharable operating costs of hospital care. The calculation, cited as 50-50 cost-sharing, included two components. Twenty-five percent of costs were based on provincial expenditures and 25% were based on national average costs. Sharable costs covered normal operation and maintenance related to ward care and excluded capital expenses and additional costs attributable to semi-private and private ward care, uninsured portions of patient hospitalization, or provincial administrative overhead.55

Although enacted the national plan was merely an enabling act. It was restricted by a clause requiring a majority of the population’s support, represented by the provinces. At the time British Columbia, Saskatchewan, Alberta and Newfoundland had public universal insurance plans in place compatible with the national program, but represented less than a quarter of the country’s population. At a Federal Provincial Conference in 1956 Premier W.A.C. Bennett of British Columbia objected to the substantial majority concept:

British Columbia recommends that any province willing to participate in a health program should not be retarded by the refusal of others to participate; …let this conference agree in principle upon the desirability of a health program adaptable to the requirements of the individual provinces; that such a plan make provision for medical, hospital, dental and pharmaceutical services; and that the federal government share equally in the costs of such health programs to the extent that they have been or may be adopted by a province to meet its special requirements…

55 Eric J. Hanson, Royal Commission on Health Services: The Public Finance Aspects of Health Services in Canada (Ottawa: Queens Printer, 1963), 25.
[We] will now enter into a program on a 50% basis with the national government.\textsuperscript{56}

Delivered on the eve of a federal election, provincial willingness to invest in a national program failed to gain attention. In June 1957 Louis St Laurent's Liberals lost to the Conservatives. A year later Diefenbaker lifted the restriction allowing the western provinces, Newfoundland and Manitoba to participate in cost-sharing as of 1 July 1958. The other provinces and territories quickly followed suit.\textsuperscript{57}

As hospital insurance came to fruition, a parallel dialogue regarding a national medical care insurance program continued between the two levels of government. Indeed, Justice Emmett Hall's 1964 Royal Commission on Health Services recalled fondly how a consensus on priorities contributed to a successful hospital insurance scheme functioning within the framework of the constitution. Hall noted,

\begin{quote}
The program appears to be a sound blend of federal financial support and respect for provincial responsibility. In fact it goes beyond that for in its administration it utilizes a number of joint Federal-Provincial Committees and working parties. It is a remarkably successful example of what has been termed 'cooperative federalism.'\textsuperscript{58}
\end{quote}

In Hall's opinion hospital insurance was only a precursor to a more elaborate national health insurance plan. Echoing the Marsh report's articulation of a "national conscience," Justice Hall argued,

\begin{quote}
...quite apart from humanitarian considerations, the health of Canadians is a concern to us as a nation, and no enlightened government can ignore that the economic capacity of its citizens to be productive depends upon their health and vigour as much as their educational attainment.... The best solution for Canada is the establishment of a comprehensive, universal health services program... Canada requires the establishment of health insurance funds, provincially administered, contributed to by the Federal
\end{quote}

\textsuperscript{56} Quoted in Taylor, 214.  
\textsuperscript{57} Ontario and Nova Scotia implemented plans in January 1959; New Brunswick July 1958; Prince Edward Island October 1959; Quebec 1961; North West Territories and Yukon 1960.  
\textsuperscript{58} Justice Emmett Hall, \textit{Royal Commission on Health Services}, (Ottawa: 1964), 413.
government from general revenue and by provincial governments as they may determine, structures along similar lines as the Hospital Insurance Program. 59

The Canadian Medical Association supported confining policy to subsidizing the vast number of individuals unable to meet their health care costs. But Hall argued subsidization could be potentially as costly as a national scheme, resulting in part from the massive administration required to conduct means testing on the Canadian public; a practice he condoned as “inherently undemocratic.” 60 After outlining a potential program he rallied an impressive call to action:

This is what Canada and the provinces working together should do. It’s not an idealists dream but a practical program within Canada’s ability financially and practically... It’s what Canadians ought to strive for and expect through their governments. They should not be content with less. 61

Following Hall’s recommendations Prime Minister Lester B. Pearson called another Federal-Provincial Conference in July 1965 to discuss a national scheme.

Pearson’s opening statement went straight to the heart of the delicate issue of jurisdiction;

Our constitution does not establish- no constitution can establish, except at the price of impractible rigidity- absolute distinctions between the functions and powers of our respective governments. Our responsibilities are mingled at different points. Our concerns overlap even more. In many areas, federal provincial governments are responsible for parallel action within their respective jurisdictions... The present government of Canada has clearly accepted the fact that many of the constitutional responsibilities of the Provinces are in areas of rapidly growing need... On that basis we will discuss to the best of our ability the responsibilities of national leadership which must be undertaken from the center and will require us to use our powers for the good of all Canadians. 62

Specifically, in discussing health services he continued:

60 The Canadian Medical Association was particularly influential in shaping health policies. They had requested the establishment of a Commission to investigate Health Insurance confident that they would favour private non-profit plans.
61 Ibid.
The item of our agenda which is most important of all, because it can most closely affect the daily lives of all Canadians, is the provision of health services... Accordingly, we have attempted... to inform ourselves... of the views of the provinces. [We are under the impression] that the provincial governments rank high among their objectives the establishment of a health services plan which will enable their residents to have access to comprehensive physician services on a prepaid basis. That, as I have said, is also the federal view... I believe that Canadian attitudes and Canadian economic standards have now developed to the point at which we are ready to regard Medicare as part of Canada's basic social standard... In giving this undertaking I am not proposing a new cost shared program... 63

Rather, if the provinces established universal, portable, comprehensive and public administrated systems, the federal government would be "prepared to accept responsibility for an amount per capita of approximately one half of the national cost of Medicare programs based on the proposed definition."64 This initial federal commitment, combined with a string of minority governments, forced politicians to address the social envelope in the wake of growing public support for expanded social programs.

Similarly, in his opening statement Premier W.A.C. Bennett reiterated a positive attitude for intergovernmental relations and aspirations for Canada’s future.

This conference should lay the ground to achieve still greater progress in the near future and over the next twenty years in the economic and social well-being of all Canadians. There is every reason to be optimistic for the future of all regions of Canada, providing we foster a dynamic cooperative federalism to ensure full employment of our human and material resources and better educational, health, and humanitarian services for all people.... Mr. Prime Minister, I wish to assure you that British Columbia is prepared to co-operate fully with the Government of Canada in vital joint programs for national development.65

In relation to medical services Bennett proclaimed "British Columbia endorses, without

63 Ibid., 15.
64 Ibid., 16. Note: cost-sharing for Medicare did not vary with provincial expenditures and thus was not termed “50/50” cost sharing.
reservation, the introduction of comprehensive medical services for all Canadians as soon as possible and irrespective of ability to pay, provided that the federal government will pay fifty percent of the costs." By this time B.C. was anxiously waiting monies since they had already established their own agency, the B.C. Medical Plan, insuring individuals or families unable to qualify for group coverage and subsidizing the premiums of low-income individuals.

Despite British Columbia's favourable attitude their view was not representative of the several provinces which argued that even though joining was voluntary, the adoption of Medicare was a coercive measure since it would be extremely difficult for non-participating provinces to ignore the power of federal coffers. Those provinces opting out also risked support of their electorate who were still obligated to contribute to the new federal Social Development Tax, implemented to help fund the program, even though they would not receive benefits. In addition to these pressures, the federal government sought to further entice and encourage consensus on the Medicare issue by introducing the Health Resources Fund in preparation for the new program. Commencing 1 January 1966 federal dollars were allotted to the provinces to aid in meeting the capital costs of planning, construction and renovations alongside provision of training programs.

After enticing the provinces with significant health care investments the Minister of National Health and Welfare, Allan MacEachen - a devoted supporter of the plan,

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66 Ibid., 79.
67 Some provinces, particularly Ontario, were especially enraged about the Social Development Tax because they were investigating introducing such a tax at a provincial level. Note: The federal Social Development Tax did not actually become effective until 1969.
68 $400 million was given to the provinces on a per capita bases, $25 million to regional Atlantic projects, and $ 75 million for projects of national significance.
brought forward a federal resolution for the introduction of Medicare on 12 July 1966. Arguing further delay would undermine the Liberals’ commitment to the program, he suggested a commencement date of 1 July 1967 – Canada’s Centennial. As included in the earlier offer, federal funds were subject to the four principles with the definition of public administration extended to include non-profit private insurers operating in concert with the provincial government. Further, federal financial contributions included a per capita payment for provincial residents enrolled in the plan, equal to one-half of the national per capita cost. Notably, there was no consideration for actual provincial costs. But deep-rooted concerns from the Finance Minister, Mitchell Sharp, regarding the fiscal pressures associated with the bill lead cabinet to postpone the program for one year. But opinion polls continued to exhibit not only wide-spread popular support, but that Canadians were willing to pay for the new program. A poll conducted late in 1960 reported that almost 6 of every 10 Canadians supported a comprehensive state medicare plan, even if it meant an increase in taxes.\(^6^9\)

Finally, despite acrimonious debate regarding finances in the cabinet on December 1966 the Medical Care Act was passed in the House of Commons, 177-2 in favour, effective 1 July 1968.\(^7^0\) British Columbia and Saskatchewan began programs on the commensuration date and by 1970 all of the provinces had instituted the program. After decades of discussion a comprehensive, national health insurance program had been achieved; the policy quickly became Canada’s most revered social program and most costly. The emergence of national health policies meant governments were willing to

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\(^6^9\) Naylor. 191.

invest in programs that Canadians deemed important, creating societal commitments and giving rise to widespread public expectations that would be difficult to reverse. Unlike other social programs the benefits of health insurance would influence the life of every single Canadian. The significance of the program, combined with the willingness of Canadians to collectively finance such a vital endeavour, has meant health insurance has become a publicly perceived right. With a national program in place the test of ensuing years became balancing sound health care policy with emerging pressures for fiscal accountability and restraint.
Chapter Two: Negotiating Funding

The founding of a comprehensive public health insurance system during the post-war era was marked by a fairly cooperative atmosphere between Dominion and provincial governments, with each striving to establish a minimum level of health services for all Canadians. Guided by numerous Royal Commissions, Advisory Committees, public forums and national opinion polls, both levels of government responded to the needs and desires of the nation’s citizens. But by the late 1970s efforts to renegotiated funding arrangements compromised the cooperative relationship. Controlling hospital and health insurance expenditures dominated governmental agendas, particularly at the federal level where spending was rapidly increasing. Motivated by a determination to limit these expenses the federal government shifted greater responsibility to the provinces by replacing the existing shared cost arrangements with block funding. Although deemed necessary by both levels of government, the parameters of the new arrangements set the stage for the future decentralization of health care services, and more specifically health care financing. While changes to the previous cost-sharing program initially failed to attract attention beyond the inner circles of government, the new arcane and complex formula further deterred public understanding of the transfer program. Even though the public continued to support the ideals of universally accessible health care they were excluded from understanding adjusted funding formulas and consequent reductions, creating a vacuum of knowledge necessary in comprehending imminent pressures and modifications to the health care system.
Increasingly fiscal concerns became a powerful factor in shaping health care policies and reform as Finance Ministers, rather than Health Ministers, became prominent in shaping the future of health care in Canada. Moreover, the complex changes in fiscal arrangements, which have continually perpetuated the illusion of crisis between the central government and the provinces, were often closed to the public and even health ministers. This emerging “fiscal presence” guided the transition from cost-shared programs to the block-fund formula known as the Established Programs and Financing Act (EPF) which effectively shifted all the risk for controlling both programs and rising costs to the provinces. The EPF provided the provinces enhanced flexibility in determining health priorities, but failed to define and guarantee federal long term financing obligations, allowing the federal government to redefine their fiscal role through a series of policy amendments in the following decades.

The complex nature of intergovernmental fiscal relations stems from a series of negotiated tax agreements created during the first half of the century. Although tax arrangements may seem far removed from the establishment of health insurance and cost shared programs, they are vital in understanding future developments in fiscal transfers. Under the BNA Act the provinces were allocated “Direct Taxation within the Province in order to raise revenue for Provincial Purposes,” most commonly defined as corporate and income taxes, although at the time of Confederation these tax bases were limited. The

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dominion government possessed taxation powers heavily weighted in its favour, empowered to gather revenues "by any Mode or System of Taxation."

In desperate need of greater revenue during the First World War, the federal government requested and received from the provinces a limited amount of tax room in the direct tax fields. Consequently, in 1917 the federal government began imposing additional income taxes on individuals and corporations. The economic depression of the 1930s further legitimized the federal role, as the agent most capable of redistributing resources to reduce regional distress across the country, promoting federal domination of the post World War I tax system. Once again, under extreme financial constraint during World War II, the Wartime Tax Agreements were extended but this time the provinces refrained from collecting personal and corporate taxes in return for compensation, mainly unconditional revenue transfers and specific purpose transfers, allowing the central government a free rein. Eager to maintain these growing sources of revenue, the federal government proposed a continuation of the agreement after the war, despite the adamant protest from some provinces, particularly Ontario and Quebec. According to David Perry, by maintaining its presence the federal government "contradicted the implied principle that the provinces had exclusive use of the direct tax field...," a principle so well established that the federal move was regarded as an "invasion of provincial taxing

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3 For example, as compensation B.C. accepted amounts equal to provincial and local revenues from the renounced taxes in the provincial fiscal year ending nearest to 31 December 1940. For a discussion on the history of tax arrangement in Canada see: Perrin Lewis, "The Tangled Tale of Taxes and Transfers," in Canadian Confederation at the Crossroads: The Search For a Federal – Provincial Balance (Vancouver: Fraser Institute, 1978), 39-102; or David B. Perry, Financing the Canadian Federation: 1867-1995 (Toronto: Canadian Tax Foundation Tax Paper 102, 1997).
powers. The prominence of direct taxes, originally designated to the provinces, had grown immensely during the war. For example, prior to the war income tax affected roughly 300,000 taxpayers, but by 1945 it had become a mass phenomenon collected from millions of Canadians, thus sparking competition between the two levels of government to secure access to these vital tax revenues.

In an effort to appease the provinces while maintaining access to the direct taxation fields, the federal government initiated a series of post World War II piecemeal changes to taxation revenue sharing. The initial change was revealed in the new terminology of the Tax Rental Agreement which by the very term “rental” implied a federal recognition of the intrusion into provincial jurisdictional authority. Under the arrangement the provinces “rented” personal, corporate and death taxes, to the federal government for a period of five years. Eight provinces by 1949 accepted the offer. The federal government accommodated the position of Ontario and Quebec by allowing a credit for the limited personal and corporate income taxes they imposed.

Further compensating the provinces, modifications to the Federal-Provincial Fiscal Arrangements Act of 1962 allowed the federal government to reduce its share of direct taxes. The previous tax rental agreement was replaced by tax collection arrangements, underlying the present system. The provinces could now obtain revenues

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3 Ibid., 383. In 1955, continued complaints from the provinces desiring recovery of tax room was eased by a standard abatement of personal income and corporate taxes, set at 7 and 5 percent respectively. Tax room allocated to the provinces gradually increased in the following years. Also see: Paul A. R. Hobson and Robin W. Broadway, Intergovernmental Fiscal Relations in Canada (Toronto: Canadian Tax Foundation Tax Paper No. 96, 1993) or A.W. Johnson, “Federal-Provincial Fiscal Relations: An Historical Perspective,” in Thomas J. Courchene, David W. Conkin, and Gail C.A. Cook eds., Ottawa and the Provinces: The Distribution of Money and Power, vol. 2 (Toronto: Ontario Economic Council, 1985), 114 - 123.
through their own legislation which, if uniform with the federal act, would be collected for the provinces while the national government absorb the administrative costs. But the actual tax transfer remained minimal, allowing the federal government to expand and finance national social policies.

In a brief presented in 1963, British Columbia Premier W.A.C. Bennett reiterated provincial arguments in stating that

the bargain made by the Provinces at Confederation to surrender their powers of indirect taxation, representing four fifths of their revenues, for per capita or fixed subsidies, quickly forced them to use their exclusive powers of ‘direct taxation within the Province’ under section 92 of the British North America Act. Sole provincial use of income taxes as respected by the Federal Government for 50 years preceding World War I. Federal entry in 1917 was explained as a temporary action in a time of national emergency.

In the emergency of World War II the provinces gave temporary control of income taxes to Canada,… but it was clearly understood that the provinces would again exercise their full taxation rights in peace time… the centralist theories have lingered on to influence succeeding national administrations, which have returned to the provinces less than 20% of the personal and corporate tax fields…. This reluctance of the Federal Government to recognize provincial taxation rights, combined with public pressures on the Provinces to meet their constitutional responsibilities, has led to the large scale substitution of national equalization and conditional grant payments to the Provinces.

In Bennett’s opinion the existing financial arrangements were not filling the fiscal gap resulting from limited revenues and increased expenditures bought on by the expansion of social programs. Specifically, in regard to establishing medical care insurance he argued “Canada and the Provinces should be sharing equally in the public costs.”

Bennett’s assertion was expressed by the earlier 1960 Royal Commission on Health

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7 Note: At the initiation of the program the tax abatement to the provinces was equivalent to 13%, by 1967 it had grown to 24%. See A.W. Johnson, 115.
8 Premier W.A.C. Bennett, Brief Presented to the Plenary Session of the Federal-Provincial Conference (Ottawa, 25 November 1963), 3.
9 Ibid., 7.
Services which claimed that "only the federal government [had] the resources to deal with health matters on a national scale..." Thus, while the provinces continually argued for a greater share in the direct tax field, a federal presence could be justified as long as they remained committed to national programs.

Clearly, the provinces experienced substantial losses in their direct taxation powers although they were compensated through a variety of extensive fiscal transfers supporting provincial policies and programs. At the same time the federal government was fulfilling its national objectives. After all, according to A.W. Johnson the Parliament of Canada has the "power to achieve national objectives by the familiar device of financing the establishment and maintenance... of nation wide programs. Parliament is, after all the nationally elected representative of ... Canadians and therefore best able to perceive the 'national interest..." By the late 1960s fiscal transfers included equalization, health, education, welfare, unemployment, pensions and a variety of specific grants to persons. However, in the decades that followed, as these programs became more expensive, fiscal responsibilities were shifted back to the provinces through block-funding and renewed taxation powers.

Despite these developments not all the provinces favoured joint funding in areas of provincial jurisdiction. Quebec vigorously argued for renewed provincial funding capacity and control over social programs. In 1965 the federal government proposed

10 Johnson, 141. Johnson also recognizes an opposing point of view.
11 A long history of French-English conflict has left francophones suspicious and opposed to federal policies in areas of provincial jurisdiction. The late 1950s marked the beginning of the "Quiet Revolution" where Quebec nationalism fuelled provincial policies that challenged Canadian federalism and the "very existence of the Canadian state." For a discussion on Quebec nationalism and the historical rational for hostile federal-provincial political relations see: Robert and Doreen Jackson, Politics in Canada: Culture, Institutions, Behaviour and Public Policy, 5th ed., (Toronto: Prentice Hall, 2001), 224-249.
the Interim Arrangements Act allowing provinces to “opt-out” out of several “established” programs, implying that these programs would remain intact without federal domination, provided the conditions of the programs were upheld. Only Quebec “opted” to receive tax room to raise revenues for various social programs. According to George E. Carter, although only one province had opted out, “the 1965 provision made the future role of shared cost programs in the other nine provinces a matter of some speculation...” The agreement foreshadowed 1967 federal tax transfers to the provinces and, more significantly, the 1977 Established Programs and Financing Act which replaced shared-cost grants for health and higher education. But as time would reveal most provinces were reluctant to abandon cost-sharing arrangements for tax room and block-funding, fearing future reductions in the federal financial commitment.

Originally, cost-sharing arrangements seemingly fit in establishing a national health insurance system, permitting both parties to achieve a basic level of health services nationwide. The provinces were able to develop programs beyond their fiscal capacity, enticed by federal dollars. In return, the federal government could claim a national program and impose minimum standards. The cost-sharing formula also recognized the broader argument of “spill-over effects,” justifying federal financial involvement because benefits were mobile and contributed to the nation as a whole.

However, almost immediately after the inception of a comprehensive national health insurance scheme, concerns surfaced over the rapidly rising costs of the program.

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Specifically, with the introduction of two new health programs federal health expenditures had risen from $3.3 billion in 1965 to over $11 billion a decade later. While actual expenditures were obviously expanding, as a percentage of the Gross National Product health care spending remained stable at around seven percent until the late 1970s. The main fear in the ensuing years was that expenditures would soon surpass economic growth. These concerns coincided with growing fiscal neo conservatism in government circles, preaching privatization, reductions in government, increased competition through deregulation, and tax cuts to stimulate the economy, all driven by growing interest to control the national debt.

A Federal Provincial Committee on Health Care Costs in 1969 suggested that the shared-cost system of financing, where federal contributions were linked to provincial spending, was actually facilitating the rapid rise in costs. Author Gwendolyn Gray argued that cost-sharing provided little incentive for the provinces to develop alternate services that may have proved more efficient or cost-effective because new initiatives, such as home care, would have to be funded at provincial expense. But to the extent that was true, many of the provinces were equally frustrated by the inflexible nature of the cost-sharing formula.

Released in British Columbia, the 1973 Foulkes Report recommended greater control over funding in order to increase efficiency in the health care field and develop

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15 Gross National Product indicates growth of the state and the economy. The GNP totals all costs arising in production and measures market value of all goods and services in the current period by Canadian factors of production. It is equal to wages and salaries, profits, interest, net rent, net income on of farm and non-farm unincorporated businesses, indirect taxes (less) subsidies, capital consumption allowances, and miscellaneous valuation adjustments.
17 Gray, 11.
provincial priorities through rationalization.\textsuperscript{18} Although the broad recommendations were largely dismissed, the report indicated that the province was not sitting idly by unconcerned over improving the efficiency and effectiveness of the health care system.

Speaking in the British Columbia legislature in 1973, Social Credit MLA, Robert McClelland, asked New Democratic Health Minister Dennis Cocke:

\begin{quote}
What kind of pressure is the Minister putting on the federal government to help us develop new programs?… much of the delay, much of the concern, much of the problem in developing these new programs is a reluctance on the part of the federal government to involve itself in cost-sharing for some of these new ideas…\textsuperscript{19}
\end{quote}

In response Cocke recognized that renewing and diversifying the federal cost-sharing agreements would be virtually an impossible request, stating,

\begin{quote}
The member from Langley said, ‘put pressure on the feds, put pressure on them to get better cost sharing.’ I don’t know what else we can do. I visited with the Ottawa people with our Premier and the Minister of Finance. We’ve done everything we can. We’ve told our story over and over and over again … it’s not going the direction that you’re suggesting it should go and that I am suggesting it should go… truly they’re trying to withdraw.\textsuperscript{20}
\end{quote}

Frustrated, provincial governments were facing pressures to reorganize health delivery, reduce costs and restructure federal-provincial funding arrangements.

The sense that the federal government was wanting to redefine fiscal arrangements dates back to 1971 when national Health Minister Marc Lalonde, eager to control expenditures, proposed replacing cost-sharing with conditional block-funding subject to the maintenance of national standards. The offer consisted of a cash contribution, based on 1970-71 figures, increasing at the same rate as the GNP. Further,

\textsuperscript{20} \textit{Ibid.}, 1601.
a “thrust fund” of thirty dollars per capita would be allocated to the provinces on a one-time basis to assist in the reorganization of health care delivery. The provinces were reluctant to accept the offer arguing that funding based on the GNP escalator would be insufficient to support increasing program costs. British Columbia continued to be leery of any proposals deviating from guaranteeing fifty-fifty formula. According to Cocke the federal offers were too restrictive. Specifically,

tying escalation to the gross national product would be the most restricting. That’s why at the present time we’ve said, ‘we don’t want any change until such time as you can come up with something better than what we have, as opposed to something less advantageous than we have at the present time.’ So that’s our position. Our position is well known and will continue on that course.

Receiving meagre enthusiasm from the first report, in 1973 Lalonde presented an inadequately revised proposal. Soon after its release federal Finance Minister John Turner stepped up discussions to find a solution to the funding dilemma. Turner’s proposal, contingent on unanimous provincial acceptance, offered a combination of per capita grants, personal and corporate income tax points and federal withdrawal of various excise taxes and duties. At a Federal – Provincial Finance meeting in July of that year, Turner proposed five options:

(1) Entire contribution in cash subject to conditions.
(2) 66 percent in cash plus 8 points personal income tax and 1 point corporate taxable income.

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21 Perry, 238.
22 Quebec, Ontario, and Alberta favoured changes to the cost-sharing financing arrangements. But rather than per capita funding they preferred a full transfer in tax points. In 1972 only Newfoundland and Prince Edward Island were willing to accept the proposal. The following year national minister of health and welfare, Marc Lalonde, presented a revised proposal. See David B. Perry, Financing the Canadian Federation, 1867-1995 (Toronto: Canadian Tax Foundation, Tax Paper 102), 238-239., or R. J. Van Loon, “From Shared Costs to Block Funding and Beyond: The Politics of Health Insurance in Canada,” in Carl A. McIlwiche and Janet Storch eds., Perspectives on Canadian Health and Social Services Policies: History and Emerging Trends (Michigan: Health Administration Press, 1980), 348.
(3) 50 percent cash, 8.5 points of personal income tax, 1 point corporate tax and 50 percent of federal excise duties and taxes on tobacco and alcohol.
(4) 50 percent cash, 12.5 personal income tax points, and 1 point of corporate taxable income.
(5) 33 percent cash, 12 points of personal income tax, 1 point corporate taxable income, and fifty percent of federal excise duties and taxes on tobacco and alcohol.24

Again, total federal contributions would be based on the national average per capita contribution of an unspecified year. While provincial reactions were mixed, British Columbia continued to support the existing cost-sharing arrangement or a straight transfer of tax points as endorsed by Alberta, Ontario and Quebec. The federal government argued that rendering the entire compensation in tax points would compromise their influence on programs.25 Although some provinces were receptive to changes in the funding formula, they were unenthusiastic about the proposal. Insufficient compensation and fear of reduced federal influence topped the list of concerns.26 In the fall of 1974 the provinces formally rejected the proposals.

As negotiations continued the provinces faced greater pressures to advance a new funding formula. In 1975 the Federal government gave formal notice of intent to terminate the Hospital Insurance and Diagnostic Services Act in 1980. Further, the federal government limited the growth rate of per capita contributions for Medicare from

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24 Perry (Tax Paper No. 102), 239. An income tax point is defined as 1 percent of basic federal tax. A corporate income tax point represents one percent of federal taxable income. Under the 1972 tax agreement the provinces rationalized their tax base with that of the federal government and the federal personal income tax base was defined as 100 tax points, of which the provinces have received a percentage of this basic federal tax.

25 Dollars distributed through tax points are not program specific and difficult to track. Cash transfers, however, provide the federal government with fiscal leverage to influence programs because they are able to withhold funds if the provinces are not complying with specific standards.

13 percent in 1976-77, down to 8.5 percent in 1978-79. Frustrated by the cuts and eager to negotiate an agreement that would account for expenditures accumulated under the Hospital Insurance and Diagnostic Services Act, the appeal of using equalized tax points was becoming more apparent to the provinces.

A week before the June 1976 first ministers' conference, Prime Minister Pierre Trudeau outlined the basic principles underlining the Establish Programs Financing (EFP) in letters to the provinces acknowledging that “the federal government should continue to pay a substantial share of program costs, in order to maintain national standards.”

(2) Federal payments should be calculated independently of provincial program expenditures, in order both to avoid distortion of priorities and provide greater certainty for both levels of government. (3) The per capita federal payments should be more nearly equal across the provinces a change that would work to the advantage of poorer provinces. (4) The arrangements should be put on a more permanent footing, in order to facilitate long-term planning by both levels of government. (5) There should be provision for continuing federal-provincial consultation and cooperation in health care and post-secondary education.

While the Prime Minister attempted to ease concerns over federal withdrawal, it was apparent that a new financing formula was becoming inevitable.

At the same time it was formally proposed to combine the new negotiations with those for federal-provincial fiscal arrangements, effectively moving funding negotiations from involving ministers of health to an exclusive discussion between ministers of

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27 The effect of imposed ceilings on the rate of growth of federal transfers was very limited because a new fiscal arrangement was reached, implemented in 1977.
28 Tax points would have to be equalized to a specified value, such as the national average, because tax-points yield less revenue in low income verses high income provinces.
finance. According to author Richard Van Loon, during the final negotiations there was "little attention to the health field" and there were no meeting of federal provincial health ministers to consider the final formula.\(^{30}\) Van Loon argues that "once medical programs become large public finance concerns, health services experts become less influential in the highest level of decisions and power passes to public financial specialists, provincial treasurers, federal finance ministers, and the premiers, prime ministers and their advisors."\(^{31}\) In the hands of the finance ministry, health content became subordinate to fiscal priorities. Further, the negotiations and new arrangements were discussed, decided and implemented beyond a public forum.

The offer hammered out at the first ministers' conference and a subsequent meeting of finance ministers and treasurers in July 1976 proposed a single funding scheme for three programs: education, medicare, and hospital insurance. The provinces agreeing to spend the funds in the designated fields, would receive a contribution consisting of two parts, cash and tax room, growing independently of provincial expenditures. The cash portion would increase at the same rate as the GNP. A levelling adjustment would bring the per capita payment to the same level, for all provinces, over a five year period. Transferred tax room would be equalized to the national average. Further a transitional payment would be available to provinces whose cash and equalized tax transfer fell short of the amount it would have received had the whole entitlement been paid in cash.\(^{32}\) The legislation would also require three years' notice for any changes, which would not be entertained until after the first two years of the program.

\(^{30}\) Van Loon, 350.
\(^{31}\) Ibid., 352.
\(^{32}\) Perry, 245 or Broadway, 46.
Considering the lack of consensus between the provinces the chances for acceptance seemed slight.

In the British Columbia legislature politicians continued to argue for the maintenance of 50/50 cost sharing. Both sides of the House spoke to growing concerns over the impending changes. From the government’s perspective, Premier Bill Bennett reiterated that the federal government had “entered cost-sharing arrangements in health, based on the principle of sharing actual costs on an average of 50 percent across [the] country” and that British Columbia was concerned over “abandonment of the 50 percent principle.” Opposition leader Dave Barrett believed the appeal of tax point transfers was growing, yet he was unconvinced the new formula would be a fair trade for 50/50 cost sharing, stating,

I don’t believe that any body is moving in the tax point area for any other reason than to get the best possible deal for their jurisdiction. I applaud that. But sometimes when pursuing the best possible tax deal for the jurisdiction you represent you miss the whole. I feel very strongly that any abandonment of the 50 percent cost-sharing of healthcare... will mean an abandonment of the high level of services to the Maritimes and Newfoundland and other Canadians. The safest course to go, in my opinion,... is not to tamper with the 50/50 cost-sharing deal.... So, Mr. Premier, I say you’ve found they wish to back out. I say let us not abandon – that is our position... regardless of rising cost 50-50 down the line. That’s the only way we will keep this country together.

While politicians voiced valid concerns over the new offers, arguably the real concern was that the provinces would be shouldering all the risk in controlling both programs and costs.

Finally, provincial ministers of finance and treasures met in September and

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34 Ibid.
October 1976 to articulate a consensus on the funding issue. Alberta’s Treasurer Merv Leitch, presented a proposal on behalf of the provinces at the Meeting of Ministers of Finance and Provincial Treasures in Ottawa the following December. Accepting many prior recommendations, the provinces nonetheless forwarded three requests. First, they wanted contributions to be based on the highest transfers from the 1975-76 fiscal year. Second, that transfers be equalized to the province with the highest yield, rather than to the national average which had previously been proposed. This would potentially allow all the provinces to achieve the same standard of per capita program expenditure as the province with the highest standard. Finally, the provinces proposed equal per capita cash payments, escalated in accordance with a three-year moving average of the GNP, to provide stable growth of federal contributions in line with the economy.

Receptive to the provincial offer the federal government tacked on a $20 per capita extended health care grant contingent on the integration of the Hospital Insurance program into the new formula.

In the end the provinces accepted the federal argument that tax points be equalized to the national average, rather than to the level of the highest province. Further, the federal government tacked on two additional personal income tax points, one to be paid in cash and one in tax, to replace the 1972 income tax revenue guarantee.

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35 The provinces wanted 1 point corporate taxable income and 12.5 points of personal income tax. The one point corporate taxable income and 4.357 points of the personal income tax represented tax room already allocated to the provinces in lieu of post-secondary education transfers in 1967-72 arrangements.
36 The Provincial Proposal is included in the appendix of the British Columbia Budget delivered January 1977.
37 The extended health care grant replaced some cost shared programs previously covered by the Canada Assistance Plan.
bringing the total tax transfer to 13.5.\textsuperscript{38} Transitional cash payments were also offered where provinces received less than they would have had the entire payment been in cash.\textsuperscript{39} As a high income province, where a large tax base existed to cover any variations in cash, British Columbia would not be a recipient of transitional payments. Further, "levelling" attempted to even out variations existent under the previous cost sharing arrangements. Provinces that received per capita payments above the national average, including British Columbia, would be levelled down over five years; provinces below the national average would be levelled up over three years. Finally, the provinces were no longer subjected to intrusive federal auditing and reporting requirements under the previous Hospital and Medicare Act. After years of negotiations, by the end of December 1976 new fiscal arrangements were nearing completion.

The actual amount to be redistributed to the provinces would be calculated through the following formula outlined in the 1977 Federal-Provincial Fiscal Arrangement and Established Programs and Financing Act:

\[
\text{Basic Cash} = \frac{\text{Base Year Contribution Per Capita} + 7.63 \times \text{escalator} \times \text{population}}{2}
\]

\[
\text{Provincial Entitlement} = \text{EPF Cash} + \text{Tax Transfer}
\]

\[
\text{EPF Cash} = \text{Basic Cash} + \text{Transitional Payment} +/\text{- levelling adjustments}
\]

Base Year Contributions = the federal per capita transfer in the 1975-76 year ($212.65 divided by in half $133.59) (7.63 = cash value of one personal income tax point given as compensation for the revenue guarantee)

Escalator = three year moving average of nominal GNP per capita

Tax Transfer = 13.5 personal + 1 corporate equalized tax point.

\textsuperscript{38} In reality the provinces received a tax transfer of 9.143, since 4.357 had been transferred under previous arrangements for post-secondary education. The revenue guarantee was included in the 1972 tax reforms to encourage the provinces to rationalize their income tax systems with the federal government. The revenue guarantee provided funds for any loses the provinces may experience as a result of reforming their tax system. Once the provinces became familiarized with the new system they were expected to adjust their tax rates to compensate for any differences. See the January 1977 British Columbia Budget for a discussion on revenue guarantee issue.

\textsuperscript{39} As the value of tax points exceeded the cash payments, transitional payments were expected to diminish over time. Transitional payments became obsolete in the new Established and Programs and Financing Act of 1982.
The complexity of the new arrangements left all but a few financial experts in the dark. Not surprisingly taxpayers have become increasingly bewildered by the source of revenue distribution. The complex nature of fiscal arrangements, and the elite realm of decision makers involved, effectively left the public shut out. Indeed, according to Thomas Courchene, as was "the case with most-federal provincial negotiations, the Canadian public (parliament included) was not privy to the nature and substances of much that formed the essence of the renegotiations." Specifically, "public opinion was not brought to bear on the new arrangements." A survey of major newspapers distributed throughout British Columbia revealed that information and debate regarding new fiscal arrangements rarely attracted media attention. In fact, the few articles printed either incorrectly lumped a number of fiscal transfers together in explaining the new program or failed to explain how the new program would operate. Further, there was virtually no debate on how the new program could affect health care delivery in the province in the future. Rather, reactions of "irked" provincial leaders and retaliations by the "dictatorship" topped the limited headlines. With little public reaction or concern the province quietly entered into a new cost-sharing program.

In concluding the new funding arrangements in December 1976, federal Health Minister Marc Lalonde summed up the benefits of the program by claiming that the amalgamation of the Hospital Insurance and Medical Care programs into the Established Programs Financing Act would create three very important results. First, the move to

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41 Ibid, 345.
42 Papers surveyed included the Vancouver Sun, The Province and the Prince George Citizen over the period from May 1976 to January 1978.
block-funding would substantially increase provincial flexibility with regard to program coordination and delivery as well as further simplify administrative procedures. Second, savings generated by reducing services would accrue totally to the provinces and would not be shared by the federal government since their contribution under established programs would not be directly related to program costs. Third, the Established Programs formula would yield more resources to the provinces than a continuation of existing arrangements for health and post-secondary education programs.

Lalonde further added,

The objective of moving away from detailed administrative arrangements should not be interpreted as a complete elimination of either the health program conditions or the need to work cooperatively in the exchange of data and information for statistical planning and purposes. The federal cash contribution would continue to be conditional upon provinces meeting broad health program conditions of the type currently embodied in the Medical Care Act. 43

However, some onlookers disagreed with this assessment. Could the conditions of universality, portability, comprehensiveness, and publicly administered programs be maintained if there were no legislated enforcement mechanisms in the EFP program? Historian Malcolm Taylor thought not, claiming “the new arrangements marked the end of a national program as the format of conditional grant in aid [was] abandoned.” 44 Writing in the wake of the deal, Courchene felt “some conditions” still remained. But in his view, “these standards will turn out to be unworkable let alone capable of being

43 Quoted in Alistair Thompson, Federal Support For Health Care: A Background Paper (Ottawa: HEAL, June 1991), 17.
44 Malcolm G. Taylor, Health Insurance and Canadian Public Policy: The Seven Decisions that Created the Health Insurance System and Their Outcomes (Montreal: McGill-Queens, 1987), 487. [Author’s emphasis.]
defined, so that for all intents and purposes the grants are unconditional." Indeed, during the 1970s implementation of user fees and extra billing expanded in many of the provinces, leading some commentators to argue that accessibility and portability of benefits were being threatened. As a result, the federal government had to review and institute policies in the early 1980s outlining financial penalties for provinces failing to ensure the four principles of Medicare were met. Had the program truly been conditional in nature these measures would never have been deemed necessary.

Despite the efforts to negotiate a new funding arrangement, it appeared that the two levels of government would continue to dispute funding obligations and commitments. Shortly after institution of the EPF the provinces once again reasserted their view that the cash component was the only source of federal funding for established programs. Although roughly eight tax points were transferred by the federal government intended to cover health spending, the provinces have historically argued these tax revenue sources had always belonged to them. Correspondingly, Paul Boothe argues "the federal government’s rhetoric claiming that it is ‘giving’ the provinces this revenue


46 Although accurate information was not recorded regarding user fees and extra billing, it is estimated that hospital user fees grew from 6.6% in 1977 to 9.4% in 1981. Over the same period extra billing rose from 4% to 4.3%. The implementation of additional charges varied throughout the provinces, but in Ontario, Alberta and Nova Scotia user fees were extensive enough to be “considered a problem.” Alberta set an alarming precedent in 1984 allowing hospitals to levy charges of up to $20 per day or $150 per patient. This trend was abated the same year by the institution of the Canada Health Act. See: Malcolm C. Brown, "Health Care Financing and the Canada Health Act," Journal of Canadian Studies (Volume 21, 1986). 123-125.

anew each year strains credulity. " Specifically tax points are difficult to claim as a federal transfer because they are calculated as provincial tax, thus not included as a federal revenue or expenditure calculation. Further tax revenues enter into general revenues and cannot be subject to conditions. Consequently, it appeared heading into the 1980s that the fiscal battles between the two levels of government would continue to be debated well into the ensuing decade.

The EPF marked a new era of federal–provincial fiscal relations. Initially, the new fiscal arrangement seemed positive in allowing the provinces greater incentive and flexibility for effective health care delivery. On the flip side however, according to economist Robert Evans, "it also gave them all the risk." The provinces were left with the responsibility to juggle rising expenditures while economic growth was beginning to decline in the early 1980s. By the end of the decade the provinces were feeling the repercussions of federal fiscal restraint measures. Given that transfers had increased unexpectedly during the first four years of the program, it is fair to suggest that the intent and purpose of the new arrangement was not to facilitate fiscal decentralization. However, emerging economic pressures and shifting political agendas, combined with federal ability to adjust the policy, lead to a series of unilateral cuts to fiscal transfers during 1980s and 1990s. As time progressed and incessant changes to the EPF were initiated, the federal fiscal role transformed. Consequently, while the new block formula

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48 Paul Boothe and Barbara Johnston, Stealing the Emperors Clothes: Deficit Offloading and National Standards in Health Care (C.D. Howe Institute, No. 41, 1993), 7.
49 Under the EPF cash transfers are directly deposited into provincial general revenues where specific transfer dollars are not tracked. Under the agreement the federal government provided a basic breakdown of spending with 17.4% designated to Medicare, 50.5% for hospital insurance, and 32.1% for post-secondary education.
qualified as a reasonable compromise to the funding dilemma at the time, the evolution
of the EPF resulted in less than equitable fiscal partnership.
Chapter Three: Compromising the System

In an examination of American and Canadian health care systems, a Common Wealth Fund study in 1988 revealed that 43 percent of Canadians thought their system had fundamental flaws.\(^1\) When asked the same question in 2001 this number swelled to 77 percent. While the study fails to pinpoint specific issues of public concern, it does document a growing dissatisfaction among Canadians with their health care system. While these "flaws," such as waitlist and staffing shortages, are most noticeable at the local level, these concerns are repercussions of unilateral funding cuts to health transfers throughout the 1980s and 1990s. As a result, Canadians have become more and more acquainted with fiscal restraint policies and how they perpetuate a sense of crisis, but few understand the historical development of a diminishing federal role.

Heading into the 1980s Canadians were increasingly concerned with issues of health care delivery, particularly accessibility and availability of services, framed by the ongoing controversy over user fees and extra billing. The rancorous debate over these two issues was not exclusively tied to earlier changes in the funding formula, but various interpretations by the provinces alleging declining federal funding led some to claim that excessive costs were driving them to apply revenue generating measures. Now that the provinces retained all the responsibility for program delivery, condoning user fees and extra billing appeared to be at their prerogative; especially since the Established Programs and Financing Act (EPF) arrangement failed to outline any penalties for provinces neglecting to uphold the four principles of Medicare. In an effort to deter the

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\(^1\) Antonia Maioni and Pierre Martin, *Crisis? What Crisis? Canadians Ponder the State of Their Health Care System* (Syracuse: Campbell Public Affairs Institute, 2002).
provinces from breeching these principles, the Federal government instituted the Canada Health Act [CHA] in 1984, which tied user fees and extra billing to dollar for dollar reductions in cash transfers. At the same time the CHA attempted to eliminate these practices, it emphasised the value of the cash component of the transfer as provincial governments and the public became attuned to possible penalties and reductions to transfers, which in time ultimately compromised local service delivery. While the debate regarding user fees, extra billing and the impending Canada Health Act was primarily about health care delivery, it also coincided with changing federal attitudes to limit expenditures in order to achieve deficit reduction goals.\(^2\) Two opposing pressures were emerging: on one hand the provinces were coerced into maintaining the availability of universal health care, while at the same time being antagonized by a federal desire to reduce and control expenditures.

Assuming power in 1984, Brian Mulroney’s Progressive Conservatives implemented their agenda to reduce the federal deficit. Achieving federal power suggests a majority of the population supported the conservative agenda. However, reducing the deficit translated into limiting federal spending on social programs, which ultimately contributed to the defeat of the Conservatives nine years later. During the mid 1980s the EPF cash transfer became the target of continuous unilateral cuts, leading the provinces to argue that the federal government had seriously reneged on prior commitments to maintain sufficient levels of funding. Meanwhile, the provinces were gaining support in their argument that tax room was not part of the transfer earmarked for

\(^2\) In 1991-92 over 30 cents of every dollar went to pay interest in the existing debt. See: Canada, Department of Finance, *Canada’s Economic Challenge- Background* (Ottawa: Department of Finance, January 1994), 46.
health, meaning that federal contributions could only really include the dwindling cash element of the transfer.

By the time the Liberal government regained power in 1993 the momentum to control and reduce expenditures was dominating political agendas. Liberal promises to preserve funding levels and the conditions of the Canada Health Act were contradicted by continued fiscal cuts to social programs. In 1994 the cash component of the EPF transfer only covered 16.2% of hospital and medical care costs in British Columbia and the province was preparing for even steeper cuts under the revised transfer program, the Canada Health and Social Transfer.³ By the mid 1990s concerns over reduced federal transfers were becoming part of the public consciousness, but by the time these concerns translated into broad pressures for an increased federal commitment, the reductions were already significant and compromising the Canadian health care system. While the public may be familiar with “funding cuts,” it is essential to understand the complex policy history regarding the federal transfers for health, particularly if Canadians are expecting to renegotiate health care delivery in the country.

By the early 1980s health care was once again topping the list of Canadian popular debate. Across the nation the prevalence of user fees and extra billing was increasing creating a continued climate of intergovernmental political discord regarding

financing commitments. Solutions to these issues were bogged down by the complex fiscal arrangements outlined in the Established Programs and Financing Act. Even former National Health Minister, Monique Bégin, admitted her initial confusion in understanding the intricacies of inter-provincial funding arrangements. In the first chapter of her book, *Medicare: Canada's Right to Health*, see recalled:

Though Minister of National Health and welfare since September 1977, I knew little about medicare, and with good reason. My predecessor Marc Lalonde, had redefined how the provinces were paid, thus changing the administrative relationships governing the federal role in health insurance. [The] 1977 [EPF] agreement would become notorious, as it laid the foundation for the crisis in medicare. But at the time it was signed, no one except those most closely involved and the staff at the Department of Finance understood much about it. It was a closed file. The sense I got from people around me was that things in health were just fine.

However, Bégin soon realized that the failure of the EPF program to outline penalties for breeching “national standards” contributed to the proliferation of direct patient charges in the early 1980s. While user fees and extra billing varied across the country, the public remained opposed to such departures from accepted practice. Indeed, in a 1983 Can West Survey in each of the 10 provinces respondents rejected user fees and extra billing by 70-80 percent. According to Bégin, “the public, media and doctors were now engaged in a full-fledged debate that received daily radio, television, and newspaper coverage right across the country. From the Atlantic Canada to the west coast, the issue

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4 Although accurately information was not recorded regarding user fees and extra billing it is estimated that hospital user fees grew from 6.6% in 1977 to 9.4% in 1981. Over the same period extra billing rose from 4% to 4.3%. The implementation of additional charges varied throughout the provinces, but in Ontario, Alberta and Nova Scotia user fees were extensive enough to be “considered a problem.” Alberta set an alarming precedent in 1984 allowing hospitals to levy charges of up to 20$ per day or $150 per patient. This trend was abated the same year by the institution of the Canada Health Act. See: Malcolm C. Brown, “Health Care Financing and the Canada Health Act,” *Journal of Canadian Studies* (Volume 21, 1986), 123-125.


6 Colleen Fuller, *Caring For Profit* (Ottawa: New Star, 1998), 77.
slowly gained wider exposure..." The debate over service delivery served to attract and heighten broad public interest, shaping Canadian expectations regarding the health care system.

Federal concerns that the principles of the national program were in danger prompted the appointment of Justice Emmett Hall of the Canadian Supreme Court, in 1979, to head a Review of Health Services, examining the rationale and justification for provincial user fees and extra billing. He sought to answers two questions: were total federal contributions declining as the provinces claimed and second, were precious health care dollars being siphoned into other areas? According to Hall, federal contributions plus tax room were actually producing more money than previous cost sharing plans, and thus were not responsible for fiscal pressures at the provincial level. In fact he claimed that when using the combined federal cash and tax transfer, in 1971 dollars, federal funding for health and post secondary education actually rose 24% in the first three years of the EPF program. Further, Hall claimed the provinces were not diverting dollars into other program areas creating a short fall in health funding. Given his findings, he criticized the provinces for implementing additional charges that were not only fiscally unfeasible but threatened the accessibility of services for average Canadians.

A 1981 Task Force on Federal-Provincial Fiscal Arrangements supported the argument that user fees and extra billing threatened national standards, specifically “accessibility” as low income earners would be deterred from receiving health care if they could not

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7 Bégin, 17.
8 Transfers were higher than anticipated because poor economic performance meant that federal tax yields were lower than expected. As a result, cash transfers had to be increased in compensation. See: Canada, *Fiscal Federalism in Canada: Report of the Parliamentary Task-Force on Federal-Provincial Arrangements* (Ottawa: Minister of Supply, 1981), 93.
afford additional charges. The Task Force recommended that the federal government use its fiscal levers as a means to shape national policies.

The Task Force believes that achievement of a comprehensive, publicly funded hospital, medical and extended health care is a major accomplishment of Canadian society, one that represents the end of a long struggle for the realization of an ideal espoused by many Canadian citizens and political leaders... this achievement could be jeopardized by reductions in current aggregate levels of federal support, because such reductions would be likely to lead to increased reliance in private funding and ultimately to higher health care costs and erosion of the program principles. The Task Force concluded that there is an overriding national interest in the operations of health insurance plans and in the effectiveness of health care delivery, and that the proper role for the federal government is the formulation, monitoring, and enforcement of conditions in its financial support of provincial programs.9

Furthermore, in agreeing that levels of funding were “adequate”, the Task Force recommended the establishment of clear program conditions with “provisions for some withholding of federal financial support to provincial plans which did not meet those conditions.”10 This notion became the foundation of the Canada Health Act policy of tying user fees and extra billing to dollar for dollar reductions in federal health transfers.

Responding to public sentiment, the federal government introduced the Canada Health Act on 1 April 1984, to halt any infringements to free and universal health care.11 The Act combined the Hospital Insurance and Diagnostic Services Act with the Medical Care Act, reaffirmed the national principles, and added restrictions to deter direct patient charges, ensuring all Canadians access regardless of their ability to pay. In order to qualify for full federal contributions the provinces were to fulfill the following criteria:

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9 Ibid, 114. [Author’s emphasis.]
10 Ibid, 115.
public administration, comprehensiveness, universality, portability and accessibility. Provisions also stipulated penalties for provinces imposing user fees and extra billing. Further, the provinces were required to provide annual statements on extra billing, user fees and the operation of their plans as they related to the criteria and conditions of the Act. Last, the provinces were required to give public recognition of federal transfers, for example through publicly released provincial budgets. The Canada Health Act served to create an “ideal” model of health care delivery, based on the expectations of Canadians, but few questioned whether public funding would remain adequate to maintain and develop these lofty goals.

From 1984 to 1986 various provincial governments, including British Columbia, faced reductions in transfers for violations of the Canada Health Act. However, the provinces were able to recover funds upon terminating all forms of direct charges before 1 April 1987 in compliance with Section 20 of the Act.\(^\text{12}\) Clearly, the EPF transfer and specifically the cash portion, could be significantly diminished for provinces continuing to impose additional fees. The Canada Health Act exemplified the federal government’s ability to influence national and provincial programs through the use of its “spending power.” While the new rules of conditionality reasserted the national nature of the program, there was no attention to securing future federal financial obligations during the negotiations leaving the provinces committed to programs, but open to future reductions in EPF transfers.

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\(^{12}\) British Columbia had banned extra billing on 1 April 1981, but had continued to allow user fees.
Beyond the view of public debate, the validity of the tax component as a federal transfer increasingly came under question. While the 1981 Task Force had claimed levels of funding were “adequate” it was also careful to note that a minority of the Task Force Members favoured excluding the display of the tax transfers in a new arrangement for support to health and post-secondary education. It was a fiction, it was argued, to continue to count their value as a federal program contribution because they were fully integrated into provincial tax systems several years ago. They also argued that the respective tax shares of the federal and provincial governments are now back to where they were prior to World War II.13

The provinces certainly agreed with this view. In 1980 when British Columbia’s Finance Minister was asked whether the value of the tax points was attributed to specific programs, the Honourable H. A. Curtis replied, “Although the tax points were given in compensation for Federal cost sharing for specific programs, under the current arrangement there is no legal obligation to spend the funds on those programs.”14 A similar sentiment was reiterated in a discussion the following year regarding the EPF. There Curtis repeated that “According to terms of Part VI of the Federal—Provincial Fiscal Arrangements and Established Programs and Financing Act, 1977, there is no allocation among these programs of the personal and corporate income tax points transferred to the Province in respect of established programs financing.”15 In fact,

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the province does not record the value of the tax points in the budget identifying “EPF transfers.” The figure only encompasses cash transfers as outlined in the Canada Health Act. Tax dollars have been included in consolidated revenue, leaving the cash element as the only visible portion of the transfer.

As a result of the Canada Health Act and shifting interpretations of the transfer the cash portion of the transfer was illuminated for the provinces, the national government, and the public. But there was little emphasis during the national health care debate regarding the consequences of potential changes to the existing EPF program. At the time, fear of federal decentralization of social programs was still in its infancy. In 1981 the federal government remained committed to cover a substantial share of program costs, roughly 47% of provincial health expenditures when combining cash and tax transfers. The Task Force on Federal-Provincial Fiscal Arrangements, anticipating renegotiations in 1982, recommended maintaining block funding for the 1982-87 period, but separating transfers for post-secondary education and health according to existing formulas of allotment (32.1% and 67.9%) in order to “clearly and visibly” allocate dollars into specific program areas. The Task Force further suggested the revenue guarantee continue as part of the EPF package. In 1981 this guarantee accounted for 6.7% of EPF transfers, dollars provided in compensation for absorbing hospital insurance into the program during the 1976 negotiations. However, during renegotiations in 1982 the federal government viewed the existence of the revenue guarantee quite differently. In their argument they recalled the original intent of the revenue guarantee and claimed

17 Ibid., 79. The division of transfers for post secondary education and health remained a recommendation by the federal government in the new agreement from 1982 to 1987.
that it should be eliminated since the provinces had ample time to adjust to changes in the
tax structure. In 1981 the federal government announced its intention to terminate the
guarantee in April 1982 commensurate of one point personal income tax room, plus the
equivalent amount in cash. A 1982 Ontario Budget Paper argued the reduction would
cost the provinces $5.2 billion over a five year period. Whether or not the revenue
guarantee was part of the program transfer was always under considerable debate, but its
extinguishment marked the beginning of constant reduction measures to the EPF
program.

Uncertainty over fiscal transfers coincided with emerging concerns regarding
increased decentralization between the two levels of government. In line with
constitutional rhetoric, Prime Minister Pierre Trudeau sought to minimize concerns about
decentralizing tendencies in a news conference conducted on 12 February 1981. Jeffery
Simpson from the Globe and Mail questioned whether upcoming negotiations would aim
to reduce the “excessive decentralization” occurring in the country resulting from a
declining national fiscal presence in social policy transfers. Trudeau responded:

You talk about or worry about excessive decentralization. I’d confess to
you that it is a worry-- ... in 1959... we were spending 52 per cent of
total government expenditures, and the provinces and municipalities, 48
percent. Now 20 years later ... the situation has changed dramatically.
Now it is one-third in the hands of the federal government; two-thirds,
66.8 per cent, in the hands of the provinces and municipalities. So, there
is no doubt that in fiscal and expenditure terms, there has been a very

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18 Malcolm G. Taylor, Health Insurance and Canadian Public Policy: The Seven Decisions that Created
the Canadian Health Insurance System, 2nd ed., (Montreal: McGill Queens, 1987), 434. Also see: Allan M.
Maslove and Bohodar Rubashewsky “Cooperation and Confrontation: The Challenges of Fiscal
Federalism,” in Michael Prince ed., How Ottawa Spends 1986-1987: Tracking the Tories (Toronto:
19 Canada, Preserving Universal Medicare: A Government of Canada Position Paper (Ottawa: Minister of
Supply and Services, 1983). Here the argument was made that the Revenue Guarantee was not considered
a reduction.
20 Quoted in Canadian Council on Social Development, Submission to the Parliamentary Task Force on
drastic decentralization in the past 20 years. And I would say quite frankly, I do not think that can continue. I think it should be arrested....We certainly don’t propose to solve this problem on the back of the poor and the sick, but we think that the federal and provincial governments together should find some ways of, shall we say, altering this trend—which is not marginal but, as I say, very, very vivid, very worrying.21

That same year the first limits to the EPF program were legislated in order to pursue deficit reduction and expenditure restraint policies. Trailing only nine months after Trudeau’s speech, the federal Minister of Finance announced plans to trim $5.7 billion from federal transfers to the provinces over the following five years for social programs including health and post-secondary education.22 Deeming federal reductions in transfers necessary, the federal government shifted from a policy of negotiating changes in fiscal transfers to announcing them, further alienating the provinces.23

The actual announcement fell in line with the Bill C-97, renewing EPF transfers for another five years. Under the new agreement basic cash, which was previously calculated independently, was now a residual value of the tax transfer. Prior, wealthier provinces, such as British Columbia, with a large tax base and revenue generating capacities were able to keep excess revenues where the value of the tax points exceeded basic cash. Now basic cash was equivalent to the provincial entitlement minus the tax

21 Quoted in ibid.
22 These proposed reductions were to be achieved by eliminating the value of the revenue guarantee from transfer payments. Allan J. MacEachen was served as Federal Finance Minister from March 1980 to September 1982.
transfer. As a result, the value of the cash portion would diminish as the value of the tax points grew. Thomas Courchene argued the federal claimed that cash transfers should decline as tax points increase was simply “weak.” The federal government argued as the value of the 14.85 equalized personal income tax points [PIT] and the one corporate income tax [CIT] point increased in value, the provinces need less cash. But as Courchene notes, “since Ottawa’s 85.14 PIT points and 99 CIT points would also increase in value … the federal government could afford to maintain the transfer.”

Despite this argument, from 1982-87 the provinces were subjected to the revised EPF formula.

While the cash portion of the transfer now seemed destined to decline, it was not until the late 1980s that continuous reductions in the cash transfer began to threaten federal-provincial relations and the national policy. In a submission to the Task Force on Federal-Provincial Fiscal Arrangements, federal Minister of Finance Allan MacEachen warned that deficit reduction goals would outweigh social policy agendas stating, “the most urgent priority of the federal government is to strengthen its fiscal position. Transfers to the provinces cannot be insulated from policies of restraint…” Less than two years after passing the Canada Health Act, a measure to ensure adequate and

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24 The new formula also meant the end of transitional payments and levelling adjustments.
appropriate health care for Canadians, further reductions to the EPF were announced by reviewing the escalator, which ensured the growth of transfers relative to inflation; threatening the maintenance of the very principles the Canada Health Act advocated. In 1986 the escalator would be reduced by two percent, followed in 1989 by an additional percentage point.

In 1991, Bill C-69, known as the Government Restraint Act, was enacted at the federal level limiting per capita entitlements under the EPF at 1989-90 levels until 1992. The escalator would be further reduced to the GNP minus three percent. Federal efforts to restrain spending outraged provincial governments. The effects of Bill C-69 were far reaching and compromised a variety of social programs including the Canada Assistance Plan [CAP], which had operated since 1967 on a fifty-fifty cost-sharing basis.

Impending cuts to federal transfers led British Columbia to turn to the B.C. Court of Appeal and the Supreme Court of Canada, where the province was denied a favourable verdict at both levels, regarding the federal government’s obligations to maintain traditional levels of funding for the Canada Assistance Plan. In arguing its case, British Columbia has raised two constitutional questions. First, “Has the Government of Canada any statutory, prerogative or contractual authority to limit its obligation under the Canada Assistance Plan Act [sic], R.S.C. 1970, c. C-1 and its Agreement with the Government of British Columbia dated 23 March 1967, to contribute 50 per cent of the cost to British Columbia of assistance and welfare services?” And second, “Do the terms

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of the Agreement dated March 23, 1967 between the Governments of Canada and British
Columbia, the subsequent conduct of the Government of Canada pursuant to the
Agreement and the provisions of the Canada Assistance Plan Act [sic], R.S.C. 1970, c. C-
1, give rise to a legitimate expectation that the Government of Canada would introduce
no bill into Parliament to limit its obligation under the Agreement or the Act without the
consent of British Columbia?” Although the questions were in relation to CAP transfers,
the judicial interpretations were relevant in determining federal obligations in all cost
sharing programs. The federal government now seemed determined to announce
intended changes rather than negotiate with the provinces, creating fiscal uncertainty and
seriously straining federal-provincial relations.

The answer to the first question at both levels was affirmative, claiming the
federal government had the authority to limit contributions because “the principle of
parliamentary sovereignty reflected in s. 42(1) of the federal Interpretation Act,” states
that "Every Act shall be construed as to reserve to Parliament the power of repealing or
amending it..." Further, “Under s. 54 of the Constitution Act, 1867, a money bill...can
only be introduced on the initiative of the government. In these circumstances, the natural
meaning to be given to the Agreement is that Canada's obligation is to pay the
contributions which are authorized from time to time and not the contributions that were
authorized when the Agreement was signed.”29 In other words the federal government
was not legally obligated to maintain funding levels, which could be altered at their
prerogative without warning or negotiation.

Regarding the second question, both the British Columbia Court of Appeal and

29bid.
the Canadian Supreme Court determined that British Columbia did not have a legitimate expectation that the federal government would not limit its obligations without the province’s consent. Specifically,

the federal government did not act illegally in invoking the power of Parliament to amend the Plan without obtaining the consent of British Columbia. The doctrine of legitimate expectations does not create substantive rights -- in this case, a substantive right to veto proposed federal legislation. The doctrine is part of the rules of procedural fairness which can govern administrative bodies.

Where it is applicable, it can only create a right to make representations or to be consulted. Moreover, the doctrine does not apply to the legislative process. The government, which is an integral part of this process, is thus not constrained by the doctrine from introducing a bill to Parliament. A restraint on the executive in the introduction of legislation would place a fetter on the sovereignty of Parliament itself. This is particularly true when the restraint relates to the introduction of a money bill. It is also fundamental to our system of government that a government is not bound by the undertakings of its predecessor. The doctrine would derogate from this essential feature of democracy.

Furthermore,

Bill C-69 was not an indirect, colourable attempt to regulate in provincial areas of jurisdiction. It is simply an austerity measure. Further, the simple withholding of federal money, which had previously been granted to fund a matter within provincial jurisdiction, does not amount to the regulation of that matter. The new legislation simply limits the growth of federal contributions. While the Government Expenditures Restraint Act impacts upon a constitutional interest outside the jurisdiction of Parliament, such impact is not enough to find that a statute encroaches upon the jurisdiction of the other level of government. The Court should not, under the ‘overriding principle of federalism,’ supervise the federal government’s exercise of its spending power in order to protect the autonomy of the provinces.

Essentially, the provinces became completely vulnerable to reductions in federal programs, even though those same programs were deemed national in scope.

30 Ibid.
31 Ibid.
Upon receiving royal assent for Bill C-69, the federal government announced the freeze on EPF transfers would be extended to 1994-95, with an anticipated saving of $2.34 billion over five years.\(^{32}\) The escalator percentage had fallen from 5.6 in 1986 to zero in 1991 where it remained until 1995.\(^{33}\) In an effort to relay concerns to the public and those employed in the health sector a growing number of organizations were cautioning about reductions in federal transfers. The Health Action Lobby, a coalition of national health and consumer associations, claimed in 1995 that reductions in the escalator resulted in a $30 billion dollar shortfall in respect to health and related transfers.\(^{34}\) Similarly the National Forum on Health began to warn that declining transfers were falling to dangerously low rates, even when including the value of the tax transfer:

Provincial expenditures have accounted for the lion’s share of health care spending in Canada.... The federal share of health care spending, while already less than fifty percent, declined from forty-one percent to 32 percent, from 1977 to 1995. And as the tax points grew, the federal cash transfers declined from 25% to 16% of total provincial health care expenditures.... Federal transfers for health care fell from 11% of total federal expenditures to around 8%.\(^{35}\)

Fearing the provinces might forego cash entitlements and breech the Canada Health Act as cash transfers plummeted, the federal government linked financial penalties associated with the Act to other transfers under Bill C-69. Parliamentary researcher Dennis


\(^{34}\) Canadian Health Care Association, *Funding Canada’s Health Care System* (Ottawa: CHCA, 1999), 1.

\(^{35}\) Ibid., 36. Similar figures are presented in Paul Boothe and Barbara Johnston, *Stealing the Emperor’s Clothes: Deficit Offloading and National Standards in Health Care* (Montreal: C.D. Howe Institute, March 1993), 4.
Frechette argued, "this virtually non-stop series of cuts and freezes in federal government transfers to the provinces pushed the federal government into a corner; it realized it risked control over national standards in health care, should transfers to any province cease entirely."\textsuperscript{36} Maintaining national standards, deficit reduction goals, and some level of public contentment appeared to be an increasingly complex juggling act.

Using British Columbia budget publications, the trend indicated by the National Health Forum with regard to health related cash transfers proves to be accurate. In Table "A" the total EPF cash transfer received each year has been divided according to the federal formula to provided the allocation of the health transfer as a percentage of the EPF. The per capita figures, in column five, are particularly revealing of the marginal growth in the transfer. During the period from 1980 to 1988, growth in transfers at the per capita level failed to be proportionate to rate of inflation, let alone the growth of provincial expenditures. And for the most part, after 1987 per capita transfers began to decline corresponding with provincial accusations that federal funding for health care had been seriously eroded.

Column seven details federal cash transfers as a percentage of provincial hospital and medical insurance spending, the two components the federal government intended to fund under the original cost sharing arrangements. From 1979 to 1994 cash transfers have fallen from 36.3 to 16.2 percent of program spending; a relative reduction of 44 percent. These figures would be even lower if EPF cash was calculated as a percentage of total provincial spending; a calculation that would be considered legitimate since block funds are not assigned to specific health programs.

\textsuperscript{36}Frechette.
<table>
<thead>
<tr>
<th>YEAR</th>
<th>EPF cash transfer Received by the Provincial government(^{37}) (In dollars)</th>
<th>Changes to EPF cash dollars transferred in 1994 budget</th>
<th>Cash dollars designated to health as 67.9% of the transfer (In dollars)</th>
<th>Population of British Columbia(^{38})</th>
<th>Funding per capita of EPF cash dollars designated to health</th>
<th>Provincial spending on hospital insurance and medicare (^{39})</th>
<th>EPF health funding as a percent of hospital and medical care spending by the province</th>
</tr>
</thead>
<tbody>
<tr>
<td>1977</td>
<td>394,567,651</td>
<td>267,911,435</td>
<td>2,595,870</td>
<td>103.21</td>
<td>923,348,903</td>
<td>36.3%</td>
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<td>1978</td>
<td>383,185,645</td>
<td>260,183,053</td>
<td>2,641,202</td>
<td>98.05</td>
<td>1,111,200,000</td>
<td>36.3%</td>
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<tr>
<td>1979</td>
<td>494,180,716</td>
<td>335,548,706</td>
<td>2,706,445</td>
<td>123.98</td>
<td>1,433,600,000</td>
<td>30.2%</td>
<td></td>
</tr>
<tr>
<td>1980</td>
<td>593,409,000(^{39})</td>
<td>402,924,711</td>
<td>2,789,552</td>
<td>144.44</td>
<td>1,627,000,000</td>
<td>26.9%</td>
<td></td>
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<tr>
<td>1981</td>
<td>638,388,000</td>
<td>433,465,452</td>
<td>2,854,237</td>
<td>151.86</td>
<td>1,905,000,000</td>
<td>23.1%</td>
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<tr>
<td>1982</td>
<td>643,861,000</td>
<td>437,181,619</td>
<td>2,888,208</td>
<td>151.36</td>
<td>1,950,000,000</td>
<td>26.9%</td>
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<tr>
<td>1983</td>
<td>652,360,000</td>
<td>442,952,440</td>
<td>2,925,731</td>
<td>151.40</td>
<td>2,177,000,000</td>
<td>27.6%</td>
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<tr>
<td>1984</td>
<td>928,536,000</td>
<td>630,475,944</td>
<td>2,960,894</td>
<td>212.93</td>
<td>2,603,400,000</td>
<td>27.6%</td>
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<tr>
<td>1985</td>
<td>1,059,490,000</td>
<td>719,393,710</td>
<td>2,988,677</td>
<td>240.71</td>
<td>2,603,400,000</td>
<td>27.6%</td>
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<tr>
<td>1986</td>
<td>1,091,252,000</td>
<td>740,960,108</td>
<td>3,023,311</td>
<td>245.08</td>
<td>2,711,700,000</td>
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<td>1987</td>
<td>1,205,263,000</td>
<td>818,373,577</td>
<td>3,082,928</td>
<td>265.45</td>
<td>2,970,200,000</td>
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<td>1988</td>
<td>1,215,270,017</td>
<td>825,168,330</td>
<td>3,158,832</td>
<td>261.23</td>
<td>3,153,700,000</td>
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<td>1989</td>
<td>1,230,181,638</td>
<td>835,293,578</td>
<td>3,248,896</td>
<td>257.10</td>
<td>3,434,200,000</td>
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<td>1990</td>
<td>1,239,750,000</td>
<td>841,790,250</td>
<td>3,338,460</td>
<td>252.15</td>
<td>3,826,600,000</td>
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<tr>
<td>1991</td>
<td>1,110,300,000</td>
<td>753,893,700</td>
<td>3,424,109</td>
<td>220.17</td>
<td>4,241,900,000</td>
<td>17.8%</td>
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<td>1992</td>
<td>1,156,000,000</td>
<td>784,942,000</td>
<td>3,525,529</td>
<td>222.64</td>
<td>4,755,800,000</td>
<td>16.5%</td>
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<tr>
<td>1993</td>
<td>1,442,600,000</td>
<td>979,525,400</td>
<td>3,628,866</td>
<td>269.92</td>
<td>4,989,000,000</td>
<td>19.6%</td>
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<tr>
<td>1994</td>
<td>1,248,100,000</td>
<td>847,459,900</td>
<td>3,737,570</td>
<td>226.74</td>
<td>5,241,500,000</td>
<td>16.2%</td>
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</table>


\(^{39}\) Unaudited value.
Even when examining total spending on health by both levels of government, it is clear that increasing provincial fiscal responsibility for health care has been the dominant trend. William Robson’s study, which examined total health expenditures charted a similar development.41

Figure A

Indeed, according to Robson’s figures, the percentage of federal health expenditures, reveal federal contributions to be a larger percentage of total health expenditures. This is because “total health expenditures” include revenues allocated by the federal government to health, such as health services for aboriginal people, the population of the Yukon,

40 Note all calculations will use values as stated in the original budget for each year, rather than numbers revised in 1994.

immigrants, veterans, inmates in federal penitentiaries and members of the Canadian Armed Forces. Federal health expenditures also encompass programs related to researching food and drug safety, medical devices and infectious diseases as well as monitoring environmental hazards and of course transfers to the provinces for health care. Even with all these areas combined federal spending in health remains disproportionately low relative to provincial commitments.

While one may legitimately argue that federal transfers to the provinces have been declining, there are serious concerns as to how these dollars are recorded and presented to the public at the provincial level. The Established Programs and Financing (EPF) Act involves a series of complex formulas which serve to deter public inquiry and scrutiny at the most basic level. Failure to define the transfers or detail subsequent changes without sufficient explanation, as well as providing incorrect summaries evident in provincial accounts has complicated matters even further. For example, while the opening chapters of the British Columbia provincial budget outline the components of the Established Programs and Financing Act as “a cash and tax transfer combined with a per capita extended health care grant,” when recording “revenues received” they fail to clarify that the “EPF Contributions from the Federal Government” only encompass the cash transfer. Failing to make this distinction in the public accounts makes it difficult for the average person to comprehend these fiscal arrangements. Even those aware that only the cash value is recorded are still left to assume that the extended health care grants are included under “Other Payments” and the tax transfer is calculated as part of “Taxation Revenue” since there is no explanation where these components of the transfer are recorded.
Further, in 1994 changes were documented for EPF revenues received from 1989 to 1993, but alterations in the report were only given for 1990 to 1992. To record changes to revenues received and spent over the course of five years makes it virtually impossible to track and account for EPF cash dollars. The explanatory note for the retroactive revisions stated that “For comparative purposes, revenue has been reinstated in 1989/90 and onwards to reflect an accounting change to record personal income tax on an accrual basis. This change also affects Established Programs Financing (EPF) revenue as the amount of the EPF entitlement is determined by deducting a tax transfer of 13.5 points of personal income tax and one point of corporate income tax. For example, in 1992/93, the effect of the accounting change increases revenue by $105.3 million – personal income tax increases by $194.2 million and revenue from Established Programs Financing decreases by $88.9 million.” These “decreases” would be reflected in the cash portion of the transfer as a residual of the tax component. In the original 1992/93 budget the cash transfer totalled $1,156,000,000, changes recorded in 1994 claimed the cash transfer received was actually $1,250,900,000 - an increase of $94.9 million. Because final figures have been provided, determining the difference in values should simply be a calculation of addition or subtraction, but clearly that is not the case.

Further, there have been instances where figures have been used incorrectly. In an effort to exhibit the decline in federal transfers the following table was posted in the 1994

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43 *Ibid.*, 235. [Author’s emphasis.]
budget as a "Summary of Federal Established Programs Financing ... Contributions to British Columbia."^44

Table II

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<thead>
<tr>
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</thead>
<tbody>
<tr>
<td>Tax</td>
<td>318.5</td>
<td>606.8</td>
<td>1,345.3</td>
</tr>
<tr>
<td>Cash</td>
<td>309.7</td>
<td>928.5</td>
<td>1,248.1</td>
</tr>
<tr>
<td>Total</td>
<td>628.2</td>
<td>1,535.3</td>
<td>2,593.4</td>
</tr>
</tbody>
</table>

EPF as a percentage of British Columbia spending in health and post-secondary education

<table>
<thead>
<tr>
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</tr>
</thead>
<tbody>
<tr>
<td>Cash</td>
<td>21.7%</td>
<td>25.0%</td>
<td>15.8%</td>
</tr>
<tr>
<td>Total</td>
<td>47.2%</td>
<td>41.3%</td>
<td>32.9%</td>
</tr>
</tbody>
</table>

The summary exhibits the same general trend in cash transfers, and corresponds with Robson's argument that federal transfers are declining even when including the value of the tax transfer. But these calculations raise some serious concerns in that incorrect values have been used. The cash values of the "EPF entitlement" for 1983/84 and 1993/94 are actually figures from budgets produced in 1984/85 and 1994/95. The cash transfer for 1983 should read $652.1 million and the value for 1993 should be $1,442.6 million.\^45 Further, the cash transfer cited for 1977 fails to correspond with any entitlements recorded during that period. Provincial budgets are public documents designed to ensure government accountability and inform the public how and where their tax dollars are spent. However, the intricate nature of the EPF means even public documents are presented in an unclear and complex fashion serving to both undermine public interest and delegitimize provincial accountability. This is all the more alarming in that these same documents were intended to better educate the public as to the

\^44 Ibid., 114.
\^45 These values are from provincial accounts for the corresponding years.
province’s financial spending commitments. Complexities in the provincial budget parallel the historical misunderstanding of the EPF program, which in both instances, was seemingly designed and destined to actually discourage public understanding and awareness.

While the intricacies of federal transfers remained blurred for much of the public, by the mid 1990s the dwindling nature of these funds was certainly attracting increased public attention. In 1995 the Established Program and Financing Act was replaced with the Canada Health and Social Transfer (CHST) which merged federal transfers for health, education and the previous Canada Assistance Plan into one unallocated block fund. While there were few structural changes to health and education transfers under the new arrangement, failure to target monies meant these three programs would now be competing for dollars. Furthermore, these funds would be subject to even further cuts. Initiated in the 1995 budget the CHST outlined cutbacks in the base allocations equivalent to $2.5 billion in 1996-97 and $4.5 billion the following fiscal year. Predictions regarding growth or reduction to transfers after 1997 were not actually acknowledged in the budget papers. However, the Government of British Columbia predicted drastic reductions in contributions to all three programs now included in the block fund. “The CHST will considerably reduce provincial social transfer revenue. In 1996/97 British Columbia’s cash transfer will be $477 million less than what it received in 1994/95. The 1997/98 entitlement will be $824 million less – a reduction of 37% from

the 1994/1995 amount. Transfers under the CHST would also continue to be calculated as residual to the existing tax point components outline in previous EPF agreements, serving to further reduce cash transfers. Fearful of this trend author Robin Broadway argued that,

the decision to fold the CHST with the EFP program and allow the resulting transfer to be comprised partly of a tax-point transfer dating back to 1977 completely defies reason... allowing the CHST cash transfer to be determined as a residual after subtracting the tax-transfer component, when combined with the cuts announced for 1996-1997 and 1997-1998, will guarantee that the cash component for the EPF and CAP combined will automatically fall to zero some time early in the twenty-first century.... Either a failure of the CHST to resume this growth path or future cutbacks in the CHST allocation as a result of the continuing budget restraint that is almost certain to come will simply accelerate the time at which the cash runs out.

Eliminating cash transfers would severely compromise federal spending power and the ability to enforce criteria of the Canada Health Act. But even more importantly, the federal government would surrender its ability to shape necessary health care reform at the national level. Aware that declining federal transfers may entice some provinces to risk forgoing penalties associated with the Canada Health Act, the CHST incorporated Bill C-20 allowing any cash transfer to be used to ensure compliance with the Canada Health Act.

Echoing a similar concern, advocacy groups such as the National Council of Welfare, were also warning that EPF payments to some provinces would become non-

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48 Tax points included in the CHST transfer are equivalent to the 14.8 personal and one corporate tax point previously included in the Established Programs and Financing Act.
existent by the year 2000. However, this was not the case owing to two distinct but related issues. First, as Canada's most revered social program, termination of federal influence in the national health program would create political turmoil for any governing party. A 1995 public survey by Ottawa based Ekos Research Associates claimed that nearly 80% of those polled wanted the federal government to either maintain or increase its role in the health care sector. Eighty-nine percent of those polled said the provinces and Ottawa should work together to improve the health-care system. Second, fiscal payments may be partially safeguarded through constitutional commitments as embodied in Section 36 of the Constitution Act of 1982. The Act states that both the federal and provincial levels of government are jointly committed to the "national equity agenda, including providing equal opportunities, reducing disparities and providing essential public services to all Canadians." In fact, then Justice Minister Jean Chrétien claimed the Constitution would foster strong public service programs. "Sharing the wealth," he declared "has become a fundamental right of Canadians and that is why the resolution ... commits both orders of government to promoting equal opportunities for the well-being of Canadians; furthering economic development to reduce disparities in opportunities and specifically providing essential public services of reasonable quality to all Canadians. By entrenching this principle in the constitution we are enshrining the obligation of sharing

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51 Colleen Fuller, Caring For Profit (Ottawa: New Star Books, 1998), 77.
53 Broadway,103.
which has been fundamental to the Canadian experience." Referring to Section 36 of the Constitution author Aymen Nader claimed that

> if the Constitution Act is to be taken seriously it also incumbent on them to legislatively ensure that these programs are of a "reasonable quality." What is clear from the wording of this section is that its provisions are directed at all Canadians. Furthermore, only the federal government is in a position that the commitments...outlined are met. While it cannot act alone, in that the participation of the provinces is essential to meeting the requirements..., the federal government is the level of government which bears ultimate responsibility for all Canadians. Only the federal government, acting with the provinces, can meet that part of the commitment that essential public services will be provided to "all Canadians." Constitutional obligations to uphold national programs essentially limited the federal option to terminate cash transfers or adopt straight tax transfers. According to Broadway, a commitment to "spending power is what reconciles the joint federal-provincial responsibility for achieving equity through the provision of public services in areas of provincial responsibility." If the federal government were to test its constitutional obligations, the provinces would then be open to pursue health care reforms with little or no commitment to maintain the standards of the Canada Health Act and only public sentiment would be left to shape health care policy.

Persistent renegotiations and direct modifications to fiscal policy has resulted in a redefined federal commitment to the national health care program. Implementation of block funding, a seemingly rational policy adjustment at the time, allowed the federal government to gradually redefine funding obligations. What began as fifty-fifty cost

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54 Quoted in Nayder, 39.
55 Ibid., 37.
sharing has fizzled into a limited cash payment complicated by tax components and competing program interests within the block fund structure. A federal desire to meet emerging economic goals, specifically debt reduction, has meant re-evaluating social policy funding mechanisms. Through this ongoing historical process the national government has also found itself in a position to shape the future of health care in Canada. Given federal commitments to reduce expenditures over the last two decades, it is highly unlikely that this trend will be reversed. As a consequence, the national government institutes pressures to encourage the provinces and the public to examine reform options in order to balance funding reductions with service delivery.

By the end of the twentieth century Canadians were becoming increasingly aware of declining federal transfers which were facilitating variation in provincial health policy. According to parliamentary researcher Jack Stillborn, “restraints on federal transfers have...coincided with growing provincial experimentation with alternative delivery mechanisms, notably in the health care field.” Fiscal constraints perpetuated the sense of “crisis” as pressures for privatization increase and citizens witness cuts and shortages at the local level. When in 2002 an Environics poll asked “Is there a crisis in health care?”—two-thirds of Canadians agreed. Whether this perception is fully justified is another debate, but it is clear Canadians are drawing a connection between funding and ensuing crisis. In the same year, an Ipsos Reid survey found that eight out of ten Canadians agreed long term sustainable funding is needed to improve the health care

58 Cited in Maioni.
The questioned remains are governments going to respond to public
dissatisfaction? Even author Thomas Courchene, who supported the CHST because it
allows greater flexibility in social assistance programming for the provinces, has
admitted that "given the series of arbitrary federal cuts, freezes and caps to transfers over
the last decade, the time has come to provide some certainty in terms of cash transfers."^®

In the 1980s Canadians were drawn into the health care debate to deal with the
visible and pressing issue of service delivery. Meanwhile, beneath the surface, fiscal
pressures were forcing governments to employ restraint measures, leading federal
transfers, specifically the EPF, to significantly diminish in the following decade. In the
process, the working relationship between the two levels of government soured as the
national program became distinctly provincial in nature. Provincial governments, in
accordance with their jurisdictional authority, essentially controlled the service and
delivery of health care shaped by the broad parameters of the Canada Health Act. But
increasingly the provinces were also footing most of the bill, calling into question the
maintenance of national standards. For the most part the public seems determined to
appeal to governments at every level to uphold these standards. As a result, frustrated
provincial governments have turned to the public to help reinstate federal funding. While
the public clearly understands provincial accusations of "under-funding," they may be ill
equipped to comprehend the complex nature of federal-provincial funding arrangements,
merged in a confluence of historical policies, funding arrangements and jurisdictional

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^9 Ipsos Ried, Poll – Second Annual Report Card on Health Care in Canada (Ipsos Ried, 19 August 2002),
www.angusreid.com/pdf/media/mr020819-1Eng.pdf
issues. This thesis exhibits how a series of seemingly minor policy adjustments compound to have broad ramifications overtime. Lacking a thorough understanding of the complexity of this historical relationship in turn cultivated public confusion as to why the two levels of government are unable to resolve the “crisis” in health care.
Conclusion:

"Building on Canadian Values:"

A Precarious Future

Through a series of negotiations, coercive directives from Ottawa, and reinterpretation of the British North America Act, a fiscal inequity between the two levels of government has emerged in regard to financing Canada's national health care program. Gradually the provinces acquired increasing responsibility to fund what many Canadians describe as our most valued and, admittedly, most expensive social program. Imbalanced fiscal relations have stemmed from a series of renegotiated transfer agreements beginning in 1977, as prior cost sharing arrangements gave way to block funding outlined in the Established Programs and Financing Act (EPF). The EPF provided a combined cash and tax transfer to the provinces to fund three existing programs, hospital insurance, Medicare and education. While the new block fund structure allowed the provinces the desired flexibility to determine service delivery and health care priorities, the new agreement relieved the federal government of conditional cash transfers and failed to ensure a long-term, legislated federal commitment, consequently opening the door for renegotiating intergovernmental transfers. Specifically, modifications during the 1980s, which sought to bring transfers in line with new federal deficit reduction and cost efficiency goals, meant the provinces would acquire greater responsibility to finance health care delivery. As a result, through a series of negotiations the cash portion became destined to decline as value of the tax transfer grew, leaving fewer federal dollars designated to these specific programs and leading the
provinces to question their obligation to maintain the principles of the Canada Health Act. The provinces’ concerns were further exacerbated during the late 1980s and 1990s as a series of unilateral adjustments to the escalator, by the federal government, significantly reduced the value of the cash transfer.¹ By the late twentieth century, funding issues combined with public outcry regarding waitlists, delisting services and fears over privatization, lead some to suggest that the Canadian Health Care system was in dire need of reform. However, restructuring Medicare can only be accomplished by evaluating and seeking solutions to the funding tug of war that has continued to plague the program. Consequently, it is important to understand the evolution of fiscal transfers over the last three decades in order for Canadians to determine the type of program that should be delivered and the fiscal commitments of the various levels of government.

Canadians have become so disheartened with the health care system that a 1999 Angus Reid survey claimed that 76 percent of those polled believed the health care system was in crisis and in serious need of reform.² Even more telling only 52 percent of Canadians believed the Canada Health Act [CHA] lived up to its principles; meaning almost half of the public felt that federal legislation designed to oversee Medicare has proven inadequate at ensuring the basic standards of the program and adapting to

emerging health needs.\footnote{Ibid. Were these polls can be deceptive in that it is unclear how many Canadians really know the principles of the Canada Health Act.} Given growing public concern regarding health care
William Robson, in a discussion on jurisdictional authority in 1995 correctly pointed out
that “it is the provincial governments who are overwhelmingly responsible for the merits
and defects of the health care system Canadians now enjoy,” and believed “it is to the
provinces that Canadians should logically turn...” with their complaints and demands for
reform.\footnote{William P. Robson “Federal Spending in Four Dimensions,” in Thomas J. Courchene and Thomas A. Wilson eds., The 1995 Federal Budget: Retrospect and Prospect (Kingston: Institute for Policy Analysis, 1995), 68.} However, if the provinces are unable to maintain services at appropriate levels
owing to disproportionate funding arrangements for a program intended to be national in
scope, should not Canadians be turning to the level of government enabling the program
and enforcing the standards? Federal neglect to maintain stable and sufficient funding
has severely jeopardized the state of health care in Canada. Through a series of unilateral
directives by the late 1990s federal funding for health care had declined to less than 27
percent when combining cash and tax transfers and less than 15 percent when only
including federal cash contributions. Increasingly the fiscal burden has rested with the
provinces, compromising service delivery and ultimately stirring demands for private
health care options.\footnote{For an early discussion on privatization options see: Health and Welfare Canada, Privatization in the Canadian Health Care System: Assertions, Evidence, Ideology and Options (Canada: Minister of Supply and Services, 1985).} This is not to say that the provinces are innocent of mismanaging the
health care system, but that the persistent battle over funding has hindered the most
important aspect of health care – program delivery. In theory, if the value of the cash
transfers continues to decline, some provinces may be inclined to forego federal transfers,
allowing them to operate systems in violation of the Canada Health Act.\textsuperscript{6} Thus, sufficient levels of funding are vital in protecting and promoting the national nature of the program.

Six years after Robson voiced his concerns the provinces sought to realign public dissatisfaction regarding the health care system with their own demands for an increased federal financial commitment by embarking on an aggressive national media campaign. In the 2001 advertisement the provinces claimed that federal contributions had declined to fourteen percent of provincial health expenditures. Essentially the provinces sought to encourage Canadians to pressure the federal government to reinvest in the national program. In response to provincial frustrations and growing dissatisfaction with the system, Prime Minister Jean Chretien appointed a Royal Commission in the same year to investigate the Future of Health Care in Canada. The study, headed by former Saskatchewan premier Roy Romanow, sought to engage Canadians in a national dialogue in order to “preserve the long term stability of Canada’s universally accessible, publicly funded health care system.”\textsuperscript{7} Without investigation, recommendation and reform, some argued, the national program could be nearing extinction. Reaching a similar historically informed conclusion as this thesis the Commission recognized that

\begin{quote}
sometimes by design, sometimes by financial necessity, and more often by default, the provinces are increasingly willing to go it alone in so far as their respective health care systems are concerned. Today, we sit on the cusp. Left unchecked, this system will inevitably produce thirteen clearly separate health care systems, each with differing methods of payment, delivery, and outcomes, coupled by an ever increasingly volatile and debilitating debate surrounding our nation, its values and principles.\textsuperscript{8}
\end{quote}

\textsuperscript{6} Forgoing federal transfers, while a threat occasionally uttered by the provinces, continues to be a limited option for most provinces since the federal government has tied penalties under the Canada Health Act to a number of provincial transfers.


\textsuperscript{8} \textit{Ibid}, XVII.
Romanow’s sense of his mandate carried the responsibility that the Commission’s final recommendations would “faithfully reflect the values Canadians want expressed in the policies and programs that define their health care system.”\textsuperscript{9} While determining the “values” of Canadians would be subjective at best, as the study could only represent those who expressed opinions, the findings were consistent with polls conducted throughout the country, in terms of support for the system and reform priorities. In fact an Ekos poll released on 5 December 2002 claimed 57% of Canadians thought the Romanow report did a good job of reflecting the core values of Canadians. This figure rose to 74% when only those clearly aware of the final report were considered.\textsuperscript{10}

Echoing the views of Mr. Justice Emmett Hall, instigator of the Canada Health Act over two decades earlier, the Commission argued that “Medicare has become one of the defining features of Canada’s national identity.”\textsuperscript{11} In their view, Canadians consider equal and timely access to medically necessary health care services on the basis of need as a right of citizenship, not a privilege of status or wealth. Building on these values, Canadians have come to view their health care system as a national program, delivered locally but structured on inter-governmental collaboration and a mutual understanding of values. They want and expect their governments to work together to ensure that the policies and programs that define Medicare remain true to these values.\textsuperscript{12}

While the system continues to exhibit fundamental flaws, the reality is that “Canadians embrace Medicare as a public good, a national symbol and a defining aspect of their

\textsuperscript{9} Ibid. XV.
\textsuperscript{10} CBC News. “Health Care Polls.” www.cbc.ca/stories/2oo2/12/05/poll_health02/205 (03/07/11).
\textsuperscript{12} Ibid. XVI.
citizenship." Therefore, reforms aimed at preserving Canada’s universal health care system would be welcomed as both justified and necessary.

Heading the list of the Commission’s concerns were improving cooperation between the two levels of government; revamping the publicly funded health system guided by a new Canadian Health Covenant; updating the CHA to reflect new priorities; address rural, remote and aboriginal health issues; address diagnostic equipment shortages and improve labour relations. But, the core concern was renegotiating federal funding commitments as the vital component in fostering reform, stability and the sustainability of Canada’s national Medicare program. In the Commission’s view the federal government contributed “less than it previously did, and less than it should.” To rectify under-funding and stabilize intergovernmental relations, the commission recommended that “adequate, stable and predictable funding arrangements” be established, particularly at the federal level where the government “should reinforce its financial commitment to health care, by replacing the current transfer system with a cash-only transfer, and build in mechanisms for adjusting the transfer on an ongoing basis.” Specifically, the report proposed several adjustments to the current transfer system under the Canada Health and Social Transfer [CHST] in order to restore adequate funding. First, it suggested separating the CHST into a health and a social services transfer to promote “accountability and transparency” by allowing health care spending to be tracked, reminiscent of the original conditional grant system. Further the new “Canadian Health Transfer,” provided in cash, should be raised to cover 25% of health

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13 Ibid. XVIII.
14 Ibid. 65.
15 Ibid, 48.
care spending as outlined in the original EPF arrangement in 1977, when 50/50 cost sharing was replaced with a combined cash and tax transfer. Consistent with these arguments, the Commission noted that cash transfers had dropped to a low of 14.6% in 2001/2002, and federal cash and tax transfer combined were as low as 27.5% — falling well short of the original 50% cost sharing arrangement at the inception of the program. Citing an estimate for 2005/2006 the new cash transfer would require $4.4 billion in investment to stabilize the transfer at 25%. They further recommended renewing the escalator to ensure growth consistent with inflation. Specifically, to guarantee constant and predictable growth the escalator should be set for five-year periods. Overall, the Commission argued that a long-term federal reinvestment is necessary to maintaining a national program.

In addition to reviving the cash transfer, the study noted certain areas requiring the immediate injection of targeted federal funds to address health care priorities. Specifically funds should be dedicated to improving rural and remote access, diagnostic services, primary health care, home care and catastrophic drug costs. These programs would require an additional $8.5 million in funds beginning in 2003, supplemented by a further $6.5 million in investment by 2005/2006. The Commission argued,

This additional funding by the federal government is not only consistent with the original Medicare commitment, it is essential to protect, promote, and enhance the national dimensions of public health care in Canada... such a reinvestment would be a prerequisite to the federal government resuming a leadership role within the Provinces in shaping the future of Medicare.

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16 Ibid, 66.
17 Ibid, 69.
18 Ibid, 71-72.
19 Ibid, 71.
20 Ibid, 70. [Author's emphasis.]
While Romanow correctly asserted that the federal government had both a fiscal and policy obligation to provide leadership through national policies such as the Canada Health Act, he failed to adequately address how to resolve the persistent conflict regarding jurisdictional authority; aside from suggesting that intergovernmental relations simply need to be more amicable and productive and that increased funding levels need to coincide with greater provincial accountability. The provinces, content to complain that their systems are inadequately funded, fail to realize that tracking health care dollars means not only being accountable to the federal government but also to the public. A public that has indicated its support for a national program, but to date have been denied cogent information regarding the source of health care funding and how these dollars are spent. The Commission even acknowledged that the fiscal arrangements remain “extremely obscure to even the most informed,” and as a result it is imperative to improve accountability.\(^21\) “Health care in this country is now a $100 billion dollar enterprise, one of our society’s largest expenditures. Yet no level of government has done a very good job of accounting how that money is spent. Canadians still do not know who to believe in the debate over which level of government is paying what share for health services.”\(^22\) In concluding the discussion on funding, the Commission warned that the failure to reach a formal agreement on these issues would mean that intergovernmental wrangling over funding obligations will continue into the future and ultimately necessary health care reforms will continue to be overshadowed by these debates. While the Commission outlined numerous recommendations for promoting sustainable health care, progressive reform continues to be framed by the status of

\(^{21}\) *Ibid*, 47.
intergovernmental fiscal relations.

Receiving exceptional fanfare, debate, and media coverage at the release of the Commission's report, "The Future of Health Care in Canada," newspapers declared that "few [Canadian's] criticized the principles expressed in the study." Upon such widespread popular approval Prime Minister Jean Chretien claimed he could make "one promise... the Romanow report will not gather dust on a self. We will move quickly." Chretien even anticipated legislation arising from the study by spring of 2003.

Accordingly, the showdown began in early 2003 as the two levels of government negotiated a new funding arrangement for health. In the end a $34.8 billion dollar deal, over five years, was signed between the provinces and Ottawa. Consistent with the Commission's recommendations the agreement included $16 billion towards a five year health care reform fund for primary care, home care and catastrophic drug charges; $13.5 billion in new funding over five years and $2.6 billion for diagnostic equipment, computers and research. In addition, a "health council" was to be established to

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22 Ibid. XIX.
monitor and report on accountability, implementation and set performance indicators.  

British Columbia is scheduled to receive approximately $325 million in new funding over the course of the new agreement.  

While there appeared to be renewed federal interest in ensuring the sustainability of health care, evident in the new funding arrangements, there are still several unresolved issues that will continue to plague the national program. First, the $13.5 billion over five years fails to renew a federal cash commitment at 25%, as a consequence fiscal negotiations will continue to be heated as the provinces recite demands for a meaningful federal financial commitment. Second, a base transfer guided by an escalator has not been established, which would ensure growth in the future. Third, the current transfer arrangement has not been separated to improve “transparency,” continuing to discourage public understanding of financing and expenditures. Failure to reinvest means the recommendations of the Commission will unlikely be pursued and other reform options, that may deviate from social expectations, will have to be investigated. Lastly, and most importantly, it appears that any further reforms, aside from an increased federal fiscal commitment, have disappeared into the bureaucratic backwoods. Canadians are once again left in the dark how funding increases are actually going to play out at the local level. Despite the economic and fiscal focus that has dominated the health care debate, ultimately governments need to be accountable for funding and providing sound, stable social policies. To this point it seems unclear that either level of government is prepared to make this kind of commitment.  

In 1978 Richard Simeon, Director of the Institute of Intergovernmental  

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Relations, authored words that continue to ring true in this century:

Our decision-makers became preoccupied with questions of structure, with fiscal relations, with constitutional change, with who does what, rather than with the concrete problems of what will be done. The institutional interests of the competing governments predominate - all carried out in an arcane language of amendment formulas, tax points whose relevance to the citizen, and to what governments actually do for them is at best unclear. Major changes in the financing of hospital and medical care insurance have occurred, yet we know little about what, if any, differences these changes will mean for citizens.\(^9\)

Given a clear framework for reform, it is up to Canadians to understand the crucial issues surrounding the health care debate and ensure reforms that reflect their values are pursued in the future.

This thesis has sought to detail the historical development of Canada’s comprehensive health care system and the sequence of adjustments to fiscal arrangements that have guided its evolution. In the process I have analyzed a variety of competing notions including jurisdictional issues and interpreting fiscal responsibilities, compounded by a wide range of social expectations. This study has highlighted the historical commitment which instigated the program and which should be honored by the federal government. As Robert Gordon suggested, our current position has been the result of a series of incremental policy adjustments overtime that gradually redefined intergovernmental transfers for health care in Canada.\(^{10}\) We are at a crossroads, and while reform must be encouraged at every level of government, it is clear that a federal presence is necessary if we want to continue to have a universally, accessible, national health care program.

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