True North in
Canadian public policy

THE MOST RESPONSIBLE POLITICIAN: **Who's the MRP for Health Care in Canada?**

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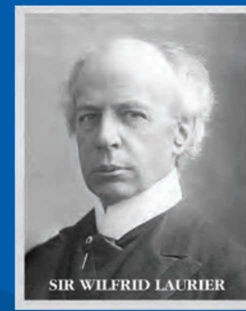

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Executive Summary

In medicine, the Most Responsible Physician or Practitioner (MRP) is ultimately responsible for overseeing the care of an admitted patient. Responsibility for clinical decisions and for a patient's ultimate outcome falls on the MRP. Any ambiguity around MRP creates the potential for bad patient outcomes.

In one particular case this author is familiar with, the entire patient outcome hinged on establishing which physician was MRP between the time an emergency physician assessed a patient with abdominal pain, and the time that the consultant saw the patient. The consultant had asked for a CT scan. The patient deteriorated in the delay before the consultant reviewed the scan or the patient and it turned out the patient was suffering from massive intraperitoneal hemorrhage – internal bleeding. The lack of absolute, explicit clarity on who was most responsible, at all times, led to a terrible outcome.

The MRP concept does not just apply to health care. It applies to all leadership scenarios: We need one person or governance unit to take responsibility for important issues. When it comes to political oversight and accountability for the Canadian health care "system," we might expand the MRP definition and ask: Who is the Most Responsible Politician for Canadian health care?

Canadian health care routinely ranks poorly against comparable OECD nations. But who should bear the blame for mediocre outcomes? On one hand, the Constitution appears to support the notion that health care is an exclusive provincial responsibility. On the other hand, the federal government uses its spending power and legislative authority, based on the Constitution, to shape health care through the *Canada Health Act* (CHA) and Canada Health Transfer (CHT) payments.

We now find ourselves in the position, as Gregory Marchildon has put it, where "provincial governments have assumed the primary responsibility and authority for public health care. At the same time, the Government of Canada, by using [its] 'spending power' … has exerted considerable influence over Medicare." Needless to say, as researchers Michael Smart and Richard Bird have noted, "The result of this fiscal churning is that no government has clear responsibility for delivering key programs and both sides readily blame the other when something goes wrong."

In the face of this wrangling, patients can end up paying the price. Identifying a Most Responsible Politician for health care might be the answer. But who should it be?

We have heard numerous arguments for maintaining and even expanding a federal role in Canadian medicare. Among them are that have-not provinces would not be able to offer the same level of medical services without federal support; that some provinces will use their greater autonomy over health care spending to decrease taxes instead of increasing health services; that federal leadership can help tackle wait times by setting national targets; and that health professionals are mobile and will move to work in more favourable provincial systems, which will create disparity between provinces unless the federal government monitors mobility. Furthermore, a federal MRP role in Canadian medicare would protect the nation-building and national identity benefits of a national approach to health care.

But there are at least an equal number of compelling arguments for supporting a provincial MRP. They include many of the same issues raised for the federal MRP, but assign the opposite normative

weight to them. Proponents argue that the provinces are better positioned, better informed, and better placed to experiment with policy options. Provinces can and do set standards for the bulk of provincial programming, holding themselves accountable to voters. In fact, health care standards could more easily be strengthened, clarified, and adhered to if there was direct accountability to the voters most affected by those standards, if provinces were the MRP for health standards.

This author asserts that a decentralized approach that brings the administration of care closer to the patient, and allows for a variety of approaches that suit the particular needs of patients in different provinces, is preferable to a top-down system dictated by the federal government. The idea that power should be devolved to those closest to the issue was clear to the drafters of Canada's Constitution, and it remains true today.

Once we've identified the Most Responsible Politician, how do we give the appropriate level of government the resources and the responsibility to ensure the job gets done? One place to start could be by reforming the health transfer and allowing for provinces to raise their own revenue for health programs, with fewer strings attached.

Ken Boessenkool builds on work by Smart and Bird by exploring options to implement a significant reduction in federal transfer payments to match a GST tax point transfer. He writes that the current approach to funding and managing health care creates confusion: "Ottawa makes political use of its pulpit and penalties, which results in confusion about which level of government is responsible for health care. This confusion is not costless: it allows the provinces to shift the blame to Ottawa when they make mistakes and allows Ottawa to claim credit for reforms it had nothing to do with."

Conveniently, the CHT stood at $36.1 billion in 2016-17. The Goods and Services Tax brought in $34.4 billion for 2016-17. Instead of having the federal government collect $34.4 billion in GST and then transfer $36.1 billion to the provinces, it seems reasonable to consider having the provinces collect the GST and stop the CHT payments, although some transfer arrangement would still be required for provinces with the smallest tax bases.

If we asked patients, they would probably place more weight on access to quality patient care than on the vague ideals in the CHA or the details of CHT payments. Bad things happen when admitted patients do not have a Most Responsible Physician. The same concept applies to health care at a system level. As it stands, the lack of clarity about which level of government carries responsibility for improving health care performance makes difficult change almost impossible.

Sommaire

En médecine, le « médecin le plus responsable » (MPR) est celui qui est principalement responsable des soins intrahospitaliers d'un patient. Les décisions cliniques et les résultats en matière de santé relèvent de sa responsabilité. Toute confusion quant à l'identité du MPR peut avoir des répercussions malencontreuses pour un patient.

Dans un cas particulier, connu de l'auteur, l'issue dépendait entièrement du délai écoulé pour identifier le MPR, entre le moment où l'urgentologue avait évalué l'état du patient, pris de douleur abdominale, et la consultation avec le spécialiste. Le spécialiste avait recommandé un examen tomodensitométrique. Toutefois, l'état du patient, qui souffrait en fait d'une hémorragie intrapéritonéale massive, c'est-à-dire de saignements internes, s'était aggravé dans l'intervalle, donc avant l'examen des résultats ou du patient par le spécialiste. Le manquement au principe de clarté absolue et explicite en tout temps quant à l'identité du MPR avait entraîné des conséquences regrettables.

Le concept de MPR ne s'applique pas uniquement aux soins de santé, mais à tous les scénarios de leadership : nous avons besoin d'une personne ou d'une unité de gouvernance pour assumer la responsabilité des problèmes importants. En ce qui concerne le contrôle politique et l'imputabilité à l'égard du « système » de soins de santé canadien, nous pourrions élargir la définition de principal responsable et nous poser la question suivante : qui est le « politicien le plus responsable » en matière de soins de santé au Canada?

Les soins de santé canadiens se classent très mal par rapport à ceux des pays comparables de l'OCDE. Qui devrait porter la responsabilité de ces résultats médiocres? D'une part, selon la Constitution canadienne, les soins de santé sont la responsabilité exclusive des provinces. D'autre part, la Constitution confère au gouvernement fédéral un pouvoir de dépenser et un pouvoir législatif dont il se sert pour influer sur les soins de santé par l'intermédiaire de la *Loi canadienne sur la santé* (LCS) et des paiements qu'il verse dans le cadre du *Transfert canadien en matière de santé* (TCS).

Nous voyons maintenant, comme l'a souligné Gregory Marchildon, les gouvernements provinciaux assumer le rôle principal en matière de responsabilité et de pouvoir en ce qui a trait à la santé publique. Parallèlement, le gouvernement du Canada, par son « pouvoir de dépenser », exerce une influence considérable sur le système de santé. Comme l'ont indiqué les chercheurs Michael Smart et Richard Bird, les conséquences de cet imbroglio fiscal sont évidentes : comme aucun palier de gouvernement n'a de responsabilité claire de mise en œuvre des programmes clés, lorsque quelque chose ne va pas, les deux parties s'accusent volontiers mutuellement.

Ces querelles peuvent imposer un prix élevé pour les patients. Désigner le politicien le plus responsable en matière de soins de santé pourrait être la solution. Mais qui devrait l'être?

Nous avons entendu de nombreux arguments en faveur du maintien et même de l'élargissement du rôle du gouvernement fédéral dans le système des soins de santé au Canada. Notons, par exemple, que les provinces pauvres ne pourraient pas offrir des services médicaux équivalents à ceux des autres provinces sans soutien fédéral; que l'autonomie accrue en matière de soins de santé inciterait certaines provinces à réduire les impôts plutôt qu'à augmenter les services; que le leadership fédéral peut contribuer à la réduction des temps d'attente grâce à la mise en place d'objectifs nationaux; et qu'en raison de leur mobilité, les professionnels de la santé sont enclins à se déplacer vers des

systèmes provinciaux plus favorables, ce qui engendre des disparités interprovinciales, à moins que le fédéral n'exerce une surveillance. En outre, un principal responsable fédéral au sein du régime canadien sauvegarderait les bénéfices d'une approche nationale des soins de santé pour la construction du pays et le renforcement du sentiment identitaire.

Toutefois, les arguments convaincants en faveur des provinces sont au moins aussi nombreux. Ils ciblent bon nombre des mêmes enjeux que ceux évoqués dans le cas d'un principal responsable fédéral, mais leur affectent un poids normatif opposé. Les défendeurs soutiennent que les provinces sont mieux placées, mieux informées et en meilleure position pour mettre des options stratégiques à l'essai. Les provinces sont en mesure de définir et définissent des normes pour la majeure partie de leurs programmes et répondent des mesures qu'elles prennent devant leurs électeurs. En fait, les normes de soins de santé pourraient être plus facilement renforcées, clarifiées et respectées si l'imputabilité était assurée plus directement envers les électeurs les plus touchés par ces normes, les provinces agissant alors en tant que principales responsables.

L'auteur de cette étude affirme qu'une approche décentralisée, qui rapproche les patients de l'administration des soins et offre une diversité de réponses à leurs besoins particuliers dans différentes provinces, est préférable à un système descendant dicté par le gouvernement fédéral. Ce constat était évident pour les rédacteurs de la Constitution du Canada et l'est encore de nos jours.

Une fois le principal responsable identifié, comment doter le gouvernement approprié des ressources et de la responsabilité nécessaires pour que le travail puisse se faire? On pourrait commencer par réformer le transfert des soins de santé, ce qui permettrait aux provinces de tirer elles-mêmes plus de revenus pour leur programme de santé, tout en allégeant les contraintes.

En s'appuyant sur les travaux de Smart et Bird, Ken Boessenkool explore les moyens d'envisager une réduction importante des paiements de transfert fédéraux combinée à un transfert équivalent des revenus sous forme de points de TPS. Il écrit que l'approche actuelle en matière de financement et de gestion des soins de santé crée de la confusion : « Ottawa utilise sa position dominante et ses sanctions à des fins politiques, ce qui crée de la confusion quant à la responsabilité ultime des soins de santé. Cette confusion n'est pas sans coût : elle permet aux provinces de tenir Ottawa responsable de leurs erreurs et à Ottawa de s'attribuer le mérite pour des réformes avec lesquelles ce palier gouvernemental n'a rien à voir ».

Fait intéressant, en 2016-2017, les dépenses au titre du TCS s'élevaient à 36,1 milliards de dollars, tandis que la taxe sur les produits et services rapportait 34,4 milliards de dollars. Plutôt que de laisser le gouvernement fédéral percevoir 34,4 milliards de dollars en TPS pour ensuite reverser 36,1 milliards de dollars aux provinces, il semblerait plus logique de proposer aux provinces de percevoir elles-mêmes la TPS, bien que certaines ententes de transfert soient encore nécessaires pour les provinces dont l'assiette fiscale est moins étendue.

Si nous interrogions les patients, nous observerions probablement qu'ils accordent plus d'importance à l'accès à des soins de qualité qu'aux idéaux vagues à la base de la LCS ou aux détails des paiements du TCS. Des incidents regrettables se produisent pour les patients hospitalisés en l'absence d'un médecin principalement responsable. Le même concept s'applique aux soins de santé à la grandeur du système. Dans l'état actuel des choses, le manque de clarté quant au palier de gouvernement qui assume la responsabilité d'améliorer le rendement des soins de santé rend les enjeux difficiles pratiquement impossibles à régler.

Introduction

Every patient admitted to hospital needs one person accountable for care and outcomes. In medicine, there is a long history, supported by case law, for the Most Responsible Physician (MRP) (*Manary v. Strban et al.*). The MRP is ultimately responsible for overseeing and providing a plan for the care of an admitted patient, even if the scope of the "medical problem is beyond the expertise of the MRP" (CMPA, 2012). Patients come to harm without an MRP. As scopes of practice for non-medical practitioners have expanded, for example with Nurse Practitioners having hospital admitting privileges, the MRP acronym has grown to now include Most Responsible Practitioner/Physician.

The MRP role includes more than just a focused devotion to one patient; it includes the duty to abide by hospital rules, adhere to regulatory oversight, be accountable for resource stewardship, and accept a host of other obligations. However, responsibility for clinical decisions and for a patient's ultimate outcome falls on the MRP, and this is especially the case when patients die. In my experience as chief and medical director of a large emergency services program, I have found that, if asked to determine whether or not a patient has received an acceptable level of care, the courts are primarily interested in whether a patient might have benefitted from an intervention, regardless of whether it was withheld in the name of resource stewardship or any other laudable goal.

Having reviewed many patient complaints, any ambiguity around MRP, or potential confusion about MRP, especially around transfers of care, creates the potential for bad patient outcomes. In one memorable case, the patient outcome hinged entirely on establishing which physician was MRP between the time an emergency physician assessed a patient with abdominal pain, and the time that the consultant saw the patient. The consultant had asked for a CT scan. The patient deteriorated in the delay before the consultant reviewed the scan or saw the patient. The lack of absolute, explicit clarity about who was most responsible, at all times, led to a terrible outcome.

The MRP concept does not just apply to health care. It applies to all leadership scenarios: We need one person or governance unit to take responsibility for important issues. When it comes to political oversight and accountability for health care, we might expand the MRP definition and ask: Who is the Most Responsible Politician for Canadian health care?

To be clear, having a Most Responsible Physician is necessary, but not sufficient, for good patient outcomes, and this would also be true for our Most Responsible Politician. Quality and service require more than just accountability. In this sense, accountability is not an end in and of itself, but it is one of the means necessary to deliver the end point: great medical care. As such, we should expect clear lines of accountability in every high-functioning, high-stakes system.

The Canadian health care "system" remains popular in Canada despite studies that show Canadians pay more for care and get less for their money than do other countries. Jane Philpott, then federal minister of health, said, "It's a myth that Canada has the best health care system in the world" (Cullen, 2016). In reference to Senator Bernie Sanders' congratulations of Canadian Medicare, André Picard, health reporter at the *Globe and Mail*, tweeted that "On health reform, Canada needs a kick in the ass, not a pat on the back…" (Picard, 2017). Canada spends $250 billion on health care, which has, at times, increased by up to 7 percent annually (CIHI 2019). Economist Don Drummond predicted years ago that at this rate, health care could consume 80 percent of provincial budgets by 2030 (Ibbitson 2011).

Canadian health care routinely ranks near the bottom when compared with that of OECD countries (Davis, Stremikis, Squires, and Schoen 2014; Schneider, Sarnak, Squires, Shah, and Doty, 2017; Carrol and Frakt 2017; Watson 2017). The number of hospital beds and doctors per 1,000 population both fall below OECD averages (2.5 vs. 4.7, and 2.7 vs, 3.5) (OECD 2019). Patients routinely spend most or all of their hospital stay in hallways or makeshift rooms (Fox 2017). In some regions, patients wait two-and-a-half years for a long-term care bed, and sometimes much longer (Hennessey 2018). Canadian patients spent $1.9 billion of their own money waiting for care in 2017 (Barua and Hasan 2018). Even back in 2007, waiting was costing the Canadian economy over $14.8 billion in lost wages for patients and caregivers, representing an additional $4.4 billion in unrealized taxes (Galloway 2008).

There is certainly room for improvement. However, it is not clear who should carry the responsibility for improving performance. Who should bear the blame for mediocre outcomes?

On one hand, the Constitution appears to support the notion that health care is an exclusive provincial responsibility. On the other hand, the federal government uses its spending power and legislative authority, based on the Constitution, to shape health care through the *Canada Health Act* (CHA) and Canada Health Transfer (CHT) payments.

Given the importance of health care to voters and the amount of money taxpayers spend on it, it is important to determine which level of government Canadians should hold responsible for health care quality and service. Does the current CHA/CHT approach support clear accountability for health care outcomes? Would it make more sense to empower the provinces to raise their own revenue to deliver care, so that voters could hold provinces accountable for outcomes? Or should the federal government play an even larger role? Who is the MRP for health care in Canada?

“Given the importance of health care to voters and the amount of money taxpayers spend on it, it is important to determine which level of government Canadians should hold responsible for health care quality and service.

The purpose of this paper is to examine the current mix of jurisdictions involved in health care funding and delivery in Canada and establish which level of government is the most appropriate to assume primary responsibility. This author asserts that a decentralized approach that brings the administration of care closer to the patient, and allows for a variety of approaches that suit the particular needs of patients in different provinces, is preferable to a top-down system dictated by the federal government.

PUTTING PATIENTS FIRST

This paper starts with the presupposition that all health care should exist primarily to benefit patients, so it focuses on policy options for improving patient care. Any health care policy that does not improve patient care raises the question of whether the policy is really about either health or care.

> "Any health care policy that does not improve patient care raises the question of whether the policy is really about either health or care.

Many Canadians might assume that this starting presupposition should be uncontroversial. What is the system for if not to serve the needs of patients? Robert G. Evans, health economist, calls this the Naïve Clinical approach (Barer, Stoddart, McGrail, and McLeod, 2016). He believes that the naïve clinical approach glosses over difficulties that arise from a lack of academic clarity around the terms "need" and "benefit." Who defines need and benefit? Whose need? Benefit to whom? Evidence exists that doctors often order tests and treatments of uncertain benefit for poorly defined conditions. Furthermore, need and benefit may be placed in the larger social context of a patient's family, or even more broadly still in the population as a whole.

Given the uncertainty injected into the concepts of need and benefit, values beyond individual patient care, such as nation-building, wealth redistribution, equality, social cohesion, the need for national standards, and many other goals, appear to deserve just as much weight as the clinical benefit to patients. Having said this, the vast majority of patients and clinicians continue to understand that health care exists, foremost, to benefit patients, regardless of other social goals.

We could also debate the means by which we achieve desired ends. Some observers find it critical to rule out certain means – for example, private or for-profit funding – from any discussion, regardless of the impact on the ends. They assume that the risk of allowing any diversity of means will inevitably corrupt the desired end of having a single-payer system. This debate strays beyond the focus of this paper. Debating the broader question of why health care exists – if you will, the teleology of health care – remains a topic for another day.

While these discussions hold value, they should not overshadow the central focus of developing a policy approach to health care that centres on creating an environment most conducive to delivering great patient care.

History

Quebec Premier François Legault told reporters recently, "We will not be dictated to by the federal government" (Richer 2018). This came in response to Federal Health Minister Ginette Petitpas Taylor's warnings to Quebec regarding its private clinics. In another recent article, Manitoba Premier Brian Pallister and Managing Director of the Macdonald-Laurier Institute Brian Lee Crowley proposed that, "Ottawa would recognize full provincial responsibility for health care… ending Ottawa's practice of spending on 'boutique' health programs within provincial jurisdiction" as part of a "grand bargain" also freeing interprovincial trade within Canada (Crowley and Pallister 2018).

Argument about who runs Canadian health care started long before Confederation. One of the founding debates centred on whether Canada should be a legislative union or a federal union. Should it be a "homogeneous whole" or a federated union of separate governments? Traditions and cultural history in Upper Canada differed from those in Lower Canada or Nova Scotia. Smaller provinces worried about being subsumed into an undifferentiated mass. In fact, "more scholarly ink has been spilt on the issue of the federal division of legislative powers than on any other aspect of Confederation" (Ajzenstat 2003, 262).

> "Health care in Canada predated Confederation by well over 200 years; the first hospital in Canada, Hotel-Dieu de Montreal, was established in 1645.

Federalism offered a path to Confederation that preserved the diversity, traditions, and unique cultures inherent in each province. For the most part, provinces surrendered authority to the federal government primarily on things that did not concern local interests. Section 92 of the *British North America Act* (BNA), 1867, outlines the "Exclusive powers of provincial legislatures." It includes the "Establishment, Maintenance, and Management of Hospitals, Asylums, Charities, and Eleemosynary Institutions in and for the Province, other than Marine Hospitals" (BNA, 1867, Section 92(7)). Clearly, this list does not encompass all that we envision is included in modern health care. Indeed, the words "health care" do not appear in the text at all (Fierlbeck 2011). At the time, institutional care represented the significant, structural examples of health care. Health care in Canada predated Confederation by well over 200 years; the first hospital in Canada, Hôtel-Dieu de Montréal, was established in 1645.

Despite appearing to give health care exclusively to the provinces, Section 91 of the BNA also gives the federal government responsibility for some aspects of health care, namely: the military (item 7), quarantine and marine hospitals (item 11), "Indians" (item 24), and prisons (item 28) (Adams 2012). Furthermore, the BNA retains for the federal government significant taxation and spending power. The federal government started using this spending power to offer conditional grants beginning in 1910. Eventually, Prime Minister P.E. Trudeau defined spending power as, "the power of Parliament to make payments to people or institutions or governments for purposes on which it (Parliament) does not necessarily have the power to legislate'" (Telford 2003).

While Canada hammered out the details of Confederation, Europeans were building a number of state-sponsored health care systems. Each country pursued state health care efforts for its own unique reasons, which extended beyond patient care to issues such as national unity or bolstering political support. Regardless of why governments pursued health care, voters supported it, so states delivered. Otto von Bismarck brought health insurance to Germany in the 1880s. After decades spent exploring the idea, Britain received Sir William Beveridge's report on health insurance in 1942, which formed the basis of the National Health Service (NHS) in that country.

Following Europe's lead, Canada embarked on its own exploration of health insurance. It commissioned Dr. Leonard C. Marsh, a member of Beveridge's team. After only 12 months, Marsh tabled his Report on Social Security for Canada (Marsh 1943). Historian Malcolm Taylor called it the "most comprehensive report on health services (558 pages) ever reported in Canada prior to the report of the Royal Commission in 1964" (Taylor 2009, 18). The Marsh report echoed much of the content from the Beveridge Report. Dr. Marsh also warned about the unique barriers in the Canadian Constitution: "the Constitution, as at present understood and interpreted, prevents the Dominion Parliament from adopting a single comprehensive national Health Insurance Act" (Taylor 2009, 18).

> "After the Second World War, allied voters held government in high regard.

After the Second World War, allied voters held government in high regard. The late Dr. Michael Bliss, professor of history at the University of Toronto with a special interest in the history of medicine wrote that, "There was a widespread belief – rooted in the command economy of wartime and in politicians' and policy makers' suspicion of the marketplace (and reinforced by their not inconsiderable hubris) – that in most areas of life, government had a better capacity than the private sector to plan, organize, and allocate resources" (Bliss 2002, 36).

Indeed, the idea that government could, and should, tackle significant social problems seemed reasonable after government had just coordinated a global victory. Why shouldn't governments try to solve impossible domestic problems, too?

Canada, like other countries in the Anglosphere, began constructing a welfare state: a public safety net where one had barely existed before. In 1948, Prime Minister King announced the National Health Grants program (Bliss 2002, 36). The grants were designed to encourage provinces to build health insurance programs, one step in a long process of building the Canadian health care system. The funding created a boom in hospital building that lasted into the 1970s.

Following the grants program, in 1957 Parliament created new legislation focused specifically on hospital services: the *Hospital Insurance and Diagnostic Services Act* (HIDSA). It provided universal, comprehensive, portable, and publicly administered funding for hospitals and diagnostic services. These same four principles would appear in all the significant federal health care legislation to follow (Canada 2018).

But the constitutional problems identified by Marsh in 1943 remained. Government faced a number of barriers starting with the federal system: "(a) It could seek a constitutional amendment enabling it to administer and finance a national plan; (b) It could increase the resources of the provinces by transfer payments enabling them to undertake programs of their own; (c) It could offer grant-in-

aid on condition that programs of specified design be introduced, and in an amount large enough to induce the appropriate provincial responses" (Taylor 2009, 182). Since the provinces could not achieve consensus on HIDSA, a constitutional amendment would not work. If the federal government increased transfer payments to the provinces, there was no guarantee that the provinces would prioritize health services. And if the federal government offered conditional grants, it ran the risk of "distorting provincial priorities and of imposing its will on the provinces" (Taylor 2009, 188).

However, all these issues faded "with the irresistible offer of federal cost-sharing" (Taylor 2009, 234) in which the federal and provincial governments agreed to share the cost of HIDSA in a 50/50 split. Patients got free hospital care and provincial politicians got to take credit for the services paid for, in part, by federal tax dollars.

"Debate continues to this day about how much the federal government should pay for health care

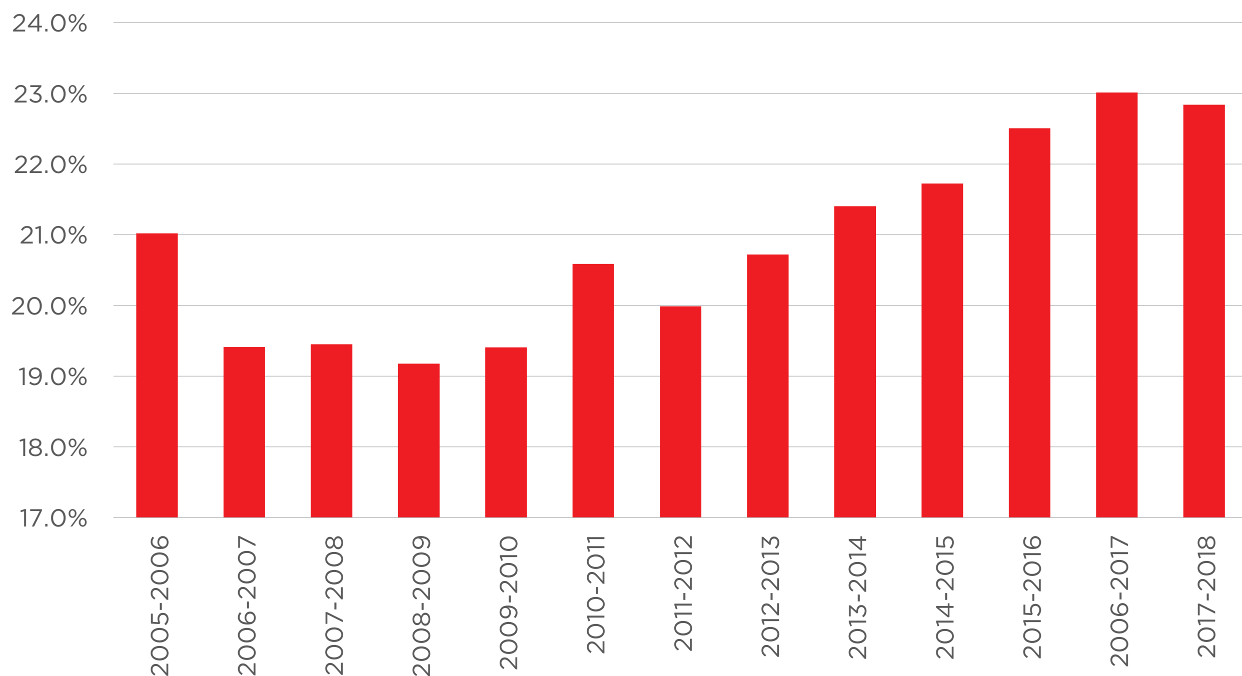
But "free" hospital and nursing services are not much good without doctors to provide care. Prime Minister Diefenbaker launched a Royal Commission led by Justice Emmett Hall to explore the idea of a national approach to funding necessary medical services. The Royal Commission reported in 1964 that Canada needed a national approach to fund universal, comprehensive, portable, and publicly administered medical care (Naylor 1986, 234). In 1966, the federal Parliament passed the *Medical Care Act* (MCA) based on these principles. Like the HIDSA, the federal and provincial governments agreed to share the costs 50/50. By 1972, every province had universal insurance plans to cover physician services (Canada 2018). Thus began the golden era of socialized medicine in Canada.

The golden era ended soon, however. The hospital building boom matched with first dollar coverage for hospital, diagnostic, and physician services created an exponential increase in the use and cost of health care. In 1977, Prime Minister Pierre Elliot Trudeau reset funding agreements with the *Established Programs Financing Act* (EPFA). EPFA ended the 50/50 cost sharing arrangement in exchange for block grants and a tax point transfer to the provinces (Adams 2011). (A tax point transfer simply means that the federal government will decrease the amount of taxes it collects to enable the provinces to raise taxes without raising the overall individual tax burden.) The message was clear: The federal government would continue to help pay for care, but it would not pay for unchecked growth. It marked a pivotal change in federal-provincial relationships around health care. In effect, block grants took away the power of politicians to promise handouts to buy votes. With EPFA, "Cost control was thereby shifted to the provinces, where both the constitutional authority for health care and the management of health-care [sic] services rest" (Naylor 1992, 129).

In terms of actual dollars, this change sounds more dramatic than it was. The federal government had never actually paid for 50 percent of any health costs. The most they paid was 36 percent, but even that was too much to bear. The federal government needed the EPFA to limit its accountability for health care costs that the feds had no means of controlling.

Debate continues to this day about how much the federal government should pay for health care (Adams 2012). Chart 1 shows that CHT payments as a percentage of provincial or territorial spending on health care remained below 23 percent from 2005 to 2019.

CHART 1: CANADA HEALTH TRANSFER SHARE OF PROVINCIAL/TERRITORIAL HEALTH SPENDING



Sources:Finance Canada/Canadian Institute for Health Information

With the EPFA, the provinces became more responsible for rising health care costs during a time of exponential growth. Hospitals charged user fees to meet their rising costs. But it was not enough. Provincial governments needed to find savings.

Like all good managers, governments looked for the largest expenditure to cut. They zeroed in on physicians' fees. In Ontario when the *Medical Care Act* came into force, governments had promised to compensate physicians at 90 percent of the doctors' published schedules of fees. With government as the single payer, doctors would have no bad debts. So doctors accepted 90 percent of their usual rates in return for 100 percent payment for the bills they submitted.

By the late 1970s, government was paying far less than 90 percent (Hurley and Grant, 2013). Doctors saw the gap opening in the late 1970s and started billing patients directly to balance the gap that government refused to fund. Doctors called it balanced billing. The media called it extra billing. Voters called it heinous and demanded a change.

The federal government took action. Mr. Justice Emmett Hall led a second review of health care and recommended that "Quebec-style 'closed' medicare be implemented nationally" (Naylor 1986, 249). "In Quebec the refusal of the government to pay medicare benefits to patients who dealt with extra-billing doctors [had] generated strong economic pressures that kept virtually all practitioners opted in" (Naylor 1986, 249). In 1984, federal health minister Monique Bégin used the Hall Report to create the *Canada Health Act* (CHA). Bégin said, "I concluded that extra-billing and user-fees were a case of erosion of the system and that something had to be done" (Fierlbeck 2011, 20).

The CHA laid out five principles: comprehensiveness, universality, portability, public administration, and access. These five principles have become part of the defining fabric of Canadian health care.

As indicated, four were not new. The CHA simply added accessibility to the four principles found in both HIDSA (1957) and MCA (1966). The unique work of the CHA focused on solving a problem the provinces could not (or would not) fix. In a regulation made under the Act, the CHA banned both user fees and balanced or extra billing (Canada 1984) and gave the federal government the right to withhold block funding to enforce the ban. (see Appendix Table 1: Deductions, Refunds, and Reconciliations under the CHST/CHT 1984–2017). The federal government used its national spending power, plus fresh legislation, to fix a provincial issue.

Technically, the CHA does not overstep constitutional bounds or force provinces to act in a particular way. Fierlbeck notes that "Provinces' participation in the *Canada Health Act* is completely voluntary; they can choose at any time to dissociate themselves from the CHA and manage their health care systems on their own" (Fierlbeck 2011, 57). However, voluntary participation became all but involuntary for the cash-strapped provinces as long as the federal government maintains funding. Furthermore, as Gregory Marchildon, Ontario Research Chair in Health Policy and System Design has stated, one of the goals of the transfer payments "is to set national standards or achieve national objectives by setting conditions on the transfers" (Marchildon 2013, 181).

"If the federal government hoped to achieve national objectives, then the cash incentive had to be large enough to remove the voluntary nature of the transfers, which is exactly what happened.

It is hard to imagine a system that is both voluntary and designed to "set national standards" and "achieve national objectives." If the federal government hoped to achieve national objectives, then the cash incentive had to be large enough to remove the voluntary nature of the transfers, which is exactly what happened.

Again, Michael Bliss described the situation: "With the passage of the Canada Health Act, the state had inaugurated the second era of Canadian medicare by effectively outlawing private medical and hospital practice… through the mechanism of a legislated monopoly. Provinces that did not agree with Ottawa's approach to health care funding again had no realistic choice: the noncompliance costs to their treasuries and taxpayers would be too great" (Bliss 2002, 40). Or as Marchildon put it: "Provincial governments have assumed the primary responsibility and authority for public health care. At the same time, the Government of Canada, by using 'spending power' – transferring a portion of the money it raises through federal taxation – has exerted considerable influence over Medicare" (Marchildon 2012, 4).

Until 1995, the federal government continued with the block grant approach under the EPFA. With the introduction of the combined Canada Health and Social Transfer (CHST) in 1995, provinces observed the continued erosion of transfer payments. Provinces tired of what they saw as federal overreach into areas of provincial jurisdiction. They wanted more autonomy if they were not going to get financial support from Ottawa.

The 1996 Premiers' Council on Social Policy Renewal reported that, "Federal efforts to reduce health funding and off-load Aboriginal health services, while simultaneously imposing unilateral interpretations of the Canada Health Act, are unacceptable" (Ministerial Council on Social Policy Reform and Renewal Undated). The premiers' passion did not last long. "The move by provinces to greater autonomy in health care was effectively checked by the vast amount of health care cash offered by Ottawa to the provinces in 2003 and 2004" (Fierlbeck 2011, 58). In 2004, Ottawa separated the CHST into the Canada Health Transfer (CHT) and the Canada Social Transfer (CST). Given the amount that provinces must spend on health care, federal funding continues to create "an element of compulsion… It is an offer the provinces are unable to refuse" (Barker 2013).

Between 2006 and 2015, the Harper government took a federalist approach, allowing provinces to lead and manage health care as they thought best. Stephen Harper reduced the GST in 2006, opening up tax room for the provinces to generate more revenue to fund programming that lay within the provincial mandates. Seven of nine provinces did just that. The Conservative government made it clear that it was focused on funding and planned to leave the management of health care to the provinces.

Many hoped Prime Minister Justin Trudeau would take a different tack. In 2016, as CMA president, Dr. Granger Avery spoke on behalf of the Canadian Medical Association and called on the federal government to take a much greater leadership role in health care, well beyond funding it (Sibbald 2016). The CMA was not pleased with the hands-off approach that the federal government took during the Harper years and called for more federal leadership and accountability.

Most Responsible Politician

In a speech to the Albany Club in 2010, Maxime Bernier, then a federal Conservative MP, discussed federal-provincial overlap (Bernier 2010). He noted that, initially, the federal government avoided intervening in areas of provincial jurisdiction without first pursing an amendment to the Constitution. Both unemployment insurance in the 1930s and old age pensions in the 1950s were established by amendments to the BNA. "Instead of sending money to the provinces, Ottawa would cut its taxes and let them use the fiscal room that has been vacated. Such a transfer of tax points to the provinces would allow them to fully assume their responsibilities, without federal control" (Leblanc 2010). But this has not happened in health care. The average citizen cannot tell who the Most Responsible Politician (MRP) is for health care.

Bernier went on:

> Why do we have waiting lines for surgery, overcrowded emergency rooms and not enough family doctors? Is it because of bad provincial management or because of insufficient federal funding? Each level of government can blame the other to score political points. There would no longer be any ambiguity if each province stopped depending on federal transfers and raised the amount of money necessary to manage its own programs (Bernier 2010).

Academics at the opposite end of the political spectrum from Bernier note the same thing. Colleen Flood, professor of health law and policy at University of Ottawa has noted: "A common complaint about publicly funded health care systems is that they are not responsive enough to the concerns and needs of citizens and patients and that there is insufficient accountability on the part of decision makers" (Flood 2003). Katherine Fierlbeck, professor of political science at Dalhousie, has also stated that one of the reasons governments adopted New Public Management in the '80s and '90s was because "the size and unwieldiness of the modern welfare state had raised concerns about the responsiveness of those providing services to those for whom such services were designed" (Fierlbeck 2011, 76). Concern about a lack of accountability appears to emerge from those with a great range of perspectives on health care.

TRANSFER GAMES

Federal spending power started in 1910 with Conditional Federal Grants (Telford 2003). The grants were designed to build a nation around shared social programs, such as health care. English-speaking Canadians still see it this way; Quebecers not so much.

Quebecers view federal transfers that come in the form of conditional grants as directly undermining Quebec identity, culture, and traditions. Although provinces can refuse established program funding, as discussed, the amounts are usually too large to ignore. Provinces feel they have to accept the grants along with the conditions attached.

Hamish Telford, a federalism researcher, writes that Quebec sees national programs forced on them as a result of federal spending power to be "nation-destroying." He quotes constitutional law expert Peter Hogg: "But of course the issue is whether this spending power authorizes for payments which are outside federal legislative competence" (Telford 2003). Telford concludes that federal spending power, or federal transfers, seems to exist in a "vacuum of political and legal uncertainty" and that, "Constitutional reform is presently in remission in Canada… Federal spending power will have to be addressed in future constitutional negotiations" (Telford 2003). As it stands, federal spending power remains the premise upon which the federal government pursues its objectives through transfer payments.

One of the goals of federal transfer payments, which include the CHT, is to fix the federal-provincial fiscal imbalance. However, transfer payments end up creating what Smart and Bird (2006) call "Transfer Games." The federal-provincial fiscal imbalance is shorthand for saying that the federal government has more money to spend on federal expenditures than the provinces have to spend on provincial endeavours, at current tax rates. In other words, the federal government can raise revenue more easily than can the provinces. Federal transfers close this fiscal "gap."

"One solution is to 'rebalance' the federal fiscal structure by reducing federal tax rates and thus federal revenues, while at the same time reducing transfers to the provinces by about the same amount" (Smart and Bird 2006). The two offer an argument for allowing provinces to increase revenue, and accountability, by transferring GST tax points to the provinces. Doing so would address the fiscal imbalance without the problems inherent in the current process.

Smart and Bird examine the current federal transfers and find the process wanting:

> The result is what can only be described as Canada's "co-dependent" constitutional relations: with our current fiscal arrangements, Ottawa raises the money and the provinces spend it. The result of this fiscal churning is that no government has clear responsibility for delivering key programs and both sides readily blame the other when something goes wrong… In short, the result is a federal government that is unable to commit credibly to a stable transfer system with clear and consistent incentives. Provincial governments have little incentive today to set their own fiscal houses in order, since spending restraint weakens the case for future increases in federal transfers (Smart and Bird 2006).

The authors go on to say, "Federal tax revenues are in effect a common pool of resources that is available to whoever is the first to exploit them. Like all poorly managed common property resources, the result is an inevitable tendency to exploitation" (Smart and Bird 2006).

They suggest that:

> A properly designed tax point transfer would put an end to the continued renegotiation of federal transfers and the resulting fiscal illusion for voters. If provinces wished to spend more on health care they would have to increase taxes directly, and face the wrath of voters on Election Day if their decisions were the wrong ones. The change might increase voter satisfaction with the federal government as well. No longer would federal tax payments seem to disappear into thin air. Both levels of government would have much stronger incentives to act responsibly (Smart and Bird 2006).

Smart and Bird argue that a GST point transfer would allow for less "blame-shifting" between different levels of government for the performance of established programs.

Yves Séguin, then Quebec's minister of finance, had suggested something similar when the CHT was combined with the Canadian Social Transfer as the CHST. Included in his Commission on Fiscal Imbalance (2002) report were recommendations that:

> For the new division of tax room, the Commission's preference is that the provinces occupy the entire GST tax field instead of personal income tax. The Commission stressed in particular the limited risk that the federal government might reoccupy the tax room, the reduced impact of this option on equalization and the fact that the GST is less sensitive to tax competition (Séguin 2002).

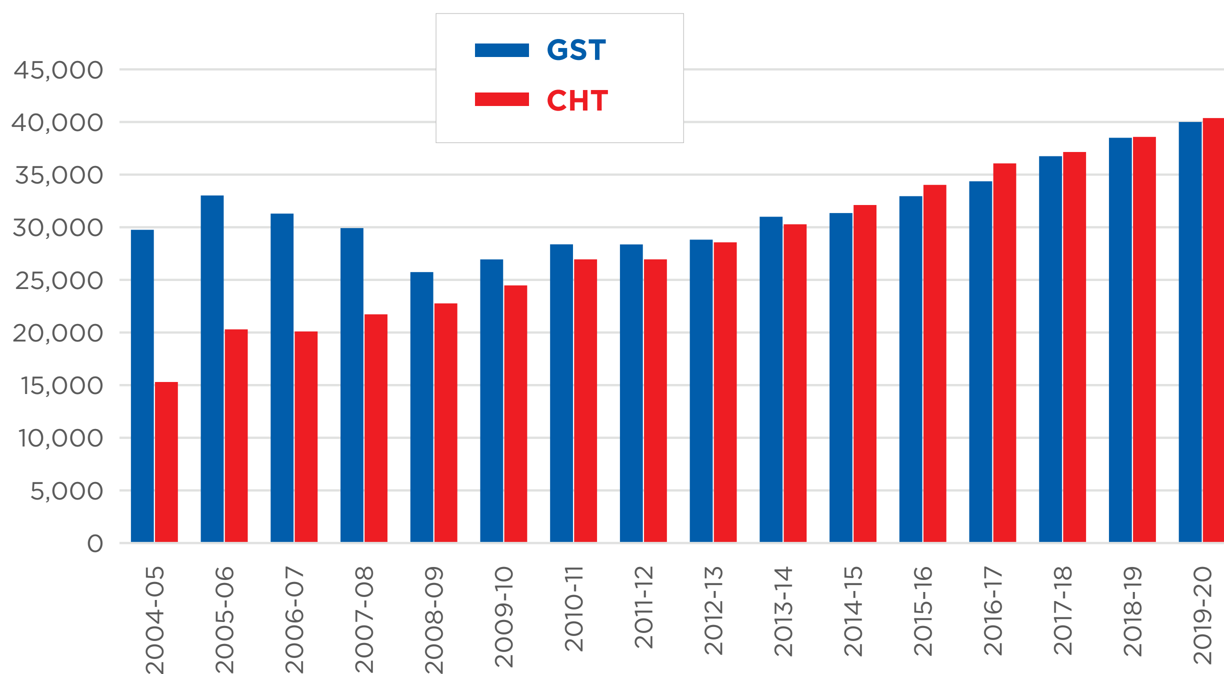
Ken Boessenkool built on Smart and Bird's research by exploring options for implementing a significant reduction in federal transfer payments to match a GST tax point transfer. "A much more radical solution would have the federal government transfer all GST revenues to the provinces at the same time as it substantially reduces federal transfers – in short a GST tax point transfer coupled with reductions in federal transfers to provinces" (Boessenkool 2018). Boessenkool argues for clear lines of accountability as a way to support improvements in health care. He does not argue for accountability for its own sake, as an independent goal, but that success is unlikely without accountability.

Boessenkool writes that the current approach to funding and managing health care creates confusion:

> All Ottawa really has is a bully pulpit based on the Canada Health Act and the stick of financial penalties under case transfers to the provinces. Ottawa makes political use of its pulpit and penalties, which results in confusion about which level of government is responsible for health care. This confusion is not costless: it allows the provinces to shift the blame to Ottawa when they make mistakes and allows Ottawa to claim credit for reforms it had nothing to do with (Boessenkool 2018).

The CHT stood at $36.1 billion in 2016-17 (Parliamentary Budget Office 2018). The Goods and Services Tax brought in $34.4 billion in the same fiscal year (Canada, Department of Finance 2017). Instead of having the federal government collect $34.4 billion in GST and then transfer $36.1 billion to the provinces (see chart 2), it seems reasonable to consider having the provinces collect the GST and stop the federal CHT payments. Anything that removes an administrative step and streamlines government process seems a worthy step towards efficiency in government, notwithstanding Janice Stein's suggestion that, "Efficiency becomes the code word for an attack on government as a provider of public goods" (Stein 2002).

CHART 2: TOTAL GST COLLECTED AND TOTAL CHT PAID OUT FROM 2004-05 TO 2018-19 (IN $ MILLIONS, NOMINAL DOLLARS)



Source: Finance Canada

Boessenkool notes that some provinces would not have the capacity to generate enough revenue with the GST to replace the amounts given up by the CHT. One option to address this issue includes a "fully equalized national average GST equalization" (Boessenkool 2013). Larger provinces could have their CHT equalization payments reduced by the amount to which their per capita GST exceeds the national average per capita GST. Regardless of which method of implementation is pursued, achieving interprovincial equalization as well as greater accountability with the GST-CHT trade seems possible and worth exploring.

Some authors suggest that the CHT payments should be seen as simply one of the major transfers in a total system of fiscal federalism (Béland, Lecours, Marchildon, Mou, and Olfert 2017, 87). Of course, equalization payments are unconditional, and the CHT is conditional. But the CHT is just another equalization payment with conditions. If we grant that assumption, then CHT payments must remain with the federal government. They must serve to promote all the secondary goals associated with a national approach to health, such as national unity, Canadian identity,[1] equity, etc. A reductionist lens that frames the CHT as nothing but a transfer payment in a larger paradigm of fiscal federalism makes the federal role for health care immovable. The only logical approach would be to increase the centralization of health care governance at the federal level.

ARGUMENTS FOR A FEDERAL MRP

Arguments in favour of maintaining and even expanding a federal role in Canadian medicare focuses on the following issues: have-not provinces would not be able to offer the same level of medical services without federal support (Haardt 2013a); without a strong federal role, some provinces will use their greater autonomy over health care spending to decrease taxes instead of increasing health services (Haardt 2013b); federal leadership can help tackle wait times by setting national targets (Pomey et al., 2017) and long waiting times for core specialized services have consistently been identified as a key barrier to access; health professionals are mobile and will move to work in more favourable provincial systems, which will create disparity between provinces unless the federal government monitors mobility (Murphy 2013); and it seems wasteful to have each province tackle programs such as pharmaceuticals when one centralized approach could perform the same function for the whole country (Marchildon 2013).

Furthermore, a federal MRP role in Canadian medicare would protect the nation-building and national identity benefits (among others) of a national approach to health care (Heard and Cohn 2013). While these other benefits do not apply directly to patient care per se, secondary benefits warrant consideration.

Those who favour a federal MRP tend to emphasize efficiency and equality. They highlight coordination, rational allocation of resources, uniformity, national standards, and breaking down silos among other goals. They see a provincial MRP approach as wasteful, redundant, and haphazard.

ARGUMENTS FOR A PROVINCIAL MRP

Those who support a provincial MRP focus on many of the same issues raised in support of a federal MRP, but assign the opposite normative weight to them. For example, provinces focus on what provincial voters want: if that means lower taxes instead of increasing health services, so be it. Federal emphasis on wait time targets for priority items such as joint replacement causes increases in waiting for non-priority procedures such as arthroscopy. Mobility of health professionals promotes increased accountability at the provincial level to offer a high functioning system that attracts top talent for the province's citizens. If remuneration and taxation levels were exactly the same for health professionals across every province, then providers would make economic decisions based on the wide variability in cost of living between provinces.[2] Furthermore, smaller provinces already rely on equalization payments to fund provincial programs. There is no reason to expect that services would decline given a provincial MRP role. The only reason provinces could not offer the same level of medical services under a provincial MRP paradigm is if equalization payments decreased.

The provinces are better positioned, better informed, and better placed to experiment with policy options (Barker 2013). Provinces can and do set standards for the bulk of provincial programming, holding themselves accountable to voters. Health care standards would not cease to exist if the federal government played a smaller role. In fact, health care standards could more easily be strengthened, clarified, and adhered to if there was direct accountability to the voters most affected by those standards – if provinces were the MRP for health standards. Furthermore, provinces could establish arm's-length independent oversight, much like the Auditor General's role in finance, which would further increase fiduciary accountability to voters.

Provinces are more than competent to lead health care; any suggestion that they are incompetent or inherently corrupt seems to beg the question. Provincial emergency services are often called on to meet the needs of First Nations, military, and RCMP patients, groups for which the federal government takes the lead. Indeed, Canada would not have its current approach to health care if Saskatchewan had not innovated and experimented in the 1950s and '60s.

> "The provinces are better positioned, better informed, and better placed to experiment with policy options.

A GST-CHT trade would place explicit responsibility on the provincial governments for health care funding and performance. This seems to be a laudable goal from an economic standpoint. But a federalist approach also makes sense from a policy perspective, assuming health care policy should focus on patient service foremost.

FEDERALISM

Given the similar issues raised to support both sides of the MRP argument and the opposite normative assessment of each, we cannot escape a discussion of federalism itself. Aristotle taught that there are pure and corrupt forms of all government. The issue is not whether centralized or decentralized forms of government produce better results. The issue is which one has the greater potential to do harm should it go astray and create bad policy.

Those involved in Canada's founding debates believed that, wherever possible, decisions should be made by the level of government closest to the issue and capable of making the decision. Government, as a concentration of power, always carries an inherent potential to cause harm, which we need to avoid. James Madison's advice for America, in "Federalist No. 51," also applies to Canada: "If men were angels, no government would be necessary. If angels were to govern men, neither external nor internal controls on government would be necessary. In framing a government which is to be administered by men over men, the great difficulty lies in this: you must first enable the government to control the governed; and in the next place oblige it to control itself" (Madison, 1788).

Not everyone takes such a skeptical view of government. Economist David Haardt complains that this view is "heavily influenced by libertarian thought." He notes that much of the "classic literature" promotes the notion that a corrupt federal government would behave better if it faced competition between the states and felt pressure from taxpayers and voters. Haardt finds "this rather naïve traditional theory of federalism is not very helpful when it comes to Canadian health care federalism…. Moreover, this theory fails to provide a rationale for why federal law makers are more likely to be corrupt than state/provincial lawmakers" (Haardt 2013b, 32).

Haardt makes a good point but avoids Madison's original one. Madison did not place preferential trust in any particular level of government. He suggested we ought to remain skeptical of all concentrations of power: federal and state or provincial. The reason to avoid concentrating responsibility for health care at the federal level is to avoid the risk of concentrating power in the hands of a few decision-makers.

The issue is not whether provincial or federal governments deserve the right to make decisions about health care, or even which level of government has the greater capacity and wherewithal to lead health care. The issue is which level of government has greater potential to do harm. Given good people making good decisions, either level of government would serve the public interest well. But given less-than-ideal candidates or less-than-ideal decisions, Canadians would be best served by having the smaller of two governments leading health care. It is a harm reduction approach.

A perfect, central government, full of people who always make great decisions, would work wonders of efficiency, planning, and coordination. But too often in real life, central governments try their best but deliver inefficient, disorganized, and uncoordinated care that is unresponsive to those who need the care most. It is unlikely that every province would fail on health care in the same way at the same time. However, if we concentrate decision-making power for health care into one governance unit – in this case, the federal government – we increase the risk that all citizens feel the impact of one bad decision. Why take such an unnecessary risk with something so important?

Knowing the strengths and limitations of a governance unit can help decrease risk. Unreasonable expectations on government will deliver disappointment. Donald Savoie wrote an extended review of government titled *What is Government Good At?* Savoie argues that government, while necessary, has "simply added one activity on top of the other without asking, what is it that government is good at?" (Savoie 2015). He outlines how bureaucracies behave and how managerialism and transparency often lead to the opposite of intended outcomes. Prime Minister Jean Chrétien said that government is good at coming up with instruments for good. But "government is not as good at deciding when the instrument has done the job and when it should be done away with" (Savoie 2015, 14).

For the most part, government and the broader public service are made up of well-intentioned people, who behave, regardless of intentions, like people everywhere else. Paul Feldstein advises that we should view government through a self-interest paradigm: "The *Self Interest Paradigm* assumes that individuals act according to self-interest, not necessarily the public interest. Individuals, as legislators or voters, are assumed to act no differently when it comes to politics than they act in private economic markets; they pursue their self-interest. For example, legislators (and regulators) are assumed to act so as to maximize the political support they receive" (Feldstein 1988, 3).

Regarding redistributive programs, "A 'normative' approach to redistribution implies that redistribution *should* be from higher- to lower-income groups. A self-interest analysis of such politics hypothesizes that redistribution will be toward those who are able to provide political support, regardless of their 'need' for wealth transfers. In the latter case, the redistribution is likely to be inequitable; lower-income groups are likely to bear costs in excess of their benefits" (Feldstein 1988, 182). In other words, we should view everyone – elected officials, public servants, and voters – as though they were each susceptible to the same potentiality for greatness and failure. We should give opportunity for greatness while maintaining a healthy skepticism to avoid the potential for failure.

The Way Forward

The *Canada Health Act* added "accessibility" to the four original, somewhat vague principles of universality, comprehensiveness, portability, and public administration. We have not reviewed the four core principles since they were introduced in the HIDSA in 1957, nor have we had a serious reconsideration the five CHA principles since it was passed in 1984. In 2002, the Romanow Commission called for an update to the CHA (Romanow 2002). The Advisory Panel on Healthcare Innovation (the 2015 "Naylor Report") also called for a review. The Panel stated that conditional CHT payments have not led to transformation: "the Panel's view is that… these investments led neither to modernization of the architecture of Canadian healthcare, nor to serious broadening of the scope of public coverage" (Fraser, Girard, Jenkins, Mintz, Naylor, and Power 2015).

If we asked patients, they would probably place more weight on access to quality patient care than on the vague ideals in the CHA or the details of CHT payments. On the one hand, pundits insist that the CHA is just a piece of financial legislation, "essentially funding criteria" (Fierlbeck 2011, 21). Steven Lewis, consultant and prolific health policy pundit, said, "[The CHA is] not that big a deal," but also implied it was one of a few "grand laws." "These kinds of laws, not only help to define what we are…they transcend their content. They have a certain aspirational, inspirational dimension" (Lewis 2015).

> "Bad things happen when admitted patients do not have a Most Responsible Physician.

Emphasis on fiscal accountability seems to weaken the case for conditional federal-provincial transfers that are designed to encourage particular outcomes that the federal government desires. If we want accountability, we need clarity about which level of government should be held responsible (McKenzie 2005). As they say, he who pays the piper calls the tune.

Although the CHA is a financial act with principles that even defenders of the Act call vague, it and the associated CHT payments influence health care for all Canadians. The CHA eliminated hospital user fees and balanced or extra billing. On that level, it was a success. It is less clear that the CHA/CHT approach has performed well in advancing concrete improvements in universality, comprehensiveness, portability, public administration, and access for patients: the Quebec plan is not portable; many Canadians lack coverage if they have been outside Canada or if they have had their coverage cancelled after a change of address; and the increase in executive health plans and private access for workers compensation patients undermines public administration.

The lack of clarity about which level of government carries responsibility for improving health care performance makes difficult change almost impossible. We should adopt an approach of "less funding with fewer strings" (Speer 2016). Transferring the GST to the provinces in exchange for decreasing (or eliminating) health transfer payments offers an opportunity to add clarity around which level of government is responsible for health care.

Bad things happen when admitted patients do not have a Most Responsible Physician. The same concept applies to health care at a system level. Hopefully we will soon identify the Most Responsible Politicians. Change to the current overlapping funding approach and blurred accountabilities will only come with a reorientation and recommitment to drafting policy and legislation judged foremost by its impact on patient care.

Appendix

TABLE 1: DEDUCTIONS, REFUNDS, AND RECONCILIATIONS TO CHST/CHT CASH CONTRIBUTIONS IN ACCORDANCE WITH THE CANADA HEALTH ACT SINCE FY 1984–1985 (IN DOLLARS)

	NL	PEI	NS	NB	QC	ON	MB	TOTAL
1984/1985	-	-	-	3,078,000	7,893,000	39,996,000	810,000	65,961,000
1985/1986	-	-	-	3,306,000	6,139,000	55,328,000	460,000	106,365,000
1986/1987	-	-	-	502,000	-	13,332,000	-	52,406,000
1987/1988	-	-	-	-	-	-	-	-
1988/1989	-	-	-	-	-	-	-	-
1989/1990	-	-	-	-	-	-	-	-
1990/1991	-	-	-	-	-	-	-	-
1991/1992	-	-	-	-	-	-	-	-
1992/1993	-	-	-	-	-	-	-	83,000
1993/1994	-	-	-	-	-	-	-	1,223,000
1994/1995	-	-	-	-	-	-	-	1,982,000
1995/1996	46,000	-	32,000	-	-	-	269,000	2,709,000
1996/1997	96,000	-	72,000	-	-	-	588,000	2,022,000
1997/1998	128,000	-	57,000	-	-	-	586,000	771,000
1998/1999	53,000	-	38,950	-	-	-	612,000	703,950
1999/2000	-42,570	-	61,110	-	-	-	-	18,540
2000/2001	-	-	57,804	-	-	-	-	57,804
2001/2002	-	-	35,100	-	-	-	300,201	335,301
2002/2003	-	-	11,052	-	-	-	-	15,662
2003/2004	-	-	7,119	-	-	-	-	133,894
2004/2005	1,100	-	5,463	-	-	-	-	79,027
2005/2006	-	-	-8,121	-	-	-	-	20,898
2006/2007	-	-	9,460	-	-	-	-	124,310
2007/2008	-	-	-	-	-	-	-	42,113
2008/2009	-	-	-	-	-	-	-	66,195
2009/2010	-	-	-	-	-	-	-	73,925
2010/2011	3,577	-	-	-	-	-	-	78,713
2011/2012	58,679	-	-	-	-	-	-	91,898
2012/2013	50,758	-	-	-	-	-	-	330,777
2013/2014	-10,765	-	-	-	-	-	-	213,803
2014/2015	-	-	-	-	-	-	-	241,637
2015/2016	-	-	-	-	-	-	-	204,145
2016/2017	-	-	-	-	9,907,229	-	-	10,091,737
TOTAL	383,799	-	378,937	6,886,000	23,939,229	106,656,000	3,625,201	246,446,329

Continued on next page

	SK	AB	BC	YT	NWT	NU	TOTAL
1984/1985	1,451,000	9,936,000	2,797,000	-	-	-	65,961,000
1985/1986	656,000	11,856,000	30,620,000	-	-	-	106,365,000
1986/1987	-	7,240,000	31,332,000	-	-	-	52,406,000
1987/1988	-			-	-	-	-
1988/1989	-			-	-	-	-
1989/1990	-			-	-	-	-
1990/1991	-			-	-	-	-
1991/1992	-			-	-	-	-
1992/1993	-		83,000	-	-	-	83,000
1993/1994	-		1,223,000	-	-	-	1,223,000
1994/1995	-		1,982,000	-	-	-	1,982,000
1995/1996	-	2,319,000	43,000	-	-	-	2,709,000
1996/1997	-	1,266,000		-	-	-	2,022,000
1997/1998	-			-	-	-	771,000
1998/1999	-			-	-	-	703,950
1999/2000	-			-	-	-	18,540
2000/2001	-			-	-	-	57,804
2001/2002	-			-	-	-	335,301
2002/2003	-		4,610	-	-	-	15,662
2003/2004	-		126,775	-	-	-	133,894
2004/2005	-		72,464	-	-	-	79,027
2005/2006	-		29,019	-	-	-	20,898
2006/2007	-		114,850	-	-	-	124,310
2007/2008	-		42,113	-	-	-	42,113
2008/2009	-		66,195	-	-	-	66,195
2009/2010	-		73,925	-	-	-	73,925
2010/2011	-		75,136	-	-	-	78,713
2011/2012	-		33,219	-	-	-	91,898
2012/2013	-		280,019	-	-	-	330,777
2013/2014	-		224,568	-	-	-	213,803
2014/2015	-		241,637	-	-	-	241,637
2015/2016	-		204,145	-	-	-	204,145
2016/2017	-		184,508	-	-	-	10,091,737
TOTAL	2,107,000	32,617,000	69,853,183	-	-	-	246,446,329

Source: Health Canada 2016

About the Author

Dr. Shawn Whatley is past President of the Ontario Medical Association (OMA) and has wide-ranging knowledge and experience in the field of healthcare policy. He is also the author of the highly-praised book on how to fix emergency wait times in Canada, *No More Lethal Waits.*

Much of his early career was spent in leadership in emergency medicine (Chief then Medical Program Director), where he gained valuable insights into what was and was not working in the Canadian system. Shawn's work has also covered a broad swath of medicine and health, including serving as a coroner and work in a vein clinic, nuclear cardiac stress testing, clinical trials, and cardiac surgical assisting.

At present, he runs a small rural family practice and is a frequent commentator on health issues in Canada.

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Endnotes

1 Notwithstanding Prime Minister Justin Trudeau's comment that Canada has no core identity (McCullough 2017).

2 New graduates in family medicine already find it nearly impossible to open a new practice in Toronto or Vancouver due to the high cost of living.

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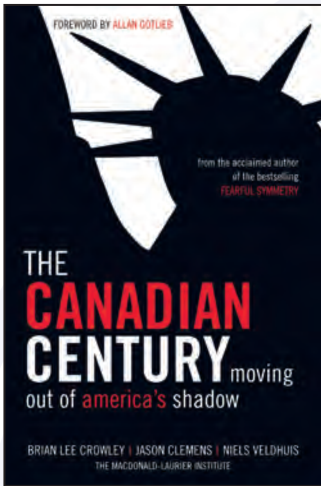

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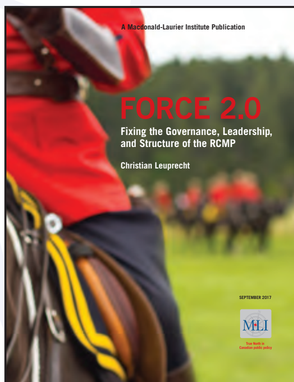

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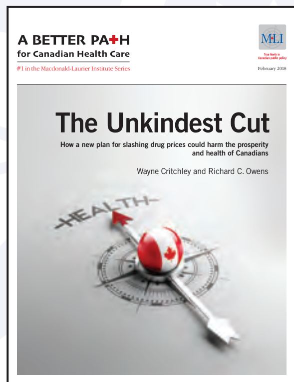
Christian Leuprecht



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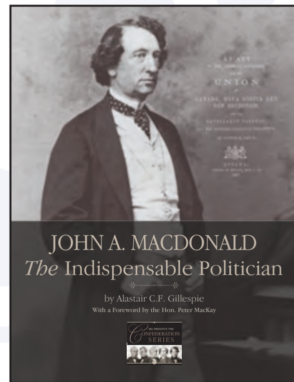

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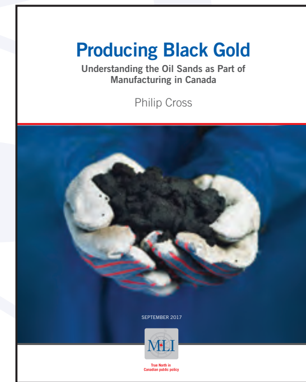
Alastair C.F. Gillespie



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Philip Cross

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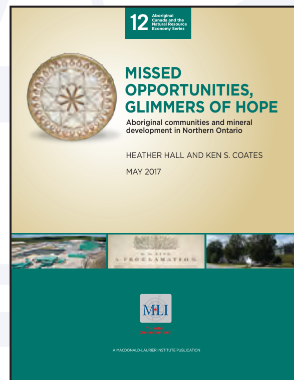
Bram Noble



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Running Out of Time
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