A BETTER PATH
for Canadian Health Care

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The Federal Department of Health Nears 100:

The Origins and Evolution of the Federal Role in Health Care and the Case for Reform

Sean Speer

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Executive Summary

The federal Department of Health will mark its centennial birthday in 2019 just as the Trudeau government is possibly creating a new national pharmacare scheme. It is an apt metaphor for the slow yet steady intrusion of the federal government into the administration and delivery of Canadian health care over the past 100 years.

Most Canadians think of the provinces and territories when it comes to health care. Our health cards are issued by these governments and people frequently hear how health-care costs are consuming a greater and greater share of provincial and territorial budgets. It is natural therefore for much of the health care focus to be directed at provincial and territorial capitals.

But it is wrong to assume that Ottawa is absent from health care policy or health-related activities and functions. The federal government spends more than $40 billion per year on health care after accounting for its transfer payments to the provinces and territories. The federal Department of Health had up until recently nearly 9000 employees and an annual budget of roughly $4 billion – larger than five provincial and territorial budgets. In fact, the department's budget has grown more than twice as fast, on average, than the Department of National Defence over the past 20 years.

Yet the role of the federal department is often neglected in public debates about the health care system and even by political actors in Ottawa. Its physical distance from the Parliamentary precinct may be one explanation. The complex evolution of its activities and functions – including the genesis of the Canada Health Act and different fiscal arrangements with the provinces and territories – has no doubt also contributed to the lack of attention and vision for the federal Department of Health.

This paper seeks to help politicians, media, and the general public better understand the evolution and role of the federal government in Canadian health care. It aims to answer some basic questions:

- How did we get to this point?
- How has the federal role evolved over the past nearly 100 years?
- How does it fit in the broader health care system?
- How can Ottawa's role enable or discourage positive health care reforms and better health outcomes?

By answering these questions, the author seeks to set out a positive vision of where and how the federal government should play a role in our health care system, rooted in a clear understanding of the benefits of federalism and the reform and experiment it can enable. There is plenty of scope to narrow Ottawa's involvement in health care without harming outcomes – in fact, a more circumscribed federal role can better serve taxpayers and patients.

This study builds on an earlier MLI report by Wayne Critchley and Richard Owens in 2018 on the role of the Patented Medicine Prices Review Board as part of a year-long series on the federal Health portfolio and Ottawa's role in the Canadian health care system. This particular contribution is focused on the origin and evolution of the federal role in health care in general and the Department of Health in particular.

As the Trudeau government contemplates an expansion of the federal role in Canadian health care, this paper's analysis points in another direction – one that narrows the ambition of federal involvement in health care and instead grants the provinces and territories greater flexibility to experiment with different models of reform. In particular, the paper sets out the following recommendations:

- Reduce federal spending that duplicates or encroaches on provincial/territorial responsibility for health care administration and delivery. Much of the roughly $400 million dedicated to the "health care systems" ought to face much greater scrutiny – shifting to a reverse onus model for justifying funding renewal is one option.

- Amend the *Canada Heath Act's* "accessibility" provisions to enable greater provincial and territorial experimentation similar to the experience following the 1977/78 reforms to federal health transfers.

- Review the Department of Health's regulatory and health promotion role to minimize duplication and overlap with the provinces and territories and achieve greater harmonization with the United States.

- Explore options to accelerate the negotiation of tripartite agreements with other provinces and territories and First Nations based on the successful experience in British Columbia.

- Launch a comprehensive review of federal spending to identify poorly-performing initiatives and focus resources on models that are demonstrating effectiveness.

This particular contribution is focused on the origin and evolution of the federal role in health care in general and the Department of Health in particular.

Adopting these recommendations would not eliminate the federal role in health care; indeed, it will continue to play a key role in health-related research, pandemic preparations, and so on. But these recommendations would represent a change from its modern history and current trajectory. Readers do not need to agree with each of these recommendations, of course. There are sensible arguments against them. But it is essential that we have a better-informed debate about the federal role in Canadian health care. This paper's insights and analysis will hopefully help in this regard.

Sommaire

Le ministère fédéral de la Santé marquera l'anniversaire de son centenaire en 2019, au moment même où le gouvernement Trudeau envisage de créer un nouveau régime national d'assurance-médicaments. La métaphore se prête bien à l'intrusion lente, mais soutenue du gouvernement fédéral dans l'administration et la prestation de soins de santé au Canada au cours des 100 dernières années.

La plupart des Canadiens pensent aux provinces et aux territoires quand il est question des soins de santé. Ces gouvernements émettent nos cartes d'assurance-maladie et les gens entendent souvent que les coûts associés aux soins de santé consomment une part toujours grandissante des budgets provinciaux et territoriaux. Par conséquent, il va de soi qu'en matière de soins de santé, l'attention se reporte principalement vers les capitales provinciales et territoriales.

Toutefois, il est erroné de présumer qu'Ottawa est absent de la politique des soins de santé ou des activités et fonctions associées à la santé. Le gouvernement fédéral dépense plus de 40 milliards de dollars annuellement pour les soins de santé après comptabilisation de ses paiements de transfert aux provinces et territoires. Le ministère fédéral de la Santé comptait jusqu'à tout récemment près de 9000 employés et disposait d'un budget annuel d'environ 4 milliards de dollars, soit une somme qui dépasse cinq budgets provinciaux et territoriaux. En réalité, le budget du ministère a connu une croissance deux fois plus rapide, en moyenne, que celui du ministère de la Défense nationale au cours des 20 dernières années.

Or, le rôle du ministère fédéral est souvent négligé lors de débats publics concernant le régime de soins de santé, il l'est même par les acteurs politiques à Ottawa. Un des facteurs serait son éloignement physique de la Cité parlementaire. L'évolution complexe de ses activités et fonctions, notamment la genèse de la *Loi canadienne sur la santé* ainsi que divers accords fiscaux avec les provinces et territoires ont sans aucun doute contribué au manque d'attention et de vision concernant le ministère fédéral de la Santé.

Le présent document a pour objectif d'aider les politiciens, les médias et le grand public à mieux comprendre l'évolution et le rôle du gouvernement fédéral en matière de soins de santé. Il vise à répondre à certaines questions fondamentales :

- Comment en sommes-nous arrivés là ?
- Comment le rôle du gouvernement fédéral a-t-il évolué au cours des 100 dernières années ?
- Comment ce rôle s'inscrit-il dans l'ensemble du régime de soins de santé ?
- Comment le rôle que joue Ottawa favorise-t-il ou décourage-t-il des réformes positives des soins de santé et de meilleurs résultats en matière de santé ?

À travers les réponses à ces questions, l'auteur cherche à dégager une vision positive des circonstances lors desquelles le gouvernement fédéral est appelé à jouer un rôle dans notre régime de soins de santé, un rôle qui se fonde sur la nette compréhension des avantages du fédéralisme et de la réforme et des expériences qu'il peut permettre. Les possibilités sont suffisamment nombreuses pour restreindre la participation d'Ottawa aux soins de santé sans nuire aux résultats – en fait, en adoptant un rôle plus circonscrit, le gouvernement fédéral peut mieux servir les contribuables et les patients. Cette étude s'appuie sur un rapport antérieur de l'IML rédigé par Wayne Critchley et Richard Owens

en 2018 sur le rôle du Conseil d'examen du prix des médicaments brevetés. Ce rapport fait partie d'une série d'un an sur le portefeuille fédéral de la santé et le rôle d'Ottawa dans le régime de soins de santé canadien. Cette contribution particulière met l'accent sur l'origine et l'évolution du rôle du gouvernement fédéral en matière de soins de santé en général et sur le ministère de la Santé en particulier.

Alors que le gouvernement Trudeau envisage l'expansion du rôle du gouvernement fédéral en matière de soins de santé au Canada, notre analyse pointe vers une autre direction qui restreint l'ambition de participation du gouvernement fédéral dans les soins de santé et accorde plutôt aux provinces et territoires une plus grande souplesse pour expérimenter différents modèles de réforme. Le document contient notamment les recommandations suivantes :

Toutefois, le rôle qu'entend jouer le gouvernement fédéral relativement aux soins de santé au Canada doit faire l'objet d'un débat éclairé.

- Réduire les dépenses du gouvernement fédéral qui chevauchent ou empiètent sur la responsabilité provinciale ou territoriale concernant l'administration et la prestation de soins de santé. Une bonne partie des quelque 400 millions de dollars attribués aux « régimes de soins de santé » doivent faire l'objet d'un examen beaucoup plus approfondi – il faut exercer l'option d'adopter un modèle de renversement du fardeau pour justifier le renouvellement du financement.

- Modifier la disposition de la *Loi canadienne sur la santé* relative à l'« accessibilité » afin de permettre une expérimentation provinciale et territoriale plus importante et semblable à celle qui a suivi les réformes des transferts fédéraux en matière de santé en 1977 et 1978.

- Réviser le rôle du ministère de la Santé en matière de réglementation et de promotion de la santé afin de minimiser le dédoublement et le chevauchement avec les provinces et les territoires et parvenir à une harmonisation accrue avec les États-Unis.

- Explorer les options qui accélèrent la négociation d'accords tripartites avec d'autres provinces et territoires et les Premières Nations en s'inspirant de l'expérience réussie de la ColombieBritannique.

- Entreprendre une révision exhaustive des dépenses du gouvernement fédéral afin de cerner les initiatives à faible rendement et de déployer les ressources pour les modèles qui se sont avérés efficaces.

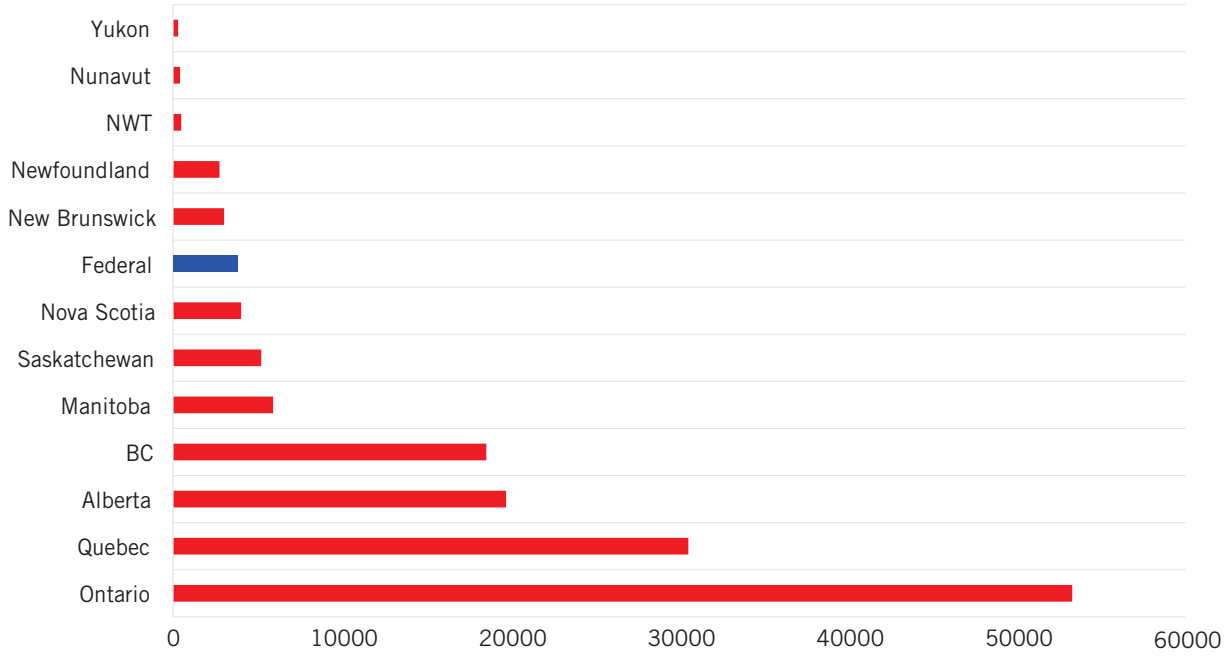
L'adoption de ces recommandations n'éliminerait pas le rôle du gouvernement fédéral dans les soins de santé, car il continuera à jouer un rôle clé dans la recherche sur la santé, les préparatifs en cas de pandémie et ainsi de suite. Toutefois, son histoire moderne et sa trajectoire actuelle s'en trouveraient modifiées. Bien entendu, les lecteurs n'ont pas à être d'accord avec chacune des recommandations. Des arguments pertinents s'élèvent à leur endroit. Toutefois, le rôle qu'entend jouer le gouvernement fédéral relativement aux soins de santé au Canada doit faire l'objet d'un débat éclairé. Nous souhaitons que les réflexions et l'analyse du présent document soient utiles à cet égard.

Introduction

Much of the public and policy discussion about Canadian health care focuses on the provinces and territories. This is understandable. Canada's constitution grants these sub-national governments the responsibility for key parts of the health care system (see article VI, Distribution of Legislative Powers).

But it would of course be wrong to assume that Ottawa has no role in Canadians's health care. It is not an accident that variations of "health care" appeared more than 40 times in the federal Liberal Party's 2015 platform. Ottawa has become a key player in the form of federal transfer payments to the provinces and territories, pandemic preparations, drug approvals, public health initiatives, and health-related research. Federal spending (including the Canada Health Transfer) now exceeds $43 billion per year representing more than 15 percent of total program spending in Ottawa's budget. The Department of Health itself employs nearly 9000 people and has up until the current year had an annual budget of roughly $4 billion – larger than five provincial and territorial budgets (see chart 1 below).

CHART 1: 2015 Health department spending by jurisdiction ($MILLIONS)



Sources: CIHI 2017 and Philpott 2016a.

This enlarged role and scope of federal intervention in health care is mostly a modern development. The federal health department was established in the post-First World War era and federal involvement in provincial/territorial health care only started after the Second World War. The Canada Health Transfer's current form and structure is not yet 15 years old.

Part of Ottawa's increasing role in health care reflects an evolution of medicine, health care and other related areas. Think for instance of the scope for bioterrorism. It has major national implications, must involve federal agencies and authorities, and is generally a modern phenomenon (Côté and Smith 2001; Prakash, Sharada, and Pradeep 2010; Das and Kataria 2010).

But another factor is simply federal overreach. It is a case of slow yet steady federal intrusion based on notions of "cooperative federalism" or cases of political calculus. One gets the sense that federal bureaucrats and politicians find it difficult to resist the temptation to involve themselves in the health care system. A lack of standardization or national priorities is seen as a "problem" to "fix." The current government's platform even criticized its predecessor for not getting more involved or meeting the provinces and territories to "strengthen the program" (Liberal Party 2015). The result is uninhibited federal lurching into the health care field.

How did we get to this point? How has the federal role evolved over the past nearly 100 years? How does it fit in the broader health care system? It is time for a rigorous legal and policy assessment of the evolution of the federal government's role in health care, how to think about how and where Ottawa should play a role, and recommendations for how it can play a more useful role in achieving better health outcomes for Canadians.

It is time for a rigorous legal and policy assessment of the evolution of the federal government's role in health care, how to think about how and where Ottawa should play a role, and recommendations for how it can play a more useful role in achieving better health outcomes for Canadians.

This study aims to fill this gap. It has three goals:

(1) Briefly examine and analyse the legal and constitutional parameters of federal involvement in health care;
(2) document the evolution of the federal role in health care including the growth of the federal Department of Health, changes to federal transfers, and its overall role in medicare; and
(3) set out recommendations to reform the federal role in Canadian health care in general and reorient the federal Department of Health to contribute to better health outcomes in particular.

The paper sets out a positive vision of where and how the federal government should play a role in our health care system rooted in a clear understanding of the benefits of federalism and the reform and experiment it can enable. There is plenty of scope to narrow Ottawa's involvement in health care without harming outcomes – in fact, a more circumscribed federal role can better serve taxpayers and patients.

This study builds on an earlier one in 2018 on the role of the Patented Medicine Prices Review Board (Critchley and Owens 2018). It will therefore exclude consideration of the role of the PMPRB. Similarly the Macdonald-Laurier Institute is planning to produce subsequent reports on the Public Health Agency of Canada and the Canadian Institutes for Health Research, so these organizations are largely omitted from this analysis. The focus here is principally about helping politicians, media, and the general public better understand the evolution and role of the federal Department of Health and how it can be reformed to improve Canada's health care system and our health outcomes.

The paper's overall recommendations are as follows:

- Reduce federal spending that duplicates or encroaches on provincial/territorial responsibility for health care administration and delivery. Much of the roughly $400 million dedicated to the "health care systems" ought to face much greater scrutiny – shifting to a reverse onus model for justifying funding renewal is one option.

- Amend the *Canada Heath Act* to liberalize the "accessibility" requirements for public insurance coverage in order to enable greater provincial and territorial experimentation similar to the experience following the 1977/78 reforms to federal health transfers.

- Review the Department of Health's regulatory and health promotion role to minimize duplication and overlap with the provinces and territories and achieve greater harmonization with the United States.

- Explore options to accelerate the negotiation of tripartite agreements with other provinces and territories and First Nations based on the successful experience in British Columbia.

- Launch a comprehensive review of federal spending to identify poorly-performing initiatives and focus resources on models that are demonstrating effectiveness.

The Constitutional and Legal Framework

The *Constitution Act, 1867* made few specific references to health care or health responsibilities at Confederation. The federal government was granted jurisdiction over marine hospitals and quarantine. The provinces were to establish, maintain, and manage hospitals, asylums, charities, and charitable institutions. The interplay of these different responsibilities and what they mean in practice has been an evolutionary process involving some trial and error and intergovernmental ebbs and flows.

The federal government's responsibility subsequently grew to include health services for Aboriginal and Inuit people, government employees, immigrants, and civil aviation personnel. It has also come to include investigations into public health threats, the regulation of food and drugs, inspection of manufacturing facilities and medical devices, the administration of health care insurance, and general information services related to health conditions and practices.

Its role in the health field is derived from the federal government's constitutional powers over criminal law, spending, and peace, order, and good government. Criminal law is the basis for legislation such as the Food and Drugs Act and Controlled Substances Act. Spending power comes from the federal role in levying taxes and appropriating funds and is the basis for the Canada Health Transfer and the Canada Health Act. The peace, order, and good government clause of the Constitution gives the authority to maintain and improve national standards in areas affecting health such as water and air quality.

The provinces and territories, by virtue of their jurisdiction over matters of a local or private nature, have also assumed an increasing role in health matters. This is the constitutional basis for many

provincial/territorial actions in health-related areas including the licensing of physicians, nurses, and other health professionals and determines the standards for licensing all hospitals. It is also the foundation for provincial-based medical insurance plans, the financing of health care facilities, and the delivery of certain public health services.

These divisions of health responsibility, both those emanating from constitutional interpretation and those derived from practices established over time, contribute to the other complexities facing Canadian health policy such as aging demographics, new and evolving technologies, and broader fiscal challenges.

The Origins and Evolution of the Federal Role in Health Care Administration and Delivery

The federal Department of Health celebrates its centennial anniversary next year. It finds its origins in early twentieth-century progressive politics and growing concerns about public health in an era of urbanization. The National Council of Women of Canada, the Trades and Labour Congress, and similar organizations (including some partly motivated by eugenics) (Rutty and Sullivan 2010) advocated for a federal role in addressing rising cases of tuberculosis and sexually-transmitted diseases.

Prior to 1919, the federal Department of Agriculture was notionally responsible for federal health matters. But health was mostly a private or familial responsibility with only a limited role for government for the first several decades following Confederation. Even the provinces had minimal health-related services or supports during this period. Most did not have departments of health (Canadian Museum of History 2010c).

But there were obvious limits to federal action on health matters and concerns about intrusion into provincial jurisdiction.

But remember the post-First World War period was marked by bursts of social progressivism. It was an era of Wilsonian idealism, expert-driven technocracy, and community activism. Ontario Liberal Party leader Newton Rowell, who was also a leading lay figure in the Methodist Church and the temperance movement, was a key voice in this trend. He had broken with the Liberal Party on conscription and went to Ottawa in 1917 to join the Unionist government led by Prime Minister Robert Borden. Rowell was soon tapped to lead the establishment of a new health department. His social progressivism made him a natural fit.

Legislation to establish a new federal Department of Health was introduced in March 1919. Bill 37, *An Act Respecting the Department of Health*, would grant the new organization with responsibility for "all matters and questions relating to the promotion of health and social welfare of the people of Canada" (Hall 2013, 17). The legislation passed that spring. The department was formally established in July 1919 with Rowell as its first minister and Dr. John Amyot, a decorated war veteran and former professor of preventive medicine and hygiene at the University of Toronto, as its first deputy minister.

The department's principal responsibilities were to be child welfare, the medical inspection and care of immigrants, the medical supervision of all methods of transportation under federal jurisdiction (such as the railway), and the collection, publication, and distribution of information to promote good health and improved sanitation. The bill also created the Dominion Council of Health comprised of the federal deputy minister, the provincial chief officers of health, and five appointed members including representatives from organized labour, women's groups, social service agencies, and universities (Rutty and Sullivan 2010). Some small-scale examples of federal-provincial cooperation – including cost-shared programming – were also included to address sexually-transmitted diseases and advance public health promotion.

But there were obvious limits to federal action on health matters and concerns about intrusion into provincial jurisdiction. The Department of Justice strongly held that the federal authorities had no legal basis for involvement in health matters other than those specified in Section 91 of the *British North America Act*. As one source puts it: "this pronouncement was to have long-term consequences for the development of health policy" (Canadian Museum of History 2010c).

The push for health insurance began in earnest in the context of the Second World War as politicians, academics, and the general public started to see a greater role for government to protect against market fluctuations and to provide for social insurance.

Research shows that the Dominion Council of Health, which met twice yearly, had a greater impact on public health than the Department of Health itself for most of the 1920s and 1930s (Rutty and Sullivan 2010). The council's work led to new standards for foods and drugs and campaigns to promote child welfare and education on child care.

The federal health department merged with the Department of Soliders's Civil Re-establishment to form the Department of Pensions and National Health in 1928. This organizational move partly reflected ongoing debates about "sickness insurance" and whether there was a need to rethink Canada's health care financing model in general and if Ottawa should play a greater role in particular. These debates were of course soon superseded by the Great Depression and the Second World War. There were various examples of provincial experimentation with different forms of insurance during this period (Hall 2013). But the federal government was mostly consumed by other priorities in the immediate term. Ottawa's disinterest in the Rowell-Sirois Commission's recommendations on the eve of the Second World War is evidence of its turn to more pressing national matters.

The one exception was the creation of an advisory council on health insurance in 1942. The group was to develop options for a federal insurance scheme to protect citizens from burdensome health care costs. It set out various ideas and options – including the principle of universality and adoption of national standards – but the committee believed that such a plan was unconstitutional. It is interesting that many of its recommendations were still ultimately implemented as part of medicare (Canadian Museum of History 2010b).

As the war approached its conclusion, the federal government started to signal new ambition for a more comprehensive welfare state. There were various factors that contributed – including the influence of the Beveridge (1942) Report in the UK, newfound confidence in the ability of state planning, a focus on minimizing post-war economic and social dislocation, and a streak of social activism

present in the elected and non-elected arms of the Canadian government. MLI research advisory body member Jack Granatstein's (1982) brilliant book, *The Ottawa Men*, captures this activist spirit of the age.

This point should not be understated. The push for health insurance began in earnest in the context of the Second World War – a time when politicians, academics, and the general public started to see a greater role for government to protect against market fluctuations and to provide for social insurance. The spectacular market failure of the Great Depression and perceived effectiveness of state planning in the war effort contributed to this newfound emphasis on a positive role for government, including in health care. Canada was hardly immune to these intellectual and political trends. The centralized model of governance during the war was carried forward into the post-war period. There would be a strong central government that would establish national programs with national standards and transfer payments – including equalization, which was eventually created in 1957 – that would ensure that the provinces had the resources to meet these standards.

Saskatchewan once again led the way in 1962 when it introduced a universal medical insurance plan to cover doctors's services for its residents. This was the catalyst for the medicare model whereby public health insurance in Canada would come to cover acute care services in and out of hospitals.

The new Department of National Health and Welfare, which replaced the Department of Pensions and National Health in 1944, was part of this trend towards greater centralization and planning. A Health Grants Program was established in 1948 to provide cost-shared financial support to the provinces for health-related activities. These health grants focused on the control of tuberculosis, cancer, and sexually-transmitted diseases, mental health care, support for disabled children, professional training, general public health, and public health research. This step has been called "the first stage in the development of a comprehensive health insurance plan for all Canada" (Chenier 2002).

The 1950s saw a continuation of this trend towards both public health insurance and a greater federal role in the health care system. Saskatchewan was the first jurisdiction to establish a province-wide, universal hospital care plan in 1947. Both Alberta and BC adopted similar plans within two years.

Pressure mounted inside and outside of Ottawa for the federal government to provide financial support to the provinces to defray the costs of these burgeoning public insurance models. Some provinces were anxious about the inevitable conditions with which federal funding would come. Others were keen to have the federal government defray a portion of the costs associated with hospital insurance (Brewster 1959).

The result was the federal government's first major foray into co-financing public insurance known as the Hospital Insurance and Diagnostic Services Act in 1957. It offered to cost-share up to one-half of provincial and territorial costs for certain hospital and diagnostic services. The Act provided for publicly administered universal coverage for a specific set of services under uniform terms and conditions (Health Canada 2005). This was the precursor to the conditions in the Canada Health Act. The 1957 law required that participating provinces and territories satisfy four conditions as follows:

- *comprehensiveness*: All-encompassing inpatient and outpatient hospital services as well as diagnostic services were to be made available under the insurance plan;
- *universality*: Services were to be made available to all residents of the province or territory;
- *accessibility*: Services were to be made reasonably accessible to insured persons in a manner that did not preclude or impede access either directly or indirectly; and
- *portability*: Provincial plans were to provide coverage for out-of-province Canadian residents who were insured by home provincial or territorial plans (Manga, Broyles, and Angus 1987).

Participating provinces and territories were also obliged to limit co-payments and other "deterrent" fees to ensure that patients were not placed under financial burden at the point of care (Taylor 1978). The federal funding formula of matching funds also worked as a disincentive against patient-based fees since federal funding was proportional to provincial and territorial contributions.

The federal government's financial contribution in support of this model was determined as a percentage (one-half) of provincial and territorial expenditures on specific insured hospital and physician services. This fixed percentage created some fiscal uncertainty for the federal government and was highly inflationary.

The Hospital Insurance and Diagnostic Services Act was initially only to take effect after a majority of provinces representing a majority of citizens had agreed to participate. This threshold was subsequently lowered and five provinces – Alberta, BC, Manitoba, Newfoundland, and Saskatchewan – started to receive matching federal grants in July 1958 (Brewster 1959). By 1961, all provinces had signed agreements establishing public insurance plans that provided universal coverage for inpatient hospital care (Kirby 2001).

Saskatchewan once again led the way in 1962 when it introduced a universal medical insurance plan to cover doctors's services for its residents. This was the catalyst for the medicare model whereby public health insurance in Canada would come to cover acute care services in and out of hospitals.

But it was not necessarily inevitable that the federal government would expand the cost-sharing model from hospitals to doctors. The Pearson government failed to win a majority government by a mere two seats in the 1965 federal election. It returned to Parliament still dependent on the New Democratic Party (now led by former Saskatchewan premier Tommy Douglas) to pass legislation and govern effectively.

The Pearson government's Medical Care Act in 1966 expanded federal cost-sharing for provincial costs for medical services provided by a doctor outside of hospitals. The government's case for the expansion of federal support for public insurance was rooted in the same argument presented today by medicare proponents. Then-health minister Allan MacEachen told Parliament:

> The government of Canada believes that all Canadians should be able to obtain health services of high quality according to their need for such services and irrespective of their ability to pay. We believe that the only practical and effective way of doing this is through a universal, prepaid, government-sponsored scheme. (Canadian Museum of History 2010d)

The Progressive Conservative Party and the Social Credit Party opposed the Medical Care Act for various reasons, including the intrusion into provincial jurisdiction (Canadian Museum of History 2010d). The bill still passed with NDP support by the end of 1966. This moment is rightly seen as foundational for the current health care model.

While the Conservatives in Parliament opposed the Medical Care Act, the research and policy foundation for the bill's model was actually found in a royal commission report that had links to the Diefenbaker government. The Royal Commission on Health Services was launched in 1961 by the then-Progressive Conservative government to

> inquire into and report upon the existing facilities and the future need for health services for the people of Canada and the resources to provide such services, and to recommend such measures, consistent with the constitutional division of legislative powers in Canada, as the Commissioners believe will ensure that the best possible health care is available to all Canadians. (Government of Canada 2005)

The commission (which was appointed by the Diefenbaker government and reported to the Pearson government) was headed up by Emmett Hall – a law school classmate of Diefenbaker's and friends with Tommy Douglas, who is now often referred to as the "father of medicare." His royal commission report recommended the creation of a new Health Charter that essentially expanded Saskatchewan's public insurance model across the country. In fact, it recommended that the new, cost-shared insurance model include: medical services; dental services for children, expectant mothers, and public assistance recipients; prescription drug services; optical services for children and public assistance recipients; prosthetic services; and home care services (Royal Commission on Health Services 1964).

The Canada Health Act was thus designed to restore provincial and territorial responsibilities for reporting on statistical information related to insured health services.

The government's Medical Care Act did not go as far as the commission recommended but it did reflect many of its key concepts. The act set out four principles – (1) universality, (2) comprehensiveness, (3) public administration, and (4) portability – similar to the 1957 law. Within six years, all the provinces and territories had universal physician services insurance plans that conformed with the federal legislative framework (Health Canada 2005). The basics of the medicare model were essentially in place.

The federal government's financial contribution in support of this model was determined as a percentage (one-half) of provincial and territorial expenditures on specific insured hospital and physician services. This fixed percentage created some fiscal uncertainty for the federal government and was highly inflationary. It basically created an incentive for provinces and territories to spend more given that 50 cents of every dollar came from Ottawa. Federal transfers therefore ballooned in tandem with provincial and territorial health care spending (Madore 1991).

The 50-percent model also represented a considerable intrusion into the basic functioning of the provincial and territorial health care systems. Provinces and territories needed to submit detailed reports on their programming and federal officials needed to determine whether a particular program – for example, a particular home for the elderly – fell inside or outside the terms of the cost-

shared program. The result was that Ottawa assumed direct and indirect responsibility for health care administration and delivery. As leading social historian Keith Banting observes, the funding formula necessarily led to "deeper [federal] intervention and deeper administrative control over provincial jurisdiction" (Kirby 2001).

Thus, after nearly 20 years of this model, Pierre Trudeau's government enacted reform. The Federal-Provincial Fiscal Arrangements and Established Programs Financing Act was passed in 1977 to replace federal cost sharing with a block transfer (combination of cash payments and tax points). The funding formula was fixed, and provinces and territories could spend as much or as little as they chose without it affecting their federal payment. The Established Programs Financing (EPF) was set with a base year of 1975/76. Provincial and territorial payments then grew year-over-year according to a formulaic escalator. This escalator corresponds to a moving average of GDP per capita over 3 years. Using a moving average made it possible to moderate any sharp fluctuations in GDP (Madore 1991).

This new financing model has subsequently been changed in different ways – including the consolidation of the Canada Health Transfer with the Canada Social Transfer from 1996/97 to 2003/04, an increase to the escalator to 6 percent annually from 2003/04 to 2013/14 and a shift to a per-capita cash payment in 2014/15 – but the basic structure has generally remained the same. The federal government continues to provide a major transfer payment that is notionally associated with helping to defray a portion of provincial and territorial spending on health care.

In fact, one can argue that by precluding cost-savings options on the part of the government, the insistence on equal access necessarily limits public insurance to hospital and physician services and erodes accessibility by requiring rationing.

The most fundamental change was the passage of the Canada Health Act in 1984. The Act's origins are rooted in the fact that while the federal conditions from the Medical Care Act remained in place, the implicit mechanism for clawing back federal funding was eliminated since it was no longer linked to actual provincial or territorial expenditures (Kirby 2001). The provinces and territories no longer had to submit information about their health care programming. Ottawa essentially had neither the mechanism nor the information to enforce any conditions. This was perceived as a "problem" by medicare proponents including members of the then-Trudeau government.

A government commissioned report by Emmett Hall (the same head of the 1960s Royal Commission) released in 1980 found evidence of extra-billing and health premiums that in his view threatened to "destroy the program" (Canadian Museum of History 2010a). In response to Hall's report, the government started to feel urgency to "fix" the issue as several provinces began to experiment with different forms of extra-billing for hospital and doctor services "through the back door" (Kirby 2001).

The Canada Health Act was thus designed to restore provincial and territorial responsibilities for reporting on statistical information related to insured health services. It also granted the federal government with the ability to impose dollar-for-dollar reductions in federal transfer payments to provinces and territories that continued to use extra-billing or user fees. The Act, which passed unanimously, for all intents and purposes reasserted federal authority to set national health standards. Then-Health Minister Monique Begin described the bill as a tool "to fix a problem, which derives, in my opinion, from EPF" (Kirby 2001).

The Canada Health Act establishes the principles and criteria for health insurance plans that the provinces and territories must meet in order to receive full federal cash transfers in support of their respective health care systems. The Act lists five basic principles:

- comprehensiveness: Provincial and territorial plans must insure all medically necessary services provided by hospitals, medical practitioners, and dentists working within a hospital setting;
- universality: Provincial and territorial plans must entitle all insured persons to health insurance coverage on uniform terms and conditions;
- accessibility: Provincial and territorial plans must provide all insured persons reasonable access to medically necessary hospital and physician services without financial or other barriers;
- portability: Provincial and territorial plans must cover all insured persons when they move to another province or territory within Canada and when they travel abroad. The provinces and territories have some limits on coverage for services provided outside Canada and may require prior approval for nonemergency services delivered outside their jurisdiction (Health Canada 2005); and
- public administration: Provincial and territorial plans must be administered and operated on a non-profit basis by a public authority accountable to the provincial or territorial government.

It is worth observing that the 2002 Senate Standing Committee on Social Affairs, Science, and Technology's report (herewith called the "Kirby Report" after its chair, Senator Michael Kirby) observed that the first four principles are patient-centric while the final one – public administration – is focused on the system's administration. As the report puts it:

> It [public administration] does not focus on the patient but is rather the means of achieving the ends to which the other four principles are directed. In our view, this distinction between ends and means explains much of the current debate about the Canada Health Act and Canada's health care system. People who agree completely on the desired ends of a public policy can nevertheless disagree strongly on the means of achieving those ends. (Kirby 2001)

This interpretation is mostly correct, though one could also describe the principle of accessibility as focused principally on means. Past MLI research has shown how accessibility – that is, equal access to health care as defined by a prohibition on any form of patient cost-sharing – is not an essential condition for achieving universality or egalitarian and fair access (Speer and Lee 2016). In fact, one can argue that by precluding cost-savings options on the part of the government, the insistence on equal access necessarily limits public insurance to hospital and physician services and erodes accessibility by requiring rationing. We will revisit this point in a later section of the paper.

A considerable body of research – including several studies and commentaries by published by MLI – shows that the infusion of funding with top-down federal priorities failed to catalyse reform.

The 1990s were marked by deep cuts to federal health transfers as part of the effort to restore Ottawa's budgetary position. Federal transfer payments were cut by $7 billion and the federal share of provincial and territorial health care spending fell as a result (Madore 2003). The provinces and territories were displeased with the drop in federal support. But

it is worth noting that past MLI research has shown that the reduction in federal funding actually catalysed some provincial/territorial reform (Speer and Crowley 2015).

It offers a useful reminder of the role of incentives and the limits of both seeing more funding and more federal involvement as the key sources of reform.

Still, as Ottawa's budgetary position improved, there were infusions of new funding including a 2000 agreement on health care with the provinces and territories and a 2003 Accord on Health Care Renewal that established the Canada Health Transfer (Health Canada 2005). The accord stemmed from a First Ministers's meeting in February 2003 and reflected a renewed interest in health care on the part of the federal government (Government of Canada 2004).

The intellectual impetus for both the incremental funding and the restoration of federal engagement was the Royal Commission on the Future of Health Care in Canada (known as the Romanow Report after former Saskatchewan Premier Roy Romanow, who chaired the study), which was released in 2002. The report proposed a major affirmation of the medicare model and more national standardization driven in large part by Ottawa. It recommended a national "health care covenant" that acted as a "social contract" with "national leadership" playing a key role. It is difficult not to see the Romanow Report (led by a former Premier and supported by leading medicare proponents) as a siren call for a renewed commitment to cooperative federalism in the health care field. As the report puts it:

> In recent years, . . . the federal government has attempted to maintain its role as the defender of Medicare's national dimensions while simultaneously reducing its responsibility and risk for managing the increasing costs and changing expectations within the system. This has put the federal government at odds with the provinces. The Canadian public nevertheless remains committed to a national approach to health care, and expects that a broad range of necessary and high-quality health services will be available to all citizens of this country on an equal basis.

Ottawa's improved public finances and the government's own progressive instincts enabled it to follow through on the spirt of the Romanow Report and even some of its recommendations. The 2003 accord was the first manifestation. A 10-year spending plan in 2004 was the second. The 10-Year Plan to Strengthen Health Care involved a significant increase in the newly-constituted Canada Health Transfer. Both were driven in large part by public concerns about spending cuts in the mid-1990s and the perceived need for an infusion of new funding to sustain and strengthen the health care system. Federal transfer payments thus began to generously flow once again with a new escalator of 6 percent annually. The enriched transfer payments were associated with various priorities and conditions negotiated between the different levels of government. Then-Prime Minister Paul Martin referred to the overall package as a plan to "fix medicare for a generation" (St-Hilaire and Lazar 2004).

This prediction proved wrong. A considerable body of research – including several studies and commentaries published by MLI – shows that the infusion of funding with top-down federal priorities failed to catalyse reform. Provincial health care spending spiked but so did wait times. Overall Canada's relative health care performance fell during this period. Former Saskatchewan Finance Minister Janice MacKinnon attributes the lack of progress to the increase in federal funding. Her explanation is that the additional resources merely went to preserving the status quo (Speer 2016b).

The 10-year plan was to come up for renewal in 2013/14. The then-Harper government grappled with what, if anything, should replace the plan and what the escalator for the Canada Health Transfer ought to be. It was the subject of considerable Cabinet discussion and debate. Options ranged from the renewal of a health accord with considerable federal conditionality to no new accord and various scenarios in between. I was part of these internal deliberations. The bureaucracy's inclination was for an accord. There was considerable enthusiasm inside the Department of Health to promote greater standardization across the provinces with regards to data collection and even service delivery.

A considerable body of research – including several studies and commentaries published by MLI – shows that the infusion of funding with top-down federal priorities failed to catalyse reform.

Ultimately Ottawa chose to renew the Canada Health Transfer for a 10-year period following the conclusion of the health accord without a new agreement. The transfer would grow by 6 percent annually until 2017/18 and would then increase at the rate of growth in the economy thereafter. There would be no targeted federal funds or new conditions. Reform would be left to the provinces and territories (Speer 2016c).

The decision attracted immediate criticism from both the provinces and territories and heath stakeholders. But, as past MLI research has shown, it is during this period of perceived federal inaction that we have witnessed greater movement in the direction of more spending control and structural reform than under the previous 10-year federal-provincial agreement (Speer 2016b). It offers a useful reminder of the role of incentives and the limits of both seeing more funding and more federal involvement as the key sources of reform. The Harper government's less intrusive model has been described by Janice MacKinnon as a "new road" that seems to be producing better results. As she observed in a 2013 interview:

> . . . what was really interesting was all of the sudden the provinces sat there and looked at each other and said, "now what are we going to do?" because the whole focus of the ministers of health had been to badger the federal government for more money. What they have never really done is what they need to do; they then have to co-operate. Only they can restrict health professional salaries and they began – they had been to some extent already – but they began working together on drugs. Why don't we buy drugs together so we can get lower prices? They started to do that. They need to do more of that; they should be working together and they should be looking more at best practices: "That really worked here, we're going to have to import it". But it's a new road for them. It'll take them some time, but it's a more realistic road than just battling the federal government. I always tell my students that health care has been like a car. The federal and provincial governments are trying to steer it, and when we have two drivers at the steering wheel, it always goes into the ditch.

The current government was critical of its predecessor's more hands-off-the-wheel approach. The 2015 Liberal Party platform states: "We will restart that important conversation and provide the collaborative federal leadership that has been missing during the Harper decade." Ottawa has since negotiated what one might call "side-car agreements" with the provinces and territories on home care and mental health but has otherwise refrained from a comprehensive accord or increasing the escalator for the Canada Health Transfer (Government of Canada 2017a). These were marginal augmentations to the current fiscal arrangement rather than a fundamental revamp – though the use of conditional funding for particular areas fails to learn the positive lessons from the previous government.

The one main area where the Trudeau government has diverged from its predecessor is in enforcing the Canada Health Act. It has taken a more activist pose. This is best represented by then-Health Minister Jane Philpot's warning to Saskatchewan to abandon its use of private MRI machines to address patient demand in the province (Fraser 2017). The high-profile threat marked a different tone about the Canada Health Act and the scope for provincial/territorial flexibility than under the Harper and even Chrétien governments. A more activist approach to enforcement of extra-billing and user fees was encouraged by unions and progressive policy voices (Meili 2016).

It is worth briefly addressing the extent to which Ottawa has exercised its legal authority to claw back transfer payments when provinces and territories contravene the principles codified in the Canada Health Act. The federal Minister of Health is required to report to Parliament on the administration and operation of the Canada Health Act, as set out in section 23 of the Act. The Minister submits the Canada Health Act Annual Report, which provides an update on the Act's administration and instances of provincial/territorial non-compliance. The 2016/17 report was released in February 2018 (Health Canada 2018).

The federal government has cumulatively clawed back $246.4 million from the provinces and territories since 1984/85. Ontario has been subjected to $106 million in deductions but none since 1986/87. British Columbia has seen its transfer payment reduced 22 times over the past 35 years. This is by far the most. Quebec by contrast has only experienced it twice. Annex 1 provides a breakdown of federal deductions to health-related transfer payments under the Canada Health Act.

The Evolution and Current Role of the Department of Health

A discussion of the administration and enforcement is a good segue to a broader review of the role and functions of the federal Department of Health. The Canada Health Act Division, which is responsible for monitoring and analysing provincial and territorial health care insurance plans for compliance with the Act, is only one part of the department (Health Canada 2018).

The department now has a workforce of approximately 9000 employees across the country and an annual budget reaching nearly $4 billion up until the current fiscal year. It maintains a presence at the provincial, municipal, and community levels. The department is responsible to Parliament through the Minister of Health and provides coordination through other parts of the Health portfolio, including the Canadian Institute for Health Research and the Public Health Agency of Canada. It is responsible for enforcing and effectuating various statutes, including the Canada Health Act, the Food and Drug Act, the Tobacco Act, and the Canadian Consumer Product Safety Act. Annex 2 provides more information about the various laws and statutes that the Department of Health is responsible for.

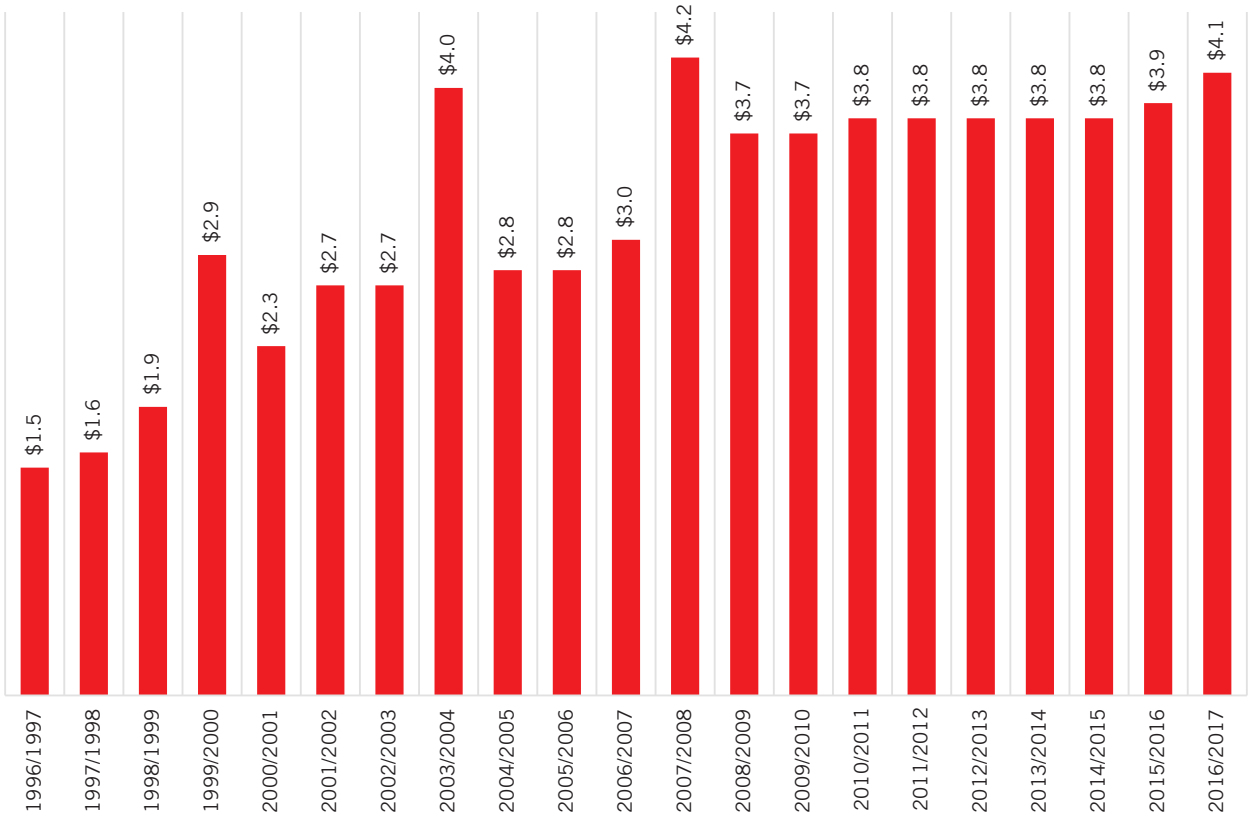
The department's annual Report on Plans and Priorities and Departmental Performance Report (now Departmental Plan) and the Public Accounts are useful sources of information about what the department does and how it does it. These reports do not however provide much analysis or explanation for why it carries out certain activities or functions.

The Office of the Auditor General of Canada has also carried out various audits related to different aspects of the department's activities. The department has been subjected to several audits in recent years on topics ranging from oral health to programs for First Nations and Inuit to pesticide safety to diabetes prevention and control. These audits provide some window into the department's efficiency and effectiveness but do not test or challenge the basic premise of its activities or functions.

It is my contention that the Department of Health has generally escaped this type of scrutiny in the past several years. The Romanow Report of course recommended a more expansive role for the federal government in the health care system and that had implications for the Department of Health. Its budget jumped from $1.5 billion in 1996/97 to $2.7 billion in 2002/03 and the number of employees went from 6300 to nearly 8000 over the same period (Government of Canada 2017b; Public Works and Government Services Canada).

The Department of Health was subjected to the second least reductions during the Program Review exercise in the 1990s (Bourgon 2009). It also only experienced a $200 million reduction during the strategic and operating review process in 2011 (Flaherty 2012). This is even overstated considering that the department's budget has increased by more than 50 percent since 2000 (see chart 2). The truth is a significant share of the health portfolio's "savings" in the 2011 process came from other parts of the Health portfolio such as the Canadian Institute for Health Research and the Public Health Agency of Canada.

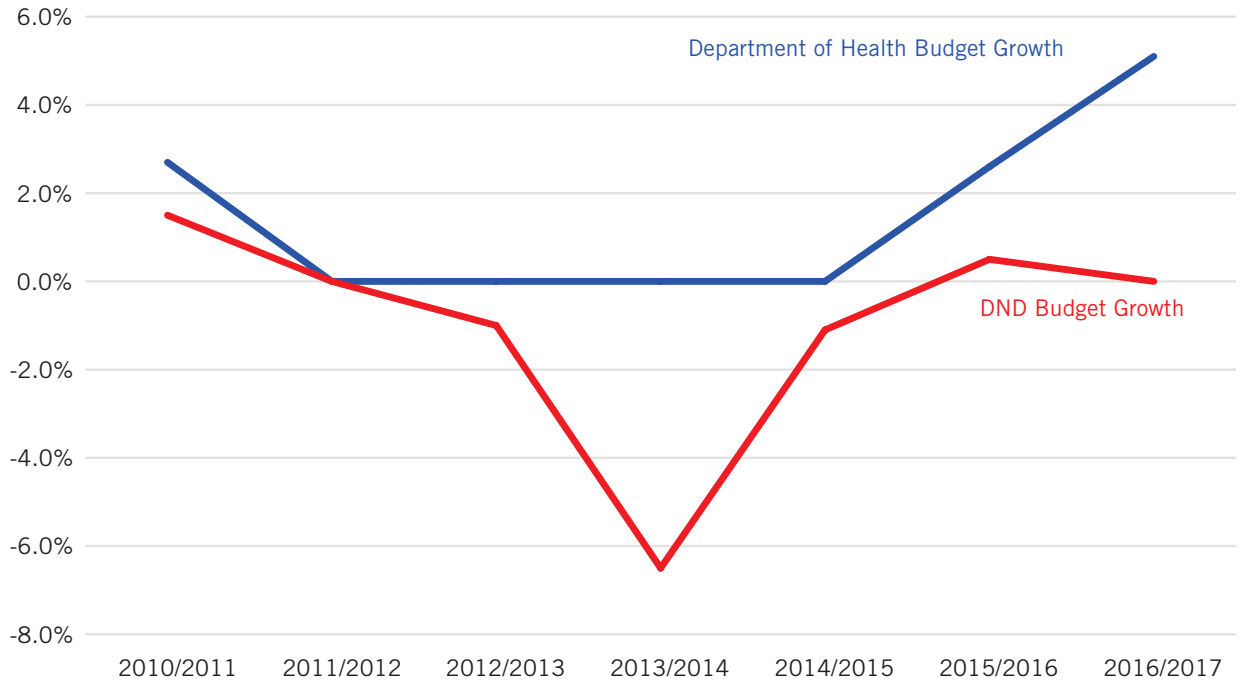
Chart 2: Department of Health annual spending, 1996/97 to 2016/17 ($BILLIONS)



Sources: Government of Canada 2017b; Public Works and Government Services Canada.

It is even more peculiar when you compare the Department of Health's budgetary treatment relative to other federal departments – including ones that *prima facie* are more clearly federal responsibilities and public goods. One example is the Department of National Defence, which represents the quintessential federal responsibility. DND's annual budget has grown, on average, by 3.1 percent since 1996/97 whereas the Department of Health has averaged 7 percent growth (Department of National Defence and the Canadian Armed Forces 2016; Government of Canada 2017b; Public Works and Government Services Canada). This discrepancy is stark following the global recession when the then-Harper government was focused on balancing the federal budget. DND experienced deep spending reductions and the Department of Health was basically protected (see chart 3).

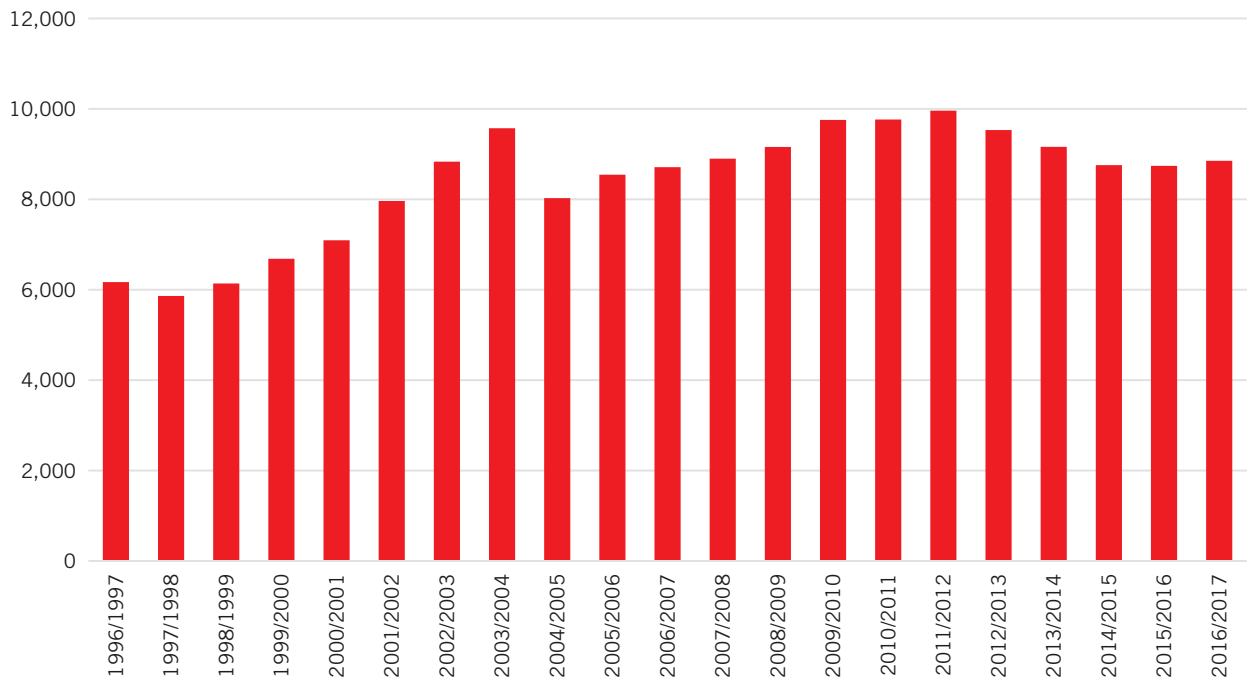
Chart 3: Annual budget growth for the Departments of Health and National Defence, 2010/11 to 2016/17



Sources: Department of National Defence and the Canadian Armed Forces 2016; Government of Canada 2017b; Public Works and Government Services Canada.

The department's budgetary stability and growth is reflected in its staffing. Its overall staffing has experienced anomalous years of decline (it inexplicably fell by 16 percent in 2004/05) but has, on average, grown by 2.1 percent annually since 1996/97. The trend is both stable and consistently growing. It has gone from about 6000 staff to roughly 9000 over this period (see chart 4).

Chart 4: Department of Health – human resources (full-time equivalents), 1996/97 to 2016/17



Sources: Government of Canada 2017b and Library and Archives Canada request.

How are these financial and human resources deployed? What value are Canadians getting from the department's various activities and functions?

These are not rhetorical questions designed to provoke anti-government reactions. It is instead about trying to understand the rationale for the department's different activities and functions and some evaluative sense of value. These are reasonable questions based in large part on my working hypothesis that the department has not been subjected to much scrutiny for several years.

The department has not had any external review in recent years. Most of the analysis has been self-driven through the 2011/12 strategic and operating review and the annual reports submitted by all government departments to Parliament mentioned above. There are obvious limits to a think-tank's ability to execute a comprehensive review given our asymmetrical access to information relative to the government. Still there is scope to analyse the department's organizational structure and different activities and functions to better understand its role in Canada's health care system.

The Department of Health's 2016/17 Report on Plans and Priorities describes its responsibilities as three-fold:

1.) Regulation – including safety of products such as food, pharmaceuticals, medical devices, natural health products, consumer products, chemicals, radiation emitting devices, cosmetics, and pesticides as well as tobacco and controlled substances.

2.) Service provision – namely for First Nations and Inuit populations including basic primary care, public health programs, and home and community care.

3.) "Catalyst for innovation, a funder, and an information provider" – including the administration of the *Canada Health Act* and promotion of the "pan-Canadian adoption of best practices."

The 2018/19 Departmental Plan helps to cast light on how the department distributes its financial and human resources across these core responsibilities (Taylor 2018). The themes remain broadly the same, but the department's responsibilities and resources have significantly changed in the current year. Its responsibilities for First Nations and Inuit health, alongside roughly $2.5 billion and 2000 employees, have been shifted to the new Department of Indigenous Services. This change does not mean that the federal government is no longer responsible for First Nations and Inuit health. It is just that the Trudeau government has chosen to reorganize the machinery of government for the administration and delivery of the services (Taylor 2018).

The result is that the Department of Health's budget becomes much more focused on the first and third set of responsibilities. New budgetary and human resource projections illustrate how it affects the department's spending and staff complement (see table 3). The description of the areas of spending is not precisely the same but "health care system" reflects the "catalyst" role, "health protection and promotion" is the "regulator" role, and First Nations and Inuit health is the "service provider" function.

TABLE 3: Department of Health – budget by core responsibilities, 2015/16 to 2020/21

AREA OF SPENDING	2015/16	2016/17	2017/18	2018/19	2019/20	2020/21
HEALTH CARE SYSTEM	402.6	399.8	414.0	1,300.0	1,540.0	1,700.0
HEALTH PROTECTION AND PROMOTION	457.8	475.6	600.5	597.6	569.6	570.6
FIRST NATIONS AND INUIT HEALTH	2,699.0	2,974.1	2,164.5	-	-	-
INTERNAL SERVICES	321.7	303.7	382.6	303.0	273.6	2,273.6
TOTAL	3,881.1	4,153.2	3,561.6	2,200.6	2,383.2	4,544.2

Source: Taylor 2018.

This spending reorganization has also led to a shift of human resources from the Department of Health to the new Department of Indigenous Services. The department is projected to experience a significant decrease in staffing related to First Nations and Inuit health, though increases in other areas such as marijuana legalization many offset some of these reductions (see table 4).

TABLE 4: Department of Health – human resources by core responsibilities, 2015/16 to 2020/21

AREA OF SPENDING	2015/16	2016/17	2017/18	2018/19	2019/20	2020/21
HEALTH CARE SYSTEM	199	198	281	276	280	280
HEALTH PROTECTION AND PROMOTION	4,372	4,376	5,301	5,591	5,626	5,673
FIRST NATIONS AND INUIT HEALTH	1,998	2,035	1,268			-
INTERNAL SERVICES	2,171	2,243	2,031	1,687	1,685	1,687
TOTAL	8,740	8,852	8,881	7,554	7,591	7,640

Source: Taylor 2018.

The upshot is that the Department of Health is now a research/policy and regulatory organization. It has largely ceded its responsibilities for health care service delivery. This is generally a positive move. But there is scope for Ottawa to be more ambitious than merely shifting First Nations and Inuit health from one federal organization to another.

Health care services for First Nations in British Columbia are delivered by the provincial government as part of a tripartite agreement between Ottawa, the provinces, and First Nations. The agreement was reached by the Harper government in 2011 and seems to be a model for other parts of the country to minimize overlap and duplication and to leverage provincial capacity with significant First Nations leadership. The department's 2016/17 Report on Plans and Priorities indicated that "Health Canada's longer-term policy approach aims to achieve closer integration of federal and provincial health programming provided to First Nations" (Philpott 2016b).

There is an opportunity to be more ambitious about expanding this type of arrangement elsewhere in the country. BC's tripartite model has been described as a "historical transformation" and a "case study" of collaboration for better health outcomes (O'Neil et al. 2016; Kehoe 2013). It is still early but evidence suggests that it may be a model that can be expanded to other provinces and territories (Auditor General of Canada 2015). It is worth noting that this may not reduce federal spending in the short- or even long-term – in fact, it may require more spending. This is a fine outcome if it involves (1) the devolution of responsibility from the federal Department of Health, which is ill-placed for administration and delivery, (2) a solid governance framework, and (3) clear metrics for assessing improvements to health outcomes. A 2015 Auditor General report on the establishment of the First Nations Health Authority in BC is a good source of insight on how to best achieve a strong governance framework (Auditor General of Canada 2015).

As for the remaining responsibilities and resources, the department basically does research/policy related to health care and regulates various health-related goods, substances, and activities from pharmaceuticals to food safety to vaping.

The department dedicated approximately $400 million to its health care related research and policy activities in 2017/18. Approximately $260 million of this amount is for "Canadian health system policy" work that is focused on "strategic policy advice, research, and analysis to support decision-making on heath care system issues." Most of these funds are dedicated to grants and contributions to national health organizations (Philpott 2016b). The rest is internally-led research and analysis. The emphasis is on "national leadership and strong partnerships" (Philpott 2016b).

It is worth noting that of this amount the administration of the Canada Health Act is only about $1.9 million per year to support the work of 19 employees. This is the group responsible for "investigat[ing] and resolv[ing] concerns which may arise" with regards to compliance with the Act that was described above.

The Department of Health's resources related to "health care systems" is projected to increase from $414 million in 2017/18 to $1.3 billion this year due to new federal funding for home care and mental health services (Taylor 2018). Incidentally this incremental funding to the provinces and territories for home care and mental health services essentially offset the difference resulting from the reduced escalator for the Canada Health Transfer. Remember the transfer grew by 6 percent per year up until 2014/15. It is now increasing based on GDP growth with a floor of 3 percent.

The Canada Health Transfer increased by 3.89 percent in 2018/19 from $37.2 billion to $38.6 billion (Department of Finance Canada 2017). Had it grown at 6 percent it would have increased from $37.2 billion to $39.4 billion. The roughly $1 billion (see table 3) dedicated for home care and mental services essentially makes up the difference even though the federal government has not explicitly communicated it that way.

The other remaining part of the department's activities is its regulatory responsibilities related to health and consumer products, food, chemicals, pesticides, environmental factors, tobacco, and controlled substances. It is a smaller share of the budget than its work on the health care system but a much larger percentage of staffing. Roughly three-quarters of the department's 7500 employees are focused on these files.

Overall, it is difficult to judge based on public documents and information whether the department's "protection and promotion" activities and functions are justified and efficient.

Overall, it is difficult to judge based on public documents and information whether the department's "protection and promotion" activities and functions are justified and efficient. There are relevant questions about potential overlap and duplication with the provinces and territories and the Public Health Agency of Canada. Questions can also be raised about the potential for greater regulatory harmonization with the United States.

Former officials and those involved in the process indicate that these discussions have been ongoing with the Food and Drug Administration (FDA) in the US for some time and that part of the delay and inaction is attributable to bureaucratic inertia in Washington. Some collaboration is presently taking place on mutual recognition of facility inspections by each jurisdiction. There should be scope to expand on this model into other areas as well.

With regards to potential overlap with the provinces and territories, there is room for a "who does what" review to enable "intergovernmental disentanglement" (Speer 2018). Food safety is one example where the federal government is responsible for safety inspection of exported goods and the provinces and territories are responsible for goods produced and sold in local markets (Mendelson, Hjartarson, and Pearce 2010). There is a case here for uploading provincial and territorial activities. But there may be others where the federal government should cede the regulatory space to the provinces and territories.

As for the potential for greater harmonization with the United States, one frequently hears about silly examples of regulatory divergence that do not seem to have any basis in health or safety concerns. One example: Canadian rules only permit 19-ounce cans of processed fruit and vegetable products (such as soup) to be sold in stores, whereas the US standard is a 16-ounce can (Speer 2017). Reducing this type of needless regulatory divergence would not only presumably reduce the size and scope of the federal Department of Health, it would also represent a considerable cost savings for Canadian businesses and consumers.

The department's final area of expenditures is internal services such as human resources, legal services, information technology support, and so on. This line item was $265 million in 2016/17 and represented just under 2000 employees (Philpott 2016b). This has fallen a bit in the 2018 Departmental Plan due to the transfer of some resources and staff related to First Nations and Inuit health (Taylor 2018). There is certainly scope to review remaining activities and spending to determine how best to deliver internal services with greater efficiency.

Reforming Ottawa's Role in Health Care

The lesson from the historical evolution of Ottawa's role in health care is not that there should be no federal involvement or that the federal Department of Health ought to be eliminated. There is certainly a role for the federal government, including on drug approvals by the department's Health Products and Food Branch due to the inefficiencies of provincial/territorial approvals, pandemic preparedness due to the global dimension, funding health research due to national externalities, and so on (Government of Canada 2015).

But while there is a role for the federal government in health care, it does not follow that the current arrangement is optimal. Past MLI research has shown that an overly-activist federal role can come to inhibit meaningful reform to administration and delivery (Speer and Crowley 2015). There is also the obvious cost associated with financing a large and active federal department. The risk of course is that taxes have to be higher than they would otherwise be, or scarce public resources are not directed to where they could make the most difference.

This study identifies five recommendations to improve the federal role in Canadian health care in general and to reorient the federal Department of Health to contribute to better health outcomes in particular.

This study identifies five recommendations to improve the federal role in Canadian health care in general and to reorient the federal Department of Health to contribute to better health outcomes in particular. The goal of these reforms is to focus the federal government on where it has a unique role and to minimize duplication and overlap elsewhere. Federalism is a virtue rather than a vice (Speer 2016a). This overriding principle should guide federal reforms – both because of Canada's institutional framework and because the evidence shows that it works in practice.

1.) *Reduce federal spending that duplicates or encroaches on provincial responsibility for health care administration and delivery*

The first of the department's two "core responsibilities" according to its 2018/19 Departmental Plan is "health care systems." Most of the activities here – including "conduct[ing] research, analysis and policy work on health care systems" – seems outside the scope of the federal role in Canadian health care. It is not clear, for example, why Ottawa is better placed to carry out analysis of "health care system modernization" than the provinces or territories (Taylor 2018).

It is also a bit presumptuous that the federal government will "work with the provinces and territories to address patient charges and strengthen reporting on the *Canada Health Act*" (Taylor 2018). Presumably the provinces and territories that impose patient charges to bring greater discipline to health spending and minimize the burden on the public treasury do not want or need Ottawa to "work with" them. Instead this seems like a sophism that actually means that the federal government will preclude the provinces and territories from considering such reforms.

Lastly, the new conditional funding for home care and mental health services assumes that this is the right priority for every province and territory. This precludes separate or different priorities based on local preferences or conditions. Maybe BC ought to be focused on something different than New Brunswick or Ontario. But incremental federal dollars create distorted incentives to instead focus scarce resources in one area over another. Sub-national governments are better placed to make these judgements than Ottawa. The federal government should therefore not try (Speer 2016c). Minimizing the federal responsibility for "health care systems" would not only free up considerable resources, it would enable much greater provincial and territorial prioritization and experimentation.

One way to move forward with this recommendation is to establish a reverse onus model for justifying funding renewal of existing activities and functions. Any funding should simply expire unless the government can make the case that it reflects a unique role for Ottawa.

2.) *Reform the Canada Heath Act to enable greater provincial and territorial experimentation*

Parts of the *Canada Health Act* such as the principle of universality and the need for portability remain important. But the notion of "accessibility" – by which the law precludes any form of user fees or patient cost-sharing for hospital and physician services – is presently too broadly applied and is a barrier to positive and indeed egalitarian reforms.

Section 12 of the Act is where these provisions are found. Sections 18–21 are also implicated. It is here the provinces and territories are disallowed from the use of extra billing and user fees (Clemens and Esmail 2002). These prohibitions are animated by the idea that accessibility means the same access to publicly-insured services irrespective of one's financial means. This strikes us as neither progressive nor prudent, particularly as the provinces and territories face serious fiscal sustainability challenges due in large part to rising health costs (Ferguson, Speer, and Freeman-Fawcett 2017).

As we have written elsewhere, Ottawa should repeal sections 18–21 of the *Canada Health Act*, which presently disallow patient charges – including any charge for an insured health service authorized or permitted by the provincial plan that is not payable by the plan – in the health care system. Such a legislative change would enable the provinces and territories to experiment with

different forms of patient cost-sharing for services and treatments that are currently covered by public insurance (Speer and Lee 2016).

Reconceptualizing accessibility to refer to access for low-income citizens to both publicly-insured and even non-insured services would involve a major shift in policy thinking. It would no longer be about precisely the same access irrespective of means and instead focus on egalitarian and fair access. Scarce public resources would target those who need help. Accessibility would now become about sheltering low-income citizens from the burden of user fees, co-pays, and other financial contributions. As past MLI scholars write: "Such a change balances the need for introducing co-pays and other user fees with our collective preference to shelter those experiencing low income from such financial burdens" (Clemens and Esmail 2002).

Allowing some forms of user fees would shift a share of hospital and doctor costs to the individual. This would lower the burden on public financing and can thus reduce the strain that health care spending is placing on government budgets. It could also create the conditions for a broader rebalancing of public and private financing across the health care system and allow for an expansion of public insurance to offset some costs for uninsured services such as drugs, dental, and outpatient services. MLI has made the case that the use of means-tested user fees would actually enable the provinces and territories to expand public insurance to presently non-insured services for low-income citizens (Speer and Lee 2016).

It is important to note that this model is not inconsistent with universality. High-income individuals who might be subjected to user fees would continue to have access to health care. It would just change how the services are accessed and financed. By enabling some scope for extra billing and user fees for these individuals, provinces and territories would now have additional resources to improve access for everyone. This would, in fact, bring Canada in line with other jurisdictions that have universal health care. Most of these countries use some form of user fees or patient cost-sharing (Simpson 2013). It also would not require provinces or territories to impose such fees. It would merely give them the option to experiment with different models. One might think of it as returning to the system that was in place between 1977/78 and the passage of the *Canada Health Act*.

Presumably if the federal government eliminated or diminished the need for "accessibility," it would also be able to reduce its own monitoring and enforcement activities since it is such a major part of its *Canada Health Act* responsibilities. This strikes me as a win-win.

3.) *Review the Department of Health's regulatory role to minimize duplication and overlap with other governments*

Many of the department's regulatory and "health promotion" activities may seem sensible. Who is opposed to properly regulating health products or food?

But it does not necessarily follow that the current model is efficient or optimal. The process for reviewing and approving new products can be slow and arduous as previous reports have shown (Rovere and Skinner 2012). There is potential for duplication and overlap with provinces, territories, and other jurisdictions. There is also potential for duplication with the Public Health Agency of Canada that has its own health promotion activities and functions.

It is no accident for instance that several of the priorities in this area in the 2018/19 Departmental Plan start by referring to "work[ing] with the provinces and territories" or "consult[ing] with the provinces and territories" or "collaborate with FPT partners" (Taylor 2018). The truth is much of these activities and functions bump up against other levels of government. Ottawa should thus launch a systematic process to better determine "who does what" and ensure that the right level of government is carrying out these responsibilities. This may involve some uploading and downloading. But it should ultimately be guided by the overriding objective of intergovernmental disentanglement. Put differently: the goal here should be to minimize cooperative federalism and instead prioritize what lawyer Asher Honickman (2017) calls "watertight compartments."

There is also room for greater regulatory harmonization with the United States – particularly in light of the renewal of the Regulatory Cooperation Council between the Trudeau government and the Trump administration (Treasury Board of Canada Secretariat 2018). A greater focus on regulatory harmonization could help to reduce costs on businesses and consumers as well for the federal Department of Health. It could also help expedite Canadian access to new drugs and medical technologies by reducing the transaction costs associated with entering the Canadian market and accelerating the regulatory review process.

It is worth recognizing that the Department of Health has long participated in the International Conference on Harmonization, which is supposed to maintain regulatory standards for the purposes of harmonization. Former officials indicate that this process has enabled much of the current collaboration with the FDA in Washington and the European Medicines Agency. Still there is considerable work to do to streamline the regulatory process vis-à-vis the provinces and territories as well as international jurisdictions.

4.) *Explore options to devolve responsibilities for First Nations and Inuit health based on BC's tripartite model*

Although First Nations and Inuit health is no longer part of the federal Department of Health, it was the department's single largest expense up until this year and remains a key responsibility for the federal government.

The tripartite agreement with the federal government, provincial government, and BC First Nations represents a fundamental shift in how Ottawa delivers on its constitutional responsibilities for First Nations and Inuit health. It is an exciting reform involving both governance and service delivery changes. It may be a model that can and should be expanded to other provinces and territories.

It would not necessarily involve less cost for Ottawa in the short- and even long-term but it seems like a better governance model – particularly since the federal government is ill-placed to be delivering primary services – and may result in better health outcomes for Indigenous peoples.

It is too early to make a judgement about the effectiveness of the tripartite model. Still federal officials should be considering how the government would go about expanding the model to other provinces and territories in case the evidence ultimately shows that it is a better model than the status quo.

5.) *Launch a comprehensive review of federal spending in health-related areas*

The Department of Health should be subjected to regularized reviews to identify efficiencies in internal services and other parts of its spending. It employs roughly 1600 people in internal services alone. This is about 1 for every 4 people involved in "health care systems" and "health protection and promotion." There should be room to drive efficiencies here using outsourcing, technological improvements, and sharing back-office functions across the Health portfolio.

Conclusion

The federal Department of Health will celebrate its centennial anniversary next year. It has gone through various iterations and evolutions over its 100-year existence. It can understandably be difficult for politicians, the media, and general public to keep track of what has happened and how we have gotten to the current model for federal involvement in Canadian health care.

This MLI study has sought to provide a basic primer on the legal and constitutional parameters of the federal role in heath care, the evolution of its role (including the establishment of the medicare model), and recommendations to reform its role – including for the federal Department of Health. It has set out a positive vision of where and how the federal government should play a role in our health care system rooted in a clear understanding of the benefits of federalism and the reform and experiment it can enable.

Adopting the five recommendations would not have the federal government abandon health care or eliminate the federal Department of Health. But it would reshape the status quo in the name of leveraging the strengths of federalism to achieve better outcomes for Canadians.

About the Author

Sean Speer is a Munk Senior Fellow at the Macdonald-Laurier Institute. He previously served in different roles for the federal government including as senior economic advisor to the Prime Minister and director of policy to the Minister of Finance. He has been cited by *The Hill Times* as one of the most influential people in government and by *Embassy Magazine* as one of the top 80 people influencing Canadian foreign policy. He has written extensively about federal policy issues, including personal income taxes, government spending, social mobility, and economic competitiveness. His articles have appeared in every major national and regional newspaper in Canada (including the *Globe and Mail* and *National Post*) as well as prominent US-based publications (including *Forbes* and *The American)*. Sean holds an M.A. in History from Carleton University and has studied economic history as a PhD candidate at Queen's University.

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ANNEX 1
DEDUCTIONS, REFUNDS, AND RECONCILIATIONS TO CHST/CHT CASH CONTRIBUTIONS IN ACCORDANCE WITH THE *CANADA HEALTH ACT* SINCE FY 1984/85 (IN DOLLARS)

	NL	PEI	NS	NB	QC	ON	
1984/1985	-	-	-	3,078,000	7,893,000	39,996,000	
1985/1986	-	-	-	3,306,000	6,139,000	55,328,000	
1986/1987	-	-	-	502,000	-	13,332,000	
1987/1988	-	-	-	-	-	-	
1988/1989	-	-	-	-	-	-	
1989/1990	-	-	-	-	-	-	
1990/1991	-	-	-	-	-	-	
1991/1992	-	-	-	-	-	-	
1992/1993	-	-	-	-	-	-	
1993/1994	-	-	-	-	-	-	
1994/1995	-	-	-	-	-	-	
1995/1996	46,000	-	32,000	-	-	-	
1996/1997	96,000	-	72,000	-	-	-	
1997/1998	128,000	-	57,000	-	-	-	
1998/1999	53,000	-	38,950	-	-	-	
1999/2000	-42,570	-	61,110	-	-	-	
2000/2001	-	-	57,804	-	-	-	
2001/2002	-	-	35,100	-	-	-	
2002/2003	-	-	11,052	-	-	-	
2003/2004	-	-	7,119	-	-	-	
2004/2005	1,100	-	5,463	-	-	-	
2005/2006	-	-	-8,121	-	-	-	
2006/2007	-	-	9,460	-	-	-	
2007/2008	-	-	-	-	-	-	
2008/2009	-	-	-	-	-	-	
2009/2010	-	-	-	-	-	-	
2010/2011	3,577	-	-	-	-	-	
2011/2012	58,679	-	-	-	-	-	
2012/2013	50,758	-	-	-	-	-	
2013/2014	-10,765	-	-	-	-	-	
2014/2015	-	-	-	-	-	-	
2015/2016	-	-	-	-	-	-	
2016/2017	-	-	-	-	9,907,229	-	
TOTAL	383,799	-	378,937	6,886,000	23,939,229	106,656,000	

Source: Health Canada 2018.

	MB	SK	AB	BC	YT	NWT	NU	TOTAL
	810,000	1,451,000	9,936,000	2,797,000	-	-	-	65,961,000
	460,000	656,000	11,856,000	30,620,000	-	-	-	106,365,000
	-	-	7,240,000	31,332,000	-	-	-	52,406,000
	-	-			-	-	-	-
	-	-			-	-	-	-
	-	-			-	-	-	-
	-	-			-	-	-	-
	-	-			-	-	-	-
	-	-		83,000	-	-	-	83,000
	-	-		1,223,000	-	-	-	1,223,000
	-	-		1,982,000	-	-	-	1,982,000
	269,000	-	2,319,000	43,000	-	-	-	2,709,000
	588,000	-	1,266,000		-	-	-	2,022,000
	586,000	-			-	-	-	771,000
	612,000	-			-	-	-	703,950
	-	-			-	-	-	18,540
	-	-			-	-	-	57,804
	300,201	-			-	-	-	335,301
	-	-		4,610	-	-	-	15,662
	-	-		126,775	-	-	-	133,894
	-	-		72,464	-	-	-	79,027
	-	-		29,019	-	-	-	20,898
	-	-		114,850	-	-	-	124,310
	-	-		42,113	-	-	-	42,113
	-	-		66,195	-	-	-	66,195
	-	-		73,925	-	-	-	73,925
	-	-		75,136	-	-	-	78,713
	-	-		33,219	-	-	-	91,898
	-	-		280,019	-	-	-	330,777
	-	-		224,568	-	-	-	213,803
	-	-		241,637	-	-	-	241,637
	-	-		204,145	-	-	-	204,145
	-	-		184,508	-	-	-	10,091,737
	3,625,201	2,107,000	32,617,000	69,853,183	-	-	-	246,446,329

ANNEX 2
LAWS AND STATUTES – FEDERAL DEPARTMENT OF HEALTH

FEDERAL STATUTE	DATE ENACTED	ISSUES ADDRESSED
Canada Health Act	1985	Outlines criteria for provinces to receive monetary transfers from federal government
Financial Administration Act	1985	Authorizes the Minister of Health to charge fees for processing drug submissions and establishes fees for providing dosimetry services
Food and Drugs Act	1985	Prevents deception regarding food, drugs, cosmetics and medical devices by governing their sale and advertisement
Hazardous Materials Information Review Act	1985	Protects confidential business information from the disclosure requirements of the Hazardous Products Act, Canada Labour Code, and provincial and territorial occupational health and safety acts
Hazardous Products Act	1985	Establishes the supplier label and safety data sheet requirements of the Workplace Hazardous Materials Information System (WHMIS)
Patent Act	1985	Establishes the Patented Medicine Prices Review Board (PMPRB) with a mandate to regulate the prices of patented medicines sold in Canada to ensure that they are not excessive; and to report to Parliament annually through the Minister of Health
Pesticide Residue Compensation Act	1985	Sets up a compensation regime under which the Minister of Health may compensate a farmer for losses attributable to the use of a pesticide in accordance with the label directions
Radiation Emitting Devices Act	1985	Prohibit the sale, lease and importation of radiation emitting devices that do not comply with the applicable standards. The Minister of Health may appoint inspectors who are empowered to search premises and to seize and detain devices, and may appoint analysts to analyse or examine radiation emitting devices and packaging
Agriculture and Agri-Food Administrative Monetary Penalties Act	1995	Minister of Health can administer monetary penalties to violators of pest control products regulations
Controlled Drugs and Substances Act	1996	Series of prohibitions regarding importation, production, exportation, possession of various drugs. Includes amendments to other Acts and repeal of Narcotic Control Act
Tobacco Act	1997	Aims to protect the health of Canadians in light of conclusive evidence implicating tobacco use in the incidence of numerous debilitating and fatal diseases
Canadian Environmental Protection Act	1999	Series of regulations regarding potential pollutants
Pest Control Products Act	2002	Series of regulations regarding pesticides
Assisted Human Reproduction Act	2004	Prohibits a number of activities pertaining to assisted reproduction and related research
Canada Consumer Product Safety Act	2010	Series of regulations regarding commercial products available in Canada

Source: Taylor 2018.

Endnotes

1 It is as much as $6.3 billion per year after accounting for the Canadian Institutes for Health Research, the Public Health Agency of Canada, and the Patented Medicines Price Review Board (Government of Canada 2017c).

2 For a good overview of the constitutional and legal underpinnings of the federal role in health policy, see chapter 1 of the Kirby (2001) report here: www.cimca.ca/i/m/The-Complete-Kirby-Report.pdf.

3 For more on Rowell, see Margaret E. Prang, 2009, "Rowell, Newton Wesley," in *Dictionary of Canadian Biography,* vol. 17.

4 The Rowell-Sirois Commission, whose official title was the Royal Commission on Dominion-Provincial Relations, was established in 1937 to consider possible changes to Canada's fiscal federalism in light of the depression experience. Its final recommendations involved sweeping changes to federal and provincial revenue sources and spending responsibilities. Sean Speer, 2007, *Technocrats and Provincialists: The Rowell-Sirois Commission's conception of Federalism*, 1937–1940, unpublished Ph.D. paper.

5 The escalator changed several times due in large part to the state of federal finances between 1980 and 2004 (Kirby 2001).

6 The department's total expenses were $4.1 billion in 2016/17 but it generated $341 million in revenue in the form of user fees and so its net cost was $3.8 billion (Philpott 2016b).

7 For a full list reports made to Parliament by the Auditor General regarding Health Canada from 2002 until the present, see http://www.oag-bvg.gc.ca/internet/English/parl_lpf_e_1201.html.

8 The 2018-19 *Departmental Plan* (Taylor 2018) now sets out two core responsibilities: (1) "Health Canada provides national leadership to foster sustainable health care systems that ensure access for Canadians to appropriate and effective health care" and (2) "Health Canada works with domestic and international partners to assess, manage and communicate the health and safety risks and benefits associated with health and consumer products, food, chemicals, pesticides, environmental factors, tobacco and controlled substances."

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CONTACT US: Macdonald-Laurier Institute
323 Chapel Street, Suite #300
Ottawa, Ontario, Canada
K1N 7Z2

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