Examining Quebec-Canada Relations: A Case-Study Of Health Care

Abstract

The original Constitution of Canada, the British North America Act of 1867 (BNAA), empowers two orders of government with clearly demarcated areas of legislative competences. The Quebec government has been keen, especially since the early 1960 with the advent of the Quiet Revolution, to occupy in full its own fields of jurisdictions and to stop Ottawa from intervening in provincial domains. This was often done through the use of an opting out clause that was made available to all provinces although, in the end, Quebec was the only one to make full use of it. This text presents a case study of the recent healthcare agreements between Quebec and the central government. It points out the different relations between the provinces in relation to health care, specifically that while all other provinces sought to find a compromise on health care agreements, Quebec was successful in having its constitutional competences recognized.

Introduction

The original Constitution of Canada, the *British North America Act* of 1867 (*BNAA*), empowers two orders of government with clearly demarcated areas of legislative competences. The Quebec government has been keen, especially since the early 1960 with the advent of the Quiet Revolution, to occupy in full its own fields of jurisdictions and to stop Ottawa from intervening in provincial domains. This was often done through the use of an opting out clause that was made available to all provinces although, in the end, Quebec was the only one to make full use of it. Cases in point include the opting out of the Established programs Financing Act of 1965 (at a time of a minority government in Ottawa) and the setting up of the Quebec Pension Fund the same year but distinct from the Canada Pension Plan. This allowed Quebec to look after important public funds and to have more flexibility in managing Quebec's finances and economic projects.[1]

Negotiating or Imposing National Standards?

It has been established that provincial governments lack the proper financial resources to fulfill all their obligations, and that the federal government's excess revenues are used to complement provincial autonomous revenues (Gagnon and Garon, 2019). This confers the central government with a significant advantage when negotiating service-provision arrangements with the provinces.

In practice, Ottawa has clearly been able to tip the balance in its favor over the last decades by using its spending power, defined as "the power of [the federal] Parliament to make payments to people or institutions or governments for purposes on which it [Parliament] does not necessarily have the power to legislate"[i]. This power is only effective if the federal government consistently collect more revenue than is needed to finance its regular program expenditures. Its exercise "has taken the form of grants to provincial governments, the creation of shared-cost programs, and direct spending in areas of provincial jurisdiction"[ii].

In principle, the exclusive power for a province to legislate is very narrowly delineated. Therefore, federal spending programs can coerce provinces into complying with *so-called* "national standards". This coercion, which takes the form of cuts in federal transfers on which provinces depend, imposes some important *de facto* constraints on the provinces' freedom to legislate in their own exclusive areas of jurisdictions. It is in defining these conditions that asymmetry is most likely to arise, and in the imposition of such conditions that provincial-federal conflicts are likely to appear. The example of health care to be discussed below reveals such tensions.

The use of the spending power has been instrumental in developing the Canadian welfare state, or social union. In particular, it has generally been used to foster a centrally-defined notion of the welfare state and of Canadian identity – for instance, debates on the Social Union framework.[iii] Transfers come to rescue provinces that differ in their state capacities, institutional abilities to design programs, deliver services and, most importantly, to raise revenues. Some provincial governments are also better equipped than others to evaluate properly the efficiency of their own service delivery. This may be problematic when the federal government establishes goal-oriented transfers, whereby evaluation is important. In terms of evaluation, the bilateral manpower agreements discussed below represent an application of asymmetry in designing, and evaluating public programs.

From Theory to Practice

In the Canadian Constitution, health care – with the exception of public health – is an exclusive provincial legislative power. However, provincial health systems are funded with the help of a dedicated transfer, the Canada Health Transfer (CHT) which consists of a per-capita cash grant paid yearly to all provincial governments. The CHT is a major source of funding for

provincial governments. To provide an order of magnitude, the CHT covered 23.3% of all provincial health care expenditures in 2016-17.[iv]

The federal government cannot directly legislate in exclusive provincial jurisdiction. Nonetheless, the federal spending power allows Ottawa to impose conditions on provinces in exchange for cash transfers.[v] The Canada Health Transfer is one of the most important "federal spending power programs". In order to receive a full CHT payment, provinces are required to comply with the Canada Health Act (1984).

The Canada Health Act is often considered as a milestone in the definition of a pan-Canadian identity. It states that health care delivery in Canada must comply with 5 principles: universality, portability, public administration, accessibility and comprehensiveness. The Canada Health Act also imposes an accountability framework, requiring provincial governments to provide the federal Health minister with information on compliance. Moreover, it gives the federal government administrative room to define the scope of health services which are subjected to these conditions.[vi]

Thus, *de jure*, provinces are responsible for the full design of their health care systems. But *de facto,* not complying with federal conditions would be very costly, both financially and, by extension, politically. In other words, provinces have their hands tied with respect to some major aspects of their health care systems.

Between 1993 and 2000, the federal government's deficit reduction plan caused its funding of provincial health care systems to reach an all-time low. In 1997-1998, the Canada Health Transfer (CHT) was merged with the Canada Social Transfer, another major conditional transfer program for social assistance. Along with this merger came rationalization, with the consequence that, in 1998-1999, federal funding covered only 14% of all provincial health expenditures. This was an all-time low, considering that around 23% of health expenses were covered by federal funding in 1984 when the Canada Heath Act was adopted, and 23,3% in 2016-17.[vii]

In the fiscal year 1998-99, the federal deficit had not only disappeared, but the budget balance was positive: Ottawa ran a surplus of $3.5 billion. Moreover, federal budget surpluses remained strong until 2008, when the world financial crisis struck. Federal surplus attained $13.8 billion in 2007-08, representing almost 1% of the gross domestic product.

With that financial breathing space the federal government's bargaining power with the provinces grew. In 1999, all provinces except Quebec agreed on the so-called "social union framework agreement – SUFA" which set-up the principle of accountability for provinces receiving earmarked or conditional federal funds. SUFA stated principles for future federal-provincial cooperation. However, its application would eventually lead to provincial compliance with "national standards" in the delivery of social programs (including health), and policy outcomes. Quebec saw, in this agreement, a violation of its exclusive legislative powers and found it inconsistent with its traditional constitutional demands.

During that period, provincial health care systems experienced some serious setbacks. Some provinces, such as Quebec, stopped providing major home care investment programs in order to maintain its own budget balanced. Waiting times and waiting lists became longer, particularly with respect to cancer treatment, hip and knee replacements, eye as well as cardiac surgeries and diagnostic imagery. Moreover "[t]he burden of chronic disease across the system is growing and emergency departments and hospitals often carry that burden unnecessarily for health conditions that could be managed in the community".[viii]

In 2001, the federal government commissioned Roy Romanow, former Premier of Saskatchewan, to "review Medicare – Canada's universally accessible, publicly funded health care system – and recommend policies and measures to improve the system and its long-term sustainability".[ix] One of the major political issues then was the waiting time necessary to obtain proper services in the public health system.

In its final report (2002), the Romanow Commission proposed the creation of the Health Council of Canada, which would foster intergovernmental cooperation with a view to "setting common indicators and benchmarks, in measuring and tracking the performance of the health system, and in reporting results regularly to Canadians".[x] Moreover, the backbone of the Council would be the creation of a Canadian Institute for Health Information, which would be instrumental in measuring outcomes and appraising results.

In 2003, provinces agreed to create the Health Council of Canada. While Alberta and Quebec did not support the initiative,

the latter agreed to cooperate but informed Ottawa and its provincial counterparts that it would not be bound by its final recommendations. In 2004, all Canadian Premiers, with the notable exception of Quebec, agreed on a 10-year plan to strengthen health care.

In recognition of the fact that Quebec already had its own plan and objectives, Quebec got a separate health care agreement. This accord was made public on a two-page press release and is entitled "Asymmetrical federalism that respects Quebec's competences". The agreement confirms Quebec's stand in its endeavour not to share its legislative powers with the central government in health. The province could then continue receiving the (newly re-established) CHT, while pursuing its own policy objectives. In terms of accountability, the agreement explicitly stated that the Quebec government would continue reporting directly to its own population. To do so, Quebec created the position of Health Commissioner.

Quebec's ministerial cabinet approved the agreement on 22 September 2004, by way of a decree that explicitly mentioned that this asymmetrical accord recognizes Quebec's willingness to exert, on its own, full responsibilities with respect to the design, planning, management and delivery of health care services on its own territory.[xii]

In return, Quebec agreed to continue to abide by the principles stated in the 1984 Canada Health Act. In practice, one may think that this recognition of Quebec's right to legislate in health matter did not change the course of policy in the province. As a matter of fact, Quebec already had a plan that met several of the federal objectives for the country. However, one has to seriously consider the counterfactual, which is, what would have happened without this political recognition? In such a scenario, Quebec would have been coerced into participating in the newly established federal institution, including the Canada Health Institute, and it would have been induced to accept the federal assessment of its own progresses with respect to the imposition of pan-Canadian standards.

Concluding Reflections

In short, we can offer five concluding remarks:

1. The central government has a tendency not too see the Canadian constitution as being the expression of a formal recognition of co-sovereignty between Canada's two founding peoples (English and French Canada (Quebec);
2. Nation building often occurs in areas of provincial jurisdictions ;
3. It has been near to impossible for a province to obtain from the central government complete willingness to respect provincial jurisdictions when provinces are not capable of maintaining a common front;
4. The simple respect of provincial competences is seen as a political victory by constitutional partners; and,
5. Historical claims emanating from Quebec are countervailed by day to day political management on the part of the central government.

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Further Reading

Béland, Daniel & André Lecours (2008). *Nationalism and Social Policy : The Politics of Territorial Solidarity*, Oxford, Oxford University Press.

Gagnon, Alain-G. & Jean-Denis Garon (forthcoming, 2019). "Constitutional and non-constitutional asymmetries in the Canadian federation: an exploration into the policy fields of immigration and manpower training" in Patricia Popelier and Maja Sahadzic, eds., *Constitutional Asymmetries in Multinational Federalism: Managing Multinationalism in Multi-Tiered Systems*, Basingstoke, Palgrave Macmillan.

Gagnon, Alain-G. & Hugh Segal, ed., (2000). *The Canadian Social Union without Quebec: 8 Critical Analyses*, Montreal and Kingston, McGill-Queen's University Press.

[1] This text expands an argument which has been first introduced in Gagnon, Alain-G. & Jean-Denis Garon (forthcoming, 2019). "Constitutional and non-constitutional asymmetries in the Canadian federation: an exploration into the policy fields of immigration and manpower training" in Patricia Popelier and Maja Sahadzic, eds., *Constitutional Asymmetries in Multinational Federalism: Managing Multinationalism in Multi-Tiered Systems*, Basingstoke, Palgrave Macmillan.

[i] Pierre Elliott Trudeau, 'Federal-Provincial Grants and The Spending Power of Parliament', *Canadian federalism: myth or reality* (Queen's Printer 1969).
[ii] Jake Stillborn, 'National Standards and Social Programs: What the Federal Government can do' (Library of Parliament 1997).
[iii] A.-G. Gagnon and Hugh Segal, ed., *The Canadian Social Union without Quebec: 8 Critical Analyses* (McGill-Queen's University Press 2000)
[iv]Gouvernement du Québec (Ministère des Finances), 'Le Plan économique du Québec – Financement de la Santé – Pour une juste part du financement fédéral en santé' (2017)
[v] Hoi L. Kong, 'The Spending Power in Canada', *The Oxford Handbook of the Canadian Constitution* (Oxford University Press 2017)
[vi] Daniel Raunet, *Monique Bégin : Entretiens* (Boréal 2016)
[vii] Gouvernement du Québec (n 47)
[viii] Canadian Nurses Association, 'Review of the 10-year Plan to Strengthen Health Care – Brief to the Senate Standing Committee on Social Affairs, Science and Technology', 2011, p. 5
[ix] Government of Canada, 'Commission on the Future of Health Care in Canada: The Romanow Commission' <https://www.canada.ca/en/health-canada/services/health-care-system/commissions-inquiries/federal-commissions-health-care/commission-future-health-care-canada-romanow-commission.html> accessed 7 July 2018
[x] Roy J. Romanow, 'Commission on the Future of Health Care in Canada' (National Library of Canada 2018) xxiv
[xi] Canadian Nurses Association, 'Review of the 10-year Plan to Strengthen Health Care – Brief to the Senate Standing Committee on Social Affairs, Science and Technology', 2011, p. 1
[xii] Gazette Officielle du Québec No. 41 du 13-10-2004, p. 4425.