Health Care in a Renewed Federalism

by

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The Caledon Institute of Social Policy occasionally publishes reports and commentaries written by outside experts. The views expressed in this paper are those of the author.
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Summary

Confusion and conflict in our fiscal federalism are inhibiting nation-wide economic, social and environmental policies of which Canada has urgent need. The impending negotiation of new financing arrangements for Medicare can be the occasion for a wide reshaping of federal-provincial relations.

Ottawa should not go on providing an escalating transfer for Medicare as it is. Instead, assured funding at about the present level should be used to lever two major changes, in policy and in procedure. One would move resources into promoting health rather than just treating sickness. The other would secure a comprehensive shift to group practices for the delivery of primary care.

In the same spirit, more federal dollars should be put to direct use for purposes crucial to our success in the globalised economy. They centre on our most under-developed resource: the abilities of all our youth. They would combat child poverty, make child care generally available, improve access to post-secondary education, and extend skills training. Tax reforms to finance these programs would include some income-related recovery of Medicare expenses.

Where we start

Medicare as it is comes to an end on March 31, 2014. A new federal-provincial agreement for its continued financing must be negotiated.

The stance of the provinces is pre-ordained. They will be seeking more of the same. In 2003 the Martin government not only restored much of the transfer to the provinces that had been previously slashed. It made a remarkable commitment to increase its funding by a further 6% every year for eight years.

This was supposed to remedy some of Medicare’s most apparent weaknesses, such as long wait times, lack of even catastrophic drug coverage, and scarcity of home care. In fact, there is little to show for the money. In fairness, it should be remembered that the 2004 “accord” was in the spirit of its times, exemplified in the Romanow report. Many people, of whom I was one, were then suggesting that better health services could be driven, in part, by more federal funding.

We can learn from experience. This paper proposes a different approach to the impending negotiations. Ottawa would give prompt assurance that there will be no cut from the 2013 level of funding, but be equally definite that in future there will be no built-in increases from this level. And it will be a different kind of funding.
Hitherto federal dollars have been provided for Medicare as a whole. Originally, but briefly, they reimbursed 50% of all that the provinces spent on physician and hospital care. For most of the time, they have been effectively a block grant, different in size at various periods but always unrelated to whatever Medicare turned out to cost provincial treasuries.

The proposal of this paper is that federal finance again be related to what provinces spend, but only for particular, priority, purposes within health policy. In this, Medicare will be unique. There is no possibility that cost-sharing will be restored for other provincial programs or instituted for new ones. Medicare is special, not only because it is so expensive but because it is so strongly identified as a service for all Canadians, wherever they live and whatever their circumstances. The politics of federal involvement are binding. The issues are to what, exactly, and how.

*From fixing-up to health*

Medicare is still, in Tommy Douglas’s phrase, not about healthy people but about “patching them up when they’re sick.” It began because the expense of the patching could be impossible for many people, financially ruinous even for the well-to-do. Over the intervening forty years, advances in medical science and technology have greatly expanded the scope for patching up, for at least alleviating illnesses. Expectations rise with availability. Upward pressure on costs is inherent in Medicare. And as the population ages, the needs for patching up tend to grow faster than tax revenues.

Prevention is not only better than cure. It is, eventually cheaper. The one good way to head off the rising cost of treating sickness is to have less of it. Otherwise, no one can be honestly confident that our present Medicare will always be financially sustainable. Tommy Douglas was ahead of his time in pointing out the need to shift the emphasis to securing healthier people. If we did not, he warned years ago, the costs of Medicare would become “so excessive” as to make people unwilling to pay the necessary taxes.

Immediately, however, preventive measures are an additional cost on top of treating existing sickness. In the battle for attention and dollars, present needs outweigh gains for voters years hence. This is the reality governing organization, priorities and procedures within provincial health administrations. More federal money injected in the present fashion would be seized for a mix of relieving some of the stress on provincial finances and correcting some of the most criticized failings in current treatments. It would not free resources to create a healthier population.

To serve that purpose, the next federal-provincial agreement should make preventive measures a specific condition for part of Ottawa’s funding. This is one of two fundamental requirements. The other will change the way most primary care is delivered.
**Medicare’s corner store**

The family doctor was among the most highly respected of men. He responded to emergencies day and night. He made house calls in all weathers. He charged all he could, but mostly he did not press bills beyond a familiar patient’s ability to pay. He did all he could with the knowledge then available.

He belonged in times when medicine was far simpler than it is today. He has been out-dated as thoroughly as the corner grocery store has been replaced by the supermarket. The difference is that often, in health care, the corner store is still the only place to go.

No doctor alone can command anything near all the information now available to guide diagnosis and prescription. In some cases, what he (or, nowadays, she) can do with confidence could be at least as well done by the new breed of nurse-practitioner. A good many other patients can only be examined and referred on, either to wait for hours in the emergency room of an infection-breeding hospital or to wait for months to be seen by a specialist.

The better way now to deliver primary care is not in serious dispute. It is by a collegial group of doctors, nurses and other professionally trained personnel. Such groups are coming, but very slowly. The brake is the conservatism, particularly of older doctors, happy with their accustomed way of working and the fee-for-service remuneration that goes with it. The medical associations are politically powerful in their provinces. Awareness of their influence, reinforced still by memories of their strikes, makes provincial governments chary of getting into any confrontation. If the modernization of health care remains provincial business, much of it will continue to be decades late.

We would never have had Medicare, in any coherent nation-wide form, without federal leadership reinforced by federal dollars. Such leadership is equally necessary now, if we are to have Medicare that is fair, efficient and sustainable in this century. Modernization is not in sight unless Ottawa puts the provinces in a position where they can insist that their doctors adapt to the times. National politicians have everything to gain by leading the change. Reluctance within some of the medical profession can deter provincial governments, but surely it is not a force sufficient to intimidate Parliament.

**Smoothing transition**

My proposal therefore is that, from 2014, the federal government should stop financial support of Medicare as it is. Instead, federal dollars should become levers for modernizing medical practice. One effect will be that provincial health administrations can say to their doctors: “If the delivery of care does not move vigorously to group practice, there will be a good deal less funding for it.”
Specifically, from 2014 Ottawa will make no contribution to provincial expenditures that provide fee-for-service remuneration to individual primary-care physicians. It will make a significant contribution to the financing of group practices.

The purpose is simply to accelerate a change that is already happening and, every realist knows, must be carried much further if Canadians are to have good health care efficiently delivered at an acceptable tax cost. Disagreement will nevertheless be strong. Dislike of the upheaval will come not only from some medical trade unions but also from sections within provincial administrations.

There will be, as well, some voicing of a more fundamental objection: that the conditions proposed for cost-sharing will make it an abuse of the federal spending power. Quebec is not the only province that may advance this argument. It will be discussed later.

Dislike of upheaval can be accommodated by a little patience. Ottawa will not succeed in reform unless it is firm, but it does not have to be brusque. It has been all too slow itself. The transition to group practice will still take more than one year to complete. So will the proposed harnessing of resources for comprehensive care of pre-teens. The slower the progress, the less a province will meantime receive under the new funding conditions. Ottawa can provide a remedy. It can undertake that if funding falls below the 2013 amount, then for a transitional period the province will receive an interim transfer equal to the shortfall. Such an undertaking cannot, of course, be open-ended. A reasonable limit might be three years, after which failure to have completed the transition to group practice and develop teen-age care would hurt a province’s finances. Such a grace period would be enough to dismiss complaints of undue pressure while keeping a strong incentive to get on with job.

Practice together

The internal arrangements of group practices can be flexible. In particular, how its various members are paid can be left to decision within each group. It seems probable, and is certainly to be hoped, that most physicians will join their colleagues in some kind of salary base. Fee-for-service remuneration in Medicare has hitherto contributed to some doctors hurrying too much through too large a patient load, as well as to redundant testing and prescribing. However, group practice will in itself diminish such problems. It is not necessary to irritate the wounds of change by making the absence of fee-for-service, a compulsory condition.

The necessity is that the group be committed to providing full primary care to a roster of registered patients. For them it must have accessible electronic health records, not scribbles in paper files. The finance provided to the group will be scaled to the number of its registered patients, but the capitation base needs weighting by their ages and should also take account of relevant social conditions in the group’s area of service. Everywhere, there must be coverage for the costs of house calls by doctors and nurses, which are key to developing more and better home care.
In thinly populated areas, doctors and nurses have to be physically far apart. Secure electronic communications could, however, link them closely with each other and with supportive services from the nearest hospital. Such a form of group practice would overcome many of the limitations of solo doctoring in remote parts of the country.

A group practice cannot bar its doors against emergency service to non-registered patients, to people away from home or who have no regular doctor. Group practices are not, however, to be confused with walk-in clinics. The purpose of the revised funding is to give people the assurance of full primary care from a team committed to providing regular service.

Provincial health administrations will determine exactly how group practices in their jurisdictions operate and are financed. The diversities must be subject, however, to a common discipline. Decisions should be made with full consciousness of their costs to provincial treasuries. Reimbursement from Ottawa must therefore be limited to a minor share of the total cost. The level I suggest is 25%. It will then be significant without impairing responsibility.

There could well be a larger contribution, however, to the transitional costs of changing medical practice. Provinces may vary as to the extent to which they ease the process by providing either loans or grants for the initial, capital costs of setting up group practices. In either case, Ottawa could well offer to reimburse a substantial share of provincial outlays for that purpose.

**Health starts in youth**

The second part of the financial revision now proposed will put more resources into the prevention of sickness. To try to do so in a quick, sweeping move is out of the question. It would have one or other of two politically unacceptable requirements. Either total Medicare funding would be subject to large increases, in 2014 and in subsequent years. Or resources would be diverted from treatments to an extent that would greatly increase wait times.

The proposal is therefore to start where more preventive care will yield its greatest benefit. That is in youth. Good health through life is most effectively promoted the earlier preventive care is provided. My proposal is to concentrate federal funding on making Medicare at last truly comprehensive for pre-teen children. This means adding more than pharmacare. It will ensure regular check-ups, inoculations, nutritional supplements, dental and optical treatments, exercise facilities; in short, full care for health.

It may be necessary to begin with pre-school children only, but all pre-teenagers should be covered as soon as resources can be marshaled for the purpose. Substantial federal funding of such a program is the investment that will best control future health and social costs. It is also the way to take the heat out of the battle between federal and provincial politicians that has inhibited many national policies for the last fifteen years. Much as both sides like to shift blame to the other, neither could afford to be seen to be letting down the children. The
provinces would not have to fear a repetition of past federal reneging on promises to them. Equally, Ottawa could be confident of public pressure for efficient, fairly-costed delivery of provincial health services to children. It could safely commit to a large share of the costs, to 40% or perhaps even, for this purpose, a reversion to full, 50% cost-sharing.

How soon, and how far, comprehensive coverage can be extended, into teenage and beyond, is for later decision. Meantime, the requirements of economic and social policy combine with political appeal to make health for children by far the best basis for a fresh start to constructive collaboration between federal and provincial governments.

**But in case, an alternative**

The suggested federal offer of continuing finance from 2014 is, in summary, 25% of provincial payments for primary care provided by group practices to adults and children of teen age, plus an addition of up to another 25% for the costs of comprehensive care provided to pre-teens.

Such expenditure is proposed as the way in which the federal government can at present most effectively discharge, within the limits of financial probity, its clear national responsibility for a healthy population. By precedent, such as hospital insurance, as well in constitutional theory, it is an entirely valid exercise of the federal spending power. That cannot be expected, however, to deter some provinces, at least, from demanding instead a continuing block grant to use as they think best. Some may press the argument to the point of refusing money on conditions, claiming that unless they get the same money anyway they will take the issue to the Supreme Court.

While the eventual outcome would be in little doubt, that could dangerously set back the improvement of Medicare. To avoid such delay is Ottawa’s responsibility. It should not undertake reform without having a fall-back plan. If a province refuses conditionality, its funding stops. But there has to be a way to avoid passing the deprivation on to the province’s people. The fall-back should be to reimburse them directly, on a scale related to income, for medical services not covered by the provincial program. For most provinces for most people that now means prescription drugs, dental and optical care. If the province cuts back on existing services, the list could be extended. In any event, the aim would be to provide, in total compensation to individuals, as much as their government foregoes in federal finance available to it.

If this plan is known in advance, provincial politicians would have good reason to sidestep a jurisdictional dispute until some kind of settlement could materialize.

**Fundamentals**

The revision of funding meantime requires clarity on three points.
First, it does not in any way change the principles of the Canada Health Act. Federal dollars will be available only to support provincial health plans that make physician and hospital care universally accessible without charge. Far from weakening Medicare, the proposed new rules for funding will better ensure that its principles are fully observed.

Second, however, that assurance makes it more important than ever to dispose of the myth that the Canada Health Act prevents people getting private care if they want and can afford it. Globalization would now make such prohibition ineffective even if it were attempted. What can and should be ruled out is monetary discrimination within Medicare. That is to say, you cannot buy faster or better delivery of tax-financed care than other people get. Group practices will be entirely divorced from any kind of additional payment, while doctors who choose to pursue private practice cannot at the same time make any claim on public funding. The shift to groups will make the separation more effective than it now is.

Third, it should be clearly acknowledged that the specific funding of group practices may not be permanent. It is designed to secure a shift from the way most care is now delivered. To end it, when that purpose has been served, would not mean an old-style cut in federal funding. There would be due notice, with time to implement new financing. For example, that might be designed to induce less, but more efficient, utilization of hospitals. While the acceleration of recent years will not be retained, in total the 2013-14 level of federal contribution to health care costs, adjusted for inflation, will at least be sustained.

The past of dollars without leverage

Nevertheless, many people may be shocked by a proposal to make federal funding strictly conditional. Having been deeply involved in its development, and subsequently its implementation by the Pearson government, I have as much reason as anyone to relish what was achieved in the 1960s by a freer kind of funding. But nostalgia is not a prescription for effective action in a different time.

Cost-sharing as we knew it rested, like many arrangements public and private, on circumstances that did not last. It was a late product of Ottawa’s glory days. In war federal administration had been modernized, while provincial governments remained small and old-fashioned. A new national spirit and the expanding economy of the postwar years combined to sustain Ottawa’s dominance of the federation. So did Canada’s unaccustomed place in world affairs, feeding international respect for the quality of our government. Into the 1960s there seemed reason for confidence that new health and social programs would be firmly seen as made-in-Ottawa even though they were delivered by provincial governments.

It was therefore thought sufficient that federal legislation should define simply the principles of programs for which Ottawa would reimburse 50% of provincial expenditures. In the spirit of the times, federal politicians largely took it for granted that they would thereby earn continuing recognition of their leadership.
In fact, concentration on federal politics came to its dizzying peak in the Trudeaumania of 1968. It promptly slumped with the lack-luster performance of Trudeau’s first term. Ottawa opinion, political and bureaucratic, quickly became defensive, and therewith resentful of having to levy taxes for provincial governments to spend the money and in practice enjoy almost all the credit. Indignation mounted as the federal government became increasingly burdened by its failure to cope with the economic woes of the later 1970s.

The consequences of this disillusion have to be briefly recalled because they shape the kind of fiscal federalism that is practicable now.

**Ottawa’s great escape and re-capture**

What remained, for a time, was enough political skill to out-maneuver the provinces with “tax points” for health and post-secondary education. Ottawa reduced its own tax rates, so that the provinces could raise theirs without any net change for the public. The legislation ingeniously provided that the remaining cash transfer would diminish as rising incomes increased provincial revenues from the tax points. All element of cost-sharing would wither away, at speeds varying with the different fiscal situations of the provinces.

Nevertheless, for fifteen years Ottawa’s spin doctors largely got away with posing as the defenders of Medicare against untrustworthy provincial politicians. They claimed that revenue Ottawa could have had, if it had not stopped levying the taxes for it, nevertheless remained in some ethereal way a transfer to provincial treasuries. Only in the fanciful world of the federal finance department could such pretence survive the further slashing of transfers to the provinces in the 1995 budget. For the last five years of the century, federal support was plainly nothing but a small block grant, unrelated to what Medicare cost the provinces, and due to get still smaller.

This time, however, it was the provinces that gained public support. The dithering Martin government was driven to the 2004 “accord,” committing much more money until 2014. The provinces were gracious. Vague declarations of intent enabled Mr. Martin to say that the federal dollars were “buying change,” to claim that Ottawa was again exercising leadership in Medicare.

**Equalization within reason**

It was not. By its nature, no block grant can be the instrument of change in an established program. However labeled, the money is in truth no more than a supplement to the general transfer that Ottawa is constitutionally required to make in the name of equalization. A block grant helps further to lessen disparities in the range and quality of programs that provinces can finance while imposing similar rates of taxation. It does not determine the terms
of the programs or how provinces will allocate finance among them. It cannot secure coherent national standards in the major public services available to Canadians throughout the land.

In theory, pretence could be dropped. Block grants could be abolished in favour of full equalization. That is, one transfer of federally-raised dollars would be so big that it gave the governments of nine provinces the ability to spend as much per capita as Alberta, while taxing their residents at only the same rate as Alberta’s.

The reality, of course, is that federal politicians would be crazy to levy so much taxation without getting anything to show for it in their own programs, while making Albertans furious enough for separatist sentiment to become a serious impediment to inter-governmental business.

Fiscal federalism should indeed include as much of the constitutionally-enjoined equalization as is politically practicable. But it leaves major needs, nation-wide, that can be served only by some kind of direct federal funding.

*The spending power, with restraint*

That cannot mean again stimulating provinces to action by providing a defined share of their costs. The tribute to how successful it was in starting programs, years ago, is that such cost-sharing is still the mechanism commonly proposed by champions of good causes. The more unworldly waste their energy campaigning for it. Federal politicians may seek votes by talking about it, when they are in opposition, or in office but desperate. The Martin-led Liberals in 2005 promised to share the cost of new day-care places. Federal politicians at all confidently in office will toss out such a scheme as unceremoniously as the Harper Conservatives promptly did, to hardly a murmur of protest. The simple fact, it must be repeated, is that the 1950s and 1960s were unusual. Cost-sharing does not fit the normal politics of federalism.

The underlying problem, today, is that classical federalism has been replaced by a dilemma in governance. The interactions fashioned by contemporary technology are too close for any clear separation between federal and provincial responsibilities. Regulatory essentials can be implemented, national purposes can be served, only in collaboration. But if the two orders of government are thereby involved in joint use of their tax dollars, political contest for credit and conflict over administration are inevitable. Policy is confused, democratic accountability lost.

That is the federalism of present times. The change that will restore productive intergovernmental relations is to marry collaboration in purposes with separatism in dollars. Medicare is an exception only because there are, within its vast expense, priority needs critical to coherent national policy.
Unfortunately, there is a politically easier use of the federal spending power, not for programs but for particular projects. The constitutional division of jurisdictions confers on provinces, with their municipalities, most of the public works that can be glorified on billboards and at the ribbon-cutting ceremonies whose photo-ops politicians love. Cost-sharing is how Ottawa types buy places in the pictures. In that form, it will not easily go away. Where it is most used can conveniently coincide with the marginality of constituencies. Hence the preference, when economic stimulus is required, for infrastructure projects rather than the direct measures to increase incomes that would be far more effective.

The more the federal government properly spends for national purposes, the less it should poke its nose into local, and therefore provincial, business. Its dollars should not be serving the electoral interests of MPs with money for golf courses and museums, for particular causes and bodies. The provinces could reasonably demand an accord defining interventions that are off-limits for Ottawa. For the sake of its own finances, as well as in principle, the federal government should gladly concur.

**Ottawa’s dollars to people**

Apart from unemployment insurance, made possible by constitutional amendment, the first major social measure undertaken by Ottawa was a simple cheque paid directly to all mothers. The family allowance was not in itself enough to prevent all child poverty. It was a solid base on which provincial social assistance could build. But the building never went far, and has declined since the abolition of the Canada Assistance Plan. Parliamentary professions of good intent are of no avail. Many poor children everywhere in Canada will remain the victims of indifference as long as politicians in the two jurisdictions can each pass by, seeing them as being on the other side of the street.

Our public policies are thereby carelessly wasting part of our most important, and scarce, asset. The finest of health care will be of limited value for the health of children who grow up ill fed, in crowded houses, handicapped in recreation, deprived of the stimulus and resources to develop their talents.

There is a nation-wide solution, with a precedent more recent than the family allowance. That is the child tax credit, provided we recognize again that it is not the child’s but the family’s poverty that has to be corrected. The appropriate measure was sketched years ago by the Macdonald Royal Commission on Canada’s economic prospects. It is a guaranteed minimum income, which can now be readily administered as a refundable tax credit.

There will still be need for some provincial money. The income that puts you above the poverty line is appreciably higher in a large city than in a rural area, but someone in Toronto cannot have a bigger call on the national treasury than a similar person in Mabou. My suggestion is therefore a tax credit that raises individuals on low incomes to $15,000 a year, with an additional $5,000 a year for each dependant. This will bring families in most small
communities to just above the poverty level. It will leave provinces with the responsibility for supplements, notably to cover higher housing costs, in their larger towns and cities.

**Look to the children**

The time, it cannot be too much emphasized, is now. There is the base for a new national policy. The necessary degree of public consensus exists. What is lacking is creative will in our federal-provincial politics.

We cannot live on non-renewable resources. For reliable, prosperous employment we must export also the products of smart people. Our role in the contemporary economy depends, above all, on investment in our human capital. While academics may tend snobbishly to identify this with higher education, practical policy-making recognizes that widespread technocratic skills, rooted in numeracy and literacy, are equally part of the mix required by the Canadian economy. There is broad understanding, too, that young people are becoming the scarcest of our resources.

Canada outside Quebec lags far behind other well-to-do countries in early childhood care and education. Pleas for Ottawa to share the costs of grand new facilities are becoming common. The trouble is that they are projects well suited to the wishes of many educated parents in sizeable communities, but by no means universally desired there, and impracticable elsewhere. The democracy of any federal subsidy would be questionable, its permanence always in doubt.

There is a fairer, steadier alternative. The federal government now makes, for the child care expenses of working couples, a tax concession that, like so many of its kind, is valuable for wealthy parents but not for poor ones. Instead, Ottawa could reimburse part of such costs, on a sliding scale according to income. More importantly, it could institute a new program for early childhood care and education. Choice could lie with the parents, no doubt largely driven by the wishes common among offspring in the neighbourhood. Ottawa would stand ready to reimburse, again on a sliding scale related to income, between almost all or a small part of the fees paid for the preferred care. Facilities responsive to the demand might be provided by school boards, non-profit agencies, or local entrepreneurs. Provinces would certify and monitor them. The wealthier parents, paying largely from their own pockets, would help to ensure fee levels reasonably in line with the quality of the care provided.

What is here proposed is a developmental process more diverse and considerably more gradual than is prescribed by enthusiasts for sweeping government action on child care. That may come. But a more experimental start to federal financing is the way most likely to bring success in a purpose of too great long-term importance to be rushed to failure.
Empowerment

There is, however, a problem. Empowering the consumer, which is the essence of the proposed financing, does not appeal to politicians and bureaucrats. It does not give them as much credit and power as creating and administering programs. I learned that 55 years ago. The CCF government of Saskatchewan had introduced hospital insurance to Canada. Other provinces were under pressure to follow. Led by the Conservatives of Ontario, they were lobbying a reluctant St-Laurent government for federal cost-sharing.

Hospital insurance alone seemed to me a distortion of health care. If people still had to pay for treatment elsewhere, they would be too ready to go to hospitals and be kept there for long recovery periods. Hospitals would over-expand. And the system would be unfair to people with expensive incapacities that did not qualify them for hospital admission.

In editorial comment I suggested an alternative. Tax legislation then provided that any medical expenses over 3% of income could be deducted in arriving at the taxable amount. That was a great boon for well-to-do people, of little or no help to others. My proposal was to stand the provision on its head. The federal government should reimburse people for medical expenses in excess of 3% of family income.

That would have had its problems. An agreed schedule of allowable expenses would be necessary to control costs. Doctors and hospitals, if not banks and insurance companies, would need to develop bridge financing to cover the gap between expense and tax refund time. But the results would have been far more equitable than hospital insurance alone, and would not have produced its distortion of medical practice.

The suggestion nevertheless got no attention. It did not suit officialdom, and there was then little sophistication in public opinion about health care. We cannot now begin over. There can be only idle speculation about how Medicare might have evolved if it had been financed entirely through federal tax provisions.

Certainly, however, jostling between two jurisdictions has produced enough inadequacies and inefficiencies for the alternative to be worth trying on the smaller scale of early childhood care and development. For that, increasingly informed public opinion might strongly prefer a policy that accommodates varying preferences, rather than imposition of even the best of one-size-fits-all models.

After school

Elementary and secondary education is too deeply entrenched in provincial administration for Ottawa to push in with money. It has long been involved in post-secondary education, with considerable benefit to research. Provincial financing of the institutions in effect subsidizes students, rich and poor alike, but leaves a widespread need for borrowing.
The favourable terms of student loans necessitate arbitrary bureaucracy in administration, followed by erratic repayments and discriminatory forgiving.

Again, Ottawa could contribute more effectively, not through the provinces but directly to students. Its loans would be replaced by what are better called advances, adequate to cover the students’ costs. Instead of being dependent solely on administrative controls, moderation would be secured by charging interest, at the current full rate for bank loans, from the day each installment of an advance is drawn down. Repayment of capital and interest would be secured by a graduated sur-tax on subsequent earnings that are above the national average for full-time work.

The same principles and procedures could be incorporated in a national, federally-financed program of skills upgrading for unemployed and under-employed people.

An important reservation applies to both these programs. The advances must be available not to Canadian residents as such but to citizens only. Arrangements can then be made to ensure that repayment is not delayed or avoided if the beneficiary moves to work outside Canada.

**Paying**

It should also be noted about these post-secondary and training programs that government can borrow the capital for them, since it is fully repaid to the treasury, with interest, through sur-tax revenue. The only budgetary charge is a small allowance for cases where the beneficiary dies, or becomes incapable of earning anything above the national average, before recovery of the advance is complete.

However, refundable tax credits and child-care reimbursements will be expensive programs. Since this is so commonly taken to mean increased income tax, personal or corporate or both, I should note that in my view they could and should be decreased. This is not the place to elaborate the tax reforms that would result in more revenue both more fairly and to the advantage of the economy. (I have done so elsewhere.) However, one relatively minor tax change would contribute considerably to the modernization of Medicare. It was excluded from the earlier proposals in order to avoid suggesting that federal taxation is currently a matter for negotiation (as distinct from discussion) with the provinces. It is, however, appropriate for the conclusion of this paper.

**Taxing health care**

Few people have much consciousness of the costs of the care they receive. Doctors harried by some patients but consulted too little and late by others, have to decide what should be done with little incentive to take relative costs into account. Indeed, with fee-for-service
remuneration, as well as from caution, they have some incentive to over-doctor. Often the understandably strongest incentive is to prescribe something that will get a complaining patient out of the door without doing him or her any harm.

In other words, the ideologues of market economics are right in the sense that a degree of waste is inherent in tax-financed medicine. The remedy most often promoted – charging a user fee as a condition of service – would breach the fundamental principle of Medicare. If big enough to be more than an irritation to most people, it would deter some from a needed visit to the doctor. The fair alternative is to relate Medicare service to the graduated income tax, as is done for a benefit as important as Old Age Security.

Computerization would now make it simple to record, and total for the year, all the costs of the medical services received by an individual or family. It would be reported on the equivalent of a T4 slip, but with a difference. However large the amount, because of treatment for a serious illness, the most that would be taken into account, in calculating tax liability, would be a small percentage addition to the taxpayer’s income as otherwise assessed. In my view, a maximum 10% addition would be reasonable.

For people on low incomes, the extra tax would be little or nothing. At most, in the case of expensive treatment given to a wealthy person paying the top tax rate, it would be no more than a 2.9% increase to his federal tax otherwise. Each province would decide whether to make a parallel increase in its tax. In any event, as a further protection against hardship, the extra levy could be deferrable, without penalty, in cases of prolonged illness.

This procedure, for extra tax after the event, does not conflict with the Medicare principle of free access to care when needed. It is, however, an imposition on being sick. If you are so unlucky, you have afterwards to pay more tax than a healthy person with the same income. Certainly that is unfair. Is it more unfair than having seriously ill people wait for care because some with minor ailments or none are clogging doctors’ offices and hospitals?

That is the ethical question. The pressing political question is one of risk. Some misuse and waste of public money is clearly visible. Exaggerated, it can be a powerful weapon in the mounting argument that Medicare is too expensive to be sustained. In my judgment, its supporters need to look to their defences. A modest tax clawback of costs would help.

Defence will help, however, only if it is joined with constructive reform. There is good reason to believe that Canadian public opinion would respond readily to a political platform that emphasized the modernization of Medicare, a program that realigned it to do more for children and to be more effectively delivered through group practices. Not alone, but as part of that package, a fair way of recovering some of the cost through personal tax could be made an acceptable element in the financing of reform.
Conclusion

The requirement that is as yet missing, for the various components of constructive national policy, is courage and competence in the politics of our federalism. The importance of health, of education, of enterprise, of opportunities for all young people to develop and productively exercise their talents: all this Canadians now well understand. This unlikely country has come far thanks to the political skills that until now have generally been deployed in its leadership. Our future lies with any men and women, in federal and provincial affairs, who can revive those skills.