

*Constructive and Co-operative Federalism?
A Series of Commentaries on the Council of the Federation*

**The Health Council of Canada Proposal in light of the
Council of the Federation**

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Foreword

Canada's Provincial and Territorial Premiers agreed in July 2003 to create a new Council of the Federation to better manage their relations and ultimately to build a more constructive and cooperative relationship with the federal government. The Council's first meeting takes place October 24, 2003 in Quebec hosted by Premier Jean Charest.

This initiative holds some significant promise of establishing a renewed basis for more extensive collaboration among governments in Canada, but many details have yet to be worked out and several important issues arise that merit wider attention.

The Institute of Intergovernmental Relations at Queen's University and the Institute for Research on Public Policy in Montreal are jointly publishing this series of commentaries to encourage wider knowledge and discussion of the proposed Council, and to provoke further thought about the general state of intergovernmental relations in Canada today.

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Harvey Lazar
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The notion of the Council of the Federation has elicited much comment since the idea was first raised at the Annual Premiers Conference in early July of this year. Indeed, the Council was the lead item in the Premiers' five-point agenda to revitalize the federation that also included: annual First Ministers' Meetings; provincial-territorial consultations on federal appointments; devolution of powers to the 3 territories; and the establishment of federal-provincial-territorial protocols of conducts -- presumably similar to what had been set out in the Social Union Framework Agreement of 1999.

This is an agenda that speaks to improving collaboration within the federation while reforming some of its institutional machinery in order to "build a new era of constructive and cooperative federalism" in the Premiers' words. This is a laudable objective. Canadians are tiring of federal-provincial warfare and want their governments to collaborate so that this country's affairs can be conducted more effectively. In an era of greater policy interdependency, most reject an agenda of federal-provincial disentanglement in favour of greater cooperation between the two orders of government. In a recent poll conducted by the Centre for Research and Information on Canada (CRIC), the majority of residents in each

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part of Canada preferred that their respective governments “work most things out together” rather than “stay out of each other’s way.” Even in Quebec where the sentiment in favour of disentanglement was highest, 65 per cent still preferred an agenda of constructive engagement. The next lowest levels of support – 82 per cent – are in Ontario and Alberta. In the rest of Canada, support for constructive engagement varies from 85 per cent in Manitoba, 88 per cent in British Columbia, 91 per cent in Saskatchewan, and 94 per cent in the Atlantic Provinces.¹

Because of the absence of any institution with effective regional representation at the centre, executive federalism has of necessity been the instrument through which the necessary compromises and tradeoffs have been made between pan-Canadian objectives or imperatives on the one hand and regional/provincial needs and aspirations on the other. Canada is unique in that most federations do have a second chamber for regional representation.² However, our collective inability to transform the Senate into such a body, combined with the exercise of party discipline in the House of Commons that inhibits members of Parliament from acting in their local interests, has guaranteed that regional representation will continue to come almost exclusively from provincial and territorial governments. As a consequence, most intergovernmental collaboration is executive by definition. We have a complex tapestry of ministerial councils on health, education, social policy, energy, forest and fisheries as well as regular meetings of the ministers and deputy ministers responsible for justice, finance, social services, immigration, justice and numerous other portfolios plus a plethora of advisory and working committees. These are all part and parcel of executive federalism in Canada today, with the Annual Premiers Conference (APC) and the First Ministers Meeting (FMM) standing at the apex of this structure.

¹ For polling data source see:

http://cric.ca/en_html/opinion/opv5n30.html#file

² Ronald L. Watts, *Comparing Federal Systems* (Montreal and Kingston: McGill-Queen’s University Press, 1999), 92-98.

The original Health Council of Canada proposal

Given the sweeping nature of the Council of Federation proposal, another recent intergovernmental proposal seems to pale in comparison. In November, 2002, the Health Council of Canada (HCC) was proposed by the Commission on the Future of Health Care in Canada (chaired by Roy Romanow) in its final report.³ In reality, however, the HCC was originally conceived as a vehicle to resolve some of the most difficult intergovernmental disputes that have bedeviled the provinces and Ottawa in recent memory. In terms of objectives and structure, the HCC as originally proposed was in many respects as ambitious an undertaking as the Council of the Federation.

In its final report, the Romanow Commission recommended the creation of a HCC that could achieve three objectives:

- To create an intergovernmental body that could minimize the conflict, mistrust, and dysfunctionality that currently characterize federal-provincial relations on health care;
- To provide stable and long-term national leadership that will provide clearer direction for any major changes through strategic analysis and advice to federal, provincial, and territorial health ministers and deputy ministers; and
- To allow for some degree of public input in the deliberations of such a Council so that the public (who own and use the system), providers (who work in the system), and experts (who study the system) can help improve the recommendations of the HCC to all Canadian governments.

The original idea was to have the HCC provide Canadians with an annual performance report concerning:

- The health of Canadians, showing variations across the country and changes over time with international comparisons;
- The performance of the health care system, noting significant variations across the

³ *Building on Values: The Future of Health Care in Canada* (Saskatoon: Commission on the Future of Health Care in Canada, 2002), 52-58.

country, again with international comparisons;

- Progress made in developing common indicators and performance measures, including waiting times for certain services and treatments as well as challenges in rural and remote areas;
- The results achieved by the myriad of intergovernmental structures, agencies, and organizations in health, providing recommendations for improvement;
- The trends in the supply and distribution of health care providers;
- Best practices in Canada in terms of initiatives improving access to health services, the quality of health services, and the efficiency of their delivery;
- Disseminating outcomes on technology assessments that are of broad interest to the public and providers;
- Progress on primary health care initiatives; and
- Issues in dispute among governments in Canada and how they are ultimately resolved.

The HCC's suggested structure, described in the box below, is based upon a regional – rather than a strictly provincial – model of equal representation. It differs from typical regional models in allocating one appointment to the three northern territories, a recognition by the Romanow Commission of the great challenges facing such governments in the provision of health care for a host of geographic, cultural, and population health reasons. During the past three decades of constitutional negotiations in Canada, there has been some debate over whether the provinces fit a four-region or five-region model. The Romanow Commission suggested a four-region model but compelling arguments can also be made for adding British Columbia as a separate region, increasing the total number of *direct* government appointees from 7 to 8, producing a final board of 15 members. The remaining 7 board members were to be drawn from the public, providers (including health managers), and experts within the country. Although the selection process was left open, it was assumed by the Romanow Commission that governments would ultimately make the

appointments, hopefully on the basis of quality. It was hoped, however, that the chair of the HCC would be selected directly by the board in the hope that this would ensure that the chair was accountable first and foremost to the HCC as an organization.

Romanow Commission's (2002) suggested Structure for Health Council of Canada

Membership

A 14-member board appointed by consensus of federal, provincial and territorial health ministers and comprised of the following:

- 3 representatives of the public
- 4 representatives of the provider and expert community recognized for their competence in health policy and practice
- 7 government appointees selected as follows:
 - 1 appointed by consensus of the governments of the Yukon, Northwest Territories and Nunavut
 - 1 appointed by consensus of the governments of British Columbia, Alberta, Saskatchewan and Manitoba
 - 1 appointed by Ontario
 - 1 appointed by Québec
 - 1 appointed by consensus of the governments of New Brunswick, Nova Scotia, Prince Edward Island, and Newfoundland and Labrador
 - 2 appointed by the government of Canada

Selection

- Board members would be appointed for a three-year term, with the possibility of one reappointment for an additional three years.
- Board members would hold a formal fiduciary responsibility to the Health Council Board; Board membership should be “personal” to the individual and should not depend on or change with a change in the board member's current employment.
- Regional appointees would require the consensus approval of the jurisdictions in that region, and all participating jurisdictions should have an opportunity to have their representative sit on the Board over time.
- To ensure that the Chair of the Board is clearly accountable to the Health Council and to signal the independence of the Council, the Chair of the Board should be selected from among board members by the Board itself. The nominee selected by the Board should be presented to federal, provincial and territorial ministers for consensus confirmation.

The Actual Health Council of Canada: A Work in Progress

Through 2003, federal/provincial/territorial (F/P/T) negotiations have produced somewhat different structure as set out in the box below. First, powerful provinces such as Alberta, British Columbia and Ontario were skeptical of the need for a HCC. These provinces had agreed in principle to the establishment of a “Health Council to monitor and make annual public reports” in the First Ministers’ Accord on Health Care Renewal on February 5, 2003. But Alberta in particular continued to drag its feet on implementation to the point that health ministers were forced to miss the three month deadline for the establishment of the HCC. Second, the then PQ government of Québec opted out of the HCC immediately by promising to create a mirror organization (Québec’s Council on Health and Welfare with a new mandate) that would collaborate with the HCC, a position that was acceded to by all other first ministers in the February 5th Accord. (I discuss the position of the new Quebec government under Jean Charest below.)

Not surprisingly, some provinces such as Alberta – a long-time proponent of provincial equality – opposed a regional model of representation. Instead, a model of strict provincial and territorial equality was adopted in which each participating jurisdiction would have one government representative and one so-called public/expert representative. This brings the board total to 27 representatives, including the Chair. The final selection of board members should be made by F/P/T ministers of health before the end of this calendar year. By that time, the mandate and role of the HCC will be finalized and submitted to first ministers for their approval. A more detailed comparison of the HCC mandate and role as set out in the Romanow report relative to the actual mandate and role of the HCC will have to wait until that time.

The F/P/T negotiations on the HCC were mired in controversy from the beginning. Part of the problem stemmed from the fact that, while accepting the Romanow Commission’s recommendation on the need for a new intergovernmental structure for health governance, Ottawa did not provide the full amount of transfer funding recommended by Romanow. In addition, the federal government

did not transform the existing cash/tax transfer into a pure cash transfer, also as Romanow recommended, adding confusion to an already heated debate. Some provinces retaliated by trying to limit the scope of the HCC while at least one other province – Alberta – characterized it as a “federal watchdog agency”.

F/P/T Health Ministers (2003) Preliminary Structure for Health Council of Canada

Membership

A 27-member board appointed by consensus of federal, provincial and territorial health ministers and comprised of the following:

- 13 expert and/or public representatives based on the nominations of each jurisdiction
- 13 government representatives directly appointed by each of nine provinces (all but Quebec), three territories and the federal government
- 1 Chair nominated by consensus of the ministers of health [conflicts with point made in text]

Selection

- Length of term and reappointment criteria not yet finalized.
- Fiduciary responsibility of board members not yet determined but decision made to have HCC “report through” F/P/T ministers of health.
- Expert and/or public representatives will be drawn from pool of 52 candidates (4 selected by each jurisdiction) by consensus of federal, provincial and territorial health ministers.
- The Chair will be selected by consensus of F/P/T health ministers.

Two Outstanding Features of the Current HCC

The potential health policy benefits of an intergovernmental health council have been discussed for many years.⁴ The idea of the health

⁴ For a summary of these earlier proposals, see Duane Adams, “Conclusions: Proposals for Advancing Federalism, Democracy and Governance of the Canadian Health System,” in Duane Adams, ed., *Federalism, Democracy and Health Policy in Canada* (Montreal and Kingston: McGill-Queen’s University Press, 2001): 271-306.

council was then refined and extended by the Romanow Commission with both health policy and intergovernmental objectives in mind, and the HCC currently being established has two features that are of potentially great importance for the future of Canadian federalism. The first feature is that the province of Quebec has once again opted out of this partnership in favour of creating its own health council. Although the provincial government promises that its health council will cooperate with the “national” health council, the position entrenches the strategy of “parallelism” that had become the orthodoxy of successive governments in Quebec City.

Parti Québécois administrations in particular have been very explicit about the degree and nature of participation in various intergovernmental bodies that have sprung up in the postwar period in response to the need for federal-provincial collaboration on numerous policy and program fronts. This policy goes beyond simply not participating in pan-Canadian intergovernmental agencies, or restricting such participation to observer status. As in the case of the Quebec health council, it sometimes involves creating parallel institutions within Quebec that replicate the function (and often the form) of various F/P/T institutions. In the health field, this means that Quebec is not a formal partner in a number of the most important F/P/T agencies and arms length bodies created in the 1990s including Canadian Blood Services, the Canadian Coordinating Office for Health Technology (CCOHTA), Canadian Institute for Health Information (CIHI), and Canada Health Infoway, despite the fact that the latter has its head office in Montréal. In addition, the government of Québec has created some parallel institutions, including *Hema-Québec* and *Agence d'évaluation des technologies et des mode d'intervention en santé*, as alternatives to participating in Canadian Blood Services and CCOHTA. Currently the CIHI mandate and function is split between two agencies in Quebec – the *Institut de la statistique de Québec* and the *Institut national de santé publique du Québec*.

This is a particularly unfortunate development given what Québec – historically a leader in many areas of health care reform and institutional experimentation – could offer the rest of its partners in the federation. And despite the benefits that Québec’s observer status in the pan-Canadian agencies might deliver to that

province, it puts a limit on what Québec can learn from its other Canadian partners. It is also disappointing that a provincial Liberal government led by a federalist premier has made no major effort to change this mode of intergovernmental engagement. Indeed, because of Québec’s decision to continue on with its own health council rather than work within the proposed HCC, the Charest government appears to have adopted the policy of “parallelism” as its own.

The second outstanding feature of the HCC is that it is an organization that involves a partnership among the provinces, the territories and the federal government. As such, the HCC bears little relationship to the Council of the Federation as proposed by the premiers since the latter has so far been restricted to a provincial-territorial (P/T) body. More importantly, the proposed Council of the Federation is not likely to have a pro-active mandate in the way it is currently designed. As a slightly more formalized Annual Premiers’ Council (APC), it will likely serve only to reinforce the current tendency of premiers to get together principally to fashion a common position against Ottawa. In most cases, this will emerge as a demand for an increase in transfer payments and/or to provide additional tax points.⁵

Why do I presume this to be the case when the Council of the Federation has not even begun operating? It is a logical inference based upon the two immediate priorities given to the Council’s first permanent secretariat. Out of the many policy and program issues crying out for improved inter-provincial coordination and collaboration, the premiers have asked their officials within the nascent Council to focus on the “structural fiscal imbalance” between the provinces and Ottawa, and to take over the work previously done by the Premiers’ Council on Canadian Health Awareness, a fancy name for an advertising campaign decrying, in a manner that played fast and loose with the facts, Ottawa’s reductions in health care transfers. Both have to do with money: money that Ottawa collects, and that the provinces argue should come their way

⁵ Gregory P. Marchildon, “A Proposal for an Effective Council of the Federation”, *Opinion Canada*, Vol. 5, no. 30, Sept. 4, 2003: http://www.cric.ca/en_html/opinion/opv5n30.html

given their onerous social policy responsibilities, particularly for health care.

A true Council of the Federation would ideally include all the members of the federation. And despite the degree of decentralization that may have taken place in Canada during the past three decades, the federal government remains an important partner. To build a more powerful agency of the premiers at this time may simply serve to reinforce the cleavage between the two constitutionally recognized orders of government. The most likely end product of a P/T Council of the Federation will be a bargaining position vis-à-vis Ottawa. In contrast, a F/P/T Council of the Federation would begin with a bargaining position but hopefully end with the tradeoffs and compromises necessary to produce a “national” solution acceptable to most if not all parties. This is the same logic behind the establishment of a F/P/T Health Council of Canada.

That said, we must all recognize the inherent limitations and democratic shortcomings of all intergovernmental institutions, whether P/T or F/P/T, including the HCC with its expert/public input. At the end of the day, each partner in the federation is responsible to the people through its own legislature. Parliamentary accountability requires that the ten provinces, three territories and the federal government must answer for their policies and programs within their own democratically elected legislatures, even when these programs have intergovernmental dimensions. For this reason, intergovernmental bodies must remain non-legal and consensual instruments. They are not a substitute for any parliament or legislature.

Conclusion: Implications for the Future of Canadian Federalism

The HCC will become an instrument to revitalize the federation to the extent that it can achieve both health policy and intergovernmental objectives. This will require both proper design as well as the political will and desire of F/P/T governments to cooperate through such an intergovernmental agency. In some ways, intergovernmental cooperation in one particular sector of social policy – as complex as health care is – may be easier than achieving effective cooperation in a larger instrument such as an F/P/T Council of the Federation. Nonetheless, it is possible that the HCC could be used to test out

the concept, and the lessons learned could be used in eventually establishing a more ambitious F/P/T Council of the Federation.

As argued, it is unlikely that a P/T Council of the Federation would improve the current intergovernmental environment. At the same time, if the federal government shows no interest in moving from the current model of First Ministers meetings in which it controls the timing and the agenda of meeting, to a more collaborative Council of the Federation model, then this will add fuel to current arguments in favour of the P/T model. If this occurs, then it is likely that the HCC, based as it is on a different model involving the central government, will soon come into conflict with the Council of the Federation, which is bound to take an adversarial position with Ottawa concerning health care and its funding.

That said, there remains a historic opportunity, particularly regarding the role of Quebec. As the province that has led the charge for a new Council of the Federation, it can convince the other provinces that there may be merit in the F/P/T Council of the Federation so long as the provinces’ role is equal to the federal government’s in terms of chairing the meetings and setting the agendas. The Charest government can also take a major step by agreeing to become a full partner in the Health Council of Canada and bringing to an end the policy of disengagement and parallelism that has dominated the Quebec approach to intergovernmental relations for the past generation. This would do more to usher in a real era of collaborative federalism than virtually any other single change in the months to come.