

The Changing Landscape of Canadian Health Care: The Rise of Non-Core Services and the Need for an Expanded Federal Role

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The Changing Landscape of Canadian Health Care: The Rise of Non-Core Services and the Need for an Expanded Federal Role

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Abstract

For many, Canada's health care system is a hallmark of the Canadian identity. While the *Canada Health Act* (1984) lays out national standards for hospital and physician services and provides the foundation for Canada's health care system, the increasing prominence of non-core services is changing the health policy landscape. While provinces and territories have provided reasonably comparable core services with limited federal leadership, this paper presents evidence revealing significant inter-jurisdictional variability in non-core services. By demonstrating how variations in access to non-core services jeopardize national values of equality and fairness, this paper presents arguments in support of an expanded federal role in the provision and standardization of non-core services.

Introduction

The findings from a March 2012 report on Canadians' attitudes toward their health care system, commissioned by Health Canada, indicate that many Canadians are concerned about the current and future state of health care in Canada. The report surveyed 2,500 Canadians and concluded "a general perception among participants was that Canada's universal single-tier health-care system is currently or at risk of losing its claim to be universal in scope" (Butler 2012). At the same time, while the report noted that most participants view Canada's system as overburdened, the majority still view it as sustainable.

Despite widespread views that Canada's health system remains

sustainable, studies show that total public sector spending on health care increased at an average annual rate of 7.4 percent between 1998 and 2008 (CIHI 2011). As costs increase, new and existing health challenges such as wait times, human resources, home care, primary care, electronic health records, access to care in the North, affordable prescription drugs and accountability will require increasingly innovative solutions to address adequately. Faced with pressing and widely shared problems, Canadians in the past have demanded leadership and action from their governments, which has often been undertaken by the federal government (Bickerton 2010:69).

Previous governments have attempted to forge links between citizenship and health care. In spite of widespread funding cuts in the 1990s and notwithstanding the fact that health care delivery and financing falls within the jurisdiction of provincial and territorial governments, Prime Minister Jean Chrétien, for example, commissioned two reports – the National Forum on Health and the Commission on the Future of Health Care. Each of these reinforced Prime Minister Chrétien’s pan-Canadian vision and demonstrated his desire to show moral authority in the realm of health (Maioni 2010:230). As Canada’s health care system continues to be stretched by funding and sustainability issues, and increasingly faces a number of borderless issues such as public health, pandemics and infectious disease, it seems reasonable to presume that federal involvement in Canadian health policy will increase.

Indeed, provinces have consistently demanded greater involvement from the federal government by way of fiscal resources to help meet their increasing public health expenditures, while at the same time demanding more flexibility on how to spend federal transfer payments (Marchildon 2005:10). Unlike recent Liberal governments, the Conservative Government under Stephen Harper unilaterally unveiled a non-negotiable funding plan that runs to 2024. The plan, which currently places no demands on how the money is spent, stipulates that federal health-care transfers will continue to increase by six per cent until 2016-17, and will then be tied to economic growth (Juneau 2011). While previous Liberal governments have attached significant normative weight to the value of shared social citizenship and the provisions of the *Canada Health Act* (CHA), Prime Minister Harper appears to be taking a step away from federal leadership in health care, thereby assigning greater importance to territorial diversity and individual provincial decisions.

When looking at health care policy in Canada, therefore, it becomes evident that a significant tension exists between the value of shared social citizenship and diversity. On the one hand, social citizenship extends social rights to all citizens in a federation. On the other hand, federalism allows for territorial diversity as constituent units make diverse choices about social policies and their attendant rights (Graefe 2008:206). Indeed, this tension inhabits Canada's federal-provincial relationship and raises questions about shared and divided identities and debates over who pays and who decides (Maioni 2010:240). More

specific to health policy, is whether federal leadership is needed to ensure the adequate delivery of health care services to Canadians on an equal basis.

Keeping this federalism tension at the centre of its analysis, this paper proceeds in three parts. The first part fleshes out the tension by examining and defining the CHA and discusses how recent federal governments have addressed these pressures. This section discusses the five CHA principles in detail and notes the links between Medicare, Canadian citizenship and equity. Given the tendency for federations to adopt national standards to reconcile differences in comparability, the second part discusses Canada's education policy to illustrate how national standards may not be a necessary condition to achieve interprovincial similarity (Wallner 2009:654). While provinces and territories have been able to provide reasonably comparable levels of physician and hospital services without explicit national standards, significant interprovincial variations in non-core services require a greater federal role. To demonstrate this variability, this section also discusses interprovincial variations in home-care, long-term care and prescription drug strategies and explores how unequal access to such services lead to increased inequality.

Lastly, the third section discusses areas of public and mental health, and how the federal government has taken a leadership role within these areas. This section draws attention to the Mental Health Commission of Canada (MHCC) and the Public Health Agency of Canada (PHAC), and discusses how federal

leadership in these areas has led to increased similarity and equality across the country. As non-core services falling outside the CHA increasingly dominate the health policy arena, it becomes clear that greater federal leadership may be required to maintain national values of equity and fairness. This paper argues that, while provinces have been able to provide reasonably comparable core services with limited federal leadership, a greater federal role is needed to ensure inter-provincial comparability of non-core services. This argument is in line with an overarching understanding that Medicare is a Canadian undertaking embodying values that extend beyond provincial borders.

Part 1: The *Canada Health Act* and Ensuing Tensions

Within the next 10 years, health care policy in Canada will become increasingly urgent yet challenging to address. Notwithstanding the intergovernmental challenges involved, limited financial and human resources will coincide with access issues and growing concerns about quality and safety. Other issues complicating the health care landscape are shifts towards team- and community-based care, the expansion in scope and practice for some non-physician providers, and an increased need to ensure the affordability of drugs. While each of these issues would be difficult to address individually, the ongoing tug-of-war and competing imperatives between the federal government and individual provinces make health care policy particularly challenging. It is not surprising, therefore, that senior government officials make reference to the “healthcare monster,” a beast that is progressively harder to reckon with and

evermore difficult to maintain (Stuart and Adams 2007:96).

Spending on healthcare in Canada appears to outpace growth in overall government program spending and economic growth, making the sustainability challenge even more difficult to address. A 2005 study indicated that if Ontario's spending continues down its current course, health care will consume more than 70 percent of its total revenues by 2022 (2005 Conference Board of Canada). Similarly, another study showed that if British Columbia maintains its current rate of spending, it will spend 71 percent of its revenue on health care by 2017 (Stuart and Adams 2007:97).

While Stuart and Adams present some of the most extreme examples, it is important to discuss more nuanced arguments to gain a comprehensive understanding of sustainability and health care. As a 2008 Report from the Health Council of Canada points out, total government expenditures on health care during the mid 2000s remained relatively flat. When the Conservative Government cut taxes and spending in other non-health sectors in 2006, however, health care spending expressed as a percentage of the government budget appeared to increase sharply and take up a greater portion of the shrinking pie (Health Council of Canada 2008:2).

Put differently, government spending as a percentage of GDP on services covered by the CHA has not changed much since the 1990s (CHSRF 2007).

What have increased significantly are areas and services that fall outside the scope of the CHA, services that are generally financed through a combination of public, private and out-of-pocket payments. For example, expenditures on prescription drugs have more than tripled their share of the GDP since 1990 (CHSRF 2007). For the purposes of this paper, it is important to note that non-core services are becoming increasingly expensive, while expenditures on doctors and hospitals remain relatively constant.

While provinces and territories are constitutionally responsible for health care in Canada, the federal government has jurisdiction over prescription drug regulation and safety, as well as the responsibility for health care for selected groups, including First Nations people living on reserves, members of the armed forces, veterans, the Royal Canadian Mounted Police (RCMP) and inmates of federal prisons (Marchildon 2005:25). The federal government is also responsible for other health-related activities, including the regulation and safety of therapeutic and natural health products, and funds major intergovernmental initiatives including the Health Council of Canada, Canada Health Infoway and the Canadian Patient Safety Institute (Marchildon 2005:29).

Despite federal jurisdiction in these particular areas, the major federal role in Canadian health care is fiscal. That is, to compensate for differences in fiscal capacity across the country, the federal government transfers funds to provinces to ensure that provincial health care complies with a set of national principles,

currently specified in the CHA. Though provinces are the primary actors in Canada's health care policy, the CHA allocates a prominent place for the federal government in the health policy environment and in Canadians' perceptions of the health care system (Maioni 2010:231). The CHA also blurs the jurisdictional line, ensuring that health will continue to be implicitly shared between the provinces and the federal government (Maslove 2012).

Canada Health Act

Passed in 1984, the CHA is the federal act that governs the operation of health care insurance and standards. The CHA stipulates that the "primary objective" of federal involvement is to "facilitate reasonable access to health services without financial or other barriers," (CHA 5) ensuring that every Canadian has the same ability to access the health care system. Consequently, the CHA includes strict standards to which the provinces will be held, such as no extra billing and a ban on user fees (Maioni 2010:233). Even though the legal scope of the CHA is explicitly limited to the cash transfers the federal government is prepared to deploy, the symbolic scope of the CHA goes much farther (Maioni 2002:6). The Act increases the federal role in health care, and gives insured services a pan-Canadian character. For a province or territory to receive the full amount from the Act, it must satisfy five basic principles: (i) comprehensiveness, (ii) public administration, (iii) universality, (iv) portability and (v) accessibility.

CHA Principles Defined

i) Comprehensiveness

The comprehensiveness principle provides the minimum standard upon which provinces must insure health services. The definition serves as a floor rather than a ceiling as provinces are allowed, but not required, to insure beyond these limits (Deber 2010:337). At the bare minimum, provinces must cover “all insured health services provided by hospitals, medical practitioners or dentists” (CHA 6). Most generally, “insured health services” refers to “medically necessary” hospital services or “medically required” physician services (CHA 3). The funding of these core services remains relatively consistent across jurisdictions, helping contribute to a pan-Canadian vision.

In contrast, a second category involving provincial programs and subsidies does not adhere to any unifying national features and varies from jurisdiction to jurisdiction. Among other things, care falling outside the CHA provisions include: home care; public health; mental health services; dental care; vision care; prescription drugs, and assistive devices (Deber 2010:337). The extent of what we might wish to call “non-core” services suggests that while public coverage may be deep (no user fees), it is also very narrow and focuses almost exclusively on hospital and physician services (Marchildon 2005:119).

Since different jurisdictions provide funding for different baskets of non-core services, it is often difficult to speak of one national health care system in

Canada. Rather, it is perhaps more accurate to speak of 14 publically funded health systems with many points of decision-making and influence inside them (CIHI 2011:3). Manitoba's health coverage, for example, insures a maximum of 12 chiropractic visits per Manitoba resident per calendar year (Government of Manitoba - Health). In contrast, provincial insurance plans in Ontario or Alberta do not cover chiropractic services. Because each province is responsible for determining eligibility criteria, inter-provincial coverage for non-core services can vary depending on different characteristics such as age, disease or income (CHSRF 2011:2).

ii) Public Administration

For many, the public administration condition is the most frequently misunderstood as it deals with insurance plans rather than delivery (Deber 2010:337). Specifically, in order to deter private insurers from covering insured services, a province's health care insurance "must be administered and operated on a non-profit basis by a public authority" (CHA 6). While the CHA does not preclude the participation of for-profit firms provided they are publically funded, the increasing prominence of non-core services suggest that private firms may become more prominent in Canada's health care system. The increasing prominence of for-profit firms in providing non-core services may lead to a situation where access to health-care services will increasingly depend on the availability of private insurance or on the ability to pay out-of-pocket (Asiskovitch 2008:12).

iii) Universality

The universality criterion requires a provincial plan to entitle 100 percent of provincial residents to receive medically necessary hospital services and medically required physician services on uniform terms and conditions (CHA 6). Though many assume that Canada's health system already provides universal access to all Canadians, the provision only covers hospital and physician services. As non-core services become increasingly prominent, however, there will be a greater need for universality for some services falling outside the CHA.

iv) Portability

Since each province has a distinct health care system and is organized on a provincial basis, the portability principle establishes criteria for handling Canadians requiring care in a province other than the one in which they are insured. Specifically, the CHA requires provincial plans to insure all residents within three months of arrival in the province (CHA 7). Following three months in a different province, the current province of residence's provincial plan takes over. This provision reinforces the pan-Canadian nature of Medicare and ensures continual access for insured health services, regardless of province of residence.

There is evidence, however, that the portability principle is being eroded. For example, because doctors in Quebec are paid roughly 30 percent less than their counterparts elsewhere in the country, many Quebec doctors have either moved to private clinics or to other provinces (Alphonso 2012). As a result, non-urgent medical procedures in Quebec often involve significant wait times, and

compel Quebecers to seek treatment in other provinces.

In theory, while the portability principle ensures that every Canadian is entitled to full medical coverage regardless of his or her province of residence, Quebec patients are often turned away or pay out-of-pocket for medical services outside their home province. This is largely due to the fact that physicians outside Quebec are not reimbursed fully by the Quebec government for the health services performed (Alphonso 2012), which results in a lack of access and affordability for certain residents of Quebec. Moving forward, given the pan-Canadian nature of Medicare and the importance of providing equal access for hospital and physician services, the apparent erosion of the portability principle represents a significant challenge that policymakers will need to address.

v) Accessibility

Lastly, the accessibility provision is a necessary component of all insurance programs. Indeed, in order to utilize provisions in any insurance program, one must be able to access it. Consequently, the CHA stipulates that provinces must ensure that Canadians have “reasonable access” to services, that physicians are paid “reasonable compensation” for services, and that hospitals are reimbursed for the cost of insured health services (CHA 8).

While neither reasonable access nor reasonable compensation are defined in the CHA, it is a widely held view that Canadians should be able to receive and access insured health services on a uniform basis without any

financial barriers. As care is shifting from the hospital to the home or community, a change in the site of care can potentially result in a shift of who pays for services, as well as who delivers health care. There are also significant challenges to the delivery of health care in terms of the range, quality and cost of services offered to rural populations, and how accessible and timely health care can be difficult to achieve for these segments of the population. Moving forward, as non-core services become more prevalent, it may be useful to define reasonable access as well as concerns regarding timeliness of treatment.

CHA and Federalism

While an explanation of the CHA provisions provide a useful introduction, it is necessary to discuss them within the broader context of Canadian federalism. Understanding these underlying dynamics, moreover, is also important within the context of reform as policy innovations could be ineffective due to a lack of understanding. Most broadly, a distinguishing feature of federalism is that it is always pointed in two contrary directions or aimed at securing two contrary ends (Diamond 1973:129). The most basic tension involves the desire for autonomy and the desire to be part of a larger whole, that is, between self-rule and shared-rule (Bakvis 2009).

For Canadian health policy, a significant tension exists between federalism and the welfare state. On the one hand, provinces have a right to preserve diversity and pursue alternative pathways to health care. On the other

hand, the federal government promises social citizenship and the equal treatment of citizens, to be achieved through common social benefits (Wallner 2010:44). Striking a balance depends on the relative normative weight one attaches to the value of shared social citizenship versus diversity, though no right balance exists. This ongoing tension creates significant conflict between the provinces and the federal government, though debate could also help transform Canadian health policy into a more efficient and equitable system. Most importantly, debates over shared and divided identities, as well as who pays and who decides, are at the heart of the relationship between health care and citizenship (Maioni 2010:240).

Some studies, for example, have concluded that federalism and decentralization have created barriers that constrain the underlying goals of a welfare state. In particular, by increasing the number of sites of political representation, the number of veto points at which action can be delayed or defeated has multiplied (Banting 2002:3). Those who are against cross-national social spending, of course, have used this argument to claim that authority and the ability to act lies exclusively with regional or provincial health bodies. Though no right answer exists, it does show the complexity of decision-making in federal states and how different intergovernmental arrangements can have significant impacts.

As described earlier, health is considered a provincial/territorial

responsibility, in part due to the *Constitution Act 1867* stating provincial responsibility for “the Establishment, Maintenance, and Management of Hospitals, Asylums, Charities, and Eleemosynary Institutions in and for the Province, other than marine Hospitals” (Section 45 *Constitution Act, 1867*). Though health care delivery is highly decentralized and provinces have a relatively high degree of autonomy to spend and deliver health care within their jurisdiction, there remains a certain dependence on the federal government with respect to the CHA and the Canada Health Transfer (CHT) since provinces have very little impact on federal decisions within these areas (Maioni 2010:236). As a result, the federal government has been able to retain a level of control over health care policy and the manner in which provinces can spend their health care transfers.

It is useful here to point out how previous federal governments have viewed their role within the larger context of Canadian health policy. Since the passing of the CHA, subsequent Liberal governments have sought to create a direct linkage between Canadian citizenship and Canada’s health care system (Maioni 2010:230). This view is consistent with collaborative federalism whereby provincial and federal governments work together to respond to complex public policy problems on the basis of an equal partnership. For many Canadians, this stance is in line with what many consider to be the touchstones of a just and fair health care system.

In 2001, for example, Prime Minister Jean Chrétien established the Commission on the Future of Health Care in Canada to review Medicare, engage Canadians in a national dialogue on its future, and make recommendations to enhance the system's quality and sustainability (Romanow 2002). Known as the Romanow Report, the flagship document underlined the importance of pan-Canadian citizenship and the importance of the central government's powers for the overall functioning of public health services. While the Report notes that provinces are central actors in the discussion of what health policies to adopt and how best to implement them, claims of provincial diversity were swamped by claims of Canadian citizenship (Graefe 2008:203).

In particular, in spite of its acknowledgement of the division of powers, the Report suggests that framers of the 1867 Constitution could not have predicted the modern assumptions and meanings of health care (Romanow 2002:3). For many analysts, during the 60 years between the Rowell-Sirois and the Romanow commissions, respecting the division of powers went from being a central concern, to being a sufficient concern in the Hall Report, to being one important concern among others in the context of a more wide-open use of the federal spending power (Graefe 2008:205). Though not obvious, this trend of diluting provincial autonomy has figured prominently in Canada's health care dynamics for the past 15 years. Given the December 2011 announcement by the Conservative Government that stipulates a new health care fee structure, the pendulum may begin to swing back to provincial autonomy and minimal federal

intervention. This dynamic and its implications will be discussed in greater detail below.

Most of the Romanow Report's recommendations were heavily focused on "the national dimensions of Medicare" (Romanow 2002:68), such as the creation of a Health Covenant and a Health Council, and sought to shift the discussion away from intergovernmental diversity towards pan-Canadian institutions. The Report also emphasized the role of citizens in policy-making and in the essential values that Canadians have imbued in their health care system (Maioni 2010:237). By consistently transferring decision-making power away from the provinces and towards citizens and national institutions, the Report further eroded the basis for provincial autonomy, which was consistent with Prime Minister Chrétien's overall view.

Not surprisingly, Prime Minister Chrétien's pan-Canadian vision, in addition to the sharp, unilateral reduction in federal transfer payments to the provinces in 1995, increased tension between the federal government and the provinces. Indeed, provinces became wary of federal funding programs and demanded more autonomy and less federal interference in areas of provincial jurisdiction. Not only did the centralizing tendencies and the decisions to cut provincial transfers create a significant vertical fiscal imbalance, intergovernmental relations during this period, and consequently health policy, were tainted by distrust and uncertainty (Bickerton 2010:59).

Prime Minister Chrétien's pan-Canadian health care vision, as well as his vision of collaborative federalism, was also championed by his successor, Prime Minister Martin. While Prime Minister Chrétien, under the advice of former Finance Minister Martin, authorized a major cut in transfers to the provinces, Prime Minister Martin somewhat ironically increased provincial transfers and signed off on a 10-year health accord with the provinces in 2004. In exchange for consistent federal transfers escalating at six per cent a year, the provinces agreed to improve wait times and work to make the health care system more efficient (Norquay 2011).

At the very least, the 2004 health accords involved the provinces and sought to create a more efficient system. In this sense, it represented a significant contrast to the unilateral funding cuts that Prime Minister Chrétien implemented in the 1990s. In addition to promoting a pan-Canadian theme, it also positioned the federal government as a primary player in Canada's health policy. It is important to note that, aside from health care policy under both Prime Minister Jean Chrétien and Paul Martin, there was little evidence of the federal government imposing policy or program obligations on provinces within other areas of provincial jurisdiction (Graefe 2008:190). These actions shed light on the unique and cross-jurisdictional dynamics of health policy in Canada, and reinforce the notion of a pan-Canadian identity promoted by the Liberal Governments in the 1990s and early 2000s.

With the accords expiring in 2014, records of success are generally mixed. Indeed, these differences in opinion point to the conflicting values placed on whether a significant role exists for the federal government in the implementation of Canada's health care policy. While many welcome this federal intervention, some, like noted journalist Chantal Hébert, believe that the federal government, under the auspices of the 2004 Accords, micro-managed the country's health care system to the point that provinces, as the primary keepers of Medicare, were now off the hook of their collective responsibility to deliver health care (Hébert 2012). Though there will continue to be advocates on both sides of the fence on whether a significant federal role exists in health care, it is important to note that the 2004 health discussions, as well as subsequent discussions at the provincial and federal level, have continued to exclude services that fall outside of the CHA.

When Stephen Harper became Prime Minister in 2006, the 2004 Accords and the resulting intergovernmental tensions figured prominently in the overall policy environment. Almost in direct contrast to both Prime Minister Chrétien and Prime Minister Martin, Prime Minister Harper championed an intergovernmental vision based on respect for provincial jurisdiction and increased cooperation. Dubbed "open federalism", Harper's intergovernmental vision would "restore the constitutional balance between the federal and provincial governments [and] . . . would work cooperatively with the provinces to improve the lives of Canadians

while respecting the division of power and responsibilities outlined in the constitution” (CPC Policy Declaration 13). Open federalism also involved limited federal spending in areas of provincial jurisdiction and authorized provinces to use the opting out formula with full compensation if they wanted to opt out of a “new or modified federal program in areas of shared or exclusive jurisdiction” (CPC Policy Declaration 13).

For the purposes of health policy, open federalism represents a focus on maintaining separate jurisdictions whereby provinces are empowered to exclusively make decisions in areas of provincial jurisdiction. While many argue against the feasibility of watertight compartments in an era of increased interlinkages and policy overlaps between both levels of government, especially in the field of health, Prime Minister Harper reaffirmed this position in a 2011 announcement on health care. In particular, the Conservative Government agreed to continue six percent annual increases in federal transfers for three years after the current health accord ends in 2014, after which transfers will be pegged at the rate of nominal GDP growth with a guaranteed base of three percent a year (Payton 2011). While the announcement adhered to the idea of watertight compartments, there was little, if any, dialogue with the provinces.

Implicit in Prime Minister Harper’s decision to provide greater health care autonomy to the provinces was the lack of emphasis on a pan-Canadian identity. While both Liberal Prime Ministers discussed above prioritized these values,

Prime Minister Harper appears to take a step back from the health care nation building process and provides space for greater territorial diversity. While the pendulum has shifted towards diversity, many worry that the key tenets of the CHA will be jeopardized, especially in light of the increasing prominence of non-core health care services. In particular, many are concerned that the current arrangement is only about money, thereby overlooking the terms of access to health care (Maslove 2012). This tension will be addressed in the last section of this paper; but it is an important theme to keep in mind.

Put another way, the differing pan-Canadian health care perspectives between Prime Minister Harper and previous Liberal governments has equity implications across the country. That is, differences in intergovernmental arrangements within federations have important implications for the equality of health services available to citizens across the country as a whole (Banting 2002:3). To this point, a distinction should be made between equity and equality in medicine. That is, equity does not mean that everybody receives the same amount of medical services; rather it refers to the level of access of individuals to adequate medical services (Asiskovitch 2010:5).

Part 2: Assessing the Comparability of Core and Non-Core Services and the Role of the Federal Government

Health care continues to rank among the top issues for Canadians and continues to touch upon questions of national identity, deeply held values, and people's direct interests (Mendelsohn 2002:22). With recent surveys suggesting

that Canadians are increasingly worried about the sustainability of the national health care system, it seems likely that most Canadians would be more open to health care reform than they may have previously been. Indeed, Canadians are now looking for ways to combine high quality, accessibility and universality in a cost effective way. In a 2002 survey, for example, Canadians strongly agreed that money alone would not answer the current health care challenges, and that the principles of Medicare should be maintained, though reformed, to improve the quality of health care in Canada (Mendelsohn 2002:22).

While provinces have the flexibility to fund, administer and define the basket of services included in Medicare, there are more similarities than differences among provincial and territorial health systems (CIHI 2011:4). While the CHA may have helped provide broad guidelines with respect to delivering medically necessary or medically required services on a universal basis, hospital and physician services across jurisdictions continue to provide reasonably comparable services with little federal involvement aside from funding. Indeed, provinces and territories have produced remarkably similar coverage for their residents despite the lack of specificity concerning any common basket of Medicare services in federal legislation (Marchildon 2005:121).

As non-core services become more prominent, however, there is a legitimate argument concerning whether national standards should be administered to ensure comparability. When asked about the issue of national

standards for health care, that is, requiring that all the provinces provide the same basic accessibility and quality of health care, 88% of respondents noted that national standards were either very essential or somewhat essential (Mendelsohn 2002:80). To gain a better understanding, this section discusses Jennifer Wallner's work on K-12 education in Canada and whether national standards are needed to ensure interprovincial comparability of services. The second part of this section discusses the significant variability in non-core services across provinces and suggests a much greater federal role to ensure relative comparability across the country.

Canada's Education Policy: A Case Study

Contrary to mainstream thinking, Wallner's work discusses whether national standards in education, and social policy more broadly, help elevate the overall quality of the sector, or whether there is a tendency to set them to the lowest common denominator (Wallner 2011:648). As a proponent for provincial autonomy and diversity, Wallner's work points to the tension between federalism and the welfare state, and presents evidence on why provincial governments should maintain complete responsibility for education policy. She notes that, despite no national department of education or national standards that the provinces are required to maintain, Canadian provinces have created similar education sectors supported by comparable levels of investments and achievements (Wallner 2010:648).

In fact, when compared to international educational outputs, Canada consistently ranks among the top performers in high school graduation rates, mathematic and reading tests and post-secondary education completion (Wallner 2008:9). Taken together, it appears as though a lack of national standards, decentralization and institutional fragmentation of Canada's education system has not affected the performance nor undermined the achievement of sub-national similarity. In fact, these impressive results suggest that provincial programs are perhaps better suited than the federal government to respond to the local needs of their populations.

Wallner pushes her argument further, suggesting that provinces are essentially forced to provide similar educational services to ensure that they resist any potential incursions from the federal government (Wallner 2010:659). As a result, communication strategies and policy exchanges are conducted at the provincial level to ensure the maintenance of jurisdictional comparability. While Wallner concludes that there is no need for direct federal involvement in the education sector, there is a vital indirect role. Specifically, the significance of fiscal federalism is a crucial factor that has enabled the relative similarity of provincial education systems (Wallner 2010:663). In this sense, through fiscal federalism, the federal government plays a vital indirect role that enables the realization of a national social policy system (Wallner 2010:663).

Wallner's conclusions present important considerations for Canada's

health care system, especially in light of the December 2011 Conservative Party announcement stating the need for classical federalism whereby both orders of government would work within their respective spheres of authority. Wallner's conclusion reinforces the Prime Minister's vision of classical federalism and suggests that there is little need for a federal role in health care beyond fiscal support. While her conclusions may apply to Canada's education sector, policy overlaps in Canada's health care system, as well as national values of equity and fairness, may require a greater federal role beyond fiscal transfers.

Comparability of Core Services Across Canada

It is important to note that measuring the comparability of core services between provinces is difficult and somewhat limiting due to differences in demographics, population size and variations in primary care, home care, and long-term care programs. For example, while Ontario has fewer physicians per capita than Quebec (CIHI 2008:16), expanded roles of nurses, physician assistants and other practitioners in Ontario could provide better access to health services (Ontario Health 2012:3). Similarly, while Ontario has fewer hospital beds per capita than any other province, aggressive long-term care and home care policies are able to provide insured health care services outside of hospital settings.

What is revealing from a cross-jurisdictional perspective, however, is public opinion data rating the state of the health care system by province. A poll

of nearly 2000 Canadians across the country, for example, asked respondents to rate the state of the Canadian health care system. With the exception of Quebec, there was little variation in responses across the country where a large majority of respondents gave either an excellent, very good or fair grade to Canada's health care system (Soroka 2011:9). In response to common challenges such as improving accessibility, quality and responsiveness, provinces and territories are also working together to create initiatives to make improvements to the health system (CHSRF 2011:10). These initiatives include the development of Western and Northern Health Human Resources Network and patient engagement initiatives (CHSRF 2011:10). Similar to K-12 education in Canada, as demonstrated by Wallner's discussion above, the relative comparability of core health services appears to stem from jurisdictional policy exchanges and communication strategies, as well as the desire of provinces to emulate one another.

Given the comparability of core services that currently exist across jurisdictions, the bulk of administration and decision-making in this area should continue to come from provinces. While the federal government should provide a minimal role to ensure that provinces have the funds and ability to ensure that core services continue to be delivered at a comparable level across provinces, there exists a larger role for the federal government with respect to non-core services.

Variability of Non-Core Services Across Canada

Non-core services are not covered under the provisions of the CHA, yet are becoming increasingly prominent and expensive. Evidence suggests that significant interprovincial variation in non-core services exists within and across provinces, and financial and non-financial barriers to access are increasing. Though this paper discusses variations in home care, long-term care and prescription drug coverage, it is reasonable to assume that inter-provincial variation exists in most areas of non-core health services.

i) Home Care

As described in Part One of this paper, the CHA provides medically necessary services delivered by physicians in hospital settings. According to the Canadian Institute for Health Information (CIHI), home care is defined as “an array of services, which enables clients incapacitated in whole or in part to live at home, often with the effect of preventing, delaying or substituting for long-term or acute care alternatives” (CIHI 2001:1). Since home care is provided in a home or community setting and involves both medical and social care, it is considered an “extended service” with no obligation on the part of governments to provide a minimum basket of services (Canadian Healthcare Association 2009:10).

In response to public pressure and growing concerns for increased home care services, however, provinces agreed on a minimum basket of services for first-dollar coverage for home care services during the 10-Year Plan to

Strengthen Health Care (2004 Accord). They agreed to publically fund two weeks of short-term acute home care after discharge from hospital; two weeks of short-term acute community mental health home care; and end-of-life care (Canadian Healthcare Association 2009:10). Generally speaking, though provinces and territories are mandated to provide home care in these areas, significant variation exists inter-provincially in terms of eligibility for home care, public coverage of services, residency requirements and access to services (Canadian Healthcare Association 2009:17). As a result, access to home care increasingly depends on where one lives or on one's ability to pay out of pocket, leading to inequitable access across the country.

The province of Saskatchewan, for example, provides case management, nursing, personal care and home IV without patient fees for up to 14 days (Health Council of Canada 2006:135). The province also provides end-of-life home care including palliative pharmaceuticals, without fees to patients or families and with no specific time frame (Health Council of Canada 2006:135). In Nova Scotia, case management, intravenous medications, and nursing services and supplies are offered at no cost, while other services, such as personal care, home support services and home oxygen services are offered with slide scale charges based on family size and income (Health Council of Canada 2006:140). Unlike Saskatchewan, no end-of-life home care services are provided in Nova Scotia. Meanwhile, due to its constitutional obligations, the federal government delivers home care services to First Nations on reserve and to Inuit in designated

communities, members of the armed forces and RCMP, inmates and eligible veterans, yet does not provide any end-of-life care (Health Council of Canada 2006:133).

Delivery models for home care also vary, which impacts public, private and out-of-pocket financing, and four basic models of home care service delivery currently exist. Certain jurisdictions, including Saskatchewan, Manitoba, Nunavut, the Northwest Territories, Quebec and Prince Edward Island, have a public provider model where government employees manage and deliver both home care and home support services. In British Columbia, New Brunswick and Newfoundland and Labrador, public employees deliver professional services, but home support services are delivered by private agencies. In Alberta and Nova Scotia, both public and private employees provide professional home care services, while Ontario contracts out all publicly paid professional home care and home support services to the private sector (Canadian Health Association 2009:25).¹

While most provinces and territories indicate that they provide some measure of home care, the type, volume and regional availability of services provided continue to vary considerably, and who pays for services largely depends on whether services are provided in the hospital or in the home. While some provinces with formal home care programs pay for nursing, physician

¹Information provided in this entire paragraph was taken from the 2009 CHA Report on Home Care in Canada.

services, and rehabilitation therapies, other provinces place limits on the amount of professional support services paid for publicly and coverage of drugs and equipment used varies from fully publicly funded to not funded (Health Council of Canada 2005:9). With no standards or operational objectives legislated at the federal level, and with home care falling outside the provisions of the CHA, unequal access to such services will persist across and within jurisdictions.²

ii) Long-Term Care

Most generally, long-term care consists of services and assistance to people who are limited in their ability to function independently on a daily basis over an extended period of time (OECD 2008:1). Though services can be provided in facilities or in homes, many services fall outside of the CHA, and the financing of long-term care varies significantly across jurisdictions. For example, while long-term care is publicly subsidized in most provinces, there is also a user-pay component for both residential and home-based long-term care (Grignon and Bernier 2012:3). At the same time, out-of-pocket expenses are usually income-tested and vary considerably across the country (Grignon and Bernier 2012:3). For institutional care (in a residential care facility), for example, maximum annual charges for standard accommodation for non-married seniors in 2008 was \$12,157 in Quebec, compared with \$33,600 in Newfoundland (Grignon and Bernier 2012:3). As a result, access to long-term care depends

² I note within jurisdictions because of the difficulties involved in reaching rural and remote areas. While this falls outside the scope of this paper, national standards home care could improve access to remote regions in provinces.

increasingly on the level of financial support from the provinces and on one's ability to pay out-of-pocket.

In large part due to an aging population across Canada, provinces are increasingly moving towards developing long-term care strategies. For informational purposes, seniors (those aged 65 or older) now account for a growing proportion of the Canadian population: the number and proportion of Canadian seniors increased from 2.7 million to 4.8 million between 1986 and 2010 (CIHI 2011:9). Though seniors currently make up 14 per cent of Canada's population, this number is expected to increase to about 25 per cent by 2036 (CIHI 2011:8). While population aging is not uniform across jurisdictions, most provinces have developed or are in the process of developing provincial long-term care strategies, although strategies continue to differ significantly as no national long-term care standards exist.

In response to issues of unequal access and the inefficient allocation of resources for provincial long-term care strategies, a June 2012 IRPP study presents an economic case in favour of a national public long-term care insurance strategy. The report notes that in the absence of such a plan, Canadians will have to either save large sums of money or buy more expensive and less satisfactory private insurance (IRPP 2012:27). As the Canadian population continues to age, and as publicly funded long-term care services continue to vary across jurisdictions, a federally-administered long-term care plan

stipulating the minimum basket of services would go a long way to create a more equitable system for all Canadians.

iii) Prescription Drug Coverage

Though a National Pharmaceuticals Strategy was established in 2004 to develop nationwide solutions to some concerns about the safety and affordability of prescription medications in Canada, the patchwork of different provincial initiatives means that not all Canadians have the same advantages (HHC 2009:1). In the words of one researcher, the patchwork of provincial, territorial and federal drug programs has created a “dog’s breakfast” of benefits and exclusions that vary across the country (Marchildon 2006:104).

For example, some jurisdictions offer coverage for the prescription drug costs for vulnerable populations, and eligibility criteria and the amount of benefits vary significantly. In addition, each jurisdiction has its own drug formulary, and makes its own final decision concerning what pharmaceutical products it will list on the basis of clinical efficacy (Marchildon 2006:101). As a result, not all Canadians have the same access to affordable medications; someone may be eligible for a government drug plan in one province, but have to pay out-of pocket if they move to another (HHC 2009:10). With no portability provision and with rising drug costs, many Canadians do not have equitable access to affordable medicines.

To showcase the rise of pharmaceutical costs in Canada, total drug expenditure grew at an average rate of 8.9 percent between 1985 and 2009, while total hospital and physician expenditure grew at average annual rates of five percent and six percent respectively (CIHI 2011:13). These rapidly increasing pharmaceutical costs represent one of the fastest growing components of total health expenditure in Canada, and highlight concerns over how uninsured Canadians will afford prescription drugs in the future. Compared to other OECD countries, moreover, Canadians already pay 30 percent more in prescription drug costs than the OECD average (Gagnon 2010:7).

Provincially speaking, considerable variation exists in drug expenditure. In terms of out-of-pocket drug expenditure per capita in 2011, for example, forecasts have ranged from \$702 in British Columbia and \$839 in Manitoba, to \$1,116 in New Brunswick and \$1,139 in Nova Scotia (CIHI 2011:17). Similarly, the proportion of prescribed drugs financed by provinces in 2011 ranged from 29.7 percent in New Brunswick and 34.2 percent in Prince Edward Island to 48.3 percent in Alberta and 49 percent in Saskatchewan (CIHI 2011:27). These significant variations point to a major east-west cleavage where drug coverage programs are considerably thinner in the four Atlantic provinces than programs offered in each of the jurisdictions west of those provinces (Marchildon 2006:104). While these figures are each part of a broader provincial drug insurance plan for prescription drugs, 23.5 percent of Canadians remain uninsured (Gagnon 2010:20), and eligibility for benefits continues to vary.

In response to these significant cross-jurisdictional variations in access due to rising drugs costs, the Canadian Centre for Policy Alternatives (CCPA) released a 2010 study presenting evidence that a universal drug plan providing first-dollar coverage would ensure greater fairness in accessing medications, improve drug safety and help contain the inflationary costs of drugs (Gagnon 2010:68). From a federalism point of view, such a program would clarify roles and responsibilities in the area of prescription drugs, especially given the ambiguity surrounding who pays, regulates and administers drug plans. In particular, while provinces currently pay for almost all public drug coverage in Canada, they lack the regulatory powers of the federal government (Marchildon 2006:102).

Lastly, a federally-administered Pharmacare program with national standards could both help eliminate the disparities of public drug coverage across the country by levelling up less generous provincial plans to more generous provincial programs, and act as a national unifier (Marchildon 2006:104). While the lack of political enthusiasm for Pharmacare can mainly be explained by fears of escalating costs, the economic analysis presented in the CCPA report suggests that the implementation of universal Pharmacare, with first-dollar coverage for all prescription drugs, would not only make access to medicines more equitable in Canada, but would also generate national savings of up to \$10.7 billion for prescription drugs (Gagnon 2010:5).

Given the significant regional disparities in home care, long-term care and prescription drug coverage across the country, it is clear that access to these non-core services is largely dependent on where one lives and how much one is able to pay. From an access and equity point of view, it is clear that a federal leadership role in standardizing care is required. While financially constrained budgets at both the federal and provincial levels ensure that these non-core services will not be added to the CHA, a federal role could provide the leadership required to establish a national standard of care that could be made available to citizens in all provinces under the same terms and conditions.

Indeed, national platforms for home care services, long-term care services and a prescription drug costs would set the minimum standard of care that must be available across the country (Romanow 2004:177). Though the federal government would establish a minimum standard, provinces would maintain the authority to improve or expand on existing benefits. This line of argument recognizes that while health care delivery is an area of exclusive provincial jurisdiction, policy overlaps and broader equity implications require a prominent federal role to ensure a more equitable health care regime where personal means do not determine levels of access (Stuart & Adams 2007:96). More broadly, health care is central to the Canadian identity where there is both the desire to collectively pool risk across the country and a belief that all Canadians should have comparable access to high quality public services, regardless of

their province of residence or level of income (Barlow & Silas 2012).

Part 3: Shaping the Role of Federal Involvement in Non-Core Health Services

As demonstrated by variations in home care, long-term care and prescription drug costs, inequity in access to health services, due to financial and non-financial barriers, continues to pose problems for lower-income individuals in Canada. To respond to issues of inequality resulting from significant inter-provincial variation in non-core services, greater political willpower is needed to ensure that Canada's system provides equal access for people with equal health needs (horizontal equity), while people with higher levels of need would be expected to have greater use of services (vertical equity) (CIHI 2011:13). Given the pan-Canadian dimension of health care whereby equality and access figures prominently in policy discussions, there exists a significant need for a greater federal role in the provision and standardization of non-core services. Federal leadership taken in areas of mental and public health provides valuable examples on what kinds of federal leadership is required.

Mental Health

While provincial and territorial governments have primary jurisdiction for the planning and delivery of mental health services in Canada, the federal government collaborates with the provinces and territories in a variety of ways to develop responsive, coordinated and efficient mental health service systems

(Health Canada, Mental Health Page). Created in 2006, the MHCC is a federal program seeking to improve mental health across the country, and was endorsed by all provincial and territorial governments (with the exception of Quebec) (MHCC Background Web Page).

In line with Canadian values of equity and fairness, one of the Commission's goals is to ensure that all Canadians have equitable and timely access to appropriate and effective programs, treatments, services, and supports that are integrated around their needs (MHCC 2009:21). With a 10-year mandate, the MHCC is helping ignite discussions around the creation of a pan-Canadian mental health system, and the Commission's initial findings suggest that political will exists for the federal government to take a leadership role in standardizing mental health services.

Importantly, a number of federal departments and agencies have developed approaches to provide a wide range of services to Canadians, and many of them are working with one another and with their provincial and territorial counterparts on mental health initiatives (Senate Committee 2006). For example, Citizenship and Immigration Canada (CIC) provides essential and emergency mental health services to immigrants and refugees unable to pay, while Health Canada provides community-based mental health care for First Nations living on reserve (Senate Committee 2006). Recognizing that First Nations and Inuit populations have health statuses well below that of the rest of

Canada, the federal government is also working with Inuit populations to develop an Inuit-specific mental health strategy (Senate Committee 2006). This distinct community-based approach to Aboriginal mental health supports the idea of vertical equity whereby some groups may require additional support and different levels of treatment in order to receive comparable levels of services and comparable levels of equality.

These specific mental health programs led by the federal government and in collaboration with the MHCC, supplement provincial and territorial mental health initiatives. This is significant as provincial strategies are not uniform across the board and the availability of, or access to, mental health services continues to vary (CIHI 2009:47). As the Senate Committee report, *Out of the Shadows at Last*, makes clear, no jurisdiction in the country can lay claim to having a genuine mental health system in place, and what generally exists is a fragmented patchwork of programs and services, many of which face struggles to find adequate resources (Senate Committee 2006).

In this sense, the MHCC helps break down silos within the mental health and health care systems and helps standardize care across the country. Most importantly, as part of the national MHCC framework and in order to provide the flexibility required to address localized needs, high-level goals were created in advance of national targets (MHCC 2009:19). In May 2012, and with significant support from the MHCC, Federal Health Minister Leona Aglukkaq released the

first-ever national strategy for mental health calling on the federal and provincial governments to increase the amount of money they spend on preventing and treating mental illness (Smith 2012).

Minister Aglukkaq's announcement suggests that the federal government will play a significant role in the national mental health strategy, and billions of federal and provincial dollars have been earmarked to encourage national standards to help provide comparable mental health services across jurisdictions. Without the initial leadership of the MHCC and the federal government, a national strategy on mental health would have been less plausible. This strategy seeking to standardize mental health services across the country, as well as the federal and provincial support behind the strategy, should be viewed as an example to replicate in other areas falling outside the CHA.

Public Health

The federal role in public health has traditionally been minimal as public health was never included as a core service in the CHA (Deber 2006). The creation of the PHAC following the 2003 Severe Acute Respiratory Syndrome (SARS) outbreak, however, provides a useful example where the federal government stepped into a leadership role on health promotion and emergency preparedness. For many intergovernmental observers, the coordination challenges and prevalence of blame avoidance politics were made evident following the pandemic, which necessitated the need for a centralizing agency to

strengthen intergovernmental collaboration on public health and facilitate national approaches to public health policy and planning (PHAC Home Page).

With a mission statement to promote and protect the health of Canadians (PHAC, Home Page), and understanding that public health is a shared responsibility, PHAC collaborates with all levels of governments, as well as NGOs and international organizations, to fulfill its mandate (PHAC Background). The rise of borderless health issues like pandemics and infectious disease, issues that fall outside the realm of the CHA, as well as coordination challenges associated with public health, provides the impetus for an increased and enhanced role of PHAC. This enhanced role for PHAC is also in line with the growing recognition that many non-medical factors, such as income inequality and educational status, affect a population's health (Bernier and Bulone 2007).

Unlike other cases discussed in this paper, the argument for expanding PHAC is not to standardize policies across jurisdictions, since healthy or unhealthy populations are not confined to one geographic province or territory. Rather, a greater federal role through PHAC is needed to reduce the major health disparities that currently exist across Canada, discrepancies that cannot be attributed to a provincial or territorial public health strategy. Specifically, the most important indicators of health disparities relate to socio-economic status and Aboriginal identity (Health Disparities Task Group 2004:1), and addressing discrepancies within these segments is necessary from an equity point of view.

Despite a higher overall use of health services for Aboriginal groups and for those within the lowest 20 percent on the socio-economic scale, the consequences of health disparities are still the most pronounced among these segments of the Canadian population (Health Disparities Task Group 2004). While PHAC supports the cross-jurisdictional Pan-Canadian Health Living Strategy (PHAC CHLS Page), a coordinated and integrated strategy focusing on the prevention of disease, disability and injury, and health promotion, and concerted federal leadership on disparities reduction are needed to support provincial initiatives in the sector. Greater federal leadership in this area is especially crucial given the wide spectrum of factors known to influence health.

Most importantly, the changing landscape of health policy characterized by broad health issues falling outside the confines of the CHA enhances the need for a greater federal role in public health. While the federal government would be well advised to take on a greater health promotion role under the auspices of PHAC, the collaborative, integrative and political will behind the Agency provides a useful example to replicate in other health areas in need of a greater federal leadership role. Indeed, to ensure sustainability, promote a pan-Canadian identity and improve efficiency among non-core services, national programs are a necessary condition for the achievement of cross-jurisdictional similarity and equality.

To this point, it is not necessary for the federal government to guarantee the exact same health benefits to every citizen, nor does it mean that the federal presence in health care is synonymous with “one size fits all” solutions (Maioni 2002). Rather, federal leadership in the provision of non-core services, as demonstrated by MHCC and PHAC, helps define minimum standards of care and helps ignite national discussions to ensure that provincial programming affords reasonable access for those in need.

Conclusion

Moving forward, provincial variations within the area of non-core services, as well as health discrepancies among certain segments of the population, require greater federal role involvement from an equity standpoint. If equal access to care is a major objective of the Canadian health system, as noted in a number of pieces of national legislation, it seems logical that the same objective be applied to services that fall outside the CHA, especially since they are gaining prominence and are becoming increasingly expensive. At the moment, depending on where one lives in Canada, variations currently exist in the level and sourcing of healthcare financing, payment mechanisms, benefits packages, and supply of health services, all of which lead to differing degrees of access (Allin 2008:84). If non-core services are not prioritized at the federal level, it seems likely that unequal access to health services will continue to exclude those who cannot afford the services.

Canada's universal and publicly funded health care system has helped remove financial barriers to core-services. Indeed, provinces continue to share best practices and deliver reasonably comparable hospital and physician services, while the federal government helps ensure that provinces abide by the minimum standards stated in the CHA. This crucial oversight role on the part of the federal government has helped build a pan-Canadian identity rooted in Medicare, and has given provinces enough flexibility to adapt and tend to the specific needs of their jurisdictions.

While Canada's Medicare system is not perfect, as demonstrated by the apparent erosion of the portability principle for Quebec residents, provinces and territories are currently providing reasonably comparable core services with little federal leadership outside of their funding and CHA watchdog role. In this sense, CHA principles continue provide the foundation for Canada's Medicare system and helps provide the glue that unites Canadians through shared values and shared health care citizenship.

While the complexity of Canada's health care system suggests that there are no quick solutions to improve the effectiveness of the overall system, Canada is at a crucial point where important decisions must be made to ensure sustainability and provide equal access to core and non-core services across the country. Despite the crucial role the CHA plays in providing relatively comparable access to core services across the country, Canada's system as a whole

continues to represent “a 1960’s view of health care” (Flood 2010). That is, the system continues to neglect non-core services and does not include universal coverage for prescription drugs or a strategy for care in home or long-term care settings.

Complicating attempts at reform are tensions associated with the federation and the need to ensure autonomy and diversity on the one hand, while maintaining social citizenship and pan-Canadian visions on the other. Indeed, past relations between the federal government and provinces have brought these tensions to the fore, and have created a culture of mistrust and uncertainty. While this culture may not be as pronounced as it once was in the late 1990s and early 2000s, the recent Conservative Party announcement where the Government unveiled the upcoming conditions for federal health transfers, without consulting the provinces, could mark the beginning of the decline in recent federal-provincial collaboration. This is further complicated by the fact that the federal government continues to provide funding to the provinces, while the provinces continue to ask for greater autonomy and flexibility in health programming. Given this increasingly tense environment, it is not surprising that health care reforms have not been forthcoming.

As non-core services continue to dominate the health policy arena, however, it is imperative that the federal government takes a leadership role in creating platforms for standardizing care and services. As discussed in this

paper, access to non-core services are plagued by financial and non-financial barriers where access varies across jurisdiction and care depends increasingly on one's ability to pay out-of-pocket. Though some progress has been made in areas of public and mental health, the scope of the challenge requires greater political will from both the federal and provincial governments. In particular, both orders of government should attempt to work with one another to create a better system for all Canadians, rather than engaging in blame games and jurisdictional disputes.

To this point, the Conservative Government should reconsider its December 2011 announcement since it does not recognize that health policy is an area of implicitly shared jurisdiction. While the announcement offers a relatively generous financial deal to provinces, it does not allocate a greater federal role for the provision and standardization of non-core services. As shown in this paper, inter-jurisdictional variation in non-core services leads to unequal access, and places unfair financial and non-financial burdens on certain segments of the population. While classical federalism may work in certain areas such as educational policy, health care is a Canadian undertaking that embodies values that extend beyond provincial borders.

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