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The Conditions for a Sustainable Public Health System in Canada

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Highlights

The sustainability of the health system depends on the financial, organizational and epistemic capacity to respond adequately to the health needs of current generations without compromising the system's ability to meet the needs of future generations. Today, changes in these capacities are being influenced by two political agendas in the discussions centred around health care reform: the agenda advanced by supporters of health system privatization; and the agenda advanced by those who support a stronger federal role vis-à-vis the provinces. By focussing on debt repayment and tax cuts, supporters of privatization are undermining provincial governments' ability to counter the negative effects that the drastic elimination of public deficits had on the health system's capacities. Proponents of a stronger federal role are doing likewise by delaying restoration of federal transfers to the provinces to the levels they had occupied before the budget cuts aimed at wiping out the federal deficit. Economic theories on the health system show us that the fundamental assumptions on which they are constructed determine the recommendations that can be drawn from them. The reform proposals made by the supporters of privatization stem from neo-classical theory, which emphasizes the system's financial capacity and overlooks the other types of capacity. The advantage of agency theory is that it factors in the health system's organizational capacity. The proposals made by supporters of a stronger federal role are more in line with this theory. To include epistemic capacity, agency theory must be complemented with a more realistic – and hence more ethically acceptable – theory, i.e., convention theory, which holds that the sustainability of the health system can be assured only if the rules/conventions that have developed over the years between patients, physicians, managers and governments are followed. Attacking these rules would result in a loss of trust between the stakeholders in the system and generate costs in excess of the savings that might eventually be reaped. Allocation of financial, organizational and epistemic resources is efficient when based on trust.

Executive Summary

The sustainability of the health system depends on the financial, organizational and epistemic capacity of Canadian society to respond adequately to the health needs of current generations without compromising the ability to meet the needs of future generations. This argument has three implications: 1) financial, organizational and epistemic capacities are essential and closely linked; 2) defining the demand for health care is a matter of ethical choices; and 3) intergenerational equity demands that we look beyond public debt and deficit considerations to incorporate protection of the organizational and epistemic capacities of Canada's health system. In recent years, a domestic and international environment favouring budget restrictions, debt repayment and tax cuts has placed a great strain on the health system's capacities.

The political and economic environment surrounding Canada's health system has changed considerably over the past decade: two political agendas now influence the discourse concerning health care reform. Under the guise of fiscal discipline, proponents of privatization have succeeded in imposing the following priorities: fiscal balance, repayment of the public debt and tax cuts. In the process, they have undermined provincial governments' capacity to counter the negative effects that the drastic elimination of public deficits had on the health system's financial, organizational and epistemic capacities. For their part, proponents of a stronger federal role vis-à-vis the provinces have, under the guise of promoting national unity, exerted the same budgetary pressures on the provincial governments by changing the levels of the fiscal transfers to the provinces and their allocation rules, and by unduly delaying restoration of these transfers to their early 1990s levels. The situation has produced strange bedfellows, since it is in both camps' interests to weaken the provincial governments. On the other hand, the reforms they are proposing are far from consistent with the explicit agenda to reform Canada's health system with an eye to improving it. The direct impact of this dynamic is a weakening of the health system in terms of its capacities – not only financial but organizational and epistemic as well – to respond to the health needs of current generations and to ensure the survival of the system for future generations. In this context, the sustainability of a public health system in Canada is not assured.

But how could such an attack on the sustainability of the Canadian health system have been justified solely on the basis of fiscal discipline? Or, as a corollary, how could the objectives of protecting the system's financial capacity have caused us to lose sight of its organizational and epistemic capacities? Economic theories might prove useful in answering this question, since they shed light on the causal relations linking a social system and its environment. Health economics proposes three main theories: neo-classical; agency and incentives; and convention. An analysis of the assumptions underlying these theories shows us that to realize the importance of a system's organizational capacity, one must move beyond the dominant economic theory (neo-classical) and adopt the perspective of agency theory, since neo-classical theory tends to focus solely on financial capacity. Furthermore, to take into account the health system's epistemic capacity, agency theory must be combined with convention theory.

Our study has led us to make five observations. 1) While necessary, sound management of the health system's financial resources is not enough to ensure its sustainability. Any reform of financial management must first be assessed on the basis of its impacts on the system's organisational and epistemic capacities. 2) Too much fiscal discipline can be counterproductive.

When budget rules do need to be applied, they must emphasize as much as possible an incentive rather than coercive approach. 3) Trust is the cornerstone of the health system. The least costly and most efficient means of reforming the health system and ensuring its sustainability is to observe the conventions linking the system's main actors. 4) There are risks of disruption in budgetary convention in Canada, both within organizations and in federal-provincial relations. If we continue requiring budget spenders to play the role of guardians and to worry more about balanced budgets than quality of services, we run the risk of distancing them too much from their primary role, which is to improve the quality and quantity of care. 5) It is essential to involve in the decision-making process specialists from fields other than economics and accounting (health specialists and social systems specialists). With the best of intentions concerning financial capacity, our accountants run the risk of weakening the system's organizational and epistemic capacities and thus setting it on the road to ruin. It would not be the first time that sorcerers' apprentices have created chaos while trying to put the house in order.

From these observations, we have formulated five recommendations:

1. Make it a priority to rapidly restore the level of federal funding for the health system by earmarking budgetary surpluses for health before paying down the debt or cutting taxes. This will enhance the system's capacity to respond to the public's health needs.
2. Reaffirm in no uncertain terms the five fundamental principles of Canada's health system (universality, accessibility, portability, comprehensiveness and public administration) and continue to insist that the provinces meet these criteria as a sine qua non for federal funding. This will preserve public trust in our political institutions and in the health system.
3. The Canada Health and Social Transfer (CHST) should be the tool of choice for funding the health system, rather than the transfer of tax points. In this way, the federal government will maintain the leverage it needs to influence the evolution of the health system in the provinces.
4. Encourage research on budgetary convention in health organizations with a view to identifying the best ways of ensuring optimum allocation of financial resources without undermining organizational and epistemic capacities, and with a view to increasing the trust of the managers and health stakeholders within these organizations.
5. Support social research on the health system, in particular on the interaction among financial, organizational and epistemic capacities.

Introduction

The aim of this paper is to answer the following question: How does a political environment geared to balancing budgets, paying down the debt and cutting taxes impact on the preservation or sustainability of the health system? We will proceed in three stages. First, we will address the notion of health system sustainability and demonstrate that it depends on the system's financial, organizational and epistemic capacities to respond to the health needs of current generations without compromising the system's ability to meet the needs of future generations. Second, we will describe Canada's political and economic environment and show that the forces at work and the international context have undermined at once the system's financial capacity and its organizational and epistemic capacities. Third and last, we will ask ourselves what could have justified such an attack on the health system's capacities. We will show that, by stressing organizations' financial capacity, the prevailing economic theory neglects the organizational and epistemic aspects of the health system's capacity, and that there are other economic theories that take these aspects into account. In conclusion, we will argue that there are certain threats to the preservation of the Canadian health system, we will identify a few principles that should be followed in order to enhance its sustainability and we will formulate recommendations in this regard.

The Sustainability of the Health System

Currently, there are two opposing schools of thought in the health world: a capacity perspective, which Moreau, Berthod-Wurmser and Béchon (1992, 205) call the OECD vision, and a needs perspective, which the same authors identify as the WHO vision. These competing viewpoints can be found in that portion of the specialized literature devoted to defining the concept of sustainability. Indeed, two meanings of this concept share centre stage in this debate, with each bringing a different perspective to health and the health system.¹ The first meaning is built on a biological analogy. It sees sustainability as the ability to last. In French, the definition given in the *Petit Larousse* (“viable: ce qui *peut* vivre”) [viable: that which *is able* to stay alive], reproduced in a recent publication of the Canadian Medical Association (CMA), speaks to this central notion of an organism’s *ability* to live or survive. Obstetrics, for example, talks in terms of a “viable” fetus, i.e., a child capable of living and developing outside the mother’s womb. The second meaning of sustainability is built on an ecological analogy and views the concept as one of sustainable development. According to the Brundtland Commission, sustainable development is “development that meets the *needs* of the present without compromising the ability of future generations to meet their own needs” (Harrison 2000, 2). Thus the ecological analogy stresses two important dimensions: needs and intergenerational equity. So we have two perspectives, which, far from conflicting, complement each other. A sober analysis of the sustainability of Canada’s health system requires us to take into account the system’s capacities, Canada’s health needs and intergenerational equity.

The Capacities of the Health System

The current discourse on the health system focusses to a great extent on its funding, testifying to the indispensable role of financial capacity as a cornerstone of a system’s sustainability. Indeed, no organization can survive without financial resources. The goods and services it consumes cost money. But there are other capacities that are also essential to a health system’s survival and development.

A social system cannot exist without organizational capacity, in other words, without the resources required to ensure cohesive decision-making structures. By this we mean the rules or standards that define the roles that each of the actors is required to play within the organization, and the actors’ conformity to these standards. Standards and conformity to standards produce a division of labour and a cohesiveness that ensure the quality of the services offered by the organization. The division of labour produced by these standards increases dramatically the scope of what the system can do. The cohesiveness that these standards create among the members of the organization ensures that a cohesive product is offered. Division of labour and cohesiveness are, in the final analysis, the main sources of efficiency.

In addition to the financial and organizational capacities, there is the epistemic capacity – without this, no health system is feasible. This capacity has to do with the knowledge and competencies acquired through formal training or through experience and learning, and which provide actors with a framework for assessing the situation to which they must react in order to

identify which course of action to take. This framework refers both to technical knowledge acquired through scientific research and to normative knowledge acquired through experience.

Thus we have three types of capacity that ensure the system's sustainability. There are two things we should point out here. First, each of these capacities is essential in preserving the system. No health system can survive in the absence of financial, organizational or epistemic capacities. If one is missing, the entire system comes crashing down. Second, these three types of capacity are not independent of one another. If one is changed there can be a major impact on the others. Thus financial, organizational and epistemic capacities are essential and closely linked. But why seek to preserve a health system if not to meet the health needs of the public? If one is to have a useful discussion on the sustainability of the health system, one must first discuss needs.

Health Needs

A sustainable health system is one that meets the health needs of the population. At first blush this may appear simple, but it is not. What, in fact, is a health need? For a long time we have distinguished between essential needs, i.e., those having to do with nature, and non-essential needs, i.e., those having to do with culture. Jean-Jacques Rousseau, for example, distinguished natural needs from artificial needs and John Maynard Keynes made a distinction between absolute and relative needs. Although attractive from an intellectual standpoint, this distinction is of little use to us because when it comes to defining health needs in terms of demand for care, the nature-culture distinction becomes blurred. When all is said and done, the needs-based demand for health care is a question of cultural artefact. To prove this point, let us deconstruct the notion of state of health according to the arguments of economist Sophie Béjean.

State of health is often defined in terms of morbidity. The process starts when the patient evaluates his own health. This evaluation, based on a psychological thought process and a social conception of health and illness, determines the perception this individual has of his need for medical services. This perceived morbidity is transformed into diagnosed morbidity through the coding carried out by the medical profession and the health apparatus. Diagnosed morbidity represents [TRANSLATION] “the outcome of a supposedly objective scientific procedure [...] In the end, it appears to be a reflection more of the institution, the health apparatus or the physician formulating this diagnosis than of the state of health it is supposed to describe” (Béjean 1994, 109). Indeed, diagnosed morbidity, as the physician's coding, can differ greatly from perceived morbidity as well as objective morbidity, since the discomfort felt by the patient can go unrecognized by the physician, just as an illness might not be felt by the patient.

And so the process of moving from need to demand for health services involves three steps: first, the morbidity felt by the patient is expressed; next, this need is codified by the physician (diagnosed morbidity); last, the physician translates this diagnosed morbidity into demand for care. Objective morbidity is a long way away from demand for care. A series of factors come into play between the two, including the psychological and social representations of illness and health on the part of the patient and the physician, the pressures brought to bear by the health system on the physician in terms of service availability, advances in medical and pharmaceutical

research and the physician's knowledge thereof, etc. State of health and, even more so, demand for health care are not simply a product of nature. They are social constructs in which the health system is directly involved. Consequently, any modification of the system's financial, organizational or epistemic capacities is likely to influence the demand for health care. This is what economists call supply inducing demand.

Intergenerational Equity

In addition to capacities and needs, the sustainability of a health system involves intergenerational equity. The question we must ask ourselves is this: Do we have obligations to future generations? Are we responsible for the impact that the decisions we take today will have on our grandchildren and perhaps on theirs? If we accept that all human beings continue, in the future, to have rights concerning the availability of adequate health care, some of the decisions we take today might violate these rights, regardless of who these future human beings will be. Thus these people could argue that they have been deprived of the right to health on account of the policies adopted in the past. Consequently, certain decisions made today might be bad for future generations, from an ethical standpoint.

There are two things we need to consider here. The first has to do with health system funding, a topic that has occupied centre stage in the recent discourse surrounding the efforts to eliminate Canada's deficit. Is it fair for us, the current generations, to benefit from a series of health services while future generations get stuck with the bill for these services in the form of the annual deficit and public debt? Borrowing to pay health costs is tantamount to shifting the burden of payment onto those who will have to pay off the debt, a sort of a negative inheritance. From the standpoint of intergenerational equity, there is no question that the health system must be funded through taxes, and the temptation to borrow must be resisted. When it comes to investments, however, debt financing is acceptable from the perspective of intergenerational equity. But investments are not confined to real estate and equipment.

This brings us to the second question raised by intergenerational ethics: What are our responsibilities toward future generations in terms of the organizational and epistemic capacities of the health system they will be inheriting? The level of health we enjoy and the quality of health services of which we can avail ourselves today are the product of the efforts made by past generations. Had Pasteur and his contemporaries not made their discoveries in the field of microscopic life, Flemming would have been unable to discover penicillin. Had Semmelweis and his contemporaries not discovered the role of hygiene in transmitting what they called puerperal fever, we would not have succeeded in bringing the perinatal death rate down to almost zero. The quality of the care from which future generations will benefit depends in large part on the investments we make today in the organizational and epistemic capacities of the health system. In this regard, we can view the extensive cuts in nursing staff – aimed at “restoring” fiscal health – as a disinvestment in the health system's organizational and epistemic capacities. From the point of view of intergenerational equity, these measures were deleterious because, all things considered, failing to protect these investments constitutes negligence on our part, and our inaction could come back to haunt future generations.

Conclusion: For an Integrated Perspective on the Sustainability of the Health System

The preceding discussion should convince us of the futility of contrasting the capacities perspective with the needs perspective. Each of these two visions tells only part of the story. If we want to see the big picture, we must adopt an integrated vision whereby the sustainability of the health system depends on the financial, organizational and epistemic capacities to adequately meet the health needs of today's generations without adversely affecting future generations. This way of looking at things suggests that the definition of demand for health care depends in large part on the health system's capacities, and that intergenerational equity requires that we look beyond deficit- and debt-related considerations to integrate protection of the organisational and epistemic capacities of Canada's health system. From that angle, one is justified in asking what impact an environment characterized by fiscal discipline, debt repayment and tax relief might have on the future of Canada's health system. That is the question we will now address.

Impact of Political and Economic Environment on Capacities of a Public Health System to Meet Needs

Canada's recent history is marked by two major events that turned the country's political and economic environment upside down. The first escaped public attention. In 1991-92, credit rating agencies downgraded the Government of Saskatchewan's rating several times in succession, to the point where the provincial government almost failed to meet its borrowing needs. This brush with bankruptcy was seen as a wake-up call by balanced-budget crusaders in the federal and provincial governments. The ensuing campaign to wipe out the deficit profoundly transformed Canada's budgetary and fiscal landscape. Under the pretext of "fiscal discipline," provincial bureaucracies were co-opted to advance the political agenda of supporters of a reduced State role in society through privatization of Canada's health system. The second event affected the vast majority of Canadians. In the referendum of 1995, 49.5 percent of Quebecers supported sovereignty. This brush with constitutional crisis was seized on by many as an opportunity to do battle with the defenders of provincial autonomy. On the pretext of "national unity," the federal bureaucracy was co-opted to advance the political agenda of those advocating a stronger central government. The impact of both political agendas was to facilitate the adoption of measures that, officially, sought to restore fiscal health with a view to strengthening over the long term the financial capacity of the federal and provincial governments to assume their functions adequately but which, in actual fact, seriously damaged the financial, organizational and epistemic capacities of the health system. To understand the impact of this climate of fiscal discipline, debt repayment and tax reduction, it is necessary to shed light on these two agendas, the first originating in the international context and the second in Canada's domestic political situation. We will begin by discussing the international context before examining the substance and effects of the privatization agenda and of the stronger central government agenda.

International Context: Governments Faced with Fiscal Crisis

Government efforts at reducing deficits, cutting taxes and paying down the debt must be seen within the international context of recurrent budgetary deficits and the growing public debt in all the industrialized nations. But make no mistake: economists do not all speak with one voice concerning the importance and potential effects of this situation. Indeed, in its report on fiscal discipline in the American federal system, the Advisory Council on Intergovernmental Relations (1987) indicates that normative discourse concerning deficits can be grouped into five schools of thought:

1. *The deficit is an illusion*, some economists argue. According to them, if the public sector used the same accounting rules as the private sector, the American federal deficit would become a surplus;
2. The deficit "problem" is an illusion. The deficit has no significant impact on interest rates and inflation rates;

3. Large recurrent deficits represent a significant economic problem. But this is a recent phenomenon, resulting from the convergence of a number of political events, and the political system will likely solve this problem shortly through administrative changes, changes in the majorities holding power or pressure brought to bear by stakeholders and the public;
4. Deficits are a problem resulting from how the decision-making process is structured. Solving this problem requires certain limited reforms in the rules governing decision making;
5. Deficits result from a major structural defect that requires radical reform.

In this battle of rhetoric, it was the most alarmist positions which prevailed in the court of public opinion, the result being that in the 1990s, fiscal discipline and control of public finances became a priority objective in most OECD countries. In Sweden, for example, the “rebuilding program” initiated in 1994, aimed at ending the cycle of budgetary deficits, reduced the overall level of transfers to households while at the same time increasing the tax burden. In the United Kingdom, fiscal belt-tightening has been one the main factors affecting the shift in social policy in recent years. Switzerland and the United States also embarked upon a process aimed at balancing the books over the medium term, while the Maastricht Agreement saw the countries of the European Union pledge to limit their deficits. In most of the cases, the belt-tightening imposed a reduction in spending on social programs and, in particular, on public health programs. Indeed, these programs take up a large part of the budget, and it is often argued that restoration of fiscal health would be impossible without reducing health spending.

On this front, Canada does not stand out from the other OECD countries. The need, already recognized prior to the 1990s, to moderate health spending stemmed from both the convergence of outside pressures and from four internal factors:

- The growing portion of the provinces’ overall budget earmarked for health: the opportunity costs associated with such an increase translate into a reduction in the resources allocated to other public services, like education and housing;
- The recession of the early 1990s reduced the provinces’ fiscal capability;
- The observation that a rise in health spending would not bring about a corresponding improvement in public health, especially when considering such indicators as infant mortality rate or life expectancy at birth;
- Where Canada ranked in relation to other countries in terms of health spending. In 1987, the OECD ranked Canada first for the volume of per capita health spending among countries with a public health system.

It is not surprising that, in a context such as this, those calling for privatization of Canada’s health system were able to lend so much visibility to their agenda.

Privatization Agenda: Reduce the Role of the State While Privatizing Health

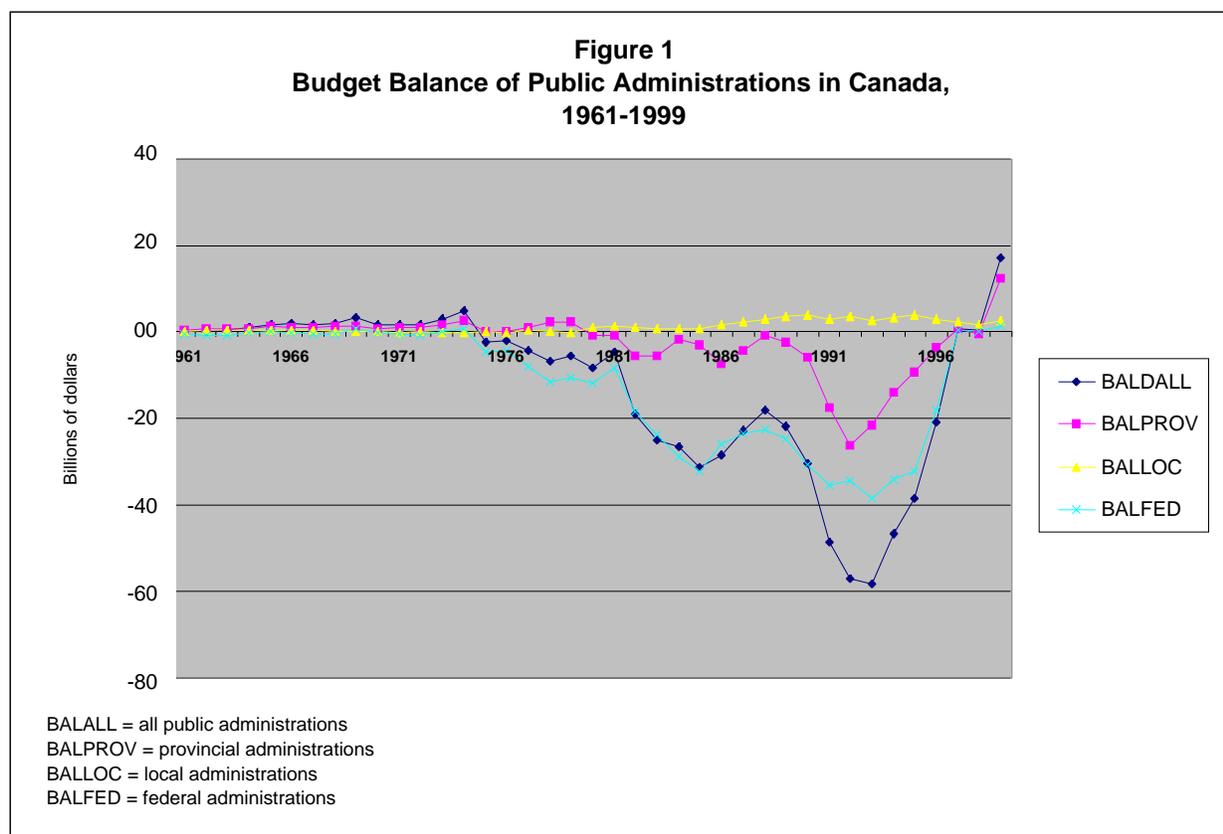
For all intents and purposes, the 1990s saw the federal and provincial governments adopt a right-wing agenda. For one thing, they now share the conviction that balancing the budget is an absolute priority, and their experience in eliminating the deficit has convinced them that they are able to impose this fiscal agenda. For another thing, they seem to have gained the certainty that cutting taxes and paying down the debt are essential to economic growth. The combination of these two elements destabilized the health system by undermining its financial, organizational and epistemic capacities to the point where the system's sustainability is now in doubt.

The period between 1992 and 1997 saw a reduction in program spending. In the wake of the scare experienced by the Government of Saskatchewan in 1992, the federal and provincial governments adopted one by one a series of draconian spending reduction measures aimed at eliminating their deficits. The result: the combined deficit of public administrations in Canada, which had sat at nearly \$60 billion in 1993, had completely disappeared by 1997 (Figure 1). As of 2001, only British Columbia and Nova Scotia are still grappling with a significant deficit. Among the 19 leading OECD countries, Canada rose during this period from the fourth to the first quartile in terms of fiscal balance. It is now one of the five countries with the highest annual budget balance (Richards 2000).

The fiscal restraint that made this possible affected almost every sector of activity. In Quebec, for example, only the budget of the ministère de la Famille et de l'Enfance escaped the budget cuts of 1995-97. The budget of the ministère de la Métropole was chopped by 67 percent, the budget of the ministère des Transports by 40 percent and those of the ministères du Conseil exécutif, du Revenu, et des Régions et affaires autochtones by more than 30 percent. Health spending was cut by 4 percent, or \$521 million. In absolute terms, the other hardest-hit sectors were education (-\$1078 million) and transportation (-\$621 million). A similar picture could be painted for most of the provinces from 1992 to 1997.²

Not only did the governments in place at the time prioritize balanced budgets by slashing their spending, but they also imposed this priority on their successors by passing "anti-deficit" laws – some of them draconian. Starting in 1993, six provinces passed laws limiting the capacity of future provincial governments to introduce budgets that show a deficit. Some of these statutes require balanced budgets annually, while others require balanced budget plans over the medium term. Some also include concrete measures to pay down accumulated debt. The Manitoba legislation even provides for penalties in the event of budgets that show a deficit: Cabinet members' annual salaries would be reduced by 20 percent the year after the government ran the deficit, and by 40 percent if the deficit continued. It also requires that any income, sales or payroll tax increases be approved by a referendum (Millar 1997). In short, a series of legislative measures have lent weight to the idea that balancing the budget has become an absolute priority.

Thus governments showed that they were capable of imposing the measures required to achieve their fiscal balance objectives. Because even though the budget cuts caused considerable pain, they generated little in the way of public reaction. Massive downsizing in the public and parapublic sectors was met with barely a murmur from the unions. Compared to the 1970s, union



mobilization was anemic. The nurses' unions in Saskatchewan and Quebec, which defied the provincial legislation, quickly fell back into line in the face of the provincial governments' resolve.

In addition to the budget cuts and anti-deficit legislation, Ottawa and all the provinces proclaimed tax cuts (Ort and Perry 1999), and most of the governments that achieved budget surpluses earmarked a portion for debt repayment. In other words, in addition to cutting spending, government revenues were reduced. The official rhetoric to the effect that the budget cuts were ad hoc measures and that the attendant decrease in services was temporary proved to be less than truthful. For by attacking government revenues it made a return to previous spending levels difficult, if not impossible.

These fiscal restraint policies disrupted the health system by directly affecting its financial capacity to meet the needs of the public. Provincial governments' health envelopes had increased by an average of 9.7 percent a year between 1976 and 1991. But starting in 1992, the provinces began to reduce their investments in health, such that between 1993 and 1996, their per capita spending on health declined year by year, from \$1,700.90 per person in 1992 to \$1,651.72 in 1996 (a decrease of 2.9 percent). Starting in 1997, the trend reversed itself but by 2001, health spending had yet to regain the pace of the increases it had seen from 1976 to 1991 (see Table 1). The severity of these fiscal restraint measures varied from province to province but all, with the exception of Newfoundland, saw their spending on health decrease in absolute terms; in 1994, Alberta reduced its spending by 8.9 percent. In this regard, Alberta stands clearly apart from the

Table 1
Year-by-year Changes in Health Spending by Provincial Governments,
in Current Dollars per Capita, by Province (as a Percentage)

	1976-1991*	1992	1993	1994	1995	1996	1997	1998-2001**	Severity***
Alberta	9.7	4.6	-2.6	-8.9	-6.2	3.3	8.6	9.5	17.7
Saskatchewan	10.7	-1.5	-6.2	1.1	1.8	2.1	6.4	7.1	7.7
Nova Scotia	10.0	1.0	-3.1	-3.5	1.6	0.8	17.4	4.9	6.6
Ontario	10.0	3.4	-2.2	-0.6	-2.3	-0.4	0.6	6.6	5.5
Quebec	9.1	2.9	1.2	0.8	-0.4	-4.0	2.3	5.1	4.4
Prince Edward Island	9.3	3.0	3.4	-3.3	0.5	3.8	-0.1	6.8	3.4
New Brunswick	10.6	3.2	0.9	2.8	3.7	-0.2	-1.8	7.6	2.0
Manitoba	9.8	4.2	-1.1	-0.2	1.7	0.6	2.6	8.0	1.3
British Columbia	9.9	5.6	3.0	3.2	0.2	-0.5	1.5	7.0	0.5
Newfoundland	9.4	2.2	0.0	3.5	3.8	1.3	5.8	8.6	0.0
Canada****	9.7	3.4	-0.7	-0.3	-1.1	-0.8	2.6	6.7	4.9

* Average annual change for the period 1976-1991. Calculated by the authors.

** Average annual change for the period 1998-2001 (the data for 2000 and 2001 are projections). Calculated by the authors.

*** Restraint severity index: sum of negative year-over-year changes (as a percentage), 1992-97. Calculated by the authors.

**** Weighted average, except for severity index.

Source: Canadian Institute for Health Information, January 4, 2002, Table 10.

other provinces with a severity index of 17.7 points, situating it 2.6 standard deviations above the provincial mean. Newfoundland and British Columbia were the provinces with the least severe budget cuts during this period.

The budget cuts had a domino effect on the system's epistemic capacity (one of the effects being a dead loss of expertise through the early retirement of the most experienced nursing staff) and its organizational capacity (changes in the roles and responsibilities of the remaining staff, decline in stakeholder motivation, numerous changes in organizational routines, restructuring, closing of hospital beds, shorter hospital stays, reduced access to operating rooms, structural changes in the decision-making process brought on by regionalization, etc.). In a nutshell, the entire organizational and epistemic capacity of Canada's health system took a direct hit.

This has set the table for privatization of health care in Canada. As Yannick Villedieu points out,

[TRANSLATION:]

We have to ask ourselves in whose interest is it to devalue the public health system? Who stands to gain from systematically denigrating and depreciating it? We must find out who in the blazes could profit from what basically looks more like a plot or even an ideological conspiracy – the campaign for privatization – than a methodical demonstration of an inexorable failure of the public health system (Villedieu 2002, 260).³

Budget cuts have thrown the system into disarray, bringing enormous pressure to bear on the quality and quantity of services. Tax cuts and debt repayment have limited governments' capacity to pump new money into the system in order to ease the crisis. The conclusion seems obvious: since the current system is not working well and governments lack the financial means

to solve the problem, the health system must be overhauled, new sources of financing must be found... in a word: privatization. This is how the agenda of the advocates of the health system privatization was implemented by the provincial governments, even though, paradoxically, it strengthens the hand of those supporting a stronger federal role at the expense of the provinces.

The Stronger Central Government Agenda: Weaken the Provincial Governments by Reducing Their Revenues

The provinces' intensive deficit-elimination campaign coincided with the trauma of the federalist camp's near defeat in the Quebec referendum of 1995. At the time, many felt that Ottawa needed to take forceful action to prevent this situation from recurring. The elimination of the federal deficit would give them the opportunity they sought, since a large portion of the federal budget consists of tax transfers to the provinces. If the level of these transfers were reduced, the distribution rules would have the effect of weakening the provincial governments – not to mention improving the federal government's bottom line.

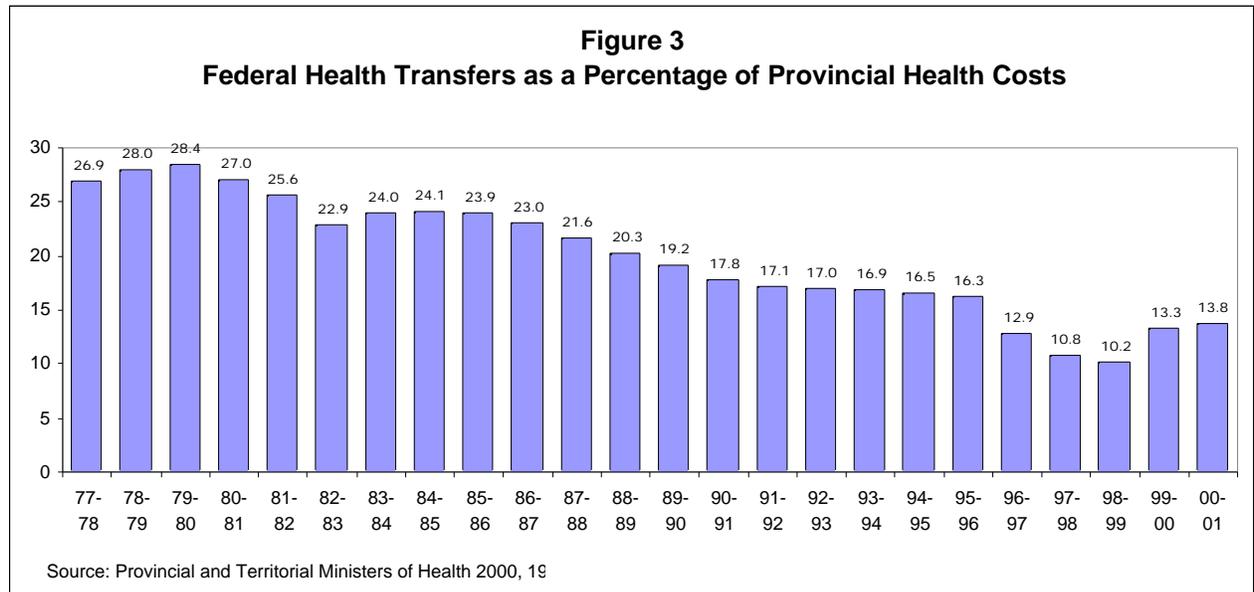
Ottawa's efforts to regain control over the growth in health and social spending are not new. Indeed, since 1957 the federal government has made significant changes in the funding of provincial social programs, changes affecting the structure of the transfers as well as the funding levels.

The changes in the structure of the transfers were carried out in three stages. From shared-cost programs (in which the program costs were shared equally between the federal government and the provinces), there was a gradual shift to block funding (whereby Ottawa determines how much it will give to the provinces, irrespective of costs). When Canada's major social programs were created (hospital insurance, health insurance, income support, etc.), the provincial governments gave up part of their constitutional jurisdiction in the area of health and social services in return for federal funding. Thus the programs' structure and contents were defined in an agreement between the federal and provincial governments, with each level of government providing 50 percent of the funding – Ottawa's share coming in the form of tax transfers to the provinces and the transfer of tax points. The sum of these transfers was therefore based on the costs of the programs implemented. This funding formula was reformed for the first time in 1976. From that point on, federal transfers in the fields of health and higher education would no longer be based on program costs but rather on a block transfer, calculated on the basis of the costs at the time. Starting in 1977, block transfers would be used to fund health and higher education programs, and funding for the Canada Assistance Plan would be provided on a shared-cost basis. In 1996 a second reform of the system of federal social transfers to the provinces transformed the final portion of shared-cost funding into block transfers, giving birth to the Canada Health and Social Transfer (CHST). Ever since, federal transfers for social programs have no longer been determined on the basis of the costs of the programs but by a decision that is Ottawa's (and Ottawa's alone) to make, the law making no provision for any formal cost indexing formula or any mechanism for taking into account changes in program costs.

Figure 2
Financial Funding of Provincial Social Programs Since 1957

Shared-cost Programs 1957-76		Mixed Financing 1977-96		Block Funding Since 1996
Hospital insurance	➔	Established programs financing EPF (Block financing)	➔	Canada Health and Social Transfer CHSTS
Health insurance				
Post-secondary education				
Canada Assistance Plan CAP	➔	Canada Assistance Plan (CAP) (Shared cost funding)		

Source: Quebec. Commission sur le déséquilibre fiscal 2001, 8.



Consequently, although the federal government’s commitment was originally linked to the costs of the services rendered, such is no longer the case.

Changes in funding levels occurred more gradually. Federal health transfers amounted to 26.9 percent of provincial health care costs in 1977-78. This share gradually fell, reaching 16.3 percent just before the introduction of the CHST. The deep cuts accompanying this change brought Ottawa’s share of the funding to 10.2 percent in 1998-99 – a drop of 62 percent over 22 years (see Figure 3). During the same period, the total cost of health services in Canada in

constant 1997 dollars went from \$42.9 million in 1978 to \$87.24 million in 1999, an increase of 103 percent.

The changes in the structure as well as the level of the federal funding for provincial health programs gave Ottawa more leeway and upped the budgetary pressure on the provincial governments. By separating its contribution from the growth in health costs, the federal government gave itself the power to alone set the level of its contribution. What a perfect opportunity for proponents of a stronger central government to weaken the provinces! The provinces bore the brunt of the budget cuts while Ottawa reaped the benefits in the form of healthy surpluses. In other words, the electoral cost of the fiscal restraint policies was not paid by the authors of these policies. The verbal sparring between the two camps on the question of restoring the federal transfers to their pre-deficit-cutting levels is a good illustration of this. The big guns on the federal side insist that the federal contribution must include the value of the tax points transferred to the provinces over the years, thereby increasing Ottawa's share of health funding and reducing the shortfall since the growth in the value of these tax points has more or less kept pace with the development of the economy. It seems clear, however, that the tax points' inclusion is nothing more than a rhetorical sleight of hand. If this truly must be taken into account to determine Ottawa's actual share, why stop at the fiscal arrangements of the 1960s and 1970s? Why not go back to the fiscal arrangements at the time of the Second World War, when the provinces undertook a massive transfer of their taxation power to the federal government? As Ontario Premier Leslie Frost pointed out during the federal-provincial conference of July 1960, shared-cost programs – like transfer programs in general – constitute a system by which Ottawa whets the provinces' appetite with their own money, money they lost since the World War II fiscal arrangements (Perry 1997, chapter 14). Today, proponents of a stronger central government are using the budgetary situation of the provincial governments and the fiscal breathing room Ottawa created by cutting its transfers to the provinces in order to push their agenda, which consists in raising the federal government's profile with voters and providing federal officials with greater powers in the field of health.

Conclusion

The discussions concerning Canada's health system are set against an economic and political backdrop such that, in addition to the explicit agenda of health system reform to ensure greater efficiency, there are hidden agendas on the part of stakeholders who are pursuing a number of political objectives. First, there are the objectives of those in favour of dismantling the welfare state. These people are looking to take advantage of health system reforms to privatize as much of the system as possible. Second, we have the supporters of stronger federal powers vis-à-vis the provinces. They too want to take advantage of the reforms, with a view to weakening the provincial governments and thereby entrenching Ottawa's hegemony in the Canadian political system. The direct impact of this dynamic is a weakening of the health system's financial capacities, but also its organizational and epistemic capacities to meet the health needs of today's generations and ensure the system's survival in the interest of future generations. From that vantage point, the sustainability of a public health system in Canada is by no means assured.

But at this point in our reflection, we have to stop and ask ourselves the following: How could fiscal discipline have served as the sole justification for such an attack on the sustainability of Canada's health system? Or, as a corollary to that question, how could the objectives of protecting the system's financial capacity have made us lose sight of the organizational and epistemic capacities? The next section is devoted to that fundamental question.

From Financial Capacity to Organizational and Epistemic Capacities: The Teachings of Economic Theory

The main threat to the sustainability of a public health system in Canada lies in the fact that we are overly concerned about financial capacity to the detriment of the system's organizational and epistemic capacities. In this section we will argue that to realize the importance of a system's organizational capacity, one must move beyond the prevailing economic theory, i.e., neo-classical theory, to embrace agency theory. And in order to take into account epistemic capacity, one must complement agency theory with convention theory. We will therefore present the basis of each of these theories, as well as the approaches they propose to the question of sustainability of a public health system in Canada.⁴

Neo-classical Theory

The first characteristic of the neo-classical model is its use of the postulate of substantial, calculating and individualistic rationality of economic agents. The neo-classical model is based on a second postulate, that of market coordination of individual behaviours. This assumption has four main implications: 1) individual decisions come together to form supply and demand; 2) prices adjust themselves until individual decisions become compatible in the whole; 3) the place where these decisions come together is the market; 4) businesses, public organizations or other aggregates of people are considered as individuals, each pursuing a sole objective. The consequence of this final implication is that we have no knowledge whatsoever of the relationships among the persons composing the aggregate.

Several analyses of the health system are based on this model. They present the patient as a consumer who "demands" health services or as an investor who would like to increase his health capital; the doctor as an individual businessman who "supplies" health services; and the hospital as a business that produces health services with an eye to responding to the "demand" from doctors and patients, or as an "office" represented by a bureaucrat looking to maximize his discretionary budget. This approach, which is the basis for recommendations aimed at privatizing health care, holds that the optimum allocation of health resources will be achieved if patients, doctors and hospitals are allowed to choose the goods and services they want to demand or supply. Through the free interaction of supply and demand, the market would be able to produce an optimum series of health goods and services without waste.

The simplicity of this model and the conviction of its adherents that they speak the truth make it a very effective tool of persuasion. But the neo-classical model is not without its problems. The first has to do with the nature of the market. The model assumes a market of perfect competition, which all serious observers agree is a fiction. Several alternative formulations have been proposed, but there is no consensus regarding the nature of the market. Next, the autonomy of the demand is negated by virtue of the asymmetry of information between patient and doctor. As we have seen, it is the latter who determines, through his diagnosis, the nature of the demand. Demand is therefore induced by supply. Furthermore, the model states that behaviours will be coordinated in the interplay between supply and demand through prices,

which result from this interplay. But the decisions that engage the health expenditures are dissociated from financial responsibility, and the fees are administered through paternal legislation. So the role played by prices is greatly reduced. Furthermore, considering the hospital as an individual actor (business or bureaucracy) conceals the fact that what is seen as the choice or behaviour of the hospital is not the result of a rational calculation but of the interaction between the members of these organizations, individuals who share neither the same interests nor the same information. The artifice of presenting the hospital as a unique entity conceals more than it reveals. Last, defining in monetary terms the resources to be allocated has the effect of focussing attention on financial capacity to the detriment of organizational and epistemic capacities. In short, the neo-classical model is seriously flawed and does not by itself suffice to guide public decisions.

When all is said and done, the applications of the neo-classical model to health systems usually consist in [TRANSLATION:] “highlighting, *in a pragmatic manner*, the inefficiency of the public sector in comparison with an ideal private sector, seen *in purely theoretical terms*” (Béjean 1994, 68, [author’s emphasis]). In the context of the inevitable political adjudication between the various interests involved, this theoretical discourse often becomes an ideological discourse whose function is to lend an air of rationalism and “truth” to the proposals of the privatization camp.

Agency and Incentives Theory

In response to these limitations of neo-classical theory, the theory of agency or the theory of contracts and incentives proposes opening the black box and analysing what is going on there while stressing information as a source of profit for the person holding it. The main way in which this theory parts company with neo-classical theory is by abandoning the theoretical fiction whereby the organization behaves as a single, profit-maximizing individual. The theory of agency is built on three postulates: 1) decisions are taken in an environment of uncertainty; 2) there is asymmetry of information (certain actors control information); 3) there is a divergence of interests among the actors (individual interests do not always coincide with the collective interest). On this basis, the relationships among the actors in an organization are seen as relationships of agency, i.e., relationships in which one of the parties, the *principal*, delegates his decision-making power in a sector of activity to another party, the *agent*. The latter possesses information which the former does not. This asymmetry of information gives a major advantage to the agent, who can often impose his agenda by choosing what information to reveal to the principal. Thus he can hide information from him regarding his own behaviour. The principal might therefore doubt the effort that the agent will make to satisfy his interests. That is what we call “moral hazard.” The agent might also conceal information on the features of the health product (cost, quality, likelihood of accident, etc.), which can lead the principal to make bad decisions (choosing goods or services that do not meet his efficiency objectives). This is what we call the risk of adverse selection. By not revealing the “truth,” the agent leads the principal to attempt to reappropriate the information, hence incentive contracts aimed at convincing the agent to reveal the truth: performance contracts, bonuses or penalties geared to results, etc.

In the area of public policy, the most important contribution of the theory of agency is to show that regulation of the public health system must not be based on prices or constraints but on incentives. The objective is to ensure that agents behave in the principal's interests, not because they are obligated to do so, but because it is in their interest to do so. In fact, some health system reforms conform to the agency approach recommendations, such as the introduction of budget allocation rules, which "interest" managers and care providers in general in the result of the action delegated to them. This is the most useful approach in terms of justifying the recommendations of the supporters of a stronger federal role. The federal government, as "principal," is thus entitled to exert control over the provincial governments, as "agents," to avoid the "moral hazard" of seeing the provinces adopt policies after the fact that are inconsistent with its priorities.

But the agency approach poses at least three problems, which are serious enough to warrant complementing it with another. The first of these problems is shared with the neo-classical model: the [TRANSLATION:] "heroic postulate of substantial rationality," which requires of the actor a phenomenal and unrealistic calculating capacity (Simon 1978). Indeed, the effectiveness of incentive contracts is tied in with the capacity of the principal and agent to "calculate" the long-term results of all the possible scenarios with a view to choosing the one most conducive to his well-being. Human beings simply do not have the cognitive capacities needed to make such an assessment of their choices in terms of their results. There are at once too many uncertainties to gain an accurate understanding of the reality involved and too much information for the human brain to be able to process it completely, hence the necessity for simplification mechanisms. The second problem has to do with the fact that the postulate of substantial rationality holds that self-interest guides all decisions and denies the existence of philanthropic, ethical or equitable behaviour among the various actors. But we know not only that these behaviours exist but that they are very prevalent in the field of health. If we exclude them from the analysis, we risk overlooking an essential dimension of a system's organizational capacity: eliciting conformity to standards. The third problem associated with agency approach is that it identifies "good guys" and "bad guys" in the organization. The "agent" is the bad guy who refuses to reveal the truth and the "principal" is the good guy who is only seeking the truth. The agency theory's positive applications are less likely to pose this problem, since they view all relations inside an organization as relationships of agency. Thus the same actor – a hospital administrator, say – is the agent in the department-hospital relationship, but the principal in the hospital-doctor relationship. The normative analysis of agency does not always bother with these subtleties and is sometimes quick to identify a guilty party, an "agent" (bureaucrat, physician or even provincial government) who knowingly conceals information to serve his (or its) self-interest. When this type of discourse prevails, how can the trust and motivation at the heart of the health system's epistemic capacity be maintained? Three problems, then, which call for a new theoretical approach based on procedural rationality: convention theory.

Convention Theory

Convention theory is quite different from agency theory in that it rejects the postulate of substantial rationality in favour of procedural rationality. This makes it possible to take into account a patient's emotional rationality, adherence by a physician to a code of professional

ethics, and equity as a founding principle of the coverage system for illness risk. It also makes it possible to take into account the knowledge acquired through the learning process inside organizations and the trust relationships on which this knowledge is based. All these characteristics contribute to a system's epistemic capacity.

The actor conceived by the conventionalist approach is neither *homo sociologicus*, whose behaviour would be predetermined by the norms and customs he acquired during the socialization process, nor *homo oeconomicus*, who would be completely motivated by a desire to maximize his own utility. He is somewhere in the middle. His behaviour is guided by convention rules, i.e., [TRANSLATION:] "systems of mutual expectations of competencies and behaviours" (Salais 1989, 213, quoted in Béjean 1994, 268). Conventions are meta-rules, some explicit and codified (e.g., codes of ethics or control processes by professional associations), others implicit and sometimes spontaneous (e.g., trust relationships, which often develop between administrators and administered in the budgetary process), which take shape over a long process of interaction among the actors in an organization and which serve as a [TRANSLATION:] "collective cognitive device" (Favereau 1989; 1993, quoted in Béjean 1994, 270), allowing for a knowledge economy. Given the flood of information submerging the members of an organization and on account of their cognitive limitations, convention rules come into being to simplify the processing of this information by establishing routines and defining roles for the main actors involved. Thus conventions are part of an organization's resources, since they increase its epistemic capacity (capacity to respond to uncertainty) and its organizational capacity because, built by a trust-based learning process, they strengthen its cohesion.

Convention theory, as applied to health economics, identifies two conventions at the heart of the health system: an activity convention, which regulates the State-doctor relationship, and a quality convention, which regulates the doctor-patient relationship.⁵

The literature on budgetary processes identifies a third convention, which is of particular importance when it comes to taking into account (as it does here) the budgetary environment: budgetary convention (Wildavsky 1964; 1975; 1988). This convention regulates the relationship between guardians and spenders of budgets within an organization by providing for a sharing of responsibilities among one another. Thus the guardian mainly looks after the budget as a whole to ensure that budgetary allocations conform to the rules of the organization, in particular those regarding deficits. By overseeing the budget, the guardian does not look after the services offered by his organization because he knows that this is being looked after by the spender. Indeed, the spender is first and foremost concerned with the quality and quantity of services produced and offered under his watch, and he makes his budgetary requests accordingly, without concerning himself with the budget as a whole, as he knows that the guardian is looking after this. Guardians have a number of reasons for limiting expenditures. If there is a deficit or mismanagement, they will be the first targets of criticism. Furthermore, their quest for power cannot be fulfilled by a growth in spending by their unit but by their control over other units' expenditures. Spenders have their own reasons to increase the quantity and quality of the services offered and therefore to increase their budget. It is easier to manage a growing budget than a shrinking budget, because it is easier to distribute additional resources to everyone than to have to choose who in your section will receive additional resources and who will not (or who will lose resources). Furthermore, a section chief's prestige is tied in, lower down, with his ability to respond to the

demands of his subordinates and, further up, with the share of the total budget he can obtain. Thus the spender will seek to increase his budget. Trust is very important in the interaction between guardians and spenders. It is built on past decisions, and therefore on learning. Without trust, guardians will impose strict controls, thereby encouraging spenders to flee to other sources. Without trust, spenders will grossly overstate needs to ensure the minimum, thus encouraging guardians to impose stricter controls. To sum up, budgetary convention provides for a sharing of responsibilities between guardians and spenders of financial resources, along with control mechanisms and sanctions aimed at dissuading potential abuses. As long as there is trust between guardians and spenders, the organization is saved the costs of non-cooperation: the costs of additional controls for guardians, the costs of lobbying and of searching for other funding sources for spenders.

Upon reflection, fiscal federalism in Canada can also be viewed as a budgetary convention regulating the relationship between Ottawa (guardian) and the provinces (spenders). As long as the actors share the responsibilities (the guardian looks after the budget as a whole and the spender looks after the quality and quantity of health care) and as long as there is trust between them, all of society is spared the costs of non-cooperation. From this vantage point, the agenda of the proponents of a stronger federal government risks breaking this convention and, as a result, adding to the costs of the health system itself the costs of non-cooperation. If fiscal federalism, as a convention, is not functioning properly, the provincial elite must devote a large portion of their resources (financial, organizational and epistemic) to lobby the federal government or seek alternative sources of funding. Utilized in this manner, these resources are no longer available to develop reforms that can increase the quality and quantity of health services.

In addition, we should ask ourselves whether the five conditions provided for in the *Canada Health Act* (public administration, comprehensiveness, universality, portability, and accessibility) do not constitute a convention between the federal State and Canadian taxpayers. Through this convention, the State identifies taxpayers' preferences (a health system that responds to these criteria) and the level of taxation they are prepared to assume. In exchange for compliance with the five principles of the Act, taxpayers are prepared to pay the taxes growing out of their application. So long as there is trust between the federal State and taxpayers on this question, the convention spares society the costs associated with the "free rider" risk that would be generated by a lack of knowledge of the actual level of taxation that taxpayers are prepared to assume, and with the moral hazard to which taxpayers would have to expose themselves to learn the government's true intentions.

Taking into account the existence of these three conventions in the health system allows us to realize that contractual rules (which, for example, lead a doctor to reveal the information he possesses to the public authorities and patients or, in another example, tie a manager's salary to the attainment of budget objectives) and constraining rules (which introduce, for example, rationing that can bring spending under control) are effective to the extent that they do not threaten the conventions which exist in the health system. As pointed out by Béjean, [TRANSLATION:] "the conventions economy does not in an overall sense call into question the market economy nor the contractual coordination of individual decisions, but assumes that their effectiveness is dependent on these principles [conventions]" (Béjean 1994, 296). The objective of expenditure or cost control must not be pursued to the detriment of the patient's, doctor's or

manager's interests, or, put another way, financial capacity must not be strengthened to the detriment of organizational and epistemic capacities. The costs generated by a loss of trust between the actors in the health system could far surpass the savings that a series of rules imposed without regard to established conventions might yield.

Conclusion: Simplicity or Realism

Which theory should we choose? The standard, prevalent reply in economics is to choose the theory with the greatest predictive power (Friedman 1953). If we follow this logic, the unrealism of the behavioural assumptions is of little importance so long as the theory allows us to deduce hypotheses supported by systematic empirical observation. The greater the number of these hypotheses, the greater the theory's predictive power. This position is acceptable in the context of scientific research, but it is morally indefensible when it comes to applying public policy. Indeed, scientific research produces far more results that invalidate hypotheses than results that confirm them. For example, in their meta-analysis, Imbeau, Pétry and Lamari (2001) showed that the 693 empirical results they analysed supported the hypothesis in only 20 percent of the cases. And these findings deal only with results published in learned journals! Are we prepared to run the risk of this type of mistake in reforming the health system when we know full well that the basic assumptions of one theory are far less realistic than those of another? Applying the criterion of predictive power in choosing a theory with a view to informing public policy decisions is tantamount to experimenting on a population to validate the theory. When the "quasi-experiment" of the "empirical test" (characteristic of social research) is replaced by an actual experiment on human subjects (characteristic of public policy), the criterion of the theory's predictive power must give way to that of realism when one must choose between theories which do not lead to the same recommendations. In the final analysis, it is not about choosing one theory and dismissing the others. Owing to the complexity of the social systems, we should make every effort to guard against this type of dogmatism. Because the theories complement one another in that they each highlight a different aspect of the reality involved. If we limit ourselves to the conclusions of neo-classical theory, we risk overlooking an important aspect of the health system's capacity to respond to Canadians' health needs, that being its organizational and epistemic capacity.

Overall Conclusion

Our examination of the sustainability of Canada's health system and the economic and political environment facing us today has led us to reformulate the question we began with, which has now become:

How might the international context of fiscal discipline and the existence of two political agendas advanced by stakeholders in the discussions on reforming Canada's health system impact on the financial, organizational and epistemic resources needed to respond satisfactorily to the health needs of today's and future generations?

From the preceding discussion, five observations and five recommendations have emerged.

Observations

1. While necessary, sound management of the health system's financial resources is not enough to ensure its sustainability. Canada's fiscal situation over the past decade has led us to focus on financial resources. In doing so we have often lost sight of the system's organizational and epistemic capacities. Only integrated management of all of the health system's capacities can shield us from pernicious, intolerable effects. Any change in financial management must be assessed on the basis of its impacts on the system's organisational and epistemic capacities.
2. Too much fiscal discipline can be counterproductive. When budget rules do need to be applied, they must emphasize as much as possible an incentive rather than coercive approach. Coercive rules involve monitoring costs that are superfluous when agents have a personal stake in adopting the behaviour sought by the rule.
3. Trust is the cornerstone of the health system. Irrespective of the measures adopted to ameliorate the health system, the rules imposed to ensure improved efficiency must in no way undermine the trust that exists among the principal actors in the system: patients, physicians and other professionals, and managers; otherwise, monitoring costs will rise needlessly. The least costly and most efficient means of reforming the health system and ensuring its sustainability is to observe the conventions linking the system's main actors. Ignoring these conventions can only jeopardize the system's sustainability.
4. There are risks of disruption in budgetary convention in Canada, both within organizations and in federal-provincial relations. If we continue requiring budget spenders to play the role of guardians and to worry more about balanced budgets than quality of services, we run the risk of distancing them too much from their primary role, which is to improve the quality and quantity of care.
5. Because organizational and epistemic capacities are necessary to ensure the sustainability of the health system, it is essential to involve in the decision-making process specialists from fields other than economics and accounting (health specialists and social systems specialists). Increasingly, we are entrusting our accountants with the task of deciding the nature, quality

and mix of services to offer, without asking ourselves if they are qualified to do so. With the best of intentions, they run the risk of weakening the system's organizational and epistemic capacities and thus setting it on the road to ruin. It would not be the first time that sorcerers' apprentices have created chaos while trying to put the house in order.

Recommendations

1. Ottawa must make it a priority to quickly restore its health funding levels by earmarking budgetary surpluses for health before paying down the debt and cutting taxes. This will increase the system's capacity to respond to the health needs of the population.
2. Unequivocally reaffirm the five fundamental principles of the Canadian health system (universality, accessibility, portability, comprehensiveness and public administration) and continue to insist that the provinces meet these criteria as a sine qua non for federal funding. This will preserve public trust in our political institutions and in the health system.
3. The CHST should be the tool of choice for funding the health system, rather than the transfer of tax points. In this way, the federal government will maintain the leverage it needs to influence the evolution of the health system in the provinces.
4. Encourage research on budgetary convention in health organizations with a view to identifying the best ways of ensuring optimum allocation of financial resources without undermining organizational and epistemic capacities, and with a view to increasing the trust of the managers and health stakeholders within these organizations.
5. Support social research on the health system, in particular on the interaction among financial, organizational and epistemic capacities.

Notes

- 1 Recognizing this dual meaning, the Canadian Medical Association employs two different French translations of the term “sustainability”: « En français, pour traduire “sustainable” dans le contexte du secteur de la santé, nous emploierons tantôt “durable” (santé durable), tantôt “viable” (système de santé viable). L’adjectif “viable” incorpore en effet les notions de durabilité et de développement » (2000, 1).
- 2 Bruce, Kneebone and McKenzie (1997) published an interesting study on Alberta’s experience at eliminating the deficit. For a description of the deficit elimination policy in Quebec, see Imbeau and Leclerc (2002). For a comparison of the experiences in Alberta, British Columbia and Saskatchewan, see Imbeau 2000.
- 3 On the same theme, see Forest (2002).
- 4 Our discussion of the economic theories in this section is freely adapted from the writings of S. Béjean, whose insightful synthesis was of valuable assistance to us.
- 5 For a description of both conventions, see Béjean 1994, p. 272-285.

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