Chapter 6

“Implementing a National Vision”: The Romanow Report’s Three Federalisms

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Canada’s universal health insurance system has been mythologized as a central symbol of a shared Canadian identity. While its importance in building a pan-Canadian identity may be exaggerated, it would be hard to deny that medicare and other social programs have contributed to developing a conception of Canadian social citizenship and of a pan-Canadian sharing community (Boychuk 2008). This integrative character is nevertheless complicated by a constitutional division of powers that gives provinces a wide leeway to adopt distinct health policies that reflect a competing territorial understanding of citizenship and community. What is raised here is the tension that Keith Banting (Banting 2006) observed across the established federations, between the logic of developing a federation-wide social citizenship and the logic of territorial diversity. In Banting’s view, the logic of social citizenship is everywhere winning hands down. But to say that social citizenship is in tension with territorial diversity needs some further elaboration – the tension lies in a vision of social citizenship that prizes individual equality, and efficiency and performance in delivering social rights to individuals regardless of subnational community of belonging.

We do not pretend to offer a theory of which trend is likely to win out, particularly since in specific cases there may well be messy compromises between the logics, as a developing logic of social citizenship must work in and around existing institutions, such as the constitutional division of power, and established ideologies about the proper sharing community. We instead work from the bottom-up, starting with the premise that we need to understand *both* the mechanisms through which attempts to build a pan-Canadian citizenship via social programs work with and around the institution of the constitutional division of powers, *and* the arguments justifying the use of these mechanisms.

It is with this question in mind that this chapter considers the report of the Royal Commission on the Future of Health Care in Canada, commonly known as the ‘Romanow report.’ In laying out recommendations for the future of health care, the Romanow Commission had to articulate a vision of the political community in terms of the relevant sharing communities

(federal and provincial), and to develop an implicit or explicit justification for that vision. By looking at the Romanow report's recommendations, we can analyze the mechanisms through which the tension between a pan-Canadian vision and the existence of a federal constitution is worked out, and the manner in which this innovates on earlier royal commissions faced with a similar tension. This chapter will argue that the Romanow report's discussion and recommendations approach the tension between federalism and social citizenship in three ways. The first two look back to the previous reports in their concerns for jurisdiction and the spending power, while the third appears to reflect post-Social Union Framework Agreement ideas about social policy governance. In all three views, however, we see the continued tendency of the logic of social citizenship, and supporting values of efficiency, to crowd out the logic of federalism.

Social Citizenship and Federalism: Why Study the Romanow Commission

Keith Banting has argued that social citizenship and federalism exist in tension. He argues that "the promise of social citizenship is the equality of treatment of citizens, to be achieved through common social benefits and public services available to all citizens throughout a country. The promise of federalism is regional diversity in public policies, reflecting the preferences of regional communities and cultures." (Banting 2006: 44) Banting's argument nevertheless seems to stand at the level of the federation as a whole, asking which mix between the goods of social citizenship and diversity will win out. Unlike his earlier work on social policy as statecraft (Banting 1995), we do not see how these logics play out between governments seeking to gain and maintain the adherence and loyalty of their citizens to their respective political communities. As Choudhry observes, the "political communities [in a federation] make claims on their citizens, and these claims compete in the same political space with one another" (Choudhry 2001: 390). This view has been taken up by recent work on the territoriality of the welfare state, whereby social policy becomes an important tool for minority nations seeking to build a national citizenship separate from (or in addition to) that of the broader state (Béland and Lecours 2008; Moreno and McEwen 2005). In other words, if we are to study the interaction of these 'promises' or 'logics,' we need to consider how they are manifested in political conflicts and debates about the appropriate definition of the political community in which social citizenship rights are to apply.

In the Canadian case, these conflicts and debates operate within the institutional

framework of *The Constitution Act, 1867*, setting out a division of powers between the federal and provincial orders of government. While the *Act* and subsequent amendments provide the federal government with an important jurisdictional basis for developing a pan-Canadian social citizenship in such areas as employment insurance, pensions, and interregional redistribution, its claim for intervening in such core areas as health care, education, and social services has historically been deemed to be weak. In seeking to develop a pan-Canadian citizenship in such areas, it has therefore had to elaborate mechanisms for engaging the provinces, especially after the provinces resisted the federal government's attempt to closely regulate the development and management of the provincial health care systems at the Dominion-Provincial Conference on Reconstruction at the end of the Second World War (Boismenu and Graefe 2003). At the same time as elaborating these mechanisms, it had to justify its actions either by making claims to the values served by its involvement or by calling upon an existing popular consensus for its participation. In Rocher's view, this justification has been served by the development of an English Canadian understanding of federalism that dates from the Rowell-Sirois Commission, one that considers federalism as a functional form of power-sharing to be evaluated on its efficiency (Rocher 2006).

In some ways, the story of how this has played out in health care is well-studied and well-known, and centres on the use of the federal spending power to induce the provinces to develop comparable universal hospital and medical insurance programs, as well as later disputes and agreements about the degree of federal oversight and funding of these now mature social programs. The academic research papers on this theme for the Romanow Commission were in fact remarkable for the similarity of their narratives, picking up the key dates of intergovernmental negotiation and disputes such as the 1945 Reconstruction conference, the 1957 *Health Insurance and Diagnostic Services Act*, the 1965 *Medicare Act*, the negotiation of the 1977 *Established Programs Financing Act*, the 1984 *Canada Health Act* and unilateral federal reductions in its EPF (established programs financing) funding culminating with the substantial cut in transfers for health, social services and post-secondary education in the 1995 federal budget (compare Maioni 2002 with Rocher and Smith 2002).

This historical narrative is nevertheless too narrow on two grounds. First, in emphasizing the spending power and associated conditions, it limits the scope of inquiry to a particular mechanism, failing to raise the question if the federal government used other tools to develop

some degree of social policy integration. Second, while the analysis captures intergovernmental negotiating and agreement, it fails to engage with the ideas presented to justify and legitimize intergovernmental agreements that departed from established readings of the constitutional rules. Poirier has noted how intergovernmental agreements are a way of working around constitutional barriers, but that in the process they also serve to redefine understandings of the constitution (Poirier 2004). To put these two critiques together, it could be said that the federal-provincial histories prepared for the Romanow Commission failed to theorize the role of ideas in shifting the ground of federal-provincial interaction.

Royal commissions can play an important role in policy development in their ability to shape the ideological framework in which policies are made. They are institutions that represent ideas. As Jenson argues, “they have often been locales for some of the major shifts in the ways that Canadians debate representations of themselves, their present and futures” (Jenson 1994: 40). Through their use of public consultation and expert advice, they move policy discussions outside of the entrenched bureaucracy and, therefore, have some capacity for successful innovation. Thus, independently of the issue of whether the specific recommendations of a commission are implemented, they contribute to shaping how citizens subsequently identify their interests and collective identities (Jenson 1994). In this chapter, we therefore assess how the Romanow Commission managed the tension of federalism and social citizenship, and partially contextualize this with respect to the range of ideas available to the commission from its published studies and from the two preceding Royal commissions that had looked closely at health care and federalism.

The Rowell-Sirois and Hall Royal Commissions

The Romanow Commission was not the first to grapple with the tension between a pan-Canadian conception of shared social citizenship and the federal division of powers, and our appreciation of its arguments is aided by a brief consideration of two important forerunners, namely the Royal Commission on Dominion-Provincial Relations (Rowell-Sirois) and the Royal Commission on Health Services (Hall). It is noteworthy that the historical papers on federal-provincial relations commissioned for the Romanow report did not have much to say about their philosophies of federalism. For ‘Rowell-Sirois,’ this may in part reflect the disagreements about its philosophy of federalism. In some interpretations, the report provided a rationale for the post-war pan-Canadian nation building-project, particularly in bringing efficiency and effectiveness to the fore as

normative standards for judging which governments should fulfill what functions (Rocher 2006). For others, the report, with its emphasis on provincial autonomy, on fiscal measures to protect that autonomy (national adjustment grants), and on the fact that just because problems recur in every province does not necessarily require central government solutions, stands as a road taken – a modern welfare state built on provincial bases (Smiley 1971; Ferguson and Wardaugh 2003). Boychuk comes closer to the heart of the matter in treating it as a provincialist report, but whose provincialism was in important ways shaped by considerations of efficiency and effectiveness (Boychuk 2008). Thus, the Rowell-Sirois report called for pan-Canadian programs in unemployment insurance and pensions, but provincial programs in health insurance, on the basis of considerations of capital and population mobility more than on any reading of the division of powers.

In anticipation of our discussion of 'Romanow,' three points are worth making. First, in discussing the federalism dimension, the division of powers is front and centre. Even in fields where the case is made for a pan-Canadian program, it is assumed that this will require a constitutional amendment. Second, in discussing the division of powers in health, the report comes down squarely on the side of health being a provincial jurisdiction. Third, the report's treatment of health contains passages extolling the importance of respecting territorial diversity. While this treatment most likely reflects a vision of subsidiarity (consistent with the value placed on efficiency, as noted by Rocher and Boychuk, it does break with a pure logic of pan-Canadian citizenship in providing some normative support for territorial diversity (Rocher 2006; Boychuk 2008).

The Hall Commission's views on federalism have been much less remarked, perhaps in part because they are relatively unremarkable for the time in which they appear. The report is remembered most for resolving the debate over the mix of public and private physician insurance by proposing the outlines of our current 'Medicare' arrangements. This included adopting the model of shared-cost programs adopted in other social policy fields in the post-war period. The Hall report therefore added a new dimension to the Rowell-Sirois. As with the earlier royal commission, the question of the division of powers was addressed, and the conclusions were remarkably similar in noting provincial predominance. However, the commission added a new dimension of thinking about the relationship between pan-Canadian social citizenship and the federal constitution in elaborating the issue of the spending power, and defining the grounds of its

legitimate use. In a sense, it raised the issue of the trade-off of central government cash for central oversight of provincially administered programs, a trade-off that remained central to most of the papers commissioned for the Romanow Commission that touched on federalism. But Hall was nevertheless careful to restrain the reach of the spending power, and to foresee it as a time-limited tool for launching a public health insurance system, but where provinces would with time run their health systems without central government conditionality. Thus, in Hall's view, the provinces would retain a good deal of control over the timing and content of their public health insurance systems, with the federal government responsible for half of the costs within a number of broadly drawn areas. The commission also suggested that once the provincial programs were well established, consideration should be given to a financing formula "whereby the Federal Government would vacate such a portion of tax fields as would yield revenues to a province corresponding to what it was receiving in the form of federal grants" (Canada 1964: 87).

The Three Federalisms of the Romanow Commission

The Romanow Commission's understanding of the 'federalism' dimensions of the Canadian political community is in some senses disjointed, and can be seen to be taking three distinct tracks. The first two of these look back to the earlier Royal commissions, while the third proposes a new track. They nevertheless all move in the direction of firming up the logic of social citizenship over the logic of federal diversity. This is indeed a key tension in the report.

Consistent with the dominant English Canadian approach to the study of federalism (Rocher 2006), the Romanow Commission seems to treat efficiency and a shared citizenship as the primary values to be served by the Canadian federal system. It wishes the system of intergovernmental relations to be functional and harmonious, and its report mentions at various times that it aims to depoliticize intergovernmental exchanges in this field. However, as already developed here, intergovernmental relations in this field are necessarily politicized as they involve considerations of defining the political community and citizenship in addition to questions of efficiency. Even if the issues of money were sorted out, the symbolic importance of health care would ensure that federal-provincial relations in this domain would remain the in the realm of high politics (Lazar 2006).

1. Jurisdiction

A first take on federalism and social citizenship looks back to the Rowell-Sirois report and the division of powers. The report does not dwell too long on this angle in an introductory section on "Health Care and the Canadian Constitution." While the Romanow report acknowledged preponderant provincial authority in health care, it made the point that "both provincial and federal governments have varying degrees of jurisdiction over different aspects of the health system" (Canada 2002: 3). In contrast to the Rowell-Sirois and Hall reports, which treated the central government's role as an exception to the general rule of provincial authority, the Commission emphasized the importance of sources of federal influence, and favoured a strong federal role in all but the most exclusive areas of provincial jurisdiction. This more aggressive stance stood on two bases. First, that federal jurisdiction in a number of 'highly specialized' areas in fact provided the federal government with a significant source of responsibility, especially with the rise of overarching views of health promotion and protection beyond direct hospital and physician care. The commission went so far as to suggest that the increased importance of the explicit federal areas might warrant a more balanced division of roles, and here made much use of Peter Hogg's assertion that "health is an 'amorphous topic'" (Ibid.). In other words, the nature of the Constitution and of health care "make it impossible to divide the management of all aspects of health care in to neat federal or provincial 'boxes'" (Ibid.: 53), so why waste precious energy trying? Second, and blurring into the next section of this chapter, the report made much of the increased constitutional standing of the spending power and of conditional funding to provinces.

It is notable that the report looks to the background papers of Bräen (2002) and Leeson (2002) to make this case, failing even to cite the Quebec nationalist view of jurisdiction found in the discussion paper by Réjean Pelletier. Strangely absent, from both the report and the commissioned papers, is any representation of a provincialist perspective, such as found through the 1990s in the statements of Western Premiers' conferences.

The report's discussion of jurisdiction shows remarkable continuity with the earlier royal commissions in noting provincial preponderance. It is noticeably more centralist in its interpretation than the earlier commissions, in part because judicial review has opened some doors to such an interpretation by blurring lines between section 91 and 92 (health as an 'amorphous topic') and by legitimizing the use of the spending power. Nevertheless, the report did not seize the openings suggested by Bräen and Leeson in their discussion papers for aggressively asserting that federal government jurisdiction extended well beyond existing uses.

This might reflect Romanow's pragmatism or his experience as a provincial premier: Leeson and Bräen's textual reading of the Constitution emphasized the outer boundaries of federal authority in the field, delimiting a territory to be filled with new federal initiatives, but clearly such initiatives would encounter both significant provincial opposition and the limits of the Canadian government's administrative capacity. However, it is our view that its greater significance is that the vision of federalism based on a strict division of powers, and of the necessity of health policies to follow the dictates of that division, is not one that animates the report and its recommendations. Indeed, as we will see, the idea of health as an amorphous topic is useful not as a means of extending the legal-constitutional understanding of jurisdiction, but of marginalizing constitutional jurisdiction as an issue that might trump other considerations. Indeed, the report later is clear on this point: "how governments do this [i.e., share responsibilities] reflects not only their formal constitutional roles, but also considerations of efficiency, equity and how best to redistribute resources" (Canada 2002: 46).

2. Spending Power

Romanow's second take on federalism and social citizenship looks back to the Hall Commission, and the idea of the spending power introducing a trade-off of cash and control. Most of the discussion papers on federalism and intergovernmental relations devoted considerable attention to this question, and to what control particular levels of expenditure should be able to buy (e.g., Institute of Intergovernmental Relations 2002; Maioni 2002; Fierlbeck 2002; Johnson Redden 2002). In other words, the legitimacy of the spending power in the Canadian federation is neither problematic in terms of federalism values nor in question in terms of constitutional law: only the fairness and effectiveness of the cost/control trade-off in particular situations needs to be weighed.

Again, it is worth remarking that the background papers did not provide much of a platform for either Quebec nationalists or Western provincialists to question the legitimacy of the spending power or the modalities of its use. The strongest nationalist arguments came from Réjean Pelletier's paper (Pelletier 2002) on intergovernmental cooperation mechanisms, although they were also given some space in Rocher and Smith's analysis of political-institutional dynamics (Rocher and Smith 2002). Provincialist views were entirely missing in action.

Similar to the point on jurisdiction, Romanow's prescriptions in his report are largely

within the mainstream of the research reports, but go beyond the Hall report in the legitimate degree of centralization they feel is permitted through the use of the spending power. The spending power is no longer a time-limited and facilitative tool to provide provinces the capacity to launch an expensive and complicated program (i.e., health insurance) within broad parameters. The idea that now that provinces have been running public health insurance programs for 30 years does not lead the Romanow Commission to advocate federal withdrawal coupled with a tax point transfer. On the contrary, Romanow speaks of the federal government taking an 'equity stake' in the program through ongoing cash transfers, tied to provincial compliance with a *Canada Health Act* that would include a principle of accountability. And he does so specifically because cash buys control: the ability to "[protect and extend] the national dimensions of medicare is directly proportional to the size of its cash contribution to provincial expenditures" (Canada 2002: 68).

Not only does this reading extend the legitimate use of the spending power, but it further contributes to the marginalization of constitutional jurisdiction as a basis for intergovernmental discussion in the field: participation in health policy, be it in terms of broad principles or more specific initiatives, is simply a good to be bought: "governments will need to agree on the changes that they are buying with their new investments both in terms of short-term fixes to the system and, more importantly, long-term changes in direction" (Ibid.: 71).

In sum, on the spending power, the Romanow Commission appears to reflect a widely held scholarly consensus that the power can be legitimately used to leverage provincial action in ways large and small, and on an ongoing basis. The real issue is: what is the 'just' price. Again here, Romanow does not get too far in front of the pack, although it is worth noting that even in the process of moving back towards what is seen as its historic share of 25 percent of health costs, the report believes the federal government can make *new* demands on the provinces to spend in targeted areas such as diagnostic services, primary care, homecare and catastrophic drugs.

3. Putting Health beyond Intergovernmental Reach

If in regard to constitutional jurisdiction and the spending power, the Romanow report opened the door to a more centralized federation, but then refused to step boldly through that door, it finally took that step in its attempt to put health beyond the reach of intergovernmental politics. In proposing new health governance institutions that were infused in every fibre by an ideal of pan-Canadian citizenship, but which could be seen as the creation of both orders of government, the

Romanow Commission brought forward a new way of working through the tension of social citizenship and territorial diversity.

The Commission proposed two new institutions, a health covenant and a health council. The covenant was supposed to serve a number of goals in terms of setting out roles and responsibilities for governments, citizens and health care providers, as well as a set of guiding values (universality, equity, solidarity, value for money etc.). Taken on its own terms, it is a relatively innocuous if overly earnest mission statement for the health care system. Therein lies the rub, because the health care system is seen as operating within the space of a pan-Canadian citizenship, wherein the objectives of the health care system, and the values serving as "a common foundation for collaboration among governments, the public, and health care providers and managers," are assumed to apply uniformly across the country (Ibid.: 49). Indeed, the proposed covenant would bind provincial governments to work for the common good of all and ensure equitable access and treatment for all Canadians.

The covenant is an attempt to depoliticize health policy making by creating a moral duty on both orders of government to collaborate and work productively together, and thus to work through differences more productively. One can be skeptical as to the likely success, but other federations do have similar norms that have had the effect of encouraging productive engagement. But the covenant also points to a deeper depoliticization in raising the duty of accountability in terms of establishing goals, targets and benchmarks (Canada 2002). This is part and parcel of increasing the role of technical and practical expertise in decision-making relative to intergovernmental negotiations, which is where the proposed Health Council of Canada steps in.

For the Commission, there was a need for a new approach to 'national leadership' given the fractious nature of federal-provincial negotiations. A health council could play a role in de-politicizing "and streamlining some aspects of the existing intergovernmental process" (Ibid.: 55) by providing impartial advice and analysis. The proposed model for the council was a multi-stakeholder forum of 14 members, 7 of whom would represent governments (2 federal, 4 provincial, 1 territorial) (Canada 2002). The Council would oversee the development of indicators, annual performance reporting, and technological assessment, and in the longer term might come to assist in developing national frameworks in primary care, monitor and measure success of new primary care initiatives, provide advice and national frameworks on the supply and roles of health care providers, and assist in resolving disputes under the *Canada Health Act*.

In short, important aspects of health care renewal could be taken away from the spotlight of intergovernmental negotiation, allowing policy to be made on the basis of expertise and evidence. Nevertheless, the territorial frame for health policy is clearly Canadian, as the agenda of reform and the metrics of success and comparison are set at the centre, and not by the provinces.

This is a relatively bold and original frame of thinking. It is noteworthy that most of the federalism papers did not even entertain such a possibility and remained in the register of the spending power. In working through the issue of cost and control, they remained tied to the idea that federal-provincial interactions would take place predominantly in the realm of intergovernmental politics, and that any centralized oversight would be purchased, so to speak, as new pan-Canadian needs and goals emerged. Thus, while the politicization of health was repeatedly bemoaned as a factor frustrating effective action in the Commission's discussion papers (Boychuk 2002; Johnson Redden 2002), solutions were in relatively short supply. Some authors such as Fierlbeck opened the door to considering new tools of federal control, such as provincial accountability and reporting or federal leadership in research and indicator development, but these tools could not fully escape politicization as they remained tied to the central government (Fierlbeck 2002). Similar to Johnson Redden's point about the *Canada Health Act*, it had the problem of imposing conditions on the province in the pursuit of a shared vision, but where the federal government could claim that vision as its own (Johnson Redden 2002).

The primary source for the health council, at least in terms of the Commission's research, appears to come from Flood and Choudhry's paper on modernizing the *Canada Health Act* (Flood and Choudhry 2002). Recognizing the difficulties of stepping up federal enforcement of the *Act*'s provisions, Flood and Choudhry seek to step up the responsiveness of provinces to their citizens, particularly in demanding processes of consultation on how to meet the *Act*'s provisions, on the one hand, and in providing an evidentiary basis for informed citizen participation on the other. To this end, the proposed the creation of a 'Medicare Commission' made up of federal and provincial representatives to oversee the development of indicators, publish annual reports of provincial performance, share best practices, and provide financial assistance to provinces undertaking processes and programs identified by the commission (Canada 2002).

This strategy, which the final report adopted in a modified form, clearly tries to insulate health policy from intergovernmental politics, seen as the source of "corrosive and divisive

debates" (Ibid.: 46), but it cannot succeed. The very act of creating new institutions like a covenant and a health council imports an understanding of the political community and so enters into tension with the existing, unreconciled, understandings. Both the health covenant and the health council signal that health care is fundamentally pan-Canadian, not only as a marker of shared citizenship rights (under the covenant), but also as the space for recognizing problems, sharing expertise, developing best practices, and comparing results. Moreover, while the composition of the proposed council gave the federal government relatively modest representation, it still provided the federal government an ongoing and institutionally legitimate voice in participating in such core areas of provincial health systems and primary care reform, workforce management and health education and training. It likewise hemmed in provincial government authority to the extent that provinces would be expected to cede some agenda-setting and policy-making autonomy to the council. While the Health Council of Canada created after the Romanow report was different from what the report recommended in several important respects, it is worth underlining that provincial resistance has hampered its effectiveness. The provinces realize the potential for even depoliticized bodies to have political impacts – for instance, in creating interprovincial beauty contests – and have not been transparent and forthcoming in fulfilling their responsibilities under the 2004 Health Accord. The Health Council's decision to criticize the provinces on these grounds in its 2008 report (Health Council of Canada 2008) is further evidence of how the politics of federalism cannot be removed from health policy by creating seemingly arms-length institutions.

Some might ask where the federalism is in all of this, involving as it does the surrender of provincial jurisdiction to set priorities and goals to an oversight body. To the extent that the cession of authority to the Council is voluntary, reversible, and limited to solving shared problems and increasing efficiencies, provinces retain a good deal of autonomy over the shape and direction of their health systems. Indeed, if the Health Council freed up resources through increased efficiency that could then be re-allocated to other priorities, what is lost in autonomy in certain specific areas might be recouped through a fuller use of jurisdiction elsewhere. However, this conclusion is likely too optimistic in the long run, as the very act of blurring jurisdiction erodes the basis for provincial claims making. Over time, bureaucratic and administrative practices have an effect on changing the manner in which the Constitution is interpreted (Poirier 2004). Similarly, the public legitimacy of claims of provincial jurisdiction will vary with the

extent to which citizens adopt a pan-Canadian citizenship. As such, even if Romanow's plan continues to foresee significant provincial roles in a fairly *decentralized* system, the capacity of provinces to protect the *non-centralized* aspect of the system would likely erode as citizens turned to central institutions (although perhaps not central government institutions) to define the character of their shared, pan-Canadian citizenship.

Conclusion

In grappling with how to combine social citizenship in health with federalism, the Romanow report represents some interesting innovations. One might be tempted to treat the report as centralist, as its reprise of debates about jurisdiction and the spending power certainly moved in that direction compared to the Rowell-Sirois and Hall commissions. However, the real innovation was to attempt to take large swathes of health policy making outside of intergovernmental politics, in essence to create central oversight institutions that were not controlled by the central government. This was a centralization along the centralization/non-centralization continuum, more than along a centralization-decentralization continuum (although also a little on the latter).

In one sense, in coming to these conclusions, the report often stuck closely to its commissioned studies, being a bit less centralist on the division of powers, within the consensus range on the spending power, and following the idea of Flood and Choudhry on the health council. Yet in another sense, its attempt to remove health from intergovernmental politics was a bold departure, strongly at odds with the understanding of the spending power papers that ultimately recognized the importance of the constitutional division of powers, even as they invented rationales for circumventing it with federal transfers.

All told, the Romanow Commission's report testifies to the perspicacity of Rocher's description of Anglophone Canada's philosophy of federalism, and its emphasis on the functional and efficient resolution of issues (Rocher 2006). This is seen in a research community that supported the Commission with studies that by-and-large shared this view, and in a manner that gave federal diversity and provincial jurisdiction shorter shrift than the Hall Commission of 40 years earlier. The Commission could limit the presence of the Quebec nationalist viewpoint to a single paper (Réjean Pelletier's, or one and a half, if one counts François Rocher's joint contribution with Miriam Smith), and entirely ignore provincialist views, without giving the sense of leaving out crucial perspectives. It is also seen in the report's bold suggestions on the health

council, in its underlying belief that the common good would be served by creating a place to solve pressing problems more efficiently because it was free of the high politics of federal-provincial diplomacy. It may be tempting to treat this solely as a sign of the decline of the federal ideal, although to the extent that doing things efficiently expands the capacity of provincial governments to act in their spheres of jurisdiction, the pattern is more complex. Perhaps the issue is more one of considering how joint action by provinces, either to counter negative externalities or reap economies of scale and coordination, can be fostered in a manner more in keeping with the respect of the constitutional division of powers and provincial autonomy.

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