

THE CANADA HEALTH ACT: OVERVIEW AND OPTIONS

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N.B. Any substantive changes in this publication which have been made since the preceding issue are indicated in **bold print**.

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THE *CANADA HEALTH ACT*: OVERVIEW AND OPTIONS*

ISSUE DEFINITION

The *Canada Health Act* (hereafter called the Act) received Royal Assent on 1 April 1984. Through this Act, the federal government ensures that the provinces and territories meet certain requirements, such as free and universal access to publicly insured health care. These requirements, or “national principles,” have helped shape provincial health care insurance plans throughout the country.

Since its inception, the Act has been subject to debate. **This debate focuses on the national principles and is part of a broad picture involving factors that are political (distribution of powers), fiscal (trade-off between health care and other priorities), and economic (greater cost-effectiveness and efficiency).** It also addresses fundamental concerns about the public sector’s role, including that of the federal government, in health care funding.

This document gives an overview of the *Canada Health Act*. It does not set out to offer a legal interpretation of the Act; rather, it seeks to take stock of the evolution of the way it is implemented and examine its future prospects. The first section reviews the justifications for government intervention in the health care sector, while the second describes the respective roles of the federal government and the provinces. The third section traces the historical background of the Act, and the fourth presents an overview of the requirements attached to it. In the fifth section, penalties for defaults under the Act are described, and the sixth section discusses the imposition of penalties. The seventh section examines the issue of privatization. In the eighth section, some options are set out for maintaining the Act or improving it.

* The original version of this Current Issue Review was published in January 1995; the paper has been updated regularly since that time.

BACKGROUND AND ANALYSIS

A. Justification for Government Intervention in Health Care

In Canada, governments are the main source of funding for health care because they play a key role in the insurance market. **The proponents of government intervention in this field generally cite economic and social equity factors, as well as administrative efficiency.** First, they explain that government intervention is necessary to correct potential problems for social equity in the operation of the private insurance market. They claim that private insurance companies could refuse to insure high-risk clients or force them to pay a much higher premium to offset the risk. They believe that government insurance can correct the shortcomings in the private market by protecting the broadest possible cross-section of the population and avoiding unreasonable premium hikes which ultimately effect no improvement in the state of health. Second, they maintain that the private insurance market does not have a regard for economic equity. They argue that in a private insurance market, individuals with health problems and a low income would be subject to the same fee structure as high-income individuals; thus, economically disadvantaged individuals would have to assume a relatively higher proportion of health care costs. Government intervention would, then, guarantee increased access to insurance, regardless of the individual's ability to pay. And third, another argument in favour of public health care insurance is that it yields more efficiencies than private insurers, in terms of lower administrative costs and economies of scale. Public insurance eliminates costs associated with the marketing of private health care insurance policies, billing for and collecting premiums, and evaluating insurance risks. This is one of the reasons cited for the relatively higher administration costs of the American system relative to Canada's.

For these reasons, governments in Canada have favoured public health care insurance over private insurance. This approach, which protects all people against risks related to illness, is essentially based on income tax: all citizens contribute in accordance with their income, rather than in accordance with the benefits they expect to derive. Thus, since its introduction, public health care insurance in Canada has stressed the principle of transferring resources from the richer to the poorer and pooling the risks between the healthy and the less healthy.

This does not mean, however, that the private sector is totally absent from this field in Canada. Private health care insurance exists, but its scope is limited. To be more precise, the private market provides additional coverage for health services that are not insured by the public plan or that are only partially insured by it.

The fact that government is present in the field of health care insurance does not mean that it is also involved in the delivery of publicly insured health services. Indeed, the delivery of health care in Canada is largely in the hands of the private sector: most medical practitioners are in private practice (small businesses) and hospitals are to a great extent private, non-profit organizations (however, physician and hospital services and remuneration for these are subject to government regulation). Laboratory and diagnostic services paid for by public health care insurance are delivered by private for-profit facilities in most provinces. Laundry services, meal preparation and other support or ancillary services that are provided in publicly funded hospitals are often delivered by private for-profit companies.

B. The Role of Governments in Health Care in Canada

The federal and provincial governments have very different responsibilities in health care. Strictly speaking, the federal government cannot establish and maintain a national health care insurance plan because it cannot regulate the delivery of health care to individuals; under the Canadian Constitution and its interpretation by the courts, health care is a field primarily under provincial jurisdiction. The only explicit references in the Constitution to health care issues give the federal government jurisdiction in matters relating to navy hospitals and quarantine. In addition, the federal government is responsible for delivering health services to groups that fall under its jurisdiction, such as Aboriginal peoples, the Canadian forces, veterans, and inmates in federal penitentiaries. Provincial governments are responsible for administering the public health care insurance plan in their own province. **They also have responsibility for health care delivery. This includes, for example: determining how many beds will be available in a province; deciding what categories of staff will be hired; determining how the system will serve the population; approving hospital budgets; and negotiating fee scales with the medical association and other health professional organizations.**

The federal government has intervened in the provincial health care field by using its constitutional “spending power,” which enables it to make a financial contribution to certain programs under provincial jurisdiction, generally subject to provincial compliance with certain requirements. Pierre Blache, in an article published in 1993 in the *Revue générale de droit*, indicates that in his opinion, it is the constitutional imbalance between powers and responsibilities, together with inter-provincial equity factors, that brought about federal transfers such as those to the health care sector:

The scale of transfer payments from the federal government to the provincial governments has increased in Canada as a result of the characteristics of the constitution and reality. It is because Canadian provinces have been given the potentially most expensive responsibilities in the modern state, while being limited to direct taxation, and because many of them have found themselves faced with a tax base below the national average, that recourse to the spending power has become so important in the practical workings of Canadian federalism. ... Against such a background, it appeared unfair to leave it to the provinces to fund the social programs demanded by the people, out of their own resources. (p. 38) [translation]

Consequently, the federal government has intervened in an area under provincial jurisdiction, but without changing the division of powers stipulated in the Constitution. Although the federal government is not responsible for health care administration, organization or delivery, it can exert considerable influence on provincial health care policies by using the political and financial leverage afforded by the spending power. In fact, by setting the requirements for providing federal funding, the *Canada Health Act* has to a large extent shaped provincial health care insurance plans throughout the country.

C. Historical Background

Public health care insurance as it is known today, in which the federal government’s financial contribution is linked to provincial compliance with specific requirements, dates back to the late 1950s. Under the *Hospital Insurance and Diagnostic Services Act* of 1957 and the *Medical Care Act* of 1966, the federal government made an offer to the provinces to fund approximately half the cost of all insured health services. In return for federal contributions, the provinces – as part of their public health care insurance plans –

undertook to insure hospital and physician services and to comply with certain requirements, such as universality. These two Acts did not prevent provinces from demanding a financial contribution from patients; however, because federal contributions were proportional to provincial government expenditures, the provincial governments had nothing to gain from imposing direct patient charges. In fact, the revenue from such charges would have resulted in a reduction in the federal contribution. This implicit reduction mechanism thus strongly deterred provinces from adopting any form of direct patient charges, such as extra-billing and user charges.

In 1977, this formula of shared costs was replaced by a method of block funding based on cash transfers and tax point transfers as part of Established Programs Financing (EPF). Both federal Acts on hospital services and medical care and the requirements attached to them were retained. However, the implicit mechanism for deducting federal contributions was eliminated with the EPF, because federal funding was no longer linked to provincial government expenditures; this resulted in a proliferation of direct patient charges. For example, Newfoundland, New Brunswick, Quebec, Ontario, Saskatchewan, Alberta and British Columbia levied user charges; and extra-billing was authorized in most provinces. The federal government saw this situation as posing a threat to the principle of free and universal access to health services throughout the country. It was therefore anxious to reassert its commitment to the principle of universal health care insurance; and it relied heavily on the criterion of economic equity to justify its intervention. A document issued by Health and Welfare Canada in 1983 stated:

The Government of Canada believes that a civilized and wealthy nation, such as ours, should not make the sick bear the financial burden of health care. Everyone benefits from the security and peace of mind that come with having pre-paid insurance. The misfortune of illness which at some time touches each one of us is burden enough: the costs of care should be borne by society as a whole. That is why the Government of Canada wishes to re-affirm in a new Canada Health Act our commitment to the essential principle of universal health insurance.

This document paved the way for the *Canada Health Act*, which, as stated earlier, was passed on 1 April 1984. The Act combined and updated the two federal Acts of 1957 and 1966. The national principles were reaffirmed in the Act, but extra restrictions were specifically added to deter any form of direct patient charges and to provide citizens of all provinces with access to health care regardless of ability to pay.

On 1 April 1996, the *Canada Health Act* was linked to the Canada Health and Social Transfer (CHST), which merged EPF transfers with Canada Assistance Plan (CAP) transfers. The method of calculation adopted for the CHST was similar to that used for the EPF, and included both cash transfers and tax point transfers. The provinces had to meet all the requirements of the Act in order to be eligible for the full CHST cash transfer. Since 1 April 2004, the *Canada Health Act* is linked to the Canada Health Transfer (CHT). The CHT resembles its predecessor; it is made up of both cash and tax point transfers, and its cash component is subject to the requirements of the *Canada Health Act*. In contrast to the CHST, however, the CHT is expressly dedicated to health care.

D. The Requirements Stipulated in the Act

The *Canada Health Act* sets out nine requirements that provincial governments must meet through their public health care insurance plan in order to qualify for the full federal cash contribution under the CHT. These nine requirements include five criteria, two specific provisions and two conditions. The five criteria, which are often referred to as the “national principles,” are public administration, comprehensiveness, universality, portability, and accessibility; they apply to insured health services. The two specific provisions relate to user charges and extra-billing for insured health services. The two conditions pertain to the provision of provincial information and provincial recognition of federal contributions; they apply to both insured health services and extended health care services.

1. Criteria

Section 8 of the Act deals with public administration. Under this section, each provincial health care insurance plan must be administered on a non-profit basis by a public authority, which is accountable to the provincial government for its financial transactions. This arrangement is largely explained by the considerable amount of money devoted to the health care sector and the need for governments to keep some control over the growth of these expenditures. It is also designed to allow information to be consolidated. **Perhaps more importantly, the original policy objective of this criterion was to prevent provinces and territories from using federal contributions to subsidize the coverage of provincial and territorial residents by private insurance companies.** In Canadian literature, reference is frequently made to the concept of “single payer” to describe the concept of administration of health care insurance by a public authority.

Under the criterion of comprehensiveness stipulated in section 9, the health care insurance plan of a province must insure all services that are “medically necessary.” The criterion of comprehensiveness refers in a way to a minimum basket of services, because the Act neither mentions the quantity of services to be provided nor gives a detailed list of what services will be insured; provincial governments can define these. Thus, the range of insured services may vary among provinces and from one year to the next.

Under section 10, the criterion of universality demands that all residents in the province have access to public health care insurance and insured services on uniform terms and conditions. Initially, the concept of universality focused on two specific objectives. First, it sought to make insured services available to everyone, everywhere. Second, it sought to pool the risks among those insured; the more people the plan covered, it was said, the more the risk-sharing would be cost-effective.

As stipulated in section 11, the criterion of portability requires provinces to cover insured health services provided to their citizens while they are temporarily absent from their province of residence or from Canada. For insured health services provided in another province, payment is made at the rate negotiated by the governments of the two provinces. For out-of-Canada services, the Act states that the amount paid will be at least equivalent to the amount the province of residence would have paid for similar services rendered in that province.

The fifth criterion, accessibility, is set out in section 12: insured persons must have reasonable and uniform access to insured health services, free of financial or other barriers. No one may be discriminated against on the basis of such factors as income, age, and health status.

2. Provisions

Free access to insured health services is the key factor of the *Canada Health Act*. The two provisions of the Act specifically discourage financial contributions by patients, either through user charges or extra-billing, for services covered under provincial health care insurance plans.

3. Conditions

With respect to the two conditions, provincial governments are required by regulation to provide annual estimates and statements on extra-billing and user charges. They are also required to provide voluntarily an annual statement describing the operation of their plans as they relate to the criteria and conditions of the Act. This information serves as a basis for the *Canada Health Act* annual report. In addition, provinces are required to give public recognition of federal transfers.

4. Insured Health Services and Extended Health Care Services

The Act makes a distinction between “insured health services” (i.e., those that have been deemed “medically necessary”) and “extended health care services.” So-called medically necessary services are defined only in the broad sense of the term in the Act. Section 2 states that insured health services – which must be fully insured by provincial health care insurance plans – comprise:

- hospital services that are medically necessary for the purpose of maintaining health, preventing disease or diagnosing or treating an injury, illness or disability, including accommodation and meals, physician and nursing services, drugs and all medical and surgical equipment and supplies;
- any medically required services rendered by medical practitioners; and
- any medically or dentally required surgical-dental procedures which can only be properly carried out in a hospital.

Section 2 of the Act also stipulates that extended health care services include intermediate care in nursing homes, adult residential care service, home care service and ambulatory health care services. Because these services are not subject to the two provisions relating to user charges and extra-billing, they can be charged for at either partial or full private rates. Similarly, extended health care services are not subject to the five criteria of the Act. As such, they do not have to be publicly administered, universal, comprehensive, accessible or portable. In addition, provincial health care insurance plans may cover other health services, such as optometric services, dental care, assistive devices and prescription drugs, which are not subject to the Act, and for which provinces may demand payment from patients. The range of such additional health benefits that are provided under provincial government plans, the rate of coverage, and the categories of beneficiaries vary greatly from one province to another.

E. Penalties for Defaults Under the Act

Penalties under the *Canada Health Act* are linked to federal transfers to the provinces. More precisely, each provincial health care insurance plan must comply with the requirements of the Act before the province receives its total entitlement of cash transfers. If a province fails to comply, the federal government may impose a penalty and withhold part or all of the transfers. Between 1984-1985 and 1990-1991, this financial penalty was applied to that portion of EPF cash transfers earmarked for health care. Between 1991-1992 and 1995-1996, financial penalties were not limited solely to federal cash transfers for health care. In fact, the government expanded the penalties to cover other cash transfers. It had become necessary to extend the financial penalty to transfer payments in other fields because of the federal government's continued restriction on the growth rate of EPF transfers and its specific impact on cash transfers. Studies such as those conducted by the National Council of Welfare in 1991 and Jenness and McCracken in 1993 had predicted that EPF cash transfers to some provinces would be non-existent by the year 2000. These additional withholdings or deductions were not stipulated in the *Canada Health Act*, but were specifically set out in paragraphs 23.2(1), 23.2(2) and 23.2(3) of the *Federal-Provincial Fiscal Arrangements Act*, the legislation that established the EPF and then governed the CHST. These provisions apply as well to the CHT under paragraphs 25.6(1), 25.6(2) and 25.6(3).

By introducing the CHST, the federal government moved to prevent the erosion of its power to enforce compliance with the *Canada Health Act* across the country. Obviously, if a province were to decide to forgo its cash entitlement under the CHST, it would no longer be required to comply with the requirements of the *Canada Health Act*. Although the Act is now linked to the new CHT, the penalties still apply to total cash transfers to the provinces for health and social programs, as well as to other federal cash transfers.

The financial penalties stipulated in the Act vary depending on whether a default is directly related to extra-billing and user charges or involves failure to satisfy any of the five criteria or the two conditions. Sections 18 to 21 of the Act, which describe the provisions relating to penalties for extra-billing and user charges, stipulate that the federal government may withhold one dollar of cash transfer for every dollar collected through direct patient charges. In the case of failure to satisfy the criteria or conditions, section 15(1)(a) of the Act stipulates that the cash value of the penalty is left to the discretion of the Governor in Council, who sets the amount depending on the "gravity" of the default. As Sheilah L. Martin suggested in a paper

published in 1989, the discretionary nature of this penalty does not require the federal government to impose a fine, but leaves it the option of doing so. At one extreme, Cabinet could decide to withhold all CHT cash transfers, and even reduce federal contributions paid as part of other programs. At the other extreme, the federal government could decide not to impose any financial penalty and to confine its action to persuasion and negotiation.

The Act also includes a conflict resolution mechanism for cases where a province violates the requirements of the Act. It is a long process, however, with the result that federal contributions are not reduced immediately. In the event that Health Canada deems that a provincial plan is failing to satisfy any one of the five criteria or the two conditions, under section 14(2) it must inform the province of the problem, obtain its explanations, draft a report on its concerns and, if the provincial Health Minister so requests, hold a meeting to discuss the issue. Section 15 states that where the Governor in Council is convinced that a province no longer meets the criteria and conditions of the *Canada Health Act*, the Minister of Health may direct by order that federal contributions be reduced or withheld.

Since April 2002, the conflict resolution mechanism embodied in the *Canada Health Act* is facilitated by a Dispute Avoidance and Resolution (DAR) process. The purpose of the DAR is to formalize and make transparent the process that the federal Minister of Health must follow prior to forming an opinion as to whether a provincial or territorial health care insurance plan has ceased to satisfy any of the Act's criteria, provisions or conditions. As a first step, the federal Minister of Health invokes, in a letter to the province(s) or territory(ies) concerned, the DAR process in relation to a potential case of non-compliance with the *Canada Health Act*. Within 60 days of the date of that letter, the governments involved in the dispute will jointly: collect and share all relevant facts; prepare a fact-finding report; negotiate to resolve the issue in dispute; and prepare a report on how the issue was resolved.

If, however, there is no agreement on the facts, or if negotiations fail to resolve the issue, any Minister of Health involved in the dispute may undertake to refer the issue to a third-party panel by writing to his or her counterpart. Within 30 days of the date of that letter, a panel will be struck. The panel will be composed of one provincial (or territorial) appointee and one federal appointee, who, together, will select a chairperson. The panel will assess the issue in dispute in accordance with the provisions of the *Canada Health Act*, will undertake fact-finding and provide advice and recommendations. The panel will then report to the governments involved on the issue within 60 days of appointment.

The final authority to interpret and enforce the *Canada Health Act* remains with the federal Minister of Health. In deciding whether to invoke the penalty provisions of the Act, the Minister will take the panel's report into consideration.

F. Imposition of Penalties

On three occasions, the federal government has resorted to mandatory penalties and reduced its contributions to some provinces that were authorizing extra-billing or imposing user charges. First, it deducted more than \$244,732,000 from EPF transfers to all the provinces from 1984-1985 to 1986-1987. However, it also complied with section 20(6) of the Act, under which a province was able to recover these funds if it terminated all forms of direct patient charges within three years after the Act came into force, i.e., before 1 April 1987. Because all provinces complied with the Act within this timeframe, the amounts withheld were all reimbursed.

Second, from 1992-1993 to 1995-1996, the federal government withheld some \$2,025,000 in EPF cash transfers to British Columbia because approximately 40 medical practitioners in that province had opted out of the province's health care insurance plan in 1993 and resorted to extra-billing. These doctors have since discontinued this practice.

Finally, since 1995-1996, the federal government has imposed penalties on provinces that permit private clinics to demand facility fees from patients for medically required services, having determined that such facility fees constitute user charges. These penalties have applied to five provinces. By the time the deductions from transfers to Alberta ended in July 1996, a total of \$3,585,000 had been deducted from that province. **Similarly, a total of \$284,430 had been deducted from Newfoundland, which started to comply with the Act in January 1998. The penalties imposed on Manitoba (\$2,355,201 in total) were discontinued as of 1 February 1999. A total of \$372,135 was deducted from transfers to Nova Scotia, which was deemed in compliance with the Act in November 2003. Between 2002-2003 and 2003-2004, a deduction totalling \$173,385 was made to British Columbia's CHST cash transfer in respect of instances of user charges levied in private surgical clinics.** Although no other deductions have been made, the issue of imposing user charges at private facilities is still ongoing in British Columbia.

Until now, however, there has been no discretionary penalty for failure to comply with the five criteria stipulated in the Act, despite some complaints regarding, for example, portability and comprehensiveness.

There are claims that several provinces are violating the criterion of portability. For example, in 1988, Quebec refused to sign the reciprocity agreement whereby other provinces would be reimbursed according to their own rates for services they provided to Quebeckers outside Quebec. Moreover, Canadians must increasingly resort to private insurance when abroad: New Brunswick, Quebec, Saskatchewan, Alberta and British Columbia have reduced their coverage for emergency hospital services obtained outside Canada. Some experts, who accuse the federal government of inaction in this area, explain that the scope of the portability criterion is clearly defined in the Act, where the terms and conditions for reimbursement of out-of-province services are stipulated. **For its part, the Commission on the Future of Health Care in Canada (Romanow Commission) recommended that the criterion of portability be limited to guaranteeing portability of coverage within Canada.**

Likewise, some people believe the criterion of comprehensiveness is not being observed in practice, because provinces do not necessarily cover the same basket of insured health services or medically required services. They also believe that cutting government expenditures could compromise this principle even further and that the process of de-insuring begun in recent years could lead to the balkanization of provincial health care insurance plans. Federal legislation defines only the major outline of insured services and leaves each province complete freedom to determine what services its public plan will provide. However, de-insurance emphasizes the gaps between provinces in their coverage of health services; these discrepancies are likely to become increasingly difficult to justify. Moreover, de-insurance with the sole purpose of reducing public health expenditures could ultimately undermine the criterion of free access, inasmuch as it has not been proved which services are or are not medically necessary. This raises the thorny problem of how to determine when a service is medically necessary. It could prove difficult to determine the limits of any list of medically necessary health services. Furthermore, it is hard to know how far the federal government can intervene in defining insured services, without encroaching on provincial jurisdiction.

It is important to note that, although discretionary penalties have never been applied, a number of cases of non-compliance have been resolved through discussion, negotiation and persuasion. Although this approach may lead to less friction in federal-

provincial relations, it does not lead to a speedy resolution of violations to the Act. In his November 1999 report (Chapter 29), the Auditor General of Canada pointed out that six cases of non-compliance had been resolved through discussion and negotiation; however, four of them took 14 to 48 months to resolve, while the remaining two went on for as long as five years without any penalty. In her September 2002 report (Chapter 3), the Auditor General of Canada identified twelve new possible cases of non-compliance that had arisen since 1999; Health Canada once again attempted to resolve them through means other than penalties. Only two of these cases have been resolved.

G. The Issue of Privatization

This section attempts to shed some light on the current confusion over the concept of privatization and its implications in terms of the *Canada Health Act*.

Privatization is the process whereby the government transfers some of its activities or responsibilities to the private sector. With respect to health care, privatization of financing is not the same as privatization of delivery. Privatization of financing is achieved by shifting the burden of funding away from public health care insurance plans and towards patients and/or their private insurance companies. Privatizing the delivery of health care implies greater reliance on individuals and institutions outside government for the production and provision of health services. In Canada, difficulties with respect to privatization revolve primarily around the financing of health care, because health care delivery is already largely private in nature. In fact, governments deliver relatively few health services directly. Most health care providers (e.g., physicians, physiotherapists and pharmacists) are in private practice; they are not government employees. The vast majority of hospitals and long-term care institutions are not-for-profit and are privately owned; although they are funded by government, they are not owned by government.

Privatization of health care financing can be achieved in two ways: either actively, by containing public health care costs; or passively, by shifting the care outside traditional settings. Active privatization is the direct result of the partial or total de-insurance of publicly funded health services. In the 1990s, in an effort to reduce public health care costs and to balance their budgets, most provinces limited the coverage provided under their health care

insurance plans. A list of de-insured services by province is presented in the following table. For the most part, medically required hospital and physician services remain covered by provincial health care insurance plans. In fact, public funding accounts for approximately 91% of hospital expenditures, while 99% of total physician services are financed by the public sector (according to data from the Canadian Institute for Health Information). Nevertheless, de-insurance has generated disparities in provincial health care coverage. For example, the removal of warts is no longer covered in Nova Scotia, New Brunswick, Ontario, Manitoba, Alberta, Saskatchewan and British Columbia, but it remains publicly insured in Newfoundland, Quebec and Prince Edward Island. Although stomach stapling is covered in most provinces, it is not insured in New Brunswick, Nova Scotia and the Yukon, and patients in these provinces/territories must pay for this procedure. In addition, coverage varies widely across the country in the areas of reproductive services.

Passive privatization mainly refers to the gradual shift towards non-institutional care provided in the home and the community. Less invasive medical techniques and shorter hospital stays have allowed Canadians to receive more medical care in their homes and in the community. As a result, many services that are deemed medically necessary today are not publicly insured because they are not provided in hospitals or by physicians. Consequently, many commentators contend that the realities of health care have shifted considerably since 1984, when the *Canada Health Act*, with its focus on hospitals and physician services, was passed. In other words, the definition of “medically necessary services” has not kept pace with the way services are now delivered. The National Forum on Health subscribed to this view when it stressed that it would be essential to “fund the care, not the institution.” Accordingly, it recommended that public health care insurance be expanded to cover a wider range of services and, in the first instance, home care and prescription drugs. It is believed that the scope of the *Canada Health Act* could be broadened without challenging in any way the requirements embodied in that Act. **The report of the Romanow Commission supported this view and made very similar recommendations.**

DE-INSURED HEALTH CARE SERVICES BY PROVINCE

Service*	Province
Routine circumcision of newborn	Nfld, PEI, NS, NB, Ont, Alta, Yk
Xanthelasma excision (removal of fatty spots on eyelids)	Nfld, NS, Ont
Hypnotherapy	Nfld
Removal of impacted teeth	Nfld
Otoplasty	Nfld, PEI, NB, Ont, Alta
Gastroplasty (stomach stapling)	NB, NS, Yk
Tattoo removal	Sask, Man, Ont
Reversal of sterilization	PEI, NB, Ont, Man, Sask, Alta, Yk (uninsured service in NS and BC)
Penile prosthesis	NS, Ont, Sask
Psychoanalysis	Man, QC
Eye examination (people aged 19 to 64)	PEI, NS, NB, QC, Man, Sask, Alta
Wart and benign skin lesion removal	NS, NB, Ont, Man, Alta, Sask, BC
Second or subsequent ultrasounds in uncomplicated pregnancies	NS, BC
<i>In vitro</i> fertilization	Ont, Man (uninsured service in Nfld, NS, NWT)
Simple sclerotherapy (removal of varicose veins)	QC, Ont, Man (uninsured service in NS)
Artificial/intrauterine insemination	NS, NB (uninsured service in Alta)
Ear wax removal	NS
Anaesthesia associated with a non-insured service	NB, Sask, Alta
Chiropractic services	Sask
Epilation of facial hair	PEI, Ont
Eye refractions	Nfld, Sask
Cosmetic surgery	Alta (uninsured service in Nfld, NS, PEI, NB, QC, Man, Sask, BC, Yk, NWT)
Breast reduction/augmentation	NS, NB, Ont, BC

* Some exceptions may apply.

Source: Canadian Medical Association, *Uninsured Medical Services – A Canadian Perspective*, February 1997.

In the Canadian context of health care, the main concern with respect to privatization is that it can lead to a “two-tier” system – one that allows some patients to pay privately and receive priority access to health care, while the rest of the population who use the publicly funded health services must face longer waiting times. The issue over privatization surfaced in 1995, when the federal government implemented its policy on private clinics.

There are two categories of private clinics: semi-private clinics and fully private clinics. Semi-private clinics are facilities that receive public funding for medically required services under a provincial health care insurance plan, but also demand payment (“facility fees”) from the patient. For the federal government, facility fees present a problem because people who can afford to pay them get faster access to services. In 1995, the federal Minister of Health stated that such semi-private clinics fall under the *Canada Health Act* because: (1) they are included in the definition of “hospitals” set out in the Act; (2) they provide medically necessary services; and (3) they receive public funding. Therefore, semi-private clinics contravene the *Canada Health Act* because the facility fees they require from patients constitute a form of user charges.

Fully private clinics are facilities that receive no government funding: the physicians are not reimbursed by the provincial health care insurance plan and their patients must pay the full cost of the services rendered to them. The creation of such clinics does not result in a reduction in provincial transfers, and the provisions relating to extra-billing or user charges do not apply in such cases. It is, however, possible that the federal government might decide to intervene by invoking the Act’s criterion of accessibility should it be decided that fully private clinics threaten access to the insured services provided by the public system. This could happen if these clinics were to offer financial incentives to health care providers that might draw them away from the public system.

In practice, few physicians leave the public system because it is hard to attract a sufficient number of patients who want to pay full health care costs when they also have access to the public system. Private insurance for medically necessary services is discouraged, by both federal and provincial legislation. The *Canada Health Act* requires provincial health care insurance plans to be accountable to the provincial government and to be non-profit, thereby effectively preventing private insurance plans from covering medically required services. Moreover, the majority of provinces (British Columbia, Alberta, Saskatchewan, Manitoba, Ontario, Quebec, New Brunswick and Nova Scotia) prohibit private insurance companies from covering services that are also guaranteed under public health care insurance plans.

Concerns over privatization were raised again in 2000, when the Alberta government enacted legislation (Bill 11) with respect to contracting with the private sector for medically necessary surgical services. This legislation allows Regional Health Authorities (which are publicly funded) to contract with a private provider – either a for-profit or a not-for-profit entity – for the provision of surgical services. The patient is not supposed to incur any out-of-pocket expenditures, as the costs related to the surgery will be fully insured by the

provincial health care insurance plan. Regional Health Authorities are also responsible for coordinating the delivery of uninsured surgical services requiring an extended stay by the patient. The Alberta government believes that contracting with privately operated facilities for surgical services will reduce waiting lists in the public system, improve access, and enhance efficiency. Private providers will be required to operate within the requirements of the *Canada Health Act*. The Alberta government believes that the Act does not prevent a public health care facility from contracting out any of its services to the private sector.

Nonetheless, the then federal Minister of Health expressed concerns over the long-term impact of the Alberta legislation. Among other things, he questioned whether private providers would provide faster or more cost-effective services than would existing public hospitals (if these were receiving the additional funding). He also raised the issue of whether the expansion of private for-profit facilities would help sustain the delivery of health care, or would undermine the letter and spirit of the *Canada Health Act*.

In some provinces, the operation of private clinics that offer magnetic resonance imaging (MRI), X-ray, ultrasound and computed tomography (CT) scanning services also raises concerns over the accessibility criterion of the Act. Queue jumping is one of the dangers of these clinics. For example, individuals who can afford to pay may be able to get their diagnostic tests done more quickly. They then return to the publicly funded system for treatment one step ahead of patients awaiting diagnostic tests. **In September 2000, the federal Minister of Health wrote to his counterparts in Alberta and Quebec to obtain more information on private diagnostic imaging clinics operating in those provinces. In July 2003, the Minister wrote again to four provinces to outline concerns about private MRI and CT scan clinics. Although consultations with provincial officials followed, these discussions were postponed at the request of the provinces.**

Once again in April 2005, the federal Minister of Health wrote to Alberta, British Columbia, Quebec and Nova Scotia to express concerns over private for-profit diagnostic imaging clinics that operate in those provinces. The concerns relate to medical necessity (comprehensiveness), private payment (user charge provisions) and queue jumping (accessibility) and the potential for non-compliance under the *Canada Health Act*. Should consultations with the four provinces prove inconclusive, the DAR process could be initiated with the view of ensuring that private clinics delivering diagnostic imaging services do so in compliance with the *Canada Health Act*. This process could yield useful information and clarification concerning the role and impact of private for-profit health care delivery.

H. The Options: Should We Keep the Act As It Is, Amend It or Repeal It?

In the current context of structural health care reform, it has often been asked whether the *Canada Health Act* can be maintained or whether it would be wiser to amend it.

Some analysts believe the Act should be kept as it is. In their view:

- any change in the five criteria on which public health care insurance is based would undermine the greatest achievements of the health care system in Canada;
- the need to contain public health care costs should not be used to justify overhauling the Act;
- the five criteria of the Act can be maintained while the system is reorganized to improve clinical and economic effectiveness;
- effective allocation of public funds, together with a more judicious use of staff and medical care, would enable the government to reduce overall public health care expenditures and fund a wide (or even wider) range of effective and necessary services; and
- the *status quo* is to some extent preferable, given that most provinces have already reformed their health care delivery system by focusing on greater efficiency.

For a growing number of experts, however, the *status quo* is unacceptable. They say the *Canada Health Act* must be amended. Some suggest clarifying what is meant by “comprehensiveness” or “medically necessary services.” Those who believe the criterion of comprehensiveness in the Act is vague and imprecise point out that clarification in this area would produce many benefits. First, the services for which the public sector must be responsible would be clearly set out; second, greater uniformity in the range of services throughout the country could be achieved, thus ending the balkanization of provincial health care insurance plans. Clarification could also help define medical necessity, taking into account important factors such as clinical, economic and ethical considerations.

The Act could be clarified in three different ways. First, a definition of the term “medically required” could be added to section 2. Second, also in section 2, definitions relating to physician services, hospital services and extended health care services could be given. Third, the provisions in section 22 could be invoked, under which the federal government may establish by regulation: (1) a definition of extended health care services; and (2) the list of hospital services that would be excluded from all insured services. The Act stipulates that such regulations cannot be made unilaterally, without the agreement of each province.

However, there is no general agreement on these three options. Some analysts claim that until now the Act has given the provinces the latitude they need to interpret these terms in keeping with their own economic, political and social conditions. They believe that excessively specific definitions might limit the options of provincial governments to address the specific needs and values of their own residents.

Some experts favour the imposition of direct patient charges for services covered by government health care insurance plans. They explain that such action would help limit the abuse of health care by some patients, while reducing public health care expenditures. The effects of user charges on the use of health services and on public expenditures have been the subject of lively debate for some time and will not be discussed here. However, it should be pointed out that many analysts believe user charges are a step backwards, because the Act was adopted with the express purpose of discouraging such fees.

Finally, some people believe the Act creates inflexibility by limiting the options available to provincial governments in their fight to reform the delivery of health care and increase effectiveness and efficiency in this sector. Their solution, which is undoubtedly the most radical, would be to repeal the Act. It is difficult to foresee the consequences of such an action. For example, it might have no effect: if the vast majority of Canadians remain satisfied with the current system, pressure from voters might in itself be sufficient to force provincial governments to maintain the requirements of public health care insurance across the country. On the other hand, repeal of the Act might result in a large number of experimental systems in Canada; provincial health care insurance plans would undoubtedly vary greatly, especially among provinces with very different tax bases.

The federal government has already made its position known. By introducing the Canada Health and Social Transfer and its successor, the Canada Health Transfer, it has taken steps to maintain an adequate level of funding as well as the authority conferred upon it by the *Canada Health Act*. **Moreover, the 1995 federal policy on private clinics and the successive letters of concern related to private diagnostic imaging clinics (2000, 2003, 2005) suggest that the federal government is prepared to initiate the DAR process to ensure compliance with the *Canada Health Act*.**

PARLIAMENTARY ACTION

In Canada, governments have intervened in health care in order to promote social and economic equity in this area. First, with the adoption of the *Hospital Insurance and Diagnostic Services Act* in 1957, and then with the *Medical Care Act* in 1966, the federal government used its spending power to transfer funds and attach requirements it considered important, but without regulating this sector, which is under provincial jurisdiction. By passing the *Canada Health Act* in 1984, however, Parliament did affect the provincial health care insurance plans in that it imposed nine requirements, including five specific criteria. These criteria guarantee all Canadians access to medically necessary physician and hospital services, free of financial or other barriers, within a system publicly administered on a non-profit basis. They also guarantee reimbursement for insured health care services received anywhere in Canada or abroad.

The five criteria stipulated in the *Canada Health Act* are not new: they were already set out in previous legislation on medical and hospital care. What was new in the 1984 Act was the provision of penalties for defaults, i.e., for the failure of provincial governments to comply, as part of their health care insurance plan, with the criteria stipulated in the Act. Federal cash transfers made as part of the EPF, CHST or CHT, as well as other transfers to provincial governments, were or are conditional on the province's compliance with these criteria.

In the years since the Act was adopted, the provinces have complied to a great extent with the five criteria and other provisions of the Act, although the federal government has had to intervene to ensure compliance with respect to extra-billing and user charges. The federal government has not, however, imposed penalties for some of the failures to comply with the five criteria of public health care insurance. It has preferred to limit its action, at least so far, to persuasion and negotiation. Some people have criticized this approach and have referred to the federal government's inaction and inability to enforce the criteria. Given the division of powers between the two levels of government, it can be expected that intervention by the federal government in this area could lead to conflict with the provincial governments and that warnings alone might not be enough to secure the provincial governments' cooperation.

Overall, any proposal for reforming the *Canada Health Act* will inevitably have to consider factors that are constitutional (distribution of powers), political (feasibility and voter approval), and economic (cost effectiveness).

CHRONOLOGY

- 1 April 1984 - The *Canada Health Act* received Royal Assent.
- May 1994 - In accordance with the Act, the Governor in Council withheld \$1,750,000 in EPF transfer payments from British Columbia because some medical practitioners in that province had withdrawn from the government health care insurance plan and resorted to extra-billing in 1993.
- September 1994 - Federal/provincial/territorial meeting of Health Ministers in Halifax, Nova Scotia. All Ministers present, except the Alberta Minister, agreed to “take whatever steps are required to regulate the development of private clinics in Canada, and to maintain a high quality, publicly funded Medicare system.”
- January 1995 - The federal Health Minister, the Honourable Diane Marleau, sent her provincial counterparts a letter informing them of the federal government’s intention to impose financial penalties on provinces whose private clinics demand extra fees from patients in addition to the amount reimbursed by health insurance. The provinces had until 15 October 1995 to comply with this new interpretation of the Act.
- June 1995 - Bill C-76, under which EPF transfers would be combined with CAP transfers to create a new form of block funding, received Royal Assent.
- Section 6 of the *Canada Health Act* was removed as a consequential amendment to Bill C-76. Despite this repeal, extended health care services continue as part of the Act in the same manner they have since 1984. As such, they still remain subject only to conditions related to the provision of information and recognition of federal transfers, as set out in section 13 of the Act.
- November 1995 - The federal Health Minister, the Honourable Diane Marleau, stated that the federal government had begun imposing cash penalties on all provinces in which semi-private clinics charged user fees. These provinces were Alberta, Manitoba, Nova Scotia and Newfoundland.
- April 1996 - The new CHST came into force, combining EPF and CAP transfers.
- July 1996 - Health Canada lifted the penalties imposed on Alberta when that province began complying with the Act.
- January 1998 - The penalties imposed on Newfoundland with respect to private clinics were lifted.

- February 1999 - Health Canada discontinued the penalties imposed on Manitoba with respect to the federal policy on private clinics.
- September 2000 - The federal Health Minister, the Honourable Allan Rock, wrote to his Alberta and Quebec counterparts to obtain more information on private MRI clinics operating in these provinces.
- July 2003 - The federal Minister of Health, the Honourable Anne McLellan, wrote to Alberta, British Columbia, Nova Scotia and Quebec to communicate her objection to the queue jumping that results from private diagnostic imaging clinics.**
- April 2005 - The federal Minister of Health, the Honourable Ujjal Dosanjh, wrote to the same four provinces to express concerns about private MRI and CT scan clinics.**

SELECTED REFERENCES

- Alberta Health and Wellness. *Policy Statement on the Delivery of Surgical Services*. Government of Alberta, 17 November 1999.
- Auditor General of Canada.
- “Federal Support of Health Care Delivery.” November 1999 Report. Chapter 29.
 - “Health Canada – Federal Support of Health Care Delivery.” September 2002 Report. Chapter 3.
- Blache, Pierre. “Le pouvoir de dépenser au cœur de la crise constitutionnelle canadienne.” *Revue générale de droit*, Vol. 24, No. 1, 1993, pp. 29-64.
- Boothe, Paul, and Barbara Johnston. “Stealing the Emperor’s Clothes: Deficit Offloading and National Standards in Health Care.” *C. D. Howe Institute Commentary*, No. 41, March 1993.
- Brooks, Janet. “Alberta’s Private MRI Clinics One Sign of Move away from Cash-free Medical Care.” *Canadian Medical Association Journal*, Vol. 151, No. 5, 1 September 1994, pp. 647-648.
- Canadian Bar Association. *What’s Law Got To Do with It? Health Care Reform in Canada*. Report of the Canadian Bar Association Task Force on Health Care. Ottawa, August 1994.
- Canadian Healthcare Association. *The Private-Public Mix in the Funding and Delivery of Health Services in Canada: Challenges and Opportunities*. Policy Brief. Ottawa, 2001.
- Canadian Institute for Health Information. *National Health Expenditure Trend (1975-1999) Report – Executive Summary*. 16 December 1999.

Canadian Medical Association.

- *Toward a New Consensus on Health Care Financing in Canada*. Discussion Paper. Ottawa, July 1993.
- *Core and Comprehensive Care Services: A Proposed Framework for Decision-Making – Executive Summary*. Ottawa, 13 May 1994.

Canadian Public Health Association. *Caring about Health*. Issue Paper on Federal/Provincial/Territorial Arrangements for Health Policy. Ottawa, 1992.

Commission on the Future of Health Care in Canada (Roy J. Romanow, Commissioner).
***Building on Values – The Future of Health Care in Canada*. November 2002.**

Courchene, Thomas J. *Social Canada in the Millennium – Reform Imperatives and Restructuring Principles*. C. D. Howe Institute, Ontario, 1994.

Evans, Robert G., Morris L. Barer, Greg L. Stoddart and Vandna Bhatia. *It's Not the Money, It's the Principle: Why User Charges for Some Services and Not Others?* Discussion Paper No. 94-06. Centre for Research on Economic and Social Policy, University of British Columbia, January 1994.

Federal, Provincial and Territorial First Ministers. *A Framework to Improve the Social Union for Canadians*. 4 February 1999.

Flood, Colleen M., and Sujit Choudhry. *Strengthening the Foundations: Modernizing the Canada Health Act*. Discussion Paper No. 13. Commission on the Future of Health Care in Canada, August 2002.

Godbout, Gilles. “Les transferts fédéraux aux provinces: une réforme nécessaire.” *Policy Options*, Vol. 14, December 1993, pp. 40-44.

Gray, Charlotte. “As Ottawa Reduces Stake in Health Care System, Does It Open Door for Private Sector?” *Canadian Medical Association Journal*, Vol. 151, No. 5, 1 September 1994, pp. 643-644.

Health and Welfare Canada. *Preserving Universal Medicare*. Ottawa, 1983.

Health Canada.

- “No Two-Tier Medicine under the *Canada Health Act* Says Diane Marleau.” News Release, 6 January 1995.
- *Canada Health Act – Annual Report*. Ottawa, various years.
- ***CHA Dispute Avoidance and Resolution, Fact Sheet, 25 November 2002***.
- ***Affidavit of Gigi Mandy, Director of the Canada Health Act Division, Health Canada. Federal Court, Trial Division, Court File No. T-709-03, October 2003***.

Jenness, R. A., and M. C. McCracken. *Review of the Established Programs Financing System*. Informetrica, Paper No. 2. Prepared for the Ministry of Intergovernmental Affairs, Government of Ontario, 29 October 1993.

Kennedy, Mark. "Is There a Cure for Medicare?" *Ottawa Citizen*, 3 September 1994, pp. B1-B2.

Leeson, Howard. *Constitutional Jurisdiction Over Health and Health Care Services in Canada*. Discussion Paper No. 12. Commission on the Future of Health Care in Canada, August 2002.

Madore, Odette. *Federal Support for Health Care Under Bill C-28: The Budget Implementation Act, 2003*. PRB 03-20E. Parliamentary Research Branch, Library of Parliament, 21 November 2003.

Martin, Sheilah L. *Women's Reproductive Health, The Canadian Charter of Rights and Freedoms and the Canada Health Act*. Canadian Advisory Council on the Status of Women, Ottawa, September 1989.

Moran, Terry. "Province's Former Health Minister Brings Private Sector MRI to BC." *Canadian Medical Association Journal*, Vol. 151, No. 5, 1 September 1994, pp. 645-646.

National Council of Welfare.

- *Health, Health Care and Medicare*. Ottawa, Fall 1990.
- *Funding Health and Higher Education: Danger Looming*. Ottawa, Spring 1991.

National Forum on Health.

- *The Public and Private Financing of Canada's Health System: A Discussion Paper*. Ottawa, 1995.
- *Canada Health Action: Building on the Legacy*. Ottawa, 1996.

Rachlis, Michael. "Le bistouri sur la gorge – Medicare, la pièce maîtresse des programmes sociaux canadiens est en danger." *Les Cahiers de l'Agora*, Vol. 1, April 1994, pp. 17-20.

Sormany, Pierre. "La médecine privatisée." *Affaires Plus*, No. 15, September 1992, pp. 18-21 and 24-25.

Standing Senate Committee on Social Affairs, Science and Technology (Hon. Michael J. L. Kirby, Chair). *Volume Six: Recommendations for Reform*. Final Report on the State of the Health Care System in Canada, October 2002.

Thomson, Alistair.

- *Federal Support for Health Care – A Background Paper*. Health Action Lobby (HEAL), June 1991.
- *Getting to the Core of Comprehensiveness – A Discussion Paper*. Health Action Lobby (HEAL), March 1994.