Current Issue Review **94-4E**

THE CANADA HEALTH ACT: OVERVIEW AND OPTIONS

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Revised 16 June 2003

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TABLE OF CONTENTS

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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 insured health care. These requirements, or "national principles," have helped shape provincial health-care insurance plans throughout the country.

Today, however, the Act is the focus of a lively debate. Factors that call into question or can be said to threaten the national principles in the Act include:

- the gradual reduction of federal transfers to the provinces in the 1990s;
- the de-insuring of services previously covered by provincial health-care insurance plans;
- the existence of private facilities in some provinces delivering uninsured and insured health services; and
- the shift towards non-institutional care.

The discussion on national principles is part of a much broader picture, involving factors that are political (distribution of powers), fiscal (balancing the budget and responding to priorities other than health care), and economic (greater cost-effectiveness). It raises fundamental concerns about the public sector's role, including that of the federal government, in health-care funding.

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

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.

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. 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.

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. Moreover, the delivery of health care is largely in the hands of the private sector: most medical practitioners are in private practice 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.

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:

- determining how many beds will be available in a province;
- determining what categories of staff will be hired;
- determining how the system will serve the population;
- approving hospital budgets;
- negotiating fee scales with medical associations; and
- administering the public health-care insurance plan in their own province.

The federal government has intervened in the health-care field by using the 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 areas 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.

Since 1 April 1996, the *Canada Health Act* has been 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 is similar to that used for the EPF, and includes both cash transfers and tax point transfers. The provinces must meet all the requirements of the Act in order to be eligible for the full cash transfer. **Beginning with the 2004-2005 fiscal year, the *Canada Health Act* will be linked to the Canada Health Transfer (CHT).**

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 contribution under the CHST. These nine requirements include five criteria, two specific provisions and two conditions. The five criteria 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. **In Canadian literature, reference is frequently made to the concept of "single payer" to describe the concept of administration 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.

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. 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 that now governs the CHST. These provisions apply as well to the CHST, but have become less relevant with the merger of EPF and CAP transfers into a single envelope. 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 forego 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 will be linked to the new Canada Health Transfer effective 1 April 2004, the penalties will apply to total cash transfers to the provinces for health and social programs.**

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 CHST 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.

F. Imposition of Penalties

On three occasions, the federal government has resorted to financial penalties and reduced its contributions to some provinces that were authorizing extra-billing or imposing user charges. First, it deducted more than $246,732,000 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 four 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 $323,000 had been deducted from Newfoundland, which started to comply with the Act in January 1998. The penalties imposed on Manitoba ($2,056,000 in total) were discontinued as of 1 February 1999. **Nova Scotia has still not complied with the *Canada Health Act* and is being penalized in the amount of $3,250 per month (a total of $317,000 was deducted from transfers to Nova Scotia between 1995-1996 and 2001-2002).**

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. This issue will undoubtedly have to be negotiated by the federal government and the provinces, if the criterion of portability is to be preserved.

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-care 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.**

On 4 February 1999, federal and provincial governments (with the exception of Quebec) signed the Social Union Framework Agreement, in which the governments reaffirmed their commitment to the five criteria of the *Canada Health Act.* The agreement also offers a process for avoiding and/or resolving disputes over interpretations of the Act. In his November 1999 report, the Auditor General of Canada welcomed this process and recommended that it be used to resolve new or outstanding issues relating to the interpretation and application of the *Canada Health Act*. **In April 2002, the federal, provincial and territorial governments agreed on a dispute avoidance and resolution process. To date, however, there has been no recourse to this new process.**

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-care 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-care 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.

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 eyes)	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
In vitro 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 MRI (Magnetic Resonance Imaging), X-ray, ultrasound and 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 MRI clinics operating in these provinces. No further action has been taken by the federal government since then.

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

The desire to reduce and eliminate the federal deficit in the mid-1980s and the 1990s has probably been largely responsible for the debate over the *Canada Health Act*. Governments have made difficult budgetary decisions in all their areas of responsibility, including health care. Any restriction in public health-care expenditures inevitably results in a challenge to the government's role in this area. Against this background, it has 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*.

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 CHST or EPF, as well as other transfers to provincial governments, 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 containment).

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.

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 were 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.

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