Chapter

3

Health Canada

Federal Support of Health Care Delivery

The audit work reported in this chapter was conducted in accordance with the legislative mandate, policies, and practices of the Office of the Auditor General of Canada. These policies and practices embrace the standards recommended by the Canadian Institute of Chartered Accountants.

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Health Canada
Federal Support of Health Care Delivery

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Key Message

3.1 Health Canada has made only limited progress in addressing the weaknesses we identified in our 1999 audit. As a result, its monitoring still does not allow it to assess and report the extent of provincial and territorial compliance with the *Canada Health Act*. Resolving disputes over compliance with the Act remains slow. Both levels of government recently agreed to a process for dispute avoidance and resolution that holds potential for improving the resolution of disputes through co-operation and collaboration. The federal government still does not identify its intended contribution to health care funding. Parliament and Canadians need that information for informed debate on the future of health care.

ORIGINAL ISSUES	STATUS	RATING*
3.2 Health Canada should assess the capacity of the information sources it uses for monitoring the operation of the *Canada Health Act* and determining the extent to which provinces and territories have satisfied the Act's criteria and conditions.	Health Canada has increased its staff and budget to monitor and assess compliance with the Act. It has also developed a process for consistent, proactive monitoring and improved its information systems. Health Canada needs to continue to work with the provinces and territories because it still does not have adequate information to assess the extent of provincial and territorial compliance with the *Canada Health Act* criteria and conditions for health care funding.	LIMITED PROGRESS
3.3 In its annual reports to Parliament, Health Canada should clearly indicate the extent to which each provincial and territorial health care insurance plan has satisfied the *Canada Health Act* criteria and conditions. Where it does not provide this information in the reports, it should clearly explain the reasons.	The Canada Health Act Annual Report provides a good description of provincial and territorial health care insurance legislation, as well as statistics on health care delivery. The Report does not indicate the extent to which each provincial and territorial health care insurance plan has satisfied the *Canada Health Act* criteria and conditions.	LIMITED PROGRESS
3.4 The federal government should explore options to improve information on its total contribution to provinces and territories for health care.	The federal government provides only limited information on its intended total contribution to the provinces and territories for future funding of health care.	LIMITED PROGRESS

* Possible ratings are completed, satisfactory progress, limited progress, no progress, rejected, unknown. (See About the Follow-Up for an explanation of the ratings.)

Health Canada and the federal government have responded. Health Canada has not agreed with the recommendations but will address any gaps with regard to information collection in order to fulfill its obligations to administer the *Canada Health Act*. Health Canada has committed to further improving its performance measurement and reporting. The federal government has agreed to continue to explore options to improve health care information. The responses are included in the chapter.

Introduction

The federal government is a significant player in health care

3.5 The federal government is not directly responsible for the delivery of health care services in the provinces and territories; that is a provincial and territorial responsibility. However, the federal government supports health care by transferring funds to the provinces and territories to assist them in carrying out their health care mandates.

3.6 The federal government funds health care in a variety of ways. It provides direct funding for research, surveillance, and the development of the health "infostructure." It also funds grants and contributions to individuals and organizations to participate in activities such as health promotion, health protection, disease prevention, and health research. The federal government does deliver health care services directly to specific groups of people, such as First Nations and Inuit, the Canadian Forces, veterans, inmates of federal penitentiaries, and members of the Royal Canadian Mounted Police.

3.7 The largest federal transfer to the provinces and territories provides support for health care, post-secondary education, and social assistance. These transfers and the other forms of health care funding make the federal government a significant player in health care.

Canada has a long history of publicly financed health care

3.8 Until the late 1940s, health care in Canada was dominated by private medicine and access to care was based on ability to pay for it. In 1947, Saskatchewan introduced a public insurance plan for hospital services that covered all residents, regardless of their ability to pay. This began the evolution of Canadian health care into the system we have today, a system that is publicly funded and aims to ensure that all residents of Canada have prepaid access to the health care they need. Exhibit 3.1 summarizes the key milestones in this evolution.

3.9 In 1957, the federal government introduced the *Hospital Insurance and Diagnostic Services Act* in an attempt to encourage all provinces to develop hospital insurance plans. Under the Act, the federal government offered to share the costs of eligible services roughly fifty-fifty with the provinces. As a condition for receiving federal money, the provinces and territories agreed to make insured services available to all of their residents on uniform terms and conditions. By 1961, all 10 provinces and the two territories had signed agreements establishing public insurance plans that provided universal coverage for in-patient hospital care.

3.10 In 1966 the government introduced the *Medical Care Act*, which provided for federal funding to cover close to half the cost of physician visits and services. To qualify for federal funding, a province or territory had to ensure that its medical insurance plan satisfied four criteria: it had to be publicly administered, portable, and universal; and insured services had to be

accessible. By 1972, all provinces and territories had extended their health insurance plans to include physician services.

3.11 The Canada Assistance Plan was also introduced in 1966. This was a federal–provincial program for sharing the costs of comprehensive welfare services. In 1977, the federal government established the Extended Health Care Services Program to provide financial assistance to the provinces and territories for ambulatory care, nursing home intermediate care, adult residential care, and home health care.

3.12 In 1977, the federal government replaced cost sharing with block funding. This move responded to concerns about the expense and unpredictability of cost sharing and allowed more flexibility for the provinces to set their spending priorities. A new mechanism for block fund transfers was introduced, called Established Programs Financing (EPF). The EPF combined federal transfers for hospital and medical services with transfers for post-secondary education and the Extended Health Care Services Program.

3.13 The federal health transfer through Established Programs Financing was in roughly equal portions of cash and tax point transfers. To provide the tax transfer, the federal government reduced its personal and corporate income tax rates, which allowed provinces to raise their tax rates by an equal amount. As a result, the revenue that would have flowed to the federal

Exhibit 3.1 Key milestones in the evolution of universal, publicly financed health care in Canada

Year	Milestone
1947	Saskatchewan introduced a public insurance plan for hospital services.
1957	The federal government introduced the *Hospital Insurance and Diagnostic Services Act*, a cost-shared program providing insurance coverage and access to hospital services.
1958–61	Provinces and territories joined the national hospital insurance program.
1961	Saskatchewan extended public health insurance to cover physician services outside hospitals.
1966	The federal government introduced the *Medical Care Act* to share the cost of medical care insurance plans with provinces.
1966	The federal government introduced the Canada Assistance Plan (CAP), a cost sharing plan for comprehensive welfare programs. The plan also covered certain health services.
1968–72	Provinces and territories joined the national medical care program.
1977	The *Federal–Provincial Fiscal Arrangements and Established Programs Financing Act* was enacted. Established Programs Financing (EPF) included transfers covering hospital insurance, medical care insurance, and post-secondary education; and the Extended Health Care Services Program.
1984	Parliament enacted the *Canada Health Act.*
1996	The federal government replaced EPF and CAP with the Canada Health and Social Transfer (CHST).
1999	The Prime minister and all premiers (except Quebec's) and territorial leaders signed the Social Union Framework Agreement.
2000	First ministers issued a communiqué on health that committed them to clear accountability reporting to Canadians.

government began to flow directly to the provincial governments. This revenue still goes to the provinces and continues to grow as their economies grow.

3.14 The *Canada Health Act* was passed in 1984, when Established Programs Financing was the main mechanism for transferring federal funds to the provinces for health care. The Act was a response to concerns that doctors' practice of extra-billing and hospitals' charging of user fees were creating a two-tiered health system that would threaten access to care. The *Canada Health Act* reaffirmed the federal government's commitment to universal, accessible, comprehensive, portable, and publicly administered health insurance (Exhibit 3.2).

Exhibit 3.2 ***Canada Health Act*: Purpose and requirements**

Purpose

The *Canada Health Act* aims to ensure that all residents of Canada have access to necessary health care on a prepaid basis.

The purpose of the *Canada Health Act* is to establish criteria and conditions in respect of insured health services and extended health care services provided under provincial law that must be met before a full cash contribution may be made.

Criteria

1. **Public administration.** The health insurance plan of a province/territory must be administered and operated on a non-profit basis by a public authority accountable to the provincial/territorial government.
2. **Comprehensiveness.** The plan must insure all medically necessary services provided by hospitals and physicians and, where permitted, services rendered by other health care practitioners.
3. **Universality.** The plan must entitle 100 percent of eligible residents to insured health services on uniform terms and conditions.
4. **Portability.** Residents are entitled to coverage when they move to another province/territory and when they travel within Canada or abroad (with some restrictions).
5. **Accessibility.** The plan must provide reasonable access to insured hospital and physician services on uniform terms and conditions. Additional charges to insured patients for insured services are not allowed. No one may be discriminated against on the basis of income, age, health status, etc.

Conditions

1. **Provision of information.** Provincial/territorial governments are required by regulations to provide annual estimates and statements on extra-billing and user charges. They are also required to voluntarily provide 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.
2. **Provincial recognition of federal contributions.** Provincial/territorial governments are required to give public recognition of federal transfers.

Provisions on extra-billing and user charges

1. **Extra-billing** for an amount in addition to any amount paid or to be paid for an insured health service by the health care insurance plan of a province.
2. **User charge** for an insured health service that is authorized or permitted by a provincial health care insurance plan that is not payable, directly or indirectly, by the plan, but does not include any charge imposed by extra-billing.

Penalty provisions

1. **Mandatory financial penalty** for extra-billing and user charges. Direct patient charges are subject to dollar-for-dollar deductions from federal transfer payments.
2. **Discretionary financial penalty** for non-compliance with the five criteria and two conditions. Financial penalties will reflect the gravity of the default.

Source: Health Canada, *Canada Health Act Annual Report*, 1997–98

3.15 In 1996, the Canada Health and Social Transfer (CHST) was introduced to replace Established Programs Financing and the Canada Assistance Plan. The CHST is a block fund or lump sum transfer from the federal government to the provinces and territories on a per capita basis to subsidize health care, post-secondary education, and social assistance. The provinces allocate the block fund among these social programs according to their own priorities.

The federal government influences health care delivery through the *Canada Health Act* and the Canada Health and Social Transfer

3.16 The federal government does not legislate health care directly. Instead, through the *Canada Health Act,* it supports the conditional transfer of payments to the provinces and territories for health care. The Canada Health and Social Transfer, administered by the Department of Finance through the *Federal-Provincial Fiscal Arrangements Act*, is a means by which the federal government influences health care in Canada.

3.17 By imposing conditions on the transfer of funds through the CHST, the *Canada Health Act* seeks to ensure that medically necessary services will be universally accessible, without direct charge, to residents of all Canadian provinces and territories. The conditions the Act imposes are its five criteria (Exhibit 3.2). The Act states that, in order that a province may qualify for a full cash contribution… [under the CHST], the health care insurance plan of the province must satisfy the criteria respecting: (a) public administration; (b) comprehensiveness; (c) universality; (d) portability; and (e) accessibility.

3.18 The five criteria of the *Canada Health Act* reflect national objectives. Health Canada's role is to assess the extent to which health care delivery in the provinces and territories complies with the *Act*'s criteria and provisions and to authorize the payment of the CHST based on that assessment.

There are variations in the delivery of publicly funded health care services

3.19 The *Canada Health Act* covers hospital, physician, and surgical-dental services in a hospital that are judged to be medically necessary and requires, under the criterion of comprehensiveness, that these services be insured by provincial health care insurance plans. Achieving comprehensiveness does not ensure the public funding of the same set of health care services in every province. There are a number of reasons for a lack of uniformity. First, the term "medically necessary" is not defined in the legislation, and may be interpreted differently in each province. Further, the provinces and territories do not use a uniform method for determining which services are medically necessary. Similarly, each province and territory is separately and independently responsible for its own decisions to delist any medical services, that is, to no longer pay for them through the public health care insurance plan. Finally, each provincial health care insurance plan covers additional services that are not covered by the CHA but are publicly funded through the provincial plan. These additional services vary from province to province.

3.20 For all of these reasons, there are variations across the country in public coverage of certain health care services. For instance, the removal of

varicose veins and eye examinations for people aged 19 to 64 are medical services that are insured in some provinces but not in others. The extent and the impact of variations across the country are not known.

Recent increases in public health care expenditures

3.21 During the period 1991 to 1997, the proportion of public to total expenditure on health care declined. After 1997 the trend reversed, because the federal government announced significant increases in the CHST (Exhibit 3.3).

3.22 The pattern of health care spending has changed over the past decade. Spending on hospital and physician services has become a smaller percentage of total health care spending. These services are covered by the *Canada Health Act.* Health care expenditures for drugs have increased as a percentage of total health care expenditures. Drugs are not covered by the *Canada Health Act* unless they are administered in a hospital.

3.23 In 1984, when the *Canada Health Act* was passed, hospitals provided many services such as drugs, rehabilitation, convalescent care, and palliative care that today are delivered increasingly in the home or community. And they are delivered by a broader range of health care providers, such as nurses, nurse practitioners, physiotherapists, and occupational therapists. These services fall outside the scope of the *Canada Health Act*, and their delivery is often paid for by patients or by private health insurance plans.

Exhibit 3.3 Health care spending in Canada, 1991 to 2001

	1991	1993	1995	1997	1999	2001 (Forecast)
Total health care expenditure ($ billions)	66.2	71.5	74.1	78.3	89.5	102.5
Public health care expenditure ($ billions)	49.35	51.95	52.8	55	63.4	74.5
Private health care expenditure ($ billions)	16.89	19.56	21.3	23.3	26.1	28
Total health care expenditure as a percentage of GDP	9.6	9.8	9.1	8.9	9.2	9.4
Public health care expenditure as a percentage of total	74.5	72.7	71.3	70.2	70.8	72.7
Private health care expenditure as a percentage of total	25.5	27.3	28.7	29.8	29.2	27.3
Total health care expenditures by use of funds as a percentage of total						
Hospitals	38.7	37.4	34.5	33.0	31.9	31.5
Physicians	15.4	14.7	14.3	14.2	13.6	13.5
Drugs (prescribed and non-prescribed)	11.6	12.7	13.5	14.4	14.9	15.2
Other	34.3	35.2	37.7	38.4	39.6	39.8

Source: Canadian Institute for Health Information

Weaknesses we identified in 1999

3.24 Our 1999 audit examined the *Canada Health Act* and the Canada Health and Social Transfer, the federal government's key mechanisms of support to the provinces and territories in their delivery of health care. Our 1999 Report (Chapter 29) discussed the way the government had used these tools as instruments of public policy, the purposes they had served, and their effectiveness in achieving the results they were designed to achieve.

3.25 We noted several weaknesses in Health Canada's reporting, monitoring, and enforcement activities, such as the following:

- The federal contribution to health care was not being reported to either Parliament or the Canadian public.
- Health Canada did not have the information it needed for effective monitoring of provincial and territorial compliance with the *Canada Health Act*.
- The Department was not reporting the extent to which the provinces and territories were complying with the Act.
- It was not rigorously enforcing the Act.

Focus of the follow-up

3.26 Our follow-up audit reviewed the current administration of the *Canada Health Act* in light of our 1999 observations and recommendations.

3.27 We looked specifically at Health Canada's activities and systems for collecting information. We assessed the Department's capacity to collect and use information to monitor and report on compliance with the Act. We examined the enforcement of the Act. Finally, we examined the Department's development of a mechanism for resolving disputes with a province or territory. Our report presents the results of the areas that were re-audited. Further details can be found about the follow-up's objectives, scope, approach, and criteria in About the Follow-Up at the end of the chapter.

Observations and Recommendations

Federal contribution to health care is still unclear

3.28 In our 1999 report, we observed that the federal government could not say how much it contributed, in total, to health care. We recognized that the design of the CHST as a block transfer meant that Parliament and the general public also had no clear idea of the amount of federal funding that was directed to health care. We also made clear our expectation that the federal government be in a position to provide Canadians with information on its contribution to health care.

3.29 The design of the CHST as a block transfer reflects a federal policy decision to give the provinces and territories more flexibility to allocate resources among the designated areas of social funding. Although the total amount allocated to social programs is known, Canadians do not know what portion of the CHST the federal government intends to contribute to health care.

3.30 In 2000, the Department of Finance made a number of estimates of the federal government's support to health provided through transfers to the provinces and territories. One of the estimates assumed the same historical allocation to health that prevailed under the transfer system prior to 1996–97 (43 percent cash and 68 percent tax points, for a weighted average of 54.3 percent). The other estimates suggested that the allocation might be higher. The Department of Finance told us that the estimate based on historical allocation was made for illustrative purposes only. In recent years, the federal government has invested additional funds, primarily for health, through the CHST (Exhibit 3.4). In July 2002, the Department of Finance made a new estimate based on provincial spending on health and other social programs covered by the CHST. Using the same breakdown, it estimated that 62 percent of the CHST ($21 billion in 2001–02), on average, is spent on health annually.

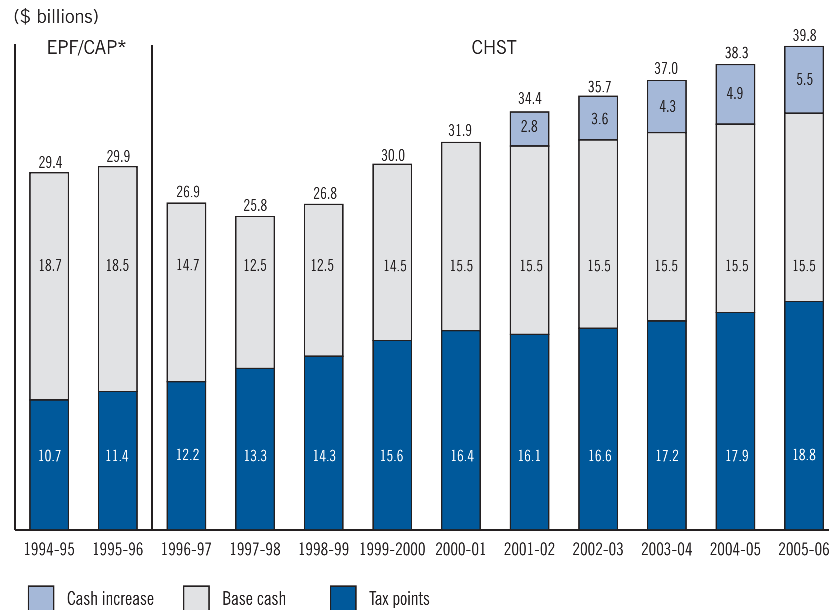
3.31 No distinction is made in the CHST to indicate how much is intended for each of the social programs it funds. The federal transfer is a combination of cash contributions and tax points for the delivery of health care, post-secondary education, and social assistance (Exhibit 3.5). There is no agreed-upon estimate that captures the federal contribution to health care. The Canadian public has not had a clear idea of the amount of federal funding directed to health care. Nor can the federal government say what its total contribution to health care will be. Consequently, parliamentarians must make decisions about federal support of health care delivery without adequate information on the federal contribution.

Exhibit 3.4 Recent federal investments in health care

Year	Investment
1999	The federal Budget announced increased funding for the Canada Health and Social Transfer (CHST) of $11.5 billion over five years, specifically for health care.
2000	The Budget announced a $2.5 billion increase in the CHST over four years to help provinces and territories fund post-secondary education and health care. First Ministers agreed on an action plan for renewing health care and investing in early childhood development. The federal government committed to invest an additional $21.1 billion in the CHST over five years, including $2.2 billion for early childhood development. It would also invest in three targeted areas: • $1 billion in 2000–01 and 2001–02, in transfers to the provinces and territories for new medical equipment; • $800 million over four years, beginning in 2001–02, in a renewed Health Transition Fund to support innovation and reform in primary care; and • $500 million to establish an independent corporation mandated to accelerate the development and adoption of modern systems of information technology, such as electronic patients' records.

Source: Department of Finance

Exhibit 3.5 Canada Health and Social Transfer (CHST)



*EPF Established Programs Financing
CAP Canada Assistance Plan

Source: Department of Finance, at 22 July 2002

3.32 Public opinion polls show that Canadians value Medicare and are concerned about its long-term sustainability. There is considerable debate over the federal contribution to health care. Much of the debate has been about incremental funding—that is, reductions in or additions to the federal contribution.

3.33 In 2000, the federal government put an additional $21.1 billion into the CHST for five years. This increase was targeted primarily to support health care delivery in the provinces and territories. When the increase was announced, First Ministers agreed to improve public reporting in their own provinces as a way to inform Canadians about some of the effects of health care spending.

3.34 The current public debate on the future of health care is evidence of Canadians' concern about their health care system. The debate is limited by a lack of sufficient information on the federal contribution to health care funding: Canadians do not know how much the federal government contributes. We would expect the federal government to be in a position to tell Canadians what it intends to contribute to health care funding in the future. This information could help to inform the current debate on health care reform. Further, federal efforts to spell out its own intent would not affect the flexibility of the provinces and territories to allocate the CHST block funding according to their own priorities.

3.35 **Recommendation.** The federal government should provide sufficient information to Parliament to allow for informed debate on future health care funding.

Government's response. The federal government provides full information on its own direct health spending through the Main Estimates and the Health Canada Web site. It also provides full information (in Budget booklets, the Finance Canada Web site, and the Main Estimates) on its transfer payments to provinces and territories, which, in the case of the Canada Health and Social Transfer (CHST), is provided to support provincial and territorial spending on health care, post-secondary education, and social assistance and social services, including early childhood development. The policy intent in establishing the CHST block fund is to provide provinces and territories with the flexibility to allocate funds according to their respective priorities; in this context, provinces and territories have the flexibility to use all of the CHST cash in support of the *Canada Health Act* if they wish. The federal government has made strides in ensuring that more information is made available on the nature and policy objectives of transfer programs, including the CHST, and will continue to explore options to improve health care information.

Monitoring compliance with the *Canada Health Act*

3.36 We observed in 1999 that Health Canada did not routinely collect the information it needed for determining to what extent the provinces and territories were complying with the *Canada Health Act*. We noted that its sources of information were not sufficient to determine the extent of compliance. We also noted that the Department had not collected reliable information on relevant indicators.

3.37 We expected Health Canada to use a monitoring system that collected sufficient relevant information on compliance with the *Canada Health Act*, analyzed it, reported it, and provided the Department with the information it needed to administer the Act.

Increased monitoring capacity

3.38 A reorganization at Health Canada in 2000 created the Canada Health Act Division. The new division's major responsibilities include monitoring provincial and territorial health insurance plans to ensure that they meet the criteria and conditions of the Act; informing the Minister of possible non-compliance and recommending appropriate action to resolve it; providing information to senior Health Canada officials on the monitoring and interpretation of the Act; reporting annually to Parliament on provincial and territorial compliance with the Act; and administering and enforcing the Act.

3.39 In the Canada Health Act Division, annual funding was increased from $2.5 million in 1999 to $4 million; the additional funding was to support activities in the Department's regions and at headquarters. Two new positions were created in each of Health Canada's six regions, and the total staff complement of the Division rose from 23 to 49. We were told that the new positions are responsible primarily to collect information for the purposes of monitoring compliance with the Act.

3.40 At headquarters, Health Canada established the Information, Analysis and Reporting Unit, responsible for collecting and analyzing information to improve the Department's capacity to monitor provincial and territorial compliance with the *Canada Health Act.* The Unit developed the Canada Health Act Information System to facilitate the storage, tracking, and analysis of information related to compliance. The unit is also responsible for producing the Canada Health Act Annual Report.

Limited number of information sources for monitoring

3.41 Our follow-up found that the sources of information Health Canada uses for monitoring purposes have not changed substantially since our 1999 audit. There are three major sources of information available to the regional analysts—third-party sources, public complaints, and voluntary submissions by the provinces and territories for the purpose of the annual report.

3.42 Third-party sources include the media, stakeholders' publications, personal and professional contacts, and conferences. The Department's regional analysts rely heavily on these sources to track and identify potential cases of non-compliance in the provincial delivery of health care. These sources still do not allow the Department to assess the extent of provinces' and territories' compliance with the *Canada Health Act.*

3.43 Complaints by individuals are the second major source of information on potential cases of non-compliance. Complaints trigger queries and investigations that can lead to the identification of cases of non-compliance with the conditions of the *Canada Health Act*. Complaint-driven monitoring assumes that where no complaints are reported, conditions are being met.

3.44 Finally, the provinces and territories submit information voluntarily to Health Canada each year, according to guidelines developed by the Department. This information describes the operation of the provincial and territorial health care insurance plans in relation to the Act. The information is analyzed by the Department to ensure that provincial and territorial health care insurance legislation comply with the *Canada Health Act.*

3.45 As in 1999, we found that these sources alone do not provide sufficient information to monitor compliance and determine the extent of compliance. Information the Department provided to us shows that none of the investigations of potential non-compliance initiated since 1999 has been related to the criteria of the Act. All new investigations reported to us have dealt with the provisions of the Act, that is, user charges and extra-billing. The fact that there are no investigations related to the criteria of the Act raises some questions.

3.46 We are concerned that there may be cases of non-compliance with the criteria of the Act that Health Canada has not investigated.

Limited access to the information that could identify non-compliance

3.47 There are no regulations that require the provinces and territories to submit specific information to Health Canada, apart from extra-billing and user charges. Health Canada attempts to monitor health care delivery in the

provinces and territories in the absence of required reporting. While the Act places conditions on the transfer of CHST funds to the provinces for health care delivery, the legislation does not include regulations to facilitate monitoring for provincial compliance with these conditions. When the Act was passed in 1984, regulations were drafted to require reporting; however, they were never promulgated. As a result, the Department has only limited ability to obtain the information it needs from the provinces.

3.48 The *Canada Health Act* defines the conditions for the federal transfer of funds to the provinces for health care. It also includes a provision for obtaining the information Health Canada needs from the provinces and territories. That provision has not been exercised. In its interactions with the provinces and territories, Health Canada has tended to take a non-intrusive approach to administering the *Canada Health Act.*

3.49 The Department's regional analysts informed us that they cannot collect information from medical facilities because delivery of services is under provincial and territorial jurisdiction. The provinces and territories are responsible for ensuring that health care delivery complies with their own health care legislation; they are not obliged to report this information to Health Canada. Thus, Health Canada does not have access to the information it needs to administer the Act.

3.50 We observed that other organizations collect data on health care delivery. The Canadian Institute for Health Information (CIHI) has collected information on waiting times in hospitals; Statistics Canada conducts the Canadian Community Health survey; and organizations outside government, such as the Canadian Medical Association and the Canadian Healthcare Association, also collect health statistics. While these organizations do not have the same mandate as Health Canada, they do collect some information that Health Canada could use for monitoring but currently is not.

Health Canada still does not report the extent of compliance

3.51 We noted in 1999 that previous editions of the Canada Health Act Annual Report to Parliament had not met the Act's requirement that Health Canada indicate to what extent each province and territory had satisfied the criteria and conditions in the Act. The annual reports were descriptive and narrative, and they did not provide enough information for Parliament to determine the extent of provincial and territorial compliance.

3.52 The Minister of Health has an obligation under the Act to report on its administration and operation, including all relevant information on the extent to which the provinces have satisfied the conditions for payment under the Act.

3.53 The Canada Health Act Annual Report contains general descriptions of the non-compliance issues under investigation. It also shows, by province and territory, penalties levied during the previous year and annual deductions since the passage of the *Canada Health Act.*

3.54 Neither of the two most recent annual reports (1999–2000, 2000–01) contains an assessment of the extent to which the provincial health care insurance plans comply with the *Canada Health Act.* The provinces and territories voluntarily submit information to Health Canada as prescribed by a template developed by the Canada Health Act Division. This information is reported in the Canada Health Act Annual Report but is not used to determine compliance. The reports provide good descriptions of provincial and territorial health care insurance legislation. Health Canada does not conclude to what extent this legislation complies with the *Canada Health Act.* The reports also provide statistics on health care delivery. Health Canada does not conclude to what extent provincial and territorial health care delivery complies with the federal legislation. As a result, members of Parliament cannot determine from the Canada Health Act Annual Report whether the spending of billions of dollars transferred to the provinces and territories results in health care delivery that meets the intent of the Act.

First Ministers agree to report publicly on performance of their health care systems

3.55 In September 2000, First Ministers issued a communiqué on health that committed them to clear accountability reporting to Canadians. This accompanied the announcement of $21.1 billion in new federal investments over five years to support health care renewal.

3.56 First Ministers directed their health ministers to collaborate on developing 14 indicator areas against which each government would begin reporting by September 2002. These indicator areas are to address health status, health outcomes, and quality of service. Public reporting would include verification by an independent party.

3.57 Each jurisdiction (federal, provincial, and territorial) was to report to its constituents in September 2002 on the 14 indicator areas agreed on. This initiative represents a step in the right direction. Among the indicators, two relate to compliance (hospital waiting times and access to first-contact health services). If the governments pursue this initiative and continue to collaborate on developing additional indicators, this type of reporting could provide Canadians with information on the public administration, universality, accessibility, comprehensiveness, and portability of health care.

3.58 Health Canada recognizes that there are shortcomings in the collection of health information. First Ministers are committed to working together on the development of a comprehensive framework using jointly agreed comparable indicators to address health status, health outcomes, and quality of service. To improve monitoring and reporting requires the collaboration of provinces and territories with the federal government.

3.59 **Recommendation.** Health Canada should, in collaboration with the provinces and territories, fulfil its obligation to administer the *Canada Health Act* by collecting the information it needs to enforce and report compliance with the Act.

Health Canada's response. Health Canada is already collecting considerable information on the activities of provincial and territorial health insurance plans. This information is used to assess provincial and territorial compliance with the criteria and conditions of the *Canada Health Act* and to report to Parliament.

Any gaps with regard to information collection will be addressed in the context of the provisions of the *Canada Health Act* Dispute Avoidance and Resolution process agreed to by the provinces and territories in April 2002. The process allows for governments to engage in discussions, information exchange, and joint fact-finding to ensure that they have all the necessary information to assess concerns with regard to the interpretation of and compliance with the *Canada Health Act*.

When non-compliance has been identified, resolution continues to be slow

3.60 In 1999 we reported that the resolution of non-compliance issues was a slow process. We cited examples of suspected non-compliance that had remained unresolved for a number of years. At the time of that report, there were 14 unresolved issues. Three of them have since been resolved; the 11 remaining issues have been outstanding for five years or longer.

3.61 The process for resolving federal/provincial differences over compliance with the CHA has remained slow. Since 1999, Health Canada has identified 12 more cases of suspected or confirmed non-compliance and has attempted to deal with them through means other than penalties. Two of the issues have been resolved; 10 remain outstanding.

3.62 We have been told that the slow resolution of disputes is partly due to difficulties encountered in the interpretation of the *Canada Health Act.* We note that Health Canada has developed the *Canada Health Act* Policy Interpretation Manual for employees of the Canada Health Act Division. However, the Department has not shared the manual with the provinces and territories because of legal constraints. Consequently, different interpretations of the Act at various levels of government have hindered the timely resolution of problems. Enforcement of the *Canada Health Act*, whether through penalties or negotiations, could be facilitated by an attempt to ensure timely and ongoing discussion of the Act's interpretation by all parties.

3.63 In 1999 we recognized the need for federal/provincial/territorial collaboration to avoid disputes or resolve them, as a means of enforcing the Act. Co-operation and collaboration were the major themes of the Social Union Framework Agreement signed in February 1999 by the Prime Minister and all premiers (except Quebec's). The Agreement describes how federal, provincial, and territorial governments will work together to sustain Canada's social programs.

3.64 In the spirit of the Agreement, Health Canada is committed to administering the *Canada Health Act* in a non-intrusive manner and in collaboration with provincial and territorial governments. To this end, the Department has worked with the provinces and territories to develop a process to facilitate the avoidance of disputes and the resolution of non-

compliance issues. Agreement on the process was reached in April 2002. It has not been used yet, but it has potential for improving collaboration to avoid and resolve non-compliance issues.

When non-compliance issues cannot be resolved, penalties may be imposed

3.65 Negotiation is the first course of action in the dispute resolution process. If negotiation fails, the Minister may impose a penalty. The *Canada Health Act* provides for two kinds of penalty. The first is a mandatory penalty related only to the provisions of the Act that cover extra-billing and user charges. A mandatory penalty amounts to a dollar-for-dollar deduction from the federal CHST payment to the province or territory that has allowed extra-billing or user charges. The second type of penalty is a discretionary penalty. Under sections 14 to 17 of the Act, discretionary penalties (CHST reductions) can be imposed if a province or territory has not satisfied any one of the Act's criteria for health care delivery and if all reasonable efforts at consultation and negotiation have failed. At this point, the Minister may refer the matter to the Governor in Council for a decision on whether the CHST should be reduced.

3.66 In 1999 we observed that enforcement of the *Canada Health Act* through penalties for non-compliance had been limited to the mandatory penalty for non-compliance with the extra-billing and user fee provisions of the Act. The federal government had never applied the discretionary penalties for non-compliance with the criteria of the Act.

3.67 The Act imposes obligations on the federal government. It defines the conditions that the provinces must meet to receive federal payments. If a provincial health care insurance plan falls short of these conditions, the federal government has the legislative authority to take measures that can include withholding all contributions to the offending province.

Few penalties have been imposed

3.68 The Canada Health Act Annual Report 2001–2002 shows that the federal government imposed one penalty for user charges. Exhibit 3.6 shows the number of penalties imposed since 1995 and their total value.

3.69 Health Canada has told us that it hesitates to impose penalties. It has shown a strong preference for consultation and negotiation to resolve disputes in collaboration with the provinces and territories. It believes that if it were to impose penalties, the provinces and territories could simply choose to absorb them and continue to contravene the Act.

Evaluating and reporting performance

3.70 In 1999 we reported that an evaluation by the Department had focussed on the Health Insurance Division's procedures for monitoring whether provincial health care delivery met the accessibility criterion of the Act. The evaluation noted that it was not clear how effectively the Division monitored the status of the health care system, including the implications of emerging issues that affect the underlying principles of the Act.

Exhibit 3.6 Annual deductions from Canada Health and Social Transfer, by province and territory ($ thousands)

Province/ territory	1995–96		1996–97		1997–98		1998–99		1999–2000		2000–01		Total gross deductions 1995–96 to 2000–01		
	Extra-billing	User charges	Extra-billing	User charges	Extra-billing	User charges	Extra-billing	User charges	Extra-billing	User charges	Extra-billing	User charges	Extra-billing	User charges	Total
Newfoundland and Labrador		46		96		128		53						323	323
Prince Edward Island															
Nova Scotia		32		72		57		39		61		58		319	319
New Brunswick															
Quebec															
Ontario															
Manitoba		269		588		587		612						2,056	2,056
Saskatchewan															
Alberta		2,319		1,266										3,585	3,585
British Columbia	43												43		43
Yukon															
Northwest Territories															
Nunavut															
Provincial/ Territorial Total	43	2,666		2,022		772		704		61		58	43	6,283	6,326

Source: Health Canada, Canada Health Act Annual Report, 2000–2001

The evaluation examined only the Division's monitoring activities; it did not question, for example, whether Canadians do in fact have reasonable access to health services across the country.

3.71 Health Canada agreed with our recommendation to deal with key issues of the *Canada Health Act* in future evaluations. However, it has suspended further evaluation of its responsibilities under the *Canada Health Act*, in light of several ongoing studies of the health care system, including the following:

- Commission on the Future of Health Care in Canada (chaired by Roy Romanow), report expected in 2002
- Standing Senate Committee on Social Affairs, Science and Technology: *The Health of Canadians—The Federal Role* (tabled by Senator Kirby), two reports in 2001 and another three to be tabled in 2002
- Alberta Premier's Advisory Council on Health (chaired by Don Mazankowski), report tabled January 2002
- Saskatchewan Commission on Medicare (chaired by Ken Fyke), report tabled April 2001
- Quebec's Commission d'étude sur les services de santé et les services sociaux (chaired by Michel Clair), report tabled December 2000

Commitment to reporting on performance and effectiveness

3.72 The 1999 Budget announced the $43 million health-related Federal Accountability Initiative. The initiative committed Health Canada to becoming more accountable to Canadians for the performance of its own health programs. The Department lacked the capacity in 1999 to undertake the initiative and we recommended that it explore options to meet its commitment.

3.73 Our follow-up found that Health Canada has done some work on this initiative, for example, its Performance Measurement Development Project. However, it has not completed the project; it has not yet fully developed performance expectations and reported against them. The Department was not able to provide us with an action plan and target dates.

3.74 **Recommendation.** Health Canada should ensure that the Federal Accountability Initiative provides the required performance measures of its own programs and reports against them.

Health Canada's response. Health Canada's investment in the Federal Accountability Initiative has served to advance the Department's policies and practices with respect to performance measurement and reporting to Canadians.

Health Canada is meeting its commitments to develop indicators and report on them. As part of the September 2000 First Ministers' commitment to regular federal/provincial/territorial reporting on health system performance, Health Canada is preparing a report on performance, including data on First Nations health as well as information with regard to veterans, inmates, and military personnel. This report will be published in September 2002.

Health Canada is working expeditiously on the development of performance indicators for the Department, which will be the basis for further improvements in performance reporting. The indicators will be proposed for internal approval in September 2002 to be used in the departmental performance report in the following year.

Conclusion

3.75 Weaknesses in the information that Health Canada collects and reports annually to Parliament on the administration and operation of the *Canada Health Act* remain a long-standing problem. Increased monitoring has not been able to remedy the problem of limited sources of information. Health Canada does not use the information it collects to assess or report on the extent of provincial and territorial compliance with the criteria and conditions of the *Canada Health Act.*

3.76 Health Canada has tended to take a non-intrusive approach to administering the Act. However, this approach has not brought about the speedy resolution of issues related to non-compliance with and interpretation of the Act. The majority of the non-compliance issues identified by Health Canada over the past 10 years have remained unresolved for five years or longer. Few penalties have been levied for non-compliance with the provisions of the Act. No penalties have been levied for non-compliance with the criteria of the Act.

3.77 Health Canada has suspended its evaluation of programs in this area because of the number of ongoing studies of the health care delivery system. The Department remains committed to measuring and reporting on performance. However, it has not yet completed the Performance Management Development Project.

3.78 The federal government needs to provide Parliament with adequate information on its contribution to provinces and territories for health care. Meaningful participation in the current debate on health care depends on a better appreciation of the federal contribution to this social program, one that Canadians have said helps to define this country.

About the Follow-Up

Objective

The objective of this follow-up audit was to identify Health Canada's progress in determining the extent to which federal efforts to support and monitor health care delivery

- reflect clear objectives,
- adequately report performance, and
- facilitate review and evaluation.

Scope and approach

The follow-up audit focussed on the recommendations made in our 1999 Report, Chapter 29, Federal Support of Health Care Delivery. Health Canada has undertaken a number of new initiatives in the last three years, which we also reviewed.

We reviewed a status report by the Department on the action it has taken in response to our recommendations. We carried out extensive interviews with Health Canada staff involved in the administration of the *Canada Health Act* and with staff of the Department of Finance and the Privy Council Office. We also met with stakeholders and Health Canada staff in some regions. Finally, we reviewed documentation related to reported activities.

Our report presents the results of the areas that were re-audited.

Criteria

We expected that Health Canada would have made satisfactory progress in implementing our recommendations.

The criteria from the 1999 audit remain relevant. Therefore, we expected to find the following:

- a commitment to achieving consensus among the federal, provincial, and territorial governments on objectives, roles and responsibilities, and standards;
- a process for collecting and reporting information on performance; and
- a process for interpretation and enforcement of the *Canada Health Act* that is effective and transparent.

Ratings

We assessed the action of The Departments or Agency against our original audit recommendations (see Key Message at the beginning of the Chapter). We used the following ratings:

- **Completed.** Corrective action has been fully implemented
- **Satisfactory progress.** Progress is being made at a satisfactory pace
- **Limited progress.** Some progress is being made, but the pace or scope is not satisfactory
- **No progress.** No evidence of progress although the department or agency accepted the recommendation from the original audit
- **Rejected.** The department or agency did not accept the recommendation from the original audit
- **Unknown.** Status of progress is unknown or information is not available

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