



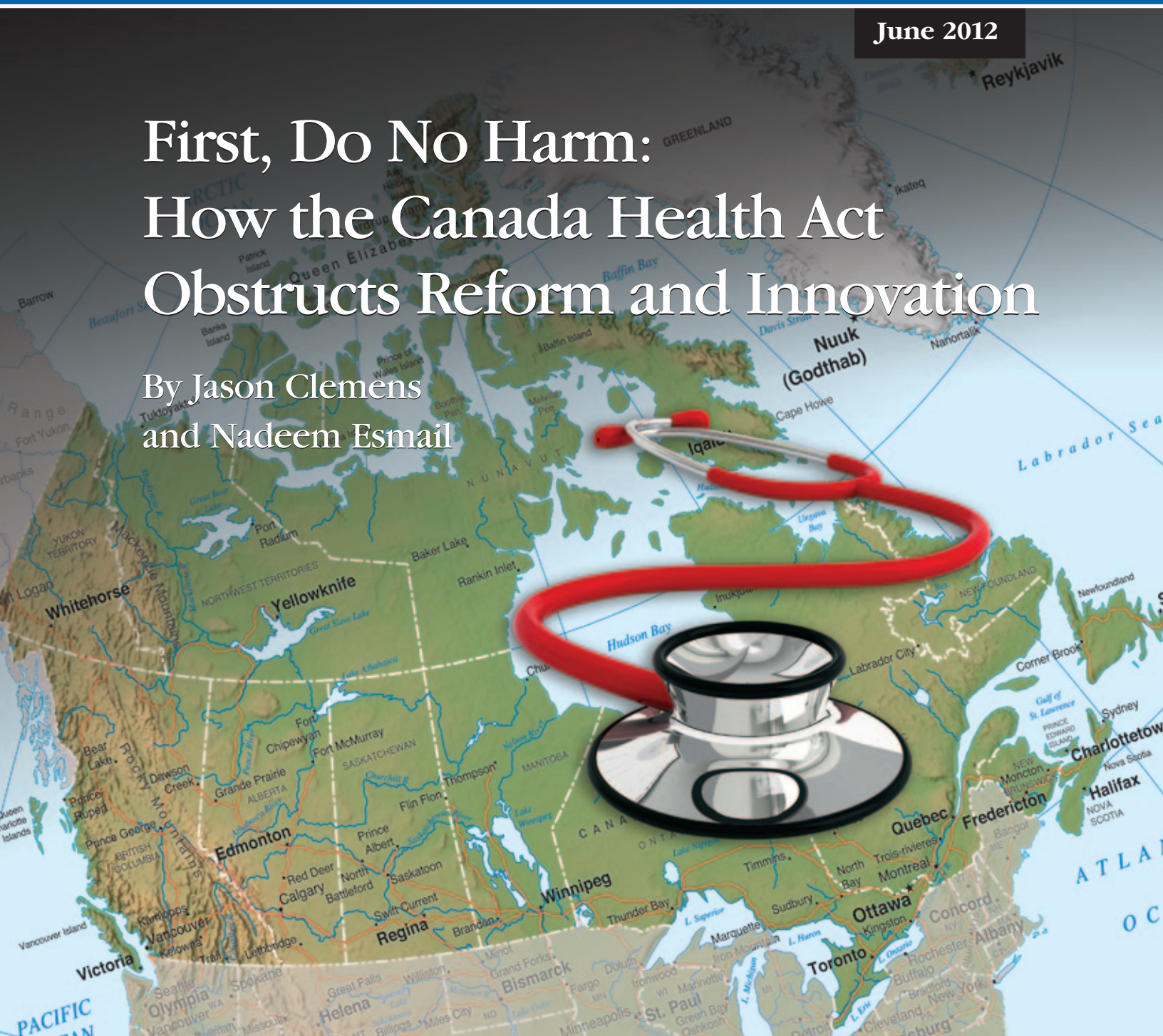
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# First, Do No Harm: How the Canada Health Act Obstructs Reform and Innovation

By Jason Clemens  
and Nadeem Esmail



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# Executive Summary

The analysis of the Canada Health Act (CHA) in this paper begins with the proposition that the welfare reform experience of the mid-1990s provides a powerful lesson for how best to reform health care in Canada. The 1995 federal budget changed the transfer to the provinces for social programs from a cost-sharing transfer to a block grant. In addition, the federal government removed most federal standards in order to free the provinces to experiment and innovate in the delivery, regulation, and financing of social assistance and related programs. Most observers agree that the totality of the reforms were quite successful in terms of reducing dependency, targeting assistance at solving problems, tailoring individual programs to individual problems, and reducing total welfare spending. The basic contours of the welfare reforms of the 1990s should form the basis for health care reform now.

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The welfare reform experience of the mid-1990s provides a powerful lesson for how best to reform health care in Canada.

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In the new federal plan that continues to support provincial health care spending through the Canada Health Transfer, a limited opportunity for experimentation and reform has been created since the federal government attached no strings to the funding. Indeed, the federal government explicitly encouraged the provinces to experiment and innovate in order to solve agreed-upon problems in the health care system.

However, a challenge remains: The Canada Health Act (CHA). The CHA is a financial act that provides the terms and conditions under which a province is entitled to its full cash transfer for health and social services from the federal government.

Unfortunately, the CHA is incompatible with a number of policy options that have been implemented in the pursuit of affordable, high-quality care by nations that share the goal of Canada's universal health care system. If Canada is to proceed with meaningful reform, the CHA will have to be revised to accommodate such reforms.

The central question posed and answered by this study is: How does the Canada Health Act impede reforms that have been employed in other industrialized countries that maintain universal health care? Countries like the United States are purposefully excluded from this analysis. This paper is only interested in assessing if and how the Canada Health Act prevents provinces from implementing reforms from other countries that provide universal health care.

## Reform Options from Other Universal Health Care Countries

It is first important to understand some of the main characteristics that differentiate Canada's universal health care system from other industrialized (mainly OECD) countries that also provide universal health care. First, nearly all developed nations that maintain universal health care allow private parallel health care where patients can choose to purchase their own health care outside of the public system. Second, privately owned and operated surgical



facilities and hospitals delivering universally accessible care can be found in the majority of developed nations that maintain universal approaches to health care. Third, in a number of countries, health practitioners can engage in “dual practice” (working in both the public and private health care systems), and health care facilities such as hospitals and surgical clinics can provide services to patients in both the public and private sectors. Fourth, patients are required to share in the cost of care consumed (through user fees/co-payments or deductibles) in the majority of developed nations that maintain universal approaches to health care. Fifth, and finally, in some countries, physicians are permitted to charge fees for medical services beyond the price found in the universal insurance scheme fee schedule.

Furthermore, in Australia, the federal government uses financial incentives to encourage residents to purchase private health insurance coverage for services that would otherwise be available through the universal health insurance scheme. Many European countries use social insurance financing (instead of taxes), which is premium-funded health insurance with management of the insurance system undertaken by a body independent from government. Within some of these systems, private insurers compete for subscribers. In the Netherlands and Switzerland, individuals can also tailor their universally accessible insurance plan.

In this paper, the CHA is examined in terms of whether it allows explicitly, disallows explicitly, or can be interpreted to disallow such policies pertaining to the broad financing and delivery of health care.

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Reform of the CHA must deal with unnecessary federal restrictions of policies employed in other universal access health care systems in the developed world.

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## Canada Health Act: Remaining Barrier to Reform

Contrary to popular opinion, analysis of the CHA reveals few clear restrictions on provincial health policy. At the same time, however, it also reveals a troubling lack of clarity that may serve to stifle provincial policy reform. A lack of clarity has also manifested itself in non-action on violations of the CHA and asymmetric applications of the CHA, both of which might be considered an arbitrary use of discretionary power by the federal government.

How then should the CHA be reformed? Any reform to the CHA must deal with unnecessary federal restrictions of policies employed in other universal access health care systems in the developed world. It must also serve to clarify the provisions of the CHA to provide greater certainty to Canada’s provincial governments. Such reform must also be feasible for the federal government for it to be at all likely to take place. With these characteristics in mind, this study makes a number of recommendations for changes to the Canada Health Act.

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**Section 8, Public Administration:** In defining the principle of public administration, Section 8 creates the single insurer structure of Medicare, making competition in universal insurance impossible. Further, for-profit ownership or operation of the sole insurance authority is not permitted. Section 8 does not, however, disallow private financing of publicly funded services.

REFORM: Revise to allow provinces the freedom to determine their own health care policies with regard to how the provincial insurance plans are operated and regulated.

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**Section 9, Comprehensiveness:** This section requires provinces to provide insurance coverage to all citizens for hospital and physician services that are “medically necessary” (hospital services) or “medically required” (physician services) and for dental services that are medically required and that must be provided in a hospital. It does not appear to preclude any of the policies successfully implemented by other developed nations with universal health care.

REFORM: No changes are recommended within this set of reforms.

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**Section 10, Universality:** This section of the CHA requires that provinces must cover 100 percent of the insured persons of the province for insured health services. However, by employing the term “uniform terms and conditions,” section 10 restricts the ability of provinces to create universal access health insurance schemes that employ multiple insurers with varying personalized health insurance arrangements as can be found in Switzerland and the Netherlands.

REFORM: Maintain the foundational principle of universality. The clause “uniform terms and conditions” should be removed to allow provinces the freedom to experiment with competition and personalization in universal insurance.

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**Section 11, Portability:** This section is designed to provide protection to insured persons during temporary absences from their province of residence. This section has the positive benefit of increasing labour mobility across Canada by removing ties to provincial health care insurance. This section does not hinder reform by limiting provincial policy choices within the province.

REFORM: Maintain inter-provincial portability.

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**Section 12, Accessibility:** This section introduces the important but undefined concept of *reasonable access*. Depending on the federal government’s interpretation, many health care policies could potentially be construed as impeding or even precluding reasonable access, including private parallel health care, private for-profit ownership of hospitals, and dual practice for medical practitioners. Section 12 leaves the provinces contending with a great deal of uncertainty about policies they can employ to improve the quality, cost-effectiveness, and accessibility of their health care systems based on the success of other universal health care countries.

REFORM: Require that provinces maintain assistance programs and/or exemptions for those experiencing low-income from any financial

contributions required to maintain universal health care insurance (such as individual premiums) or access the universal health care system (such as co-payments or deductibles). Provinces will be considered to have met this condition if they present the federal government with a policy that defines low income cut-offs below which subsidies or exemptions will apply and that provides for proactive administration and automation of the application of these subsidies and exemptions.

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**Sections 18 – 21, Extra-Billing and User Charges:** These sections of the CHA clearly and explicitly disallow user charges (any charge for an insured health service authorized or permitted by the provincial plan that is not payable by the plan), and extra-billing (an amount in addition to the amount covered by the plan) by medical practitioners or dentists for insured health services, with non-discretionary penalties. This restricts any sharing of costs between private payers and the public system.

REFORM: These sections need to be repealed in order to allow for cost sharing.

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## Conclusion

These reforms to the CHA are suggested in order to provide the provinces greater clarity and flexibility to experiment and innovate in the delivery, regulation, and financing of provincial health care within a universal, portable framework. The suggested changes are based on needed accommodations for policies observed in other universal health care countries.



# Sommaire

L'analyse de la Loi canadienne sur la santé (LCS) présentée dans cet article propose comme point de départ que l'expérience de réforme de l'aide sociale du milieu des années 1990 comporte une importante leçon quant à la façon optimale de réformer les soins de santé au Canada. Le budget fédéral de 1995 a modifié le transfert aux provinces en matière de programmes sociaux de sorte qu'il est passé d'un transfert fondé sur le partage des frais à une subvention globale. De plus, le gouvernement fédéral a retiré la plupart des normes fédérales afin de laisser les provinces libres d'expérimenter et d'innover en matière de prestation, de réglementation et de financement des programmes d'aide sociale et des programmes connexes. La plupart des observateurs s'entendent pour dire que ces réformes furent en grande partie fructueuses au sens où elles ont aidé à réduire la dépendance, à mieux cibler l'aide pour résoudre des problèmes, à concevoir des programmes particuliers pour des problèmes particuliers et à réduire les dépenses totales dédiées à l'aide sociale. Les grandes lignes des réformes de l'aide sociale des années 1990 devraient servir de base à une réforme actuelle de la santé.

Le nouveau régime fédéral, qui continue de contribuer aux dépenses de santé provinciales par l'entremise du Transfert canadien en matière de santé, a créé des occasions restreintes d'expérimentation et de réforme puisque le gouvernement fédéral n'a imposé aucune condition au financement. En effet, ce dernier a ouvertement encouragé les provinces à expérimenter et à innover afin de régler des problèmes – déterminés conjointement – au sein du système de santé.

Toutefois, un défi demeure : la Loi canadienne sur la santé (LCS). La LCS est une loi à portée financière qui prévoit les modalités et conditions en vertu desquelles une province a droit de recevoir un paiement de transfert intégral en matière de santé et de services sociaux de la part du gouvernement fédéral.

Malheureusement, la LCS est incompatible avec certaines des mesures qui ont été mises en œuvre afin d'assurer des soins abordables et de grande qualité par des pays qui partagent l'objectif du système de santé universel canadien. Pour que le Canada puisse adopter des réformes constructives, la LCS devra être revue afin d'accorder la flexibilité nécessaire à celles-ci.

La question centrale que pose cette étude – et à laquelle elle répond – est la suivante : de quelle façon la Loi canadienne sur la santé entrave-t-elle des réformes qui ont été adoptées dans d'autres pays industrialisés qui possèdent un système de santé universel? Des pays comme les États-Unis sont volontairement exclus de cette analyse. Cet article vise seulement à évaluer dans quelle mesure et de quelle façon la Loi canadienne sur la santé empêche les provinces d'entreprendre des réformes semblables à celles d'autres pays possédant un système de santé universel.

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L'expérience de réforme de l'aide sociale du milieu des années 1990 comporte une importante leçon quant à la façon optimale de réformer les soins de santé au Canada.

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## Options de réformes inspirées d'autres pays possédant un système de santé universel

D'abord, il est important de comprendre certaines des caractéristiques principales qui différencient le système de santé canadien de celui des autres pays industrialisés (surtout des membres de l'OCDE) qui possèdent également un système universel. Premièrement, la quasi-totalité des pays développés qui possèdent un système de santé universel autorisent parallèlement des soins de santé privés, ce qui permet aux patients de choisir de se faire soigner ailleurs que dans le système public. Deuxièmement, des cliniques de chirurgie et des hôpitaux appartenant au secteur privé et gérés par celui-ci offrent des soins accessibles par tous dans la majorité des pays développés qui possèdent un système de santé universel. Troisièmement, dans un certain nombre de pays, les professionnels du milieu de la santé peuvent avoir une « pratique mixte » (c'est-à-dire, travailler à la fois au sein du réseau public et dans le secteur privé) et les établissements de santé comme les hôpitaux et les cliniques de chirurgie peuvent offrir des services aux patients à la fois dans le secteur public et dans le privé. Quatrièmement, les patients doivent contribuer à payer une partie du coût des soins reçus

(par l'entremise d'un ticket modérateur – aussi appelé coassurance – ou d'une franchise) dans la majorité des pays développés qui possèdent un système universel. Cinquièmement et pour terminer, dans certains pays, les médecins sont autorisés à facturer des frais pour des services médicaux qui dépassent le montant prévu par la grille tarifaire du régime d'assurance maladie universelle.

En outre, en Australie, le gouvernement fédéral fournit des incitations financières pour encourager les citoyens à souscrire une assurance maladie privée couvrant des services qui seraient autrement offerts par le régime universel d'assurance maladie. Beaucoup de pays européens ont recours au financement de la sécurité sociale (plutôt qu'à des impôts), un type de régime d'assurance maladie financé par des cotisations et dont la gestion est prise en charge par un organisme indépendant du gouvernement. Dans le cadre de certains de ces systèmes, des assureurs privés se font concurrence pour attirer des adhérents. Aux Pays-Bas et en Suisse, les gens peuvent aussi personnaliser leur régime d'assurance maladie universelle.

Dans cet article, la LCS est examinée afin de savoir si elle autorise expressément, si elle interdit expressément ou si elle peut être interprétée de manière à interdire de telles mesures liées de façon générale au financement et à la prestation des soins de santé.

## La Loi canadienne sur la santé : toujours un obstacle à des réformes

Contrairement à la croyance populaire, une analyse de la LCS révèle peu de restrictions manifestes aux politiques des provinces en matière de santé. Parallèlement, toutefois, elle dévoile également un troublant manque de clarté qui peut avoir un effet dissuasif sur de potentielles réformes provinciales. Ce manque de clarté a aussi mené à des cas d'inaction à la suite de violations de la LCS ainsi qu'à l'application asymétrique de celle-ci, deux situations qui doivent être considérées comme un usage arbitraire d'un pouvoir discrétionnaire par le gouvernement fédéral.

Toute tentative de réforme de la LCS devra passer par un retrait des restrictions fédérales qui limitent inutilement l'adoption de mesures présentes dans d'autres pays développés possédant un système de santé universel.

Par conséquent, de quelle façon la LCS doit-elle être réformée? Toute tentative de réforme de cette loi devra passer par un retrait des restrictions fédérales qui limitent inutilement l'adoption de mesures présentes dans d'autres pays développés possédant un système de santé universel. Elle devra également clarifier les dispositions de la loi pour assurer aux gouvernements provinciaux un plus haut degré de certitude juridique. Une telle réforme devra aussi être réalisable du point de vue du gouvernement fédéral si elle veut avoir une quelconque chance d'être mise en œuvre. En gardant ces caractéristiques en tête, cette étude propose aussi quelques recommandations dans le but de modifier la Loi canadienne sur la santé.

**Article 8, gestion publique :** en définissant le principe de gestion publique, l'article 8 établit la structure du régime d'assurance maladie à payeur unique, ce qui rend impossible la concurrence en ce qui a trait à l'assurance maladie universelle. De plus, la propriété ou la gestion privée à but lucratif de l'autorité unique responsable du régime est interdite. L'article 8, par contre, n'empêche pas le financement privé de services assurés par le régime public.

**RÉFORME :** donner aux provinces la liberté de déterminer leurs propres politiques de santé en ce qui concerne la manière dont leur régime d'assurance maladie est administré et réglementé.

**Article 9, intégralité :** cet article exige que les provinces fournissent une couverture d'assurance à tous les citoyens pour les services « médicalement nécessaires » fournis par les hôpitaux, les médecins et les dentistes (ce dernier cas concerne seulement les services accomplis dans un hôpital). Il ne semble bloquer aucune des mesures mises en place avec succès dans d'autres pays développés possédant un système de santé universel.

**RÉFORME :** aucune modification n'est recommandée quant à cette condition.



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**Article 10, universalité :** cet article de la LCS exige que les provinces couvrent 100 % de leurs assurés pour les services de santé assurés. Cependant, en employant l'expression « selon des modalités uniformes », l'article 10 limite la capacité des provinces à mettre en place un régime d'assurance maladie universelle ayant recours à plusieurs assureurs offrant divers services personnalisés comme on le voit en Suisse et aux Pays-Bas.

RÉFORME : préserver le principe d'universalité de base, mais retirer le passage « selon des modalités uniformes » pour donner aux provinces la liberté d'expérimenter en matière de concurrence et de personnalisation quant à l'assurance maladie universelle.

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**Article 11, transférabilité :** cet article vise à protéger les personnes assurées pendant des absences temporaires de leur province de résidence. Il a une influence positive en facilitant la mobilité de la main-d'œuvre partout au pays parce qu'il coupe les liens avec un régime d'assurance maladie provincial en particulier. Cet article n'a pas d'effet dissuasif sur des réformes potentielles, car il ne limite pas les choix de politiques d'une province à l'intérieur de celle-ci.

RÉFORME : préserver la transférabilité interprovinciale.

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**Article 12, accessibilité :** cet article énonce le concept important – mais non défini – d'accès satisfaisant. Plusieurs politiques de santé pourraient être interprétées – en fonction de l'interprétation privilégiée par le gouvernement fédéral – comme limitant ou même empêchant un accès satisfaisant, y compris les soins de santé privés parallèles, la propriété privée à but lucratif des hôpitaux et la pratique mixte pour les professionnels de la santé. L'article 12 laisse les provinces avec un haut degré d'incertitude quant aux mesures qu'elles peuvent adopter pour améliorer la qualité, l'efficacité et l'accessibilité de leur système de santé en s'inspirant des succès d'autres pays possédant un système de santé universel.

RÉFORME : exiger que les provinces maintiennent – pour les patients à faible revenu – des programmes d'aide ou des exemptions (ou les deux) quant à toute contribution financière requise afin de demeurer un adhérent au régime d'assurance maladie universelle (comme les primes individuelles) ou pour accéder au système de santé universel (comme un ticket modérateur ou une franchise). Cette condition sera considérée comme respectée par la province si elle présente au gouvernement fédéral une politique définissant des seuils de faible revenu en dessous desquels des subventions ou des exemptions s'appliqueront et prévoyant l'administration proactive et l'automatisation de l'application de ces subventions et exemptions.

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**Articles 18 à 21, surfacturation et frais modérateurs :** ces articles de la LCS interdisent expressément et sans ambiguïté les frais modérateurs (tout paiement demandé pour obtenir un service de santé assuré autorisé ou permis par un régime provincial d'assurance maladie, mais non payable au titre de ce régime) de même que la surfacturation (tout paiement en excédent par rapport au montant couvert au titre du régime provincial) par les médecins et les dentistes quant aux services de santé assurés, sous peine de pénalités non discrétionnaires. Ces dispositions limitent le partage des coûts entre des payeurs privés et le régime public.

RÉFORME : ces articles doivent être abolis afin de permettre le partage des coûts.

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## Conclusion

Ces réformes de la LCS sont proposées afin d'assurer aux provinces un plus haut degré de certitude juridique et une plus grande flexibilité d'expérimentation et d'innovation dans la prestation, la réglementation et le financement des soins de santé provinciaux dans le cadre d'un régime universel et transférable. Les modifications proposées découlent d'ajustements requis pour adopter des mesures présentes dans d'autres pays possédant un système de santé universel.

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Les réformes proposées  
préserveraient le principe  
d'universalité de base et la  
transférabilité interprovinciale.

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# Introduction

Prime Minister Stephen Harper and the governing Conservatives have subtly but nonetheless importantly further devolved responsibility for health care to the provinces. In doing so, the Conservatives may be in the process of establishing a genuine environment for reform of Canadian health care. The extension of the Canada Health Transfer to 2025, albeit with likely lower transfers starting in 2018, coupled with the absence of any strings or requirements attached to the funding have provided the provinces with a great deal of flexibility.<sup>1</sup> Indeed the Prime Minister himself has encouraged the provinces to experiment and innovate in order to solve observed problems.<sup>2</sup> However, one obstacle remains: The Canada Health Act.

There is no doubting the near iconic status that the Canada Health Act<sup>3</sup> enjoys in Canada:

*“The principles of the Canada Health Act began as simple conditions attached to federal funding for medicare. Over time, they became much more than that. Today, they represent... the values underlying the health care system.... The principles have stood the test of time and continue to reflect the values of Canadians.”*

Roy J. Romanow<sup>4</sup>

*“The Canada Health Act is an essential foundation of the Canadian value system.”*

Prime Minister Paul Martin<sup>5</sup>

Both those in favour of market-based reform of health policy and those who defend the current package of health policies in Canada have been heard to claim the Canada Health Act disallows all manner of reform options including private competition in delivery and financing. For one side, this is a travesty that requires nothing short of withdrawal of the CHA so that provinces have the freedom to reform health care policy appropriately. For the other side, the CHA is a sacred Canadian law that safeguards the very foundations of Canada’s universal access health care system.

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The Canada Health Act (CHA), now nearly 30 years old, has achieved iconic status in the health reform debate in this country.

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But is this interpretation of the CHA’s strict constraints on provincial policy freedom correct? A careful reading of both the CHA and the research discussing its history suggests not. That said, the enforcement mechanisms in the CHA mean this finding is subject to an important caveat.

This study aims to explore the CHA in detail to determine whether or not it limits provincial freedoms in setting health care policy and how it does so. It also aims to explore how it might be reformed to better respect provincial jurisdiction in setting health care policy and to better allow provinces to innovate and experiment with health policy at the provincial level as well as learn lessons from such innovation and experimentation. The first section of this study gives a broad overview of the CHA, the debate surrounding the CHA,

and why its place as a barrier to health care reform is important to consider. The second section examines the CHA in detail, including a detailed review of components of the CHA to determine what barriers to reform can be explicitly found in the CHA and those that might be read into the CHA. The third section of this report offers a series of reform options that might be pursued to increase policy freedom for Canada’s provinces.

# I. Health Policy Reform and the Canada Health Act

The function of the Canada Health Act, enacted in 1984, is often grossly misunderstood in the Canadian health care debate. This common lack of knowledge results in often misleading statements about the CHA and how it may apply to a given health policy or situation. Further, this general confusion serves to muddy debates about health care reform at the political level as various public positions are taken using incorrect claims about the CHA.

It is important to recognize that the CHA does not apply to any citizen or corporate entity in Canada. The CHA applies only to the relationship between the federal and provincial governments, and only in a very particular manner. The CHA is a financial act that provides the terms and conditions under which a provincial government will be entitled to its full cash transfer for health and social services from the federal government.<sup>6</sup>

Importantly, the CHA does not set health policies directly but is an exercise of the federal spending power.<sup>7</sup> Under the Constitution, health care policy is a matter of exclusive provincial jurisdiction, and it is therefore outside the jurisdiction of the federal government to set health care policies to be followed by individual Canadians and Canadian businesses. Rather, the CHA encourages provinces to set certain health care policies within their provincial health policy frameworks and ties substantial cash transfers to provincial adherence to these policy requirements.

Enforcement of the CHA occurs through reductions or withdrawals of both the Canada Health Transfer and Canada Social Transfer from Ottawa.<sup>8</sup> Importantly, while the CHA is tied to the Canada Health Transfer (Madore 2005), the federal government's cash contribution is defined in the CHA as the "Canada Health and Social Transfer." Thus both the Canada Health Transfer and Canada Social Transfer, which were created by a separation of the Canada Health and Social Transfer in 2004-05, could be subject to reductions or withdrawals.<sup>9</sup>

Enforcement of the CHA is both non-discretionary for extra-billing<sup>10</sup> and co-payment<sup>11</sup> and is at the federal government's discretion for any other perceived violation of the CHA. While a complete withdrawal of all transfers has not occurred and penalties to date have been only a portion of transfers to a given province (Boyчук 2008a), the size of cash transfers to the provinces suggests the federal government has considerable leverage. For example, in 2011-12, cash transfers for health and social services subject to potential withdrawal under the CHA are expected to total some \$38.5 billion (Department of Finance Canada 2012); provincial and territorial health expenditures are forecast to be \$131 billion in 2011-12 (CIHI 2011).<sup>12</sup>

The result is that Canada's provinces have all enacted health care policies, including the prohibition of co-payments and extra-billing, in order to preserve their access to federal cash transfers for health and social services. From these policies comes much debate between those who wish to see Canada's health care policies reformed to more closely align with health care policies employed in Europe and other universal-health care countries, and those who see Canada's health care policies to be appropriate if not ideal for the creation of a universal access health care system, with many others spread between these two positions. Central to this debate, and often overlooked in the debate itself, is whether or not the CHA actually requires the provinces to restrict competition and private activity to the extent they have.

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The function of the CHA is often grossly misunderstood in the Canadian health care debate. The CHA applies only to the financial relationship between the federal and provincial governments.

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Boyчук finds that current provincial restrictions on private sector provision and funding of health care services parallel to the universal access health care system as well as the requirement that physicians operate either fully inside or fully outside the public insurance scheme are not required under the CHA.

A number of analyses of the CHA have found that provincial policies may in fact go beyond what is required by the CHA for access to federal cash transfers. For example, Boychuk (2008a) finds that current provincial restrictions on private sector provision and funding of health care services parallel to the universal access health care system as well as the requirement that physicians operate either fully inside or fully outside the

public insurance scheme are not required under the CHA. This suggests that there may be much more latitude for health care reform under the CHA than commonly perceived.

On the other hand, various examinations have found that the CHA can be interpreted to place extensive restrictions on private financing and delivery. For example, Madore (2005) argues that a private parallel health care sector could be disallowed under the principles of the CHA. Similarly, a legal analysis provided to the Canadian Union of Public Employees (CUPE) found that the greater role for the private sector in the financing and delivery of health care proposed in Alberta's Bill 11<sup>13</sup> from 2000 (which was ultimately passed and is now known as the *Alberta Health Care Protection Act*) would violate three of the CHA's five principles (CUPE 2000). Former federal minister of health Ujjal Dosanjh proposed that the CHA precluded allowing physicians to provide the same services in both the publicly insured sector and on a privately paid basis (dual practice) (Madore 2006).

This contradiction in interpretations stems from the vagueness of the CHA with regard to many areas of health care policy. Extra-billing by physicians and co-payments for services provided under the provincial health insurance plan are notable exceptions; the CHA is reasonably clear. This vagueness is problematic for Canada's provincial governments because it fails to provide them with clear boundaries within which they

may reform health care policies. Compounding this problem is the fact that interpretation of the CHA is entirely at the discretion of the federal government,<sup>14</sup> which means this vagueness could be used to both permit and disallow a range of policies by different governments with a different philosophical approach to health care policy.<sup>15</sup>

This vagueness is also problematic for Canadians. Critically, it leaves them with a lack of clarity over which level of government is responsible for what health care policy choice, making their responsibility for rating their government's actions at the polling station more difficult. Further, this vagueness often generates contradictory positions in the health policy debate, denying Canadians clarity over which reforms to health policy might be possible under the current regime and which reforms would require a change of that regime.

The next section of this paper examines the CHA in detail to determine where this vagueness on various health policies arises and how the CHA may be applied to restrict provincial policy freedoms. Of course, such an analysis is not possible without some lens through which the CHA can be examined. The perspective taken in the next section is one of reducing federal intrusions into provincial health care decision making (an area of exclusive provincial jurisdiction) to the minimum necessary based on Canada's successful experience with removing federal standards for welfare in the mid-1990s.

In the mid-1990s, the federal government implemented a fundamental change to federal transfers for social programs, moving from a cost-sharing arrangement with federal standards to a block grant with greater latitude to experiment and innovate in the design and delivery of welfare and related services. The result of this change was stunning: The number of Canadians receiving welfare fell from a peak of 3.1 million before the reforms to 1.7 million in 2009 (as a percentage of the population the decline went from 10.7 percent to 5.1 percent) without a "race to the bottom" effect in either standards or benefit rates. This marked improvement in welfare dependency and the resulting reduction in government expenditures resulted directly from the removal of federal restrictions on provincial policy making. Equally importantly, while provinces were free to experiment with a much broader range of policies than previously, their approaches

differed considerably with some provinces undertaking broad reform with unique approaches while others reformed little. Further, provinces were not only able to learn from one another but were now also able to tailor their policy approach to their unique circumstances.<sup>16</sup>

The successful reform of the federal government's approach to welfare in the mid-1990s provides a powerful lesson for reform of the federal government's approach to health care. As it did with welfare, the federal government should allow the provinces greater latitude to experiment and innovate in the design and delivery of health care services while restricting its role to the minimum necessary to maintain universal access to health care.

This minimum is determined in this paper by examining policies employed by other countries who share Canada's goal of universal access health care. It is important to recognize that other countries, while sharing the noble goal of Canada's Medicare system, have in the pursuit of affordable, universal-access, high quality health care chosen policies that are incompatible with the CHA (or ways the CHA has been interpreted). Critically, the federal government should not disallow policy options consistent with the overarching goal of Medicare that have proven their efficacy and worth in other comparable jurisdictions.

Specifically, the CHA is examined in terms of whether it allows explicitly, disallows explicitly, or can be interpreted to disallow the following policies pertaining to the broad financing and delivery of health care:

- Can a province deliver publicly-funded hospital and surgical services through facilities owned/operated by private companies, and allow private (both for- and not-for-profit) ownership of hospitals under the CHA? Internationally, privately owned/operated surgical facilities and hospitals delivering universally accessible care can be found in the large majority of developed nations that maintain universal approaches to health care insurance (Esmail and Walker 2008).
- Can a province allow privately funded purchases (either directly or through insurance) of medically necessary services by citizens of a province under the CHA? Internationally, every developed nation that maintains a universal health care insurance scheme – save Canada – allows a private parallel health care sector where patients can choose to purchase their health care (Ramsay 2002).
- Is a province able to encourage uptake of private health insurance for medically necessary health care services through financial incentives under the CHA? In Australia, the federal government uses financial incentives to encourage residents to purchase private health insurance cover for services that would otherwise be available through the universal health insurance scheme (Harper 2003).
- Can a province allow practitioners to be active and health facilities to treat patients in both the publicly funded and privately funded sectors under the CHA? Put differently, does the CHA require provinces to mandate that practitioners and facilities operate either wholly inside or wholly outside the public funding envelope? Practicing in both the public and private health care systems for practitioners, known as “dual practice,” can be found in Australia, Denmark, England, Finland, Ireland, Italy, New Zealand, Norway, Spain, and Sweden (Hurst and Siciliani 2003). Health care facilities such as hospitals and surgical clinics providing services to patients in both the public and private sectors can be found in Australia, Denmark, England, and Ireland (Hurst and Siciliani 2003).<sup>17</sup>
- Can a province use social insurance financing (premium-funded health insurance with management of the insurance system undertaken by a body independent from government) under the CHA or must health care systems in Canada be tax-funded to be CHA compliant? Internationally, social-insurance health care

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Interpretation of the CHA is entirely at the discretion of the federal government.

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Other countries, while sharing the noble goal of Canada's Medicare system, have chosen policies incompatible with the CHA in the pursuit of affordable, universal-access, high quality health care.

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systems can be found in Austria, Belgium, Czech Republic, Germany, Hungary, Japan, Korea, Luxembourg, the Netherlands, Poland, the Slovak Republic, and Switzerland (Saltman 2004).

- Can a province, under a social insurance financing regime, allow private insurers to compete for the provision of universally accessible insurance/care where residents of a province have the freedom to select their universal access health insurance provider under the CHA? Private insurers competing for subscribers under a universal access health insurance construct can be found in Germany, the Netherlands, and Switzerland (Green and Irvine 2001; van de Ven and Schut 2008; Colombo 2001).
- Can a province allow individuals to tailor their universally accessible insurance plan to their own unique preferences under the CHA? Such voluntary changes to the terms of universally accessible insurance plans by individuals can be found in the Netherlands and Switzerland (van de Ven and Schut 2008; Colombo 2001).
- Can a province require co-payments for medical services (including user fees, co-insurance payments, and deductibles) where patients are required to share in the cost of health care provided under the CHA? Co-payments for medical services can be found in the majority of developed nations that maintain universal approaches to health care insurance (Esmail and Walker 2008).
- Can a province allow practitioners to charge patients for amounts greater than the fee/reimbursement provided by the provincial insurance program for medical services under the CHA? Physicians in Australia, France, and New Zealand, for example, are permitted to charge fees for medical services beyond the price found in the universal insurance scheme fee schedule (Docteur and Oxley 2003).<sup>18</sup>

Importantly, the analysis in the next section examines the CHA for interpretations that *could* be used to disallow such policy reforms, including those interpretations that have been used in the past. This is a different approach from that taken by Boychuk (2008a) where the CHA is examined in light of current provincial policies the federal government has not determined to be violations of the CHA. This departure from the examination of current precedent is taken for two reasons. First, because interpretation of the CHA is entirely at the discretion of the federal government and not subject to court ruling, unprecedented changes to interpretation are possible and should be considered as potential impediments to provincial policy choices. Second, Boychuk (2008b), Flood and Choudry (2002), and others have noted asymmetric application of the CHA across Canada's provinces suggesting that those policies which are allowed in some provinces today might still be judged to violate the CHA if they were introduced in other provinces tomorrow.

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Provinces are required to satisfy the five “principles” of Medicare: Public administration, comprehensiveness, universality, portability, and accessibility.

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## II. The Canada Health Act – What Does It Say? What Might It Say?

The Canada Health Act is comprised of 23 sections, including a short title and definitions, along with a preamble on the CHA's purpose and intent. With respect to this study, some sections of the CHA are more important than others to examine because they provide the terms and conditions under which the federal government may reduce or withdraw health and social cash transfers to a province. Specifically, under section 14 which discusses defaults or violations of the CHA, provinces are required to satisfy sections 8 through



12 (the commonly recognized five “principles”<sup>19</sup> of public administration, comprehensiveness, universality, portability, and accessibility) and section 13 (reporting to the federal government and recognition of financial support). Further, sections 18 through 21 set out non-discretionary penalties for co-payments and extra-billing. This study examines and focuses on these aspects of the CHA.

## Section 8 – Public Administration

*(1) In order to satisfy the criterion respecting public administration,*

- a) the health care insurance plan of a province must be administered and operated on a non-profit basis by a public authority appointed or designated by the government of the province;*
- b) the public authority must be responsible to the provincial government for that administration and operation; and*
- c) the public authority must be subject to audit of its accounts and financial transactions by such authority as is charged by law with the audit of the accounts of the province.*

*(2) The criterion respecting public administration is not contravened by reason only that the public authority referred to in subsection (1) has the power to designate any agency*

- a) to receive on its behalf any amounts payable under the provincial health care insurance plan; or*
- b) to carry out on its behalf any responsibility in connection with the receipt or payment of accounts rendered for insured health services, if it is a condition of the designation that all those accounts are subject to assessment and approval by the public authority and that the public authority shall determine the amounts to be paid in respect thereof.*

Upon careful examination, it is clear that in defining the principle of public administration, section 8 of the CHA creates the single insurer structure of Medicare. Further, for-profit ownership or operation of the sole insurance authority is not permitted by the CHA. It does not, however, require a single payer.

While the text of section 8 does not appear to preclude a social insurance system, where an agency designated by government but functionally independent from government operates the health insurance program on a premium funded basis,<sup>20</sup> it does preclude multiple insurance programs competing with one another by referring to “a public authority” (emphasis added). Madore (2005) notes the original objective of this section was to prevent provinces from using federal transfers to subsidize residents buying into private insurance plans. Thus, an important policy freedom – competition in the delivery of universally accessible insurance as exists in Switzerland, the Netherlands, and Germany among others – is restricted by section 8 of the CHA.<sup>21</sup>

Other than this important restriction, section 8 of the CHA defining the principle of public administration does not appear to preclude any of the other policies listed in the framework above. Importantly, this section refers only to the insurance plan of the province<sup>22</sup> and does not refer to the delivery of health care services and how that delivery is organized. Further, only the insurance plan “of a province” is to be administered on a not-for-profit basis by a public authority, placing no restriction on health insurance plans that are not operated by the provincial government. It is also noteworthy that, while section 8 was intended to preclude subsidies for private insurance plans, this section does not appear to preclude financial incentives (including premium subsidies) for residents of a province to secure private parallel health care insurance as is done in Australia.<sup>23</sup>

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Only the insurance plan “of a province” is to be administered on a not-for-profit basis by a public authority, placing no restriction on health insurance plans that are not operated by the provincial government.

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## Section 9 – Comprehensiveness

*In order to satisfy the criterion respecting comprehensiveness, the health care insurance plan of a province must insure all insured health services provided by hospitals, medical practitioners, or dentists, and where the law of the province so permits, similar or additional services rendered by other health care practitioners.*

Some definitions provided in section 2 of the CHA are necessary here to clarify the meaning of this section:

*“[I]nsured health services” means hospital services, physician services, and surgical-dental services provided to insured persons, but does not include any health services that a person is entitled to and eligible for under any other Act of Parliament or any Act of the legislature of a province that relates to workers’ or workmen’s compensation;*

*“[H]ospital services” means any of the following services provided to in-patients or out-patients at a hospital, if the services are medically necessary for the purpose of maintaining health, preventing disease or diagnosing or treating an injury, illness or disability, namely,*

- (a) accommodation and meals at the standard or public ward level and preferred accommodation if medically required,*
- (b) nursing service,*
- (c) laboratory, radiological and other diagnostic procedures, together with the necessary interpretations,*
- (d) drugs, biologicals and related preparations when administered in the hospital,*
- (e) use of operating room, case room and anaesthetic facilities, including necessary equipment and supplies,*
- (f) medical and surgical equipment and supplies,*
- (g) use of radiotherapy facilities,*
- (h) use of physiotherapy facilities, and*
- (i) services provided by persons who receive remuneration therefor from the hospital,*

*but does not include services that are excluded by the regulations;*

*“[P]hysician services” means any medically required services rendered by medical practitioners;*

*“[S]urgical-dental services” means any medically or dentally required surgical-dental procedures performed by a dentist in a hospital, where a hospital is required for the proper performance of the procedures[.]*

Essentially, this section of the CHA requires provinces to provide insurance coverage to all citizens for hospital and physician services that are “medically necessary” (hospital services) or “medically required” (physician services) and for dental services that are medically required and that must be provided in a hospital. This section of the CHA is important for several reasons including the creation of a reliance on an undefined term (medically necessary/medically required) and for its focus on physician and hospital services. The former is the source of considerable provincial latitude in defining the extent of public coverage while the latter is more the result of historic factors, rather than a deliberate action by the federal government to focus on these two areas of health care.

Importantly, the CHA was introduced to deal explicitly with the phenomenon of extra-billing, and to amalgamate and update the regulations previously imposed on the provinces through the agreements on federal transfers in support of hospital services (*Hospital Insurance and Diagnostic Services Act 1957*) and physician services (*Medical Care Act 1966*). Thus, it should not be a surprise that section 9 of the CHA dealing with the principle of comprehensiveness focuses on hospital care and physician care while not

referring to the many different methods and places of care that exist in a modern health care system. This has both benefits and drawbacks.

With respect to benefits, this limited focus gives the provinces some additional policy freedom as technology progresses and allows more care to be delivered outside of hospitals and by practitioners other than doctors. This freedom has been employed in practice. For example, provincial governments have taken differing policy approaches with governmental pharmaceutical coverage, with coverage as well as regulation and allowance of private diagnostic services in free-standing facilities, and with governmental coverage of complementary and alternative medicines.

There is also an important drawback to this particular construct: It may encourage provinces to reduce coverage for non-physician and non-hospital services in times of fiscal constraint to the detriment of insured populations. Further, the federal-provincial health care dynamic where the provinces have in the past blamed the federal government's lack of sufficient contributions for poor health system performance, may mean that this limitation of the CHA has led provinces to not implement expansions to health insurance coverage beyond physician and hospital services under the same terms.

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Home care and long term care are impacted by the CHA's emphasis on hospital services.

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A notable example of this is the lack of inclusion of outpatient pharmaceuticals under universal access health insurance schemes. Despite the fact that research has shown the benefits of pharmaceuticals in improving health cost effectively, especially newer and typically more costly pharmaceuticals (see for example, Frech and Miller 1999; Lichtenberg 2001 and 2003), they are not universally covered in most provinces. On its own, this is not necessarily a problem as provinces do have exclusive jurisdiction over policy in this area and are responsible to their citizens (to whom they are more proximate than the federal government) and so are free to introduce universal drug coverage.

However, the CHA does create an important distortion in the health care marketplace that is relevant. Specifically, the CHA (as will be seen in later sections) requires provinces to provide physician and hospital services with no co-payments and provides federal funds to help the provinces with the associated cost. Thus, patients in the province are encouraged to seek the “free” care provided by physicians and hospitals and forgo the privately funded or subject to co-payments and deductible care provided by pharmaceuticals unless the province sets the deductible/co-payments to zero in the provincial drug plan and bears the full cost. This either harms the health of patients and decreases cost-effectiveness by effectively discouraging pharmaceutical use, or forces the policy hand of provincial governments choosing to provide universal pharmaceutical insurance. It is worth noting that this distortionary effect relates to many areas of health care, including home care and long term care,<sup>24</sup> in addition to pharmaceuticals.

The lack of a precise definition of “medically necessary”/“medically required” is also important when considering the impact of section 9 on provincial health policy.<sup>25</sup> Importantly, this lack of definition allows provinces a considerable amount of freedom in defining what will and will not be covered by the universal access health insurance program. Thus, provinces are able to react without the federal government to changes in medical evidence<sup>26</sup> and manage the services covered under governmental insurance. Not surprisingly, this freedom has been the subject of much discussion and debate in Canada especially as fiscal constraint has resulted in reductions in the range of services covered (see, for example, Charles et al. 1997).

A less obvious freedom is to use the term “medically necessary” to create room for a private parallel medical sector in the event it is prohibited either by provincial legislation (which may be difficult to change for political reasons) or interpreted to be disallowed by the CHA. In this application, “medically necessary” can be defined not only as the particular health service in question but also the time frame in which that service is expected to be delivered by the public health care system. If a private sector provider were to deliver the



service in an expedited fashion, the service might be considered not “medically necessary” and thus not subject to restrictions on private financing and delivery (see for example, Smith 2006; Shimo 2006).

Other than these important features, section 9 of the CHA defining the principle of comprehensiveness does not appear to preclude any of the other policies listed in the framework above. As was the case with section 8, this section also refers primarily to the insurance plan of the province and makes no reference to the delivery of health care services and how that delivery is organized. Policies such as private ownership of health care facilities and dual practice for medical practitioners would not be covered by this section. Section 9 also does not disallow a private parallel health care sector. Restrictions on the ability to individually tailor the universal insurance product/policy and for-profit ownership of the universal insurance providers discussed under section 8 are also not disallowed by section 9, which focuses on what the provincial health insurance plan should cover.

## Section 10 – Universality

*In order to satisfy the criterion respecting universality, the health care insurance plan of a province must entitle one hundred per cent of the insured persons of the province to the insured health services provided for by the plan on uniform terms and conditions.*

The definition of insured person provided in section 2 of the CHA provides further insight into the meaning of this section:

*“[I]nsured person” means, in relation to a province, a resident of the province other than*

- a) a member of the Canadian Forces,*
- b) a member of the Royal Canadian Mounted Police who is appointed to a rank therein,*
- c) a person serving a term of imprisonment in a penitentiary as defined in the Penitentiary Act, or*
- d) a resident of the province who has not completed such minimum period of residence or waiting period, not exceeding three months, as may be required by the province for eligibility for or entitlement to insured health services[.]*

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Section 10 introduces the important concept of “uniform terms and conditions,” which restricts the ability of provinces to create universal access health insurance schemes that employ multiple insurers with varying health insurance arrangements as can be found in Switzerland and the Netherlands.

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Section 10 introduces the important concept of “uniform terms and conditions.” This construct originates in the 1957 *Hospital Insurance and Diagnostic Services Act* that created a federal cost sharing program encouraging provinces to create universal hospital insurance programs for residents. When introduced as a condition for funding in that legislation, this term effectively prevented provinces from creating programs that subsidized individuals to assist them in paying premiums for non-government insurance plans (Taylor 1990 cited in Boychuk 2008b).

From the modern health reform perspective, the effect of section 10 is to restrict the ability of provinces to create universal access health insurance schemes that employ multiple insurers with varying health insurance arrangements as can be found in Switzerland and the Netherlands.<sup>27</sup> Provinces must maintain a single set of terms and conditions for all residents. When combined with section 8, which requires a single agency, any opportunity for individuals to tailor their universal insurance policy to their unique situation and preferences is disallowed.

Beyond these restrictions, section 10 does not impact provincial policy freedom in the other areas of health care policy outlined above. By

relating once more only to the insurance plan of the province, policies relating to delivery of health care are unconstrained by section 10. Further, subsidies for private parallel health insurance and the ability of individuals to purchase and insure for medical services privately are also not covered by section 10.

## Section 11 – Portability

- 1) *In order to satisfy the criterion respecting portability, the health care insurance plan of a province*
  - a) *must not impose any minimum period of residence in the province, or waiting period, in excess of three months before residents of the province are eligible for or entitled to insured health services;*
  - b) *must provide for and be administered and operated so as to provide for the payment of amounts for the cost of insured health services provided to insured persons while temporarily absent from the province on the basis that*
    - i) *where the insured health services are provided in Canada, payment for health services is at the rate that is approved by the health care insurance plan of the province in which the services are provided, unless the provinces concerned agree to apportion the cost between them in a different manner, or*
    - ii) *where the insured health services are provided out of Canada, payment is made on the basis of the amount that would have been paid by the province for similar services rendered in the province, with due regard, in the case of hospital services, to the size of the hospital, standards of services, and other relevant factors; and*
  - c) *must provide for and be administered and operated so as to provide for the payment, during any minimum period of residence, or any waiting period, imposed by the health care insurance plan of another province, of the cost of insured health services provided to persons who have ceased to be insured persons by reason of having become residents of that other province, on the same basis as though they had not ceased to be residents of the province.*
- 2) *The criterion respecting portability is not contravened by a requirement of a provincial health care insurance plan that the prior consent of the public authority that administers and operates the plan must be obtained for elective insured health services provided to a resident of the province while temporarily absent from the province if the services in question were available on a substantially similar basis in the province.*
- 3) *For the purpose of subsection (2), “elective insured health services” means insured health services other than services that are provided in an emergency or in any other circumstance in which medical care is required without delay.*

Section 11 is important in helping to create a national health insurance program that follows an individual from province to province, and places few restrictions on the policies provinces may employ in their own health care systems. The Epp interpretation letter (the first of two such letters that guide federal interpretation of the Canada Health Act) points out that the intent of this section is to “provide insured persons continuing protection... when they are temporarily absent from their province of residence or when moving from province to province.” (Health Canada 2010, 161). The Epp letter adds that “[w]hile temporarily in another province of Canada, bona fide residents should not be subject to out-of-pocket costs or charges for necessary hospital and physician services.” (Health Canada 2010, 161).

One point that perhaps should be made about section 11 is that it serves as an example of asymmetric federalism in Canada. The province of Quebec has been recognized to be in violation of the inter-provincial

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Section 11 places few restrictions on the policies provinces may employ in their own health care systems.

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portability requirement and yet has not been penalized for this breach of the CHA's principles (Flood and Choudhry 2002; Boychuk 2008a). Further, five other provinces have been found to be in violation of the requirement that costs of services provided outside Canada are reimbursed at a rate similar to that paid in the province, but again no penalty has been applied (Flood and Choudhry 2002; Boychuk 2008a).

Beyond the requirement for covering the cost of health care (to at least some extent) in other jurisdictions, section 11 does not impact provincial policy freedom in the areas of health care policy outlined above. Critically, section 11 refers only to out-of-province health care coverage and does not limit provincial policy choices regarding health care financing or delivery within the province.

## Section 12 – Accessibility

- 1) *In order to satisfy the criterion respecting accessibility, the health care insurance plan of a province*
  - a) *must provide for insured health services on uniform terms and conditions and on a basis that does not impede or preclude, either directly or indirectly whether by charges made to insured persons or otherwise, reasonable access to those services by insured persons;*
  - b) *must provide for payment for insured health services in accordance with a tariff or system of payment authorized by the law of the province;*
  - c) *must provide for reasonable compensation for all insured health services rendered by medical practitioners or dentists; and*
  - d) *must provide for the payment of amounts to hospitals, including hospitals owned or operated by Canada, in respect of the cost of insured health services.*
- 2) *In respect of any province in which extra-billing is not permitted, paragraph (1)(c) shall be deemed to be complied with if the province has chosen to enter into, and has entered into, an agreement with the medical practitioners and dentists of the province that provides*
  - a) *for negotiations relating to compensation for insured health services between the province and provincial organizations that represent practising medical practitioners or dentists in the province;*
  - b) *for the settlement of disputes relating to compensation through, at the option of the appropriate provincial organizations referred to in paragraph (a), conciliation or binding arbitration by a panel that is equally representative of the provincial organizations and the province and that has an independent chairman; and*
    - c) *that a decision of a panel referred to in paragraph (b) may not be altered except by an Act of the legislature of the province.*

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Section 12 of the CHA introduces a number of possible policy restrictions for provincial governments.

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Section 12 of the CHA introduces a number of possible policy restrictions for provincial governments seeking access to federal cash transfers for health and social services and introduces a suggestion for provincial labour negotiations. Part 2 of this section of the CHA encourages provincial governments to determine wages for medical practitioners and dentists through agreements negotiated between the province and provincial medical organizations. Part 1 of this section repeats one important concept, *uniform terms and conditions* (discussed above), and introduces the important concept of *a basis that does not impede or preclude ... reasonable access to those services by insured persons*.

The automatic agreement with section 1c created by provincial adherence to section 2 has a great deal to do with the history of the CHA. At the time of its introduction, there was much concern about the prevalence of extra-billing by physicians, and concern among practitioners that provinces would not provide sufficient



payment for services to compensate them for the loss of extra-billing resulting from a federal condition. Section 2 of the CHA provided practitioners some comfort of protection from “unreasonable” compensation practices in return for the prohibition of extra-billing (Taylor 1987).

The concept of provinces being required to create a set of policies *on a basis that does not impede or preclude ... reasonable access to those services by insured persons* in order to qualify for the full federal cash transfer for health and social services is problematic for two reasons. Firstly, it's problematic from the perspective of increasing provincial policy freedom based on the successful experience with federal reform of social transfers in the 1990s, and secondly it's particularly troublesome given the policy reforms outlined previously based on the successes of other universal health care countries. Importantly, the term “reasonable access” is not defined anywhere in the CHA and is defined at the full discretion of the federal government. Thus, many health care policies (including those mentioned above) can be read to impede or preclude reasonable access depending on the interpretive bent of the federal government at the time regardless of whether or not they would actually result in some individuals not having access to medically necessary health care.

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The term “reasonable access” is not defined anywhere in the CHA, but at the full discretion of the federal government.

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For example, Madore (2005) notes that fully private medical clinics (operating separately from the universal insurance scheme) might be disallowed under the CHA if the federal government decided that such facilities threaten access to insured services in the universal system. This could happen if, for example, it were determined by the federal government that such clinics could draw needed health care providers away from the public system. This argument could easily be extended to any private parallel health care activity as well as subsidies for individuals to secure private parallel insurance cover.

CUPE (2005) goes further and states that this section of the CHA, taken together with the definitions of comprehensiveness (section 9) and universality (section 10), imposes a restriction on private parallel health care. According to the interpretation in CUPE (2005), an individual's inability to pay should not prevent them from receiving quality and speed of care equal to that received by an individual with the same medical condition but a greater ability to pay. Thus any policy that allows the quality or speed of *insured health services* to vary with ability to pay will *impede or preclude ... reasonable access by insured persons*. This reading of the CHA could also preclude charges for enhanced services that provide a higher quality service (such as a superior implant or advanced cancer treatment) without affecting timeliness.

Private for-profit ownership of facilities could also be disallowed under section 12 of the CHA. Many in the Canadian health care debate have argued that for-profit ownership of surgical clinics and hospitals will lead to poorer outcomes and could also lead to facilities preferring less-sick patients over more-sick patients who may require more complex treatment (see for example, Devereaux et al. 2002; Deber 2002). While there is debate over this position, and while alternate examinations of the evidence disagree (see for example, Currie et al. 2003; Esmail and Walker 2008; Ramsay and Esmail 2005), a federal government could nevertheless agree with one position over the other and disallow for-profit ownership of facilities in a province. It is noteworthy that the CHA interpretation letter sent to the provinces in 1995 by then Health Minister Diane Marleau (the second of two such letters that guide federal interpretations of the CHA) stated that private clinics raise several concerns for the federal government, and that appropriate regulations should be put in place to “ensure reasonable access to medically necessary services” (Health Canada 2010, 166).

Dual practice for medical practitioners, where practitioners are active in both the universal/publicly funded system and in the privately funded system, has also been suspected of having the potential to increase waiting times for those in the public or universal system (Hurst and Siciliani 2003). While there are important qualifications to this argument that must be considered (including whether practitioners are salaried in the public system) and while many developed nations have not seen fit to prohibit this practice in their universal access health care systems, a federal government could nevertheless determine that such a practice would

harm access to health care in the public system. If they were to go so far as to consider this an impediment to “reasonable access”, the policy could be disallowed under section 12. It is noteworthy that former federal Minister of Health Ujjal Dosanjh suggested that section 12 of the CHA precluded dual practice (Madore 2006).

This list of policies that could be disallowed under the CHA by differing interpretations of Section 12 is by no means exhaustive. The vagueness of the text of section 12 provides the federal government a great deal of latitude in determining which policies will be and will not be permitted at the provincial level. It also leaves the provinces contending with a great deal of uncertainty about policies they can employ to improve the quality, cost-effectiveness, and accessibility of their health care systems as some policy choices may result in a political stand-off with the federal government over their permissibility under the CHA. Perhaps it is not surprising then that Canada’s provinces have largely adhered to a policy approach that is strongly dominated by government and thus likely to allow them to avoid any conflict with an intrusive federal government over their adherence to the principles of the CHA.

## Section 13 – Conditions

*In order that a province may qualify for a full cash contribution referred to in section 5, the government of the province*

- a) shall, at the times and in the manner prescribed by the regulations, provide the Minister with such information, of a type prescribed by the regulations, as the Minister may reasonably require for the purposes of this Act; and*
- b) shall give recognition to the Canada Health and Social Transfer in any public documents, or in any advertising or promotional material, relating to insured health services and extended health care services in the province.*

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Section 13 does not place restrictions on provincial policy freedom.

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Section 13 is, from the perspective of this study, not one that merits much consideration in terms of restrictions on provincial policy freedom. As long as provinces supply information requested by the Minister and provide sufficient recognition to the federal government for their cash contributions they run little risk of reductions in transfers resulting from non-compliance with section 13.

## Sections 18 to 21 – Extra-Billing and User Charges

- 18. In order that a province may qualify for a full cash contribution referred to in section 5 for a fiscal year, no payments may be permitted by the province for that fiscal year under the health care insurance plan of the province in respect of insured health services that have been subject to extra-billing by medical practitioners or dentists.*
- 19. (1) In order that a province may qualify for a full cash contribution referred to in section 5 for a fiscal year, user charges must not be permitted by the province for that fiscal year under the health care insurance plan of the province;*
  - (2) Subsection (1) does not apply in respect of user charges for accommodation or meals provided to an in-patient who, in the opinion of the attending physician, requires chronic care, and is more or less permanently a resident in a hospital or other institution.*
- 20. (1) Where a province fails to comply with the condition set out in section 18, there shall be deducted from the cash contribution to the province for a fiscal year an amount that the Minister, on the basis of information provided in accordance with the regulations, determines to have been charged through extra-billing by medical practitioners or dentists in the province in that fiscal year or, where information is not provided in accordance with the regulations, an amount that the Minister estimates to have been so charged.*

- (2) *Where a province fails to comply with the condition set out in section 19, there shall be deducted from the cash contribution to the province for a fiscal year an amount that the Minister, on the basis of information provided in accordance with the regulations, determines to have been charged in the province in respect of user charges to which section 19 applies in that fiscal year or, where information is not provided in accordance with the regulations, an amount that the Minister estimates to have been so charged.*
- (3) *The Minister shall not estimate an amount under subsection (1) or (2) without first undertaking to consult the minister responsible for health care in the province concerned.*
- (4) *Any amount deducted under subsection (1) or (2) from a cash contribution in any of the three consecutive fiscal years the first of which commences in April 1, 1984 shall be accounted for separately in respect of each province in the Public Accounts for each of those fiscal years in and after the amount is deducted.*
- (5) *Where, in any of the three fiscal years referred to in subsection (4), extra-billing or user charges have, in the opinion of the Minister, been eliminated in a province, the total amount deducted in respect of extra-billing or user charges, as the case may be, shall be paid to the province.*
- (6) *Nothing in this section restricts the power of the Governor in Council to make any order under section 15.*

*21. Any deduction from a cash contribution under section 20 may be made in the fiscal year in which the matter that gave rise to the deduction occurred or in the following two fiscal years.*

Two definitions provided in section 2 of the CHA are necessary here to clarify the meaning of this section:

*“[E]xtra-billing” means the billing for an insured health service rendered to an insured person by a medical practitioner or a dentist in an amount in addition to any amount paid or to be paid for that service by the health care insurance plan of a province;*

*“[U]ser charge” means any 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 a provincial health care insurance plan, but does not include any charge imposed by extra-billing.*

Sections 18 through 21 of the CHA clearly and explicitly disallow *user charges...under the health care insurance plan of the province* (except for accommodation or meals for patients who require chronic care and are more or less permanent residents in a hospital or other institution), and *extra-billing by medical practitioners or dentists for insured health services*. These sections set up non-discretionary dollar-for-dollar reductions in federal cash transfers for the amount that is determined to have been charged in the province. Among the various policy restrictions contained in the CHA, those found in sections 18 through 21 are the clearest and best defined and include non-discretionary penalties in instances where provinces have reported the presence and costs of these activities.

Sections 18 through 21 also implicitly restrict the interface between the public insurance scheme and a private sector. Importantly, following the definitions of extra-billing and user charges, health services that are funded by a provincial health insurance plan must be fully funded without any permitted or authorized additional charge to patients. This reading of the restrictions imposed here is supported by the Marleau interpretation letter on private clinics, in which then Health Minister Diane Marleau states:

Where [facility fees] are charged for medically necessary services in clinics which receive funding for these services under a provincial health insurance plan, they constitute a financial barrier to access. As a result they violate the user charge provision of the Act (section 19). The accessibility criterion in the Act, of which the user charge provision is just a specific example, was clearly intended to ensure that Canadian residents receive all medically necessary care without financial or other barriers and regardless of venue. (Health Canada 2010, 165)

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Sections 18 through 21 of the CHA clearly and explicitly disallow user charges and extra-billing.

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Put simply, insured health services provided through the public scheme must be fully funded (100 percent paid for). There is no allowance for the private sector to fund a portion of the cost (such as a facility fee) while the public sector funds the remainder. While this does not restrict direct subsidies for the purchase of private health insurance, it does restrict the subsidization of privately funded care by covering a portion of the cost of care through the public insurance scheme.

## Summary

The CHA's two conditions (section 13), five criteria (sections 8 through 12), and non-discretionary penalties for extra-billing and user charges (sections 18 through 21), place the following restrictions on provincial health policy freedoms:

SECTION 8: Multiple insurers for Medicare services disallowed.

SECTION 9: No restrictions.

SECTION 10: Individual tailoring of universal coverage disallowed.

SECTION 11: No restrictions.

SECTION 12: *Reasonable access* subject to broad interpretation and could be used to disallow any number of policies including private parallel health care, private for-profit ownership of hospitals, and dual practice for medical practitioners.

SECTION 13: No restrictions.

SECTIONS 18-21: User charges and extra-billing disallowed with non-discretionary penalties. Also restricts any sharing of costs between private and public system.

What is surprising from this examination is the broad range of health care policies that Canada's provinces have not pursued that are not restricted in clear terms by the CHA. For example, provinces are free to allow private ownership of hospitals and medical facilities, are free to permit the creation of a privately funded health care sector (as long as there is no sharing of costs with the public system), are free to encourage private insurance contracts through subsidies, are free to allow dual practice for physicians, and are free to depoliticize insurance decisions by designating a social insurance agency to manage/operate the health insurance system (as long as it is a monopoly and not run on a for-profit basis). Of course, one explanation for why some of these policies have not been introduced or in many cases even proposed is that there may be concern that these policies *could* be determined to be disallowed by the CHA through federal interpretation of section 12. Given this lack of clarity, a risk-averse approach to public policy would be to restrict a much broader range of health care policies in order to avoid potential future conflict with the federal government. Further, there are some policies that are clearly disallowed by the CHA that are in use in other developed nations that maintain universal approaches to health insurance, raising the question of why such restrictions are necessary or desirable.

**There is a broad range of health care policies that Canada's provinces have not pursued that are not restricted in clear terms by the CHA. For example, provinces are free:**

- to allow private ownership of hospitals and medical facilities;
- to permit the creation of a privately funded health care sector as long as there is no sharing of costs with the public system;
- to encourage private insurance contracts through subsidies;
- to allow dual practice for physicians, and;
- to depoliticize insurance decisions by designating a social insurance agency to manage/operate the health insurance system (as long as it is a monopoly and not run on a for-profit basis).



### III. Desirable Reforms to the Canada Health Act

A careful analysis of the CHA reveals few clear restrictions on provincial health policy. It also reveals a troubling lack of clarity that may serve to stifle provincial policy experimentation and reform. Of equal concern is the fact that a lack of clarity has also manifested itself in non-action on violations of the CHA and asymmetric applications of the CHA, both of which might be considered an arbitrary use of discretionary power by the federal government.

Violations of section 11 of the CHA, which requires provinces to pay for health services residents receive while temporarily absent from the province, provide an example of a lack of federal response to contraventions of the CHA. Quebec breaches the requirement under section 11 with its refusal to pay for health care services its residents receive in other provinces (Flood and Choudhry 2002). Another five provinces breach the section 11 requirement that services provided to residents outside Canada should be reimbursed at a rate similar to that paid in the province (Flood and Choudhry 2002). In both cases, no penalty has been forthcoming under the CHA (Boychuk 2008a).

There are also differences in provincial legislation regarding public reimbursement for unrestricted fees charged by practitioners that have to date not been addressed through penalties under the CHA. Importantly, the CHA explicitly disallows the practice of extra-billing, defined as *an amount in addition to any amount paid or to be paid for that service by the health care insurance plan of a province*. Yet, both PEI and Newfoundland allow physicians to bill patients directly at unrestricted rates while the provincial government provides patients public compensation up to the provincial fee schedule. While this may not be occurring in practice, it is allowed under provincial legislation and no penalty under the CHA has been forthcoming (Boychuk 2008a).

This legal allowance for a practice is important whether or not that practice is taking place, as the debate surrounding Alberta's Bill 11 demonstrates. The Bill proposed, among other changes, allowing add-on fees for enhanced health care, allowing private clinics to keep patients overnight and potentially charge patients for these "hotel" arrangements, and prohibiting both private ownership of hospitals and queue jumping. Opponents of Alberta's Bill 11 claimed the legislation contravened the CHA leading to a political standoff between the province of Alberta and the federal government prior to its passage. It is also important to note an asymmetric application of argument against provincial reforms here: The government of Alberta argued that the provisions in Bill 11 were already in place in other provinces. Yet, the federal government clearly stated its opposition to the bill and was unwilling to make a determination of compliance with the CHA prior to the legislation being finalized and implemented (Boychuk 2008a). The federal government ultimately conceded Alberta's new legislation did not violate the CHA, though they could have taken issue with it by interpreting the federal legislation differently.

This debate and outcome highlights the problems with the uncertainty created by the vague language of the CHA. A lack of clarity gives the federal government a great deal of latitude in determining the permissibility of provincial health policy.<sup>28</sup> As a result, debates over whether changes to health care policy are CHA compliant have multiple possible outcomes depending on the extent to which the federal government chooses to involve itself in provincial policy making, and how aggressive the provincial government chooses to be in its position including its willingness to debate CHA compliance in the public sphere, among many other factors.

The potential for differing outcomes to a debate over compliance with the CHA highlights an overarching but not yet explicitly discussed reality: Enforcement of the CHA (outside of penalties for co-payments and extra-billing) is a political rather than a legal matter. Political realities are both changing over time and differ from province to province, which means asymmetric applications of the CHA that allow Quebec greater

## Health Care Policy in Switzerland: A Policy Construct Disallowed Under the CHA

The Swiss health care system has been recognized as a high performing, if high cost, health care system that provides relatively rapid access to high quality health care (see table 1). This impressive record suggests that it could serve as a model for those interested in improving the universal access health care system in a Canadian province. Unfortunately, many of the health care policies that guide the Swiss health care system would be disallowed under the Canada Health Act.

Switzerland's universal access health insurance program is built on a model of competitive insurers where individuals can not only choose their insurance company but also have the ability to tailor their insurance plan. For example, individuals can vary the deductible on their insurance plan (trading off a higher deductible for lower premiums) or can opt for managed care plans. Universality is ensured by making insurance purchase mandatory, by providing a health insurance subsidy to lower-income households and individuals, and by requiring insurers to accept all customers under a community-rated premium. Importantly, both multiple insurers and individually tailored policies are disallowed by the CHA, which requires a single public authority providing care under uniform terms and conditions.

The Swiss health care system also employs both deductibles and user fees to more efficiently allocate health care resources. After the deductible has been reached annually, a 10 percent user fee applies to insurance-funded health care purchases up to an annual user fee ceiling. Lower ceilings and exemptions apply for select population groups such as children. The CHA disallows this policy approach by requiring first dollar coverage for all insured health services and includes prescribed penalties for provinces that require user fees for access to health care.

Delivery of health care services is competitive in Switzerland and involves both public and private organizations. Further, individuals are not restricted to receiving medical care from their universal insurance plan – Swiss citizens can choose to finance their health care services privately. While neither of these policies is clearly disallowed by the CHA, both could be interpreted to impede “reasonable access” by the federal government and thus be disallowed.

**TABLE 1 Health care performance: Canada vs. Switzerland**

Indicator	Canada	Switzerland
Total health expenditures (% GDP, 2009)	11.4	11.4
Physicians (per thousand pop., 2009)	2.36	3.83
CT Scanners (per million pop., 2009)	13.9	32.8
PET Scanners (per million pop., 2009)	1.1	3.0
Waited less than 30 minutes in emergency room before being treated (% of patients, 2010)	20%	44%
Same- or next-day appointment with doctor or nurse when sick or needed care (% of patients, 2010)	45%	93%
Waited less than one month for specialist appointment (% of patients, 2010)	41%	82%
Waited less than one month for elective surgery (% of patients, 2010)	35%	55%
Waited four hours or more in emergency room before being treated (% of patients, 2010)	31%	6%
Waited six days or more for access to doctor or nurse when sick or needed care (% of patients, 2010)	33%	2%
Waited two months or more for specialist appointment (% of patients, 2010)	41%	5%
Waited four months or more for elective surgery (% of patients, 2010)	25%	7%

Sources: OECD 2011; Commonwealth Fund 2010; Colombo 2001; European Observatory on Health Care Systems 2000.

leeway than other provinces like Alberta should perhaps not be surprising. It should, however, be troubling: As the CHA stands today, the federal government has the ability to shape health care policy across Canada irrespective of constitutional jurisdiction or the differing political, demographic, and economic realities faced by Canada's provinces.<sup>29</sup>

How then should the CHA be reformed?<sup>30</sup> Proponents of the current health care policy model have argued that the federal government should reform the CHA to be more restrictive and provide greater federal oversight of provincial processes and decisions, along with a broader scope of coverage to be included under the CHA (see, for example, Flood and Choudhry 2002). Others have argued for the elimination of federal cash transfers, or at least a decoupling of the CHA from cash transfers, in order to remove the federal government's ability to financially enforce compliance with the Canada Health Act (Bernier 2010; Blomqvist 2002).

Each of these perspectives has merit depending on the view one takes of constitutional jurisdiction, political dynamics, optimal policy, and which level of government is best entrusted with safeguarding universal access to health care insurance. The former recommendation, however, is at odds with this analysis, which is rooted in reforming the federal role in health care based on the successful welfare reforms of the 1990s. While the latter proposal of removing financial enforcement of the CHA is perhaps more in keeping with that aim, it is also perhaps difficult to achieve in practice. Of course, it is entirely within the federal government's purview to unilaterally change the CHA and health transfers as it sees fit, since the CHA is federal legislation, not an intergovernmental agreement, and since transfers are an exercise of the federal spending power.

It is clear then that any reform to the CHA must deal with unnecessary federal restrictions of policies employed in other universal access health care systems in the developed world. It must also serve to clarify the provisions of the CHA to provide greater certainty to Canada's provincial governments. Such reform must also be feasible for the federal government for it to be at all likely to take place. With these characteristics in mind, this study makes the following recommendations for changes to the Canada Health Act:

## Sections 2 and 5 – Cash Contribution

Sections 2 and 5 of the CHA should be amended to refer only to the Canada Health Transfer rather than the Canada Health and Social Transfer. Importantly, the Canada Social Transfer contains the federal government's cash transfer in support of post-secondary education and social assistance and thus should not be included under an Act focusing on health care insurance. Further, the inclusion of the Canada Social Transfer under the cash contributions that can be withdrawn for violations of the CHA provides the federal government with leverage over provincial health policy decisions unreasonably disproportionate to the federal government's financial contribution to provincial health care systems. Restricting penalties under the CHA to only the Canada Health Transfer also serves to add clarity to the health care debate in Canada including Ottawa's financial contribution to provincial health care programs.

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Sections 2 and 5 should be amended to refer only to the Canada Health Transfer.

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*Recommendation: Sections 2 and 5 of the CHA should be amended to refer only to the Canada Health Transfer rather than the Canada Health and Social Transfer.*

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## Section 8 – Public Administration

One potential path for reform of Section 8 can be found in a report prepared for the Commission on the Future of Health Care in Canada by Colleen Flood and Sujit Choudhry (2002). In their report, they recommend recasting this section as *public governance and democratic accountability* “to emphasize the importance of good governance and accountability of decision makers at all levels” (2002, 29).<sup>31</sup> This construct has the appealing advantage of removing the restriction on provinces allowing multiple insurers to provide

the universal insurance product and doing so on a for-profit basis. Flood and Choudhry (2002) further recommend an increase in federal monitoring of health care delivery by for-profit firms and recommend the CHA require provinces to account for their governance and accountability processes. Both of these further recommendations create further intrusion into provincial policy making and would not be in keeping with this study's focus on using the successful reform of federal transfers for welfare in the 1990s, which allowed the provinces greater freedom to experiment and innovate, as a guide for reform of the CHA. Unfortunately, the latter further recommendation from Flood and Choudhry was necessary in their view to avoid a circular

logic where the unclear term "public administration" is replaced with another unclear term, and so the first component of their recommendation cannot be used alone.

While the first component of the Flood and Choudhry (2002) recommendation has the appealing characteristic of removing an important restriction on provincial policy making, it fails to resolve a core concern with the Canada Health Act introduced earlier in this paper, namely the lack of clarity in the public sphere over which level of government (federal or provincial) is responsible for health care policy making. This lack of clarity makes the public's responsibility for rating their government's actions at the polling station more difficult and serves to muddy the public debate over health care policy reform in Canada. Indeed, the Flood and Choudhry construct may serve to compound this lack of clarity. Thus, a revision of section 8 of the CHA along the lines proposed by Flood and Choudhry (2002) that clarifies

which level of government is responsible for health care policy making would be both in keeping with this study's focus on learning from successful reforms of the 1990s and would help to resolve the current lack of clarity in which level of government is ultimately responsible for health policy making.

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*Recommendation: Section 8 of the Canada Health Act should be recast as "Provincial Governance" and state that provinces are ultimately responsible to their citizens for the health care policies that are implemented. Further, section 8 should state clearly that provinces are free to determine their own health care policies with regard to how the insurance plan will function and who will operate and oversee it.*

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## Section 9 – Comprehensiveness

This section has been the subject of much debate in Canada. Importantly, this section as it is currently presented provides provinces with the freedom to choose which health care services are to be covered and which services will not be, though this freedom may be constrained by the risk of federal intrusion or legal challenge (Madore 2005; Charles et al. 1997). This has led to many arguments being made about the need to broaden the scope of comprehensiveness in the CHA to include services other than those provided by physicians and hospitals (non-hospital diagnostic imaging services, for example). Further, as noted above, the current section 9 (along with sections 18 through 21) creates a distortion in the health care marketplace by requiring first-dollar coverage for physician and hospital services which has the effect of discouraging individuals from using other potentially more-cost effective health care services that may be subject to co-payments.

Considering the ever-changing delivery of health care, where services are increasingly possible outside of hospitals and through the use of technology rather than medical practitioners, and where pharmaceuticals are playing an ever more important role, there seems to be little justification for the CHA to continue to focus specifically on physician and hospital services. This said, it would neither be reasonable nor appropriate for the federal government to unilaterally expand public coverage through a revision of the CHA. Indeed, Canada's experience with welfare reform in the 1990s suggests that the policy freedom for provincial governments that is currently present under section 9 should be maintained and that a federal expansion

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Section 8 should state clearly that provinces are free to determine their own health care policies with regard to how insurance will function, who will operate it, and who will oversee it.

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of coverage would be counterproductive. In addition, concerns about the distortion presently created by section 9 (along with sections 18 through 21) and about which level of government is ultimately responsible for health care policy making are dealt with in recommended revisions to other sections of the CHA, leaving little clear reason to revise this section.

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*Recommendation: Section 9 need not be revised under this set of reforms to the CHA.*

## Section 10 – Universality

Section 10 of the CHA is likely to be perceived as the section that provides the fundamental value that forms the foundation of the Canadian approach to health care policy. While this value is not unique to Canada, this is nevertheless an important section from a political perspective as it creates the requirement that provincial health insurance plans must provide protection for all citizens (regardless of their health status, longevity in the country after a minimum residence requirement, or ability to pay). The specific wording of this section does unnecessarily reduce provincial policy making freedom. Correcting this intervention and focusing more clearly on the fundamental value under protection should be the focus of reform for this section.

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*Recommendation: Section 10 should continue to require that provinces must entitle one hundred percent of the insured persons of the province to insured health services provided for by the plan. However, the clause “uniform terms and conditions” should be removed from the CHA so that provinces are not restricted from experimenting with competition and personalization in the universal insurance marketplace.*

## Section 11 – Portability

Section 11 of the CHA is one where some allowance for federal intrusion might be acceptable for broader economic reasons. The principle of interprovincial portability, from the economic perspective, is of value as it increases labour mobility across Canada by removing ties to provincial health care insurance. This allows Canadians to move to areas where there may be stronger economic growth and more work opportunities without concern for losing health insurance coverage even temporarily, thus easing labour cost increases during economic expansions and reducing unemployment in depressed regions. Critically, while it is likely to be in a province's interest to maintain a high-performing universal access health care system it may not be in their interest to fund health care services for those who have left for another province or for those who are temporarily in another province.

Requiring provinces to pay for medical services outside Canada while residents are temporarily absent from the province is a less reasonable intervention. The central purpose of a universal access health care program is to ensure protection against the cost of needed health care services for those with insufficient means to do so privately. It is not unreasonable to assume that those travelling internationally can afford to purchase travel insurance to protect themselves from the costs of medical calamity while abroad. Thus, the justification for requiring provinces to insure these costs is weak.

The recommendation below for section 11 is similar to recommendations for this section made by both Flood and Choudhry (2002) and the Commission on the Future of Health Care in Canada (2002) and aims to reduce federal intrusion into health care policy to a level arguably beneficial for the economy of Canada.

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*Recommendation: Section 11 should be amended to remove the requirement for provinces to pay for out-of-country treatment.*

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The justification for requiring provinces to insure international travellers is weak.

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## Section 12 – Accessibility

Section 12 of the CHA contains what is perhaps the most troublesome condition in the CHA (*reasonable access*) in terms of the latitude provided to the federal government for interpretation and intervention into provincial affairs. It also contains a number of clauses relating to professional compensation that were included for historic reasons, namely professional resistance to the introduction of the CHA and concerns about compensation (Boychuk 2008b; Taylor 1987). These are perhaps less relevant and important today than they were in 1984. Finally, section 12 of the CHA duplicates responsibility unnecessarily. It requires provinces to create universal insurance programs that do not preclude or impede reasonable access to the satisfaction of the federal government, but they ostensibly are already satisfying the electorate to whom they are ultimately responsible and accountable by doing so.

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Reasonable access to health care can be maintained by assistance and exemption programs for costs such as premiums, increasing provincial reform options.

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There is however an important protection that could be enshrined in the Canada Health Act to ensure that negative consequences from the repeal of sections 18 through 21, which would have the effect of allowing provinces to implement co-payment regimes, are avoided. Importantly, the seminal study on co-payments (the RAND Health Insurance Experiment) found that co-payments could improve the efficiency of health expenditures but that the health of the sick poor was adversely affected by co-payment arrangements (Newhouse et al. 1993). Work on the effects of co-payments in Nordic countries (Denmark, Finland, Iceland, Norway, and Sweden) emphasizes the need for appropriate and effective exemptions for low-income individuals in order to ensure that these individuals are able to access the health care system in times of need (Øvretveit 2001). Studies have shown that these exemptions should be proactively administered and automated as much as

possible in order to ensure that all who qualify for an exemption are receiving that exemption, since a lack of knowledge of exemptions, social stigmas, and the need to complete special forms (increasing the cost of getting exemptions) can result in many individuals not receiving appropriate assistance or protection (Warburton 2005; Øvretveit 2001).

Given this evidence, section 12 should be revised to clearly present a federal position on the protection of access to health care for those of limited means. However, this revision should do so without unnecessarily limiting provincial reform options. Finally, a clear requirement for complying with section 12 should also be included to provide provinces with certainty that they have met this condition.

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*Recommendation: Section 12 of the Canada Health Act should be amended to require that provinces maintain assistance and exemption programs for those in a state of low income from any financial contributions required to acquire universal health care insurance (such as individual premiums) or access the universal health care system (such as co-payments or deductibles). Provinces will be considered to have met this condition if they present the federal government with a policy that defines low income cutoffs below which subsidies or exemptions will apply and that provides for proactive administration and automation of the application of these subsidies and exemptions.*

## Sections 18 Through 21 – Extra-Billing and User Charges

Sections 18 through 21 provide the clearest restriction on provincial policy freedoms found in the CHA and provide its only non-discretionary penalties for provincial violations. This restriction is an unnecessary federal intervention into provincial policy making. Importantly, the majority of developed nations who maintain universal access insurance schemes maintain cost-sharing regimes, suggesting that their prohibition is unnecessary to protect universality (Esmail and Walker 2008). Further, many of these developed nations

outperform Canada in either access or health outcomes measures, suggesting that the prohibition of co-payments is also not necessarily access or quality enhancing (Esmail and Walker 2008). Additionally, France and Australia have both been recognized as high-performing systems yet allow extra-billing by practitioners<sup>32</sup> (Esmail and Walker 2008; World Health Organization 2000), suggesting that the prohibition of this practice is also not necessary for either protection of universality or quality. Given the international evidence on co-payments, not to mention the economic literature showing the value of co-payments in an insurance scheme (see, for example, Ramsay 1998; Newhouse et al. 1993), it would seem the objections to co-payments and extra-billing contained in sections 18 through 21 are ideological in nature. There is little reason for such an intervention into provincial jurisdiction to remain in a reformed CHA.

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*Recommendation: Sections 18 through 21 of the Canada Health Act, which explicitly disallow user charges and extra-billing and set in place non-discretionary penalties for these policy choices, should be repealed.*

While each of these reforms is significant – indeed, the repeal of sections 18 through 21 are likely the most difficult to accomplish politically – these changes would modernize the CHA in ways that are important for the future of the Canadian health care system. With these reforms in place, provinces would have clear lines of accountability to the citizens they serve with less confusion over which level of government is responsible for the setting of health care policy (provincial governance). Provinces would have the ability to experiment with different health policy reforms, building from experiences in other developed nations and perhaps even forging their own paths. This experimentation would not only allow provinces to contend with the important problems of high costs, unsustainability, and lack of timely access to medical services being endured in Canada’s health care system today, but would allow the creation of competition between provinces for the highest quality health care system in order to attract economic activity. This would all still be occurring within a national health care system that allows individuals to move between Canadian jurisdictions without fear of losing their health benefits (portability), and whose core principles (universality and comprehensiveness) remained under the protection of the federal government.

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Sections 18 through 21, which explicitly disallow user charges and extra-billing, should be repealed.

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## Conclusion

In the mid-1990s, the federal government implemented fundamental changes to federal transfers for social programs, moving from a cost-sharing arrangement with federal standards to a block grant with greater latitude for provinces to experiment and innovate in the design and delivery of welfare and related services. The successful reform of the federal government’s approach to welfare in the mid-1990s provides a powerful framework for reform of the federal government’s approach to health care now. As it did with welfare, the federal government should allow the provinces greater latitude to experiment and innovate in the design and delivery of health care services while restricting its role to the minimum necessary to maintain universal, portable access to health care.

Recently, the federal government explicitly encouraged the provinces to experiment to solve agreed-upon problems in health care. This encouragement was supported by the extension of the Canada Health Transfer agreement to 2025 with no additional regulations or stipulations imposed by Ottawa as a condition of the grant.

However, a challenge remains: The Canada Health Act (CHA). The CHA is a financial act that provides the terms and conditions under which a province is entitled to its full federal cash transfer for health care.

It is important to recognize that other countries, while sharing the goal of Canada's Medicare system, have chosen policies that are incompatible with the CHA (or ways the CHA has been interpreted) in the pursuit of affordable, universal-access, high quality health care. Critically, the federal government should not disallow policy options consistent with the overarching goal of Medicare that have proven effective in other industrialized countries. If the provinces are to proceed with meaningful reform, the CHA will have to be revised to accommodate such reforms.

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### Changes are needed to the CHA dealing with public administration, accessibility, and the use of user charges and extra-billing.

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Providing the provinces with greater freedom to deliver and finance health care does not require abolishing the CHA. Indeed, it's worth recognizing a number of aspects of the CHA that should not be changed. Specifically, the principles of inter-provincial portability (section 11) and comprehensiveness (section 9) should be retained in their current form. No changes are needed in these sections in order to allow provinces to explore policy options that other nations have employed in the pursuit of high quality, cost-effective, universal access health care.

Only minor changes are needed to sections 2, 5, and 10 of the CHA. Sections 2 and 5, defining the cash contribution governed by the CHA, currently refer to the Canada Health and Social Transfer (CHST). These sections should be updated to reflect the division of the CHST into the Canada Health Transfer and Canada Social Transfer.

Section 10, which contains the requirement for universality, restricts personalization and competition in the universal insurance marketplace with the clause "uniform terms and conditions." Removing this clause will allow provinces room to experiment while maintaining the foundational principal of universality in the CHA.

Some sections of the CHA do, however, need more significant revisions in order to provide the provinces with greater clarity and flexibility regarding reforms to provincial health care based on observed successes in other universal health care countries.

Section 8, which contains the requirement for public administration, requires a single, non-profit insurer, thus preventing competition and alternate forms of ownership and operation of the insurer. We recommend revisions such that the provinces are clearly responsible to their citizens for the health care policies that are implemented, and that provinces are free to determine their own health care policies with regard to how the insurance plan will function and who will operate and oversee it.

Section 12 covers accessibility and is one of the more problematic sections of the CHA in terms of limiting provincial reform options. It is also intimately related to sections 18 through 21, which disallow the use of extra-billing and user charges. We recommend repealing these sections based on the successful use of direct financial incentives in other universal health care countries.

We also recommend Section 12 should focus on accessibility for those experiencing low-income by encouraging the provinces to shelter such people from the burden of user fees, co-pays, or other financial contributions. Such a change balances the need for introducing co-pays and other user fees with our collective preference to shelter those experiencing low-income from such financial burdens.

These reforms would result in significant changes to the CHA. Provinces would have greater clarity and flexibility to experiment and innovate in the delivery, regulation, and financing of provincial health care. This experimentation would take place within a universal, portable framework that protected the core principles of Medicare.



## About the Authors



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# Endnotes

- 1 For a summary of the Canada Health Transfer extension please see <http://www.fin.gc.ca/fedprov/cht-eng.asp>.
- 2 For examples see: John Ibbitson, Bill Curry, Ian Bailey, and Dawn Walton. 2011. "Provinces get more autonomy to drive health-care reform." *Globe and Mail*, December 20. Available at <http://www.theglobeandmail.com/news/politics/provinces-get-more-autonomy-to-drive-health-care-reform/article2278748/>; and John Ibbitson. 2011. "By attaching no strings, Flaherty binds irate provinces to health plan." *Globe and Mail*, December 20. Available at <http://www.theglobeandmail.com/news/politics/john-ibbitson/by-attaching-no-strings-flaherty-binds-irate-provinces-to-health-plan/article2277435/>.
- 3 For an overview of the Act as well as several government reports relating to the Act, please see <http://www.hc-sc.gc.ca/hcs-sss/medi-assur/cha-lcs/index-eng.php>.
- 4 Commission on the Future of Health Care in Canada (2002, 60).
- 5 Canadian Press (2004).
- 6 The federal government provides financial support for health care through two mechanisms: Cash transfers and tax point transfers. The CHA governs only cash transfers.
- 7 For an interesting discussion of the federal spending power, see Courchene (2008).
- 8 There are numerous steps that occur in the event the federal government decides to or is required by the CHA to penalize a province via a reduction in cash transfers both as a result of provisions in the CHA and a 2002 agreement between the federal government and 9 of Canada's provinces (Health Canada 2010). Despite this process, final authority to interpret and enforce the CHA remains with the federal government, specifically the Minister of Health (Madore 2005). See Madore (2005), Boychuk (2008a), and Health Canada (2010) for a more detailed description of the process through which enforcement occurs.
- 9 Interestingly, the Canada Health Act Annual Report 2009-2010 states provinces must fulfill the criteria and conditions established in the CHA "to receive the full federal cash contribution under the Canada Health Transfer (CHT)" (Health Canada 2010, 3).
- 10 A charge levied by a provider in addition to payment provided by or authorized under the provincial health insurance plan.
- 11 A point of service charge to users or a portion of the cost of insured health services that must be paid by users that is authorized, permitted, or required by the provincial health insurance plan.
- 12 Of course, in the absence of substantial federal cash transfers, the CHA would lose its "teeth" as the federal government would no longer have a meaningful financial penalty that could be imposed on non-compliant provinces. Ultimately, this discussion of compliance with the CHA and the effect it has had on provincial health care reforms is only relevant to the Canadian health policy debate to the extent that the federal government is able to impose financial penalties for non-compliance and to the extent that Canadians perceive the Act to be an important guide for provincial policy making.
- 13 Bill 11 proposed, among other changes, allowing add-on fees for enhanced health care, allowing private clinics to keep patients overnight and potentially charge patients for these "hotel" arrangements, and prohibiting both private ownership of hospitals and queue jumping.
- 14 Boychuk notes that the CHA "is not justiciable – it is neither agreed to by both parties, legally binding on either party, nor does it create a set of citizen entitlements which may be claimed through the courts" (2008a, 5). Bridge notes that "[c]ourts have consistently held that they cannot rule on whether a province has complied with the CHA...this is a political rather than a legal matter" (2007, 9).
- 15 Of course, this vagueness could also be clarified by the federal government if it chose to clearly outline what is and what is not permissible under the CHA. It is noteworthy that no federal government has chosen to do so in the Act's nearly 30 year history. Since the enactment of the CHA, the federal

government has made two key interpretive statements: The Epp letter (1985) that gave a broad overview of the federal position on the interpretation and implementation of the CHA, and the Marleau letter (1995) that outlined the federal position on facility fees in private clinics (Health Canada 2010).

- 16 For more information on the parallels and lessons to be learned from the successful welfare reforms of the 1990s please see: Jason Clemens. 2011. Reforming the Canada Health Transfer: Applying the welfare reform lessons of the 1990s to healthcare today. Ottawa, ON: Macdonald-Laurier Institute. Available at <http://www.macdonaldlaurier.ca/files/pdf/Reforming-the-Canada-Health-Transfer-October-2011.pdf>.
- 17 While dual practice for practitioners and treatment of both publicly funded and privately funded patients is permitted in these nations, various restrictions and limitations may apply (Hurst and Siciliani 2003).
- 18 While practitioners are free to bill in excess of the universal system's fee schedule, physicians may receive benefits from the universal insurance scheme for not doing so.
- 19 The term "principle" does not actually appear in the CHA. These five sections of the Act might more technically be considered discretionary criteria. For the purposes of this paper, the widely recognized term "principle" is used in discussion of these five sections.
- 20 According to the Epp interpretation letter from 1985, premium financing of the provincial scheme is not precluded by the CHA but care and insurance coverage should not be denied as a result of an inability to pay premiums (Health Canada 2010).
- 21 For more on Switzerland see Colombo 2001. For more on Germany see Green and Irvine 2001. For more on the Netherlands, see van de Ven and Schut 2008.
- 22 Defined in the CHA *as a plan or plans established by the law of the province to provide for insured health services*.
- 23 For more on financial incentives supporting private insurance purchase in Australia see Harper 2003.
- 24 This may in fact be having a negative impact on the availability of Medicare services. Importantly, Canada's provinces commit a great deal of money to acute care services, which are delivered at zero direct cost to the patient, but spend much less on chronic disease management and care supports which often fall outside Medicare. This may result in patients who could be better cared for outside hospitals remaining in or unnecessarily occupying hospital beds and thus 'blocking' access to services for others.
- 25 It should be noted that the definition of "hospital services" frames medically necessary as: *medically necessary for the purpose of maintaining health, preventing disease, or diagnosing or treating an injury, illness or disability*.
- 26 Though their record suggests a poor performance in this regard.
- 27 For more on Switzerland see Colombo 2001. For more on the Netherlands, see van de Ven and Schut 2008.
- 28 As noted above, a risk-averse response to this lack of clarity would be for provincial governments to introduce far more restrictive health care policies than those clearly required by the Canada Health Act in order to avoid potential conflict with (and financial penalties imposed by) the federal government.
- 29 Of course, any such action would be constrained by public support for such changes. According to a 2006 Ipsos-Reid poll, net support for the CHA across Canada (support for strong CHA enforcement less support for greater provincial latitude) was negative (Boychuk 2008a).
- 30 Of course, in the absence of substantial federal cash transfers, the CHA would lose its "teeth" as the federal government would no longer have an effective penalty that could be imposed on non-compliant provinces. Ultimately, this discussion of reform of the CHA is only relevant to the extent that the federal government is able to impose financial penalties for non-compliance and to the extent that Canadians perceive the Act to be an important guide for provincial policy making.
- 31 Flood and Choudhry (2002) further recommend having the federal government monitor the growth of health care delivery by for-profit firms while acknowledging the CHA does not disallow this change.
- 32 France and Australia provide benefits to physicians who opt to not extra bill patients.

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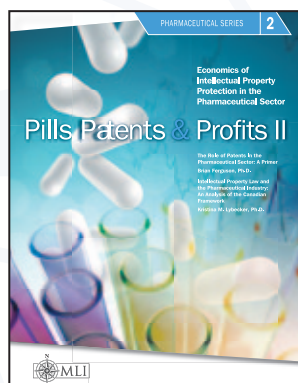
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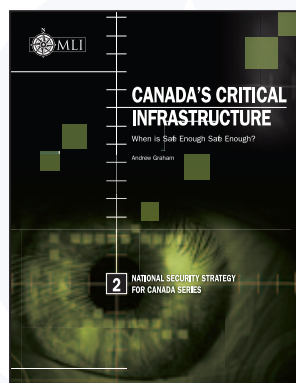
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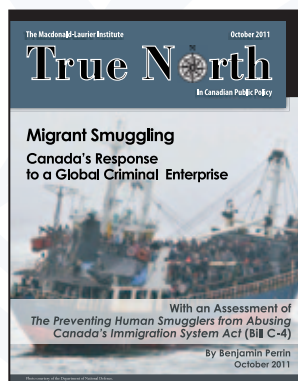
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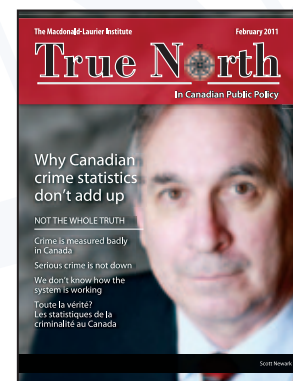
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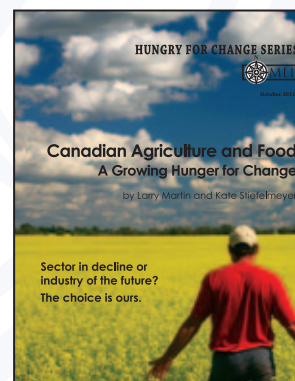
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JOCK FINLAYSON, EXECUTIVE VICE PRESIDENT  
OF POLICY, BUSINESS COUNCIL OF  
BRITISH COLUMBIA

*Very much enjoyed your presentation this morning. It was first-rate and an excellent way of presenting the options which Canada faces during this period of "choice"... Best regards and keep up the good work.*

PRESTON MANNING, PRESIDENT AND CEO,  
MANNING CENTRE FOR BUILDING  
DEMOCRACY