HEALTH POLICY REPORT

Canada's Health Care System — Reform Delayed

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The foundation of Canada's government-funded health insurance system was laid in 1957, when the federal government passed legislation providing financial incentives for the provincial governments to establish universal hospital insurance. Thereafter, major reforms in the health insurance system have occurred three times. In 1968, insurance for physician services was added. In 1977, the federal government altered its cost-sharing arrangement with the provinces, abandoning its previous commitment to pay approximately 50 percent of provincial health care costs. Instead, cash transfers were cut at the same time as some federal tax rates were reduced, leaving provinces the option of funding health care from additional taxes. The result was an immediate reduction in the federal contribution to health care and greater interprovincial variation in funding. Then, in 1984, the Canada Health Act consolidated previous legislation and imposed financial penalties on provinces that allowed physicians to charge patients more than the amount listed in the negotiated provincial Schedule of Fees, which led all provinces to ban the practice known as "extra billing."

The year 2003 was expected by many to be another watershed year, as the federal and provincial governments responded to two major reports aimed at renewing the framework for organizing, financing, and delivering health care services to the 30 million citizens of Canada. However, prospects for major change have rapidly receded, and cautious province-specific incrementalism with a temporizing injection of federal funds now appears to be the order of the day.

In 2000, Iglehart reviewed the Canadian health care system and issues facing Canadian policymakers at that time.[1] In this article, we provide a sequel to that report, focusing on what has happened during the past three years, the "New Deal" between the federal and provincial administrations, and the prospects of the public system that Canadians call Medicare.

CONSTITUTIONAL CONTRADICTION, STRUCTURAL GRIDLOCK

Canada's constitution puts the authority for taxation largely in the federal sphere but the management of health care systems under provincial jurisdiction. The inevitable byproduct of this division of powers is recurrent squabbling among levels of government about health care. Because the federal government has very limited powers to promulgate legislation or regulations that control provincial health services, it can lead only by persuading the provinces to accept conditions on funds that it transfers to them. If the provinces fail to comply with the conditions set by the federal government, the only recourse is to impose financial penalties by withholding portions of the transfer payments. Most provinces, in turn, have resisted the imposition of conditions on federal transfers, and the resulting negotiations among provinces and with the federal government are usually intense.

As a result, Canada's health care system is best described as a collection of plans administered by the 10 provinces and 3 territories, each differing from the others in some respects but similarly structured to meet the federal conditions for funding. The simplicity of the five federal conditions is arguably one of the beauties of the Canadian system. They are the provision of all medically necessary services (defined as most physician and hospital services), the public administration of the system, the portability of coverage throughout Canada, the universal coverage of all citizens and residents, and the absence of user charges at the point of care for core medical and hospital services.

To meet these conditions, each province runs a publicly administered and publicly funded universal health plan that insures physician services and funds general hospital care. Physicians practice mostly on a fee-for-service basis as independent professionals but are unincorporated, and investor-owned agencies and facilities play only a small part in medical

care. Similarly, general hospitals are structured as private nonprofit corporations, publicly funded by block budgets with some incentives for complexity and volume of services. For all intents and purposes, they are public institutions. In fact, even though they are not "owned" by governments, they are referred to as "public hospitals" — terminology that causes some confusion. There are only a handful of private, investor-owned hospitals, because they do not qualify for block funding from provincial governments. The system is unique in the world in that it bans coverage of these core services by private insurance companies, allowing supplemental insurance only for perquisites such as private hospital rooms. This ban constrains the emergence of a parallel private medical or hospital sector and puts pressure on the provinces to meet the expectations of middle-class Canadians.

During the 1980s and 1990s, government expenditures shifted away from general hospitals in favor of home-based care and prescription drugs (Table 1). For example, in Ontario, expenditures for home-based care increased by an average of 16 percent per year during the 10 fiscal years from 1984 to 1993. This shift occurred without parallel revisions of the Canada Health Act that had consolidated the federal–provincial framework for the funding and administration of health care. As noted, its provisions apply specifically to physician and hospital services. Thus, although publicly-funded drug coverage for elderly persons and recipients of social assistance ("pharmacare") is the provincial norm, several provinces have adopted user charges and blended public–private plans for prescription-drug coverage. There is also interprovincial variation in the financing and scope of home-based care services. These inconsistencies became increasingly difficult to reconcile with the ideal of a truly national health care system.

Another shift in the 1990s occurred as 9 of the 10 provinces adopted regionalized administration of health care, folding a variety of acute care, long-term care, and rehabilitation institutions together under a single administrative umbrella. Several provinces also moved to population-based funding formulas for health regions. Home-based health care services were often added to regional administrations in an attempt to improve the integration of institutional and community care. Nonetheless, service remains poorly integrated in some respects. For example, even in the nine provinces where regional health authorities exist, control over "pharmacare" budgets for physicians and outpatients is invariably outside the scope of the regional authority. And Ontario, Canada's largest province, has rejected regionalization, leaving acute care and long-term care institutions organized as scores of independent nonprofit corporations without any integration or alignment of incentives.

STRAINS ON THE SYSTEM

As Iglehart[1] has reported, during the 1990s, the federal government took aggressive action to cut spending. In essence, the federal government downloaded its operating deficit to the provinces and municipalities by reducing its cash transfers for a wide variety of programs, including health care. The proportion of provincial health care expenditures covered by a direct cash transfer from the federal government in Ottawa decreased from 30.6 percent in 1980 to 21.5 percent, on average, in 1996 and to much lower levels in richer provinces. This reduced transfer of funds weakened the ability of the federal government to impose the terms of the Canada Health Act on the provinces.

The hospital sector took the brunt of the financial pressure as real spending decreased. Between 1986 and 1994, the number of staffed beds in short-term care units in all categories of public hospitals decreased by 30,023, or 27 percent, despite the ongoing growth and aging of the population. As noted above, in most provinces, countless hospital boards (and their hospitals) were consolidated under regional governance. In Ontario, with the absence of regionalization and with virtually no voluntary closures, the government appointed a Health Services Restructuring Commission in 1996 and gave it wide-ranging powers to rationalize hospital services. The commission ordered more than 40 institutions to close or merge during its term.[3]

By the end of the decade, the federal government had rebalanced its budget and, amid growing concern about the sustainability of Medicare, reached an agreement with the provincial governments in 2000 to provide new funds. At that time, the total annual Canada Health and Social Transfer (CHST) from the federal government to the provincial governments was $15.5 billion per year (this and all subsequent amounts are given in Canadian dollars). Of this amount, $7.235 billion was notionally allocated to health care expenditures representing 10.49 percent of all public expenditures and 7.43 percent of total expenditures on health care in Canada.[2] (The

Table 1. Health Care Expenditures in Canada, 1975 to 2002.*

Fiscal Year	Health Care Expenditures							
	Total	Per Capita	Public Sector	Hospitals	Other Institutions	Physician Services	Drugs	Other
	billions of dollars (% of GDP)	*dollars*	*billions of dollars*	*% of total expenditures*				
1975	43.70 (7.0)	1,888.21	33.31	44.71	9.22	15.08	8.82	4.59
1980	51.39 (7.1)	2,096.11	38.83	41.86	11.37	14.74	8.44	4.75
1985	63.36 (8.2)	2,451.61	47.88	40.81	10.30	15.17	9.54	5.17
1990	76.87 (9.0)	2,774.85	57.27	39.03	9.42	15.15	11.36	6.70
1995	83.15 (9.1)	2,832.81	59.21	34.60	9.62	14.36	13.63	8.07
2000	101.85 (9.1)	3,307.90	72.18	32.07	9.38	13.34	15.45	8.29
2002†	112.21 (9.8)	3,572.07	NA	31.33	9.27	13.38	16.16	8.01

* Data are derived from Romanow.[2] All dollar amounts were calculated in constant 2002 Canadian dollars, with the use of price indexes for public and private expenditures in each province or territory. Public-sector expenditures include those of provincial or territorial governments, direct federal expenditures, those of municipal governments, and social-security funds, including worker's compensation. "Other institutions" include residential care facilities such as nursing homes and facilities for persons with physical disabilities. Drugs include both prescription and over-the-counter drugs. "Other" includes health research, home-based care, training of health care professionals, and transportation (ambulances). Some components of the total health care expenditures are not shown, so the percentages given do not add up to 100 percent. GDP denotes gross domestic product, and NA not available at that time.

† Data are forecasted figures.

other portions of the CHST were notionally earmarked for social services and education but may also have been redirected in part to health care in some provinces.) In 2000, the federal government agreed to increase the CHST by a total of $21.5 billion over the course of the next five years, or about $4 billion per year.[4] Some of these funds were earmarked for specific pressure points such as access to diagnostic imaging techniques, but most of the funds were not specifically targeted. Sporadic reports and audits since that time have suggested that some of the targeted money was misdirected, and press reports have popularized the view that funds meant for magnetic resonance imaging were used instead to purchase nonmedical equipment such as lawn tractors.[5]

Given the fiscal strains on provincial systems and the limited federal response in 2000, several provinces commissioned reports on health care. High-profile reports in Alberta, Saskatchewan, and Quebec[6-8] highlighted the need to integrate systems, improve coverage for prescription drugs and home-based health care, reform the provision of primary care, augment health promotion, develop better information systems, enhance mechanisms for accountability in terms of clinical performance and value for money, and eliminate various perverse incentives. However, the reports varied markedly in the extent to which they embraced the private sector. The Mazankowski Report in Alberta was the most aggressive, recommending more experimentation with the private delivery of health care and more pluralistic financing of the system, allowing parallel private insurance, increased cost sharing by consumers through "medical savings accounts," and the delivery of specialized care such as small surgical procedures (e.g., arthroscopy and cataract extraction) and diagnostic imaging by for-profit, investor-owned facilities.

Another strain arose from reduced access to physicians, particularly specialists. The sizes of medical school classes throughout Canada were reduced by 11.3 percent over a period of three years in the early 1990s, partly on the basis of the recommendations in a report produced by two health economists, Barer and Stoddart.[9,10] These authors also recommended reforming the delivery of health care so that other professionals could substitute for physicians, but these recommendations were generally overlooked. Instead, restrictions on immigration were imple-

mented that further reduced the supply of physicians. The public perception in the early 1990s of a surplus of physicians providing unnecessary services was transformed over less than a decade into a widespread public perception of a shortage of physicians, resulting in increased waiting times for appointments. Between 1996 and 2002, the provincial governments induced medical schools to increase their class size by 22.4 percent.[10] Attempts have also been made to coordinate regulatory and immigration agencies so as to increase the number of foreign-trained physicians admitted to Canada. Despite these changes, apparent shortages, not only of physicians but also of nursing and other health professionals, have persisted.

Pressure on the federal government to restore health care spending mounted as successive national budgets showed a surplus. The surplus peaked at $17.1 billion in the 2000–2001 fiscal year and was still $8.9 billion in 2001–2002.[11,12] (To put these numbers into context, total federal expenses in 2001–2002 were $169.7 billion, of which $130.5 billion was spent on programs and $39.2 billion was spent on interest payments on the national debt.) However, the federal government recognized that it had extracted little accountability from the provinces for the flow of cash in the 2000 agreement. There was also increasing concern that the provincial reports and directions would undermine the federal government's ability to provide uniform standards for the health insurance system.

Public opinion, meanwhile, suggested that the cash transfers initiated in 2000 appeared to be too little, too late. Blendon and Donelan and their coworkers have been surveying various national samples of adults for their views on health care for more than a decade. As recently as the early 1990s, Canadians who participated in international surveys consistently expressed the highest levels of satisfaction and confidence. However, with system restructuring and funding restrictions, public perceptions shifted sharply. In 1988, 56 percent of Canadians said that their system needed only minor changes, but by 1998 only 20 percent of Canadians had this level of comfort with the status quo.[13] The same survey showed that although 18 percent of people in the United States believed that recent changes in health care had harmed the quality of care, 46 percent of people in Canada held this view. A national survey in 2001 showed that approximately 59 percent of Canadians believed that the health care system required some fundamental changes, and about 18 percent believed that a complete rebuilding of the system was in order.[14]

A more recent survey[15] of noninstitutionalized adults with chronic health problems showed that more than half the Canadian respondents viewed shortages of health care professionals or hospital beds as the leading problem with the system. A similar proportion reported difficulties with outpatient access to specialists — a figure that had changed little since the 1998 survey.[13] Surveys of Canadian physicians also show increasing dissatisfaction, with two thirds being very concerned that the quality of care would decline in the future and only 24 percent in 2000 feeling that the system worked well and required only minor changes — down from 33 percent in 1991.[16] Despite decreasing satisfaction, there is little evidence to suggest that large numbers of Canadians were seeking health care in the United States.[17]

THE ROMANOW AND KIRBY REPORTS

In this troubled context, the provinces complained louder than ever that they were not being treated fairly by the federal government, and the federal government complained, in turn, that the provinces were not managing the system adequately. Seeking to resolve these mounting tensions and move forward, the federal House of Commons commissioned former Saskatchewan Premier Roy Romanow to review the entire system and make specific recommendations. Coincidentally, the federal Senate (a nonelected upper house) commissioned its own report to the Standing Senate Committee on Social Affairs, Science and Technology, chaired by Senator Michael Kirby. During the next two years, there was widespread public consultation as the two reports were prepared.

During the consultations for these reports, the debate seemed to polarize around three issues. The first was the role of for-profit corporations in the organization and delivery of services. Governments in Alberta, British Columbia, and Ontario were already giving for-profit intermediaries a larger role in the management and delivery of publicly funded services. Ontario has also encouraged public–private partnerships that give investor-owned companies a role in the financing and building of general hospitals. Canadians on the political right argued in generalities that the private sector offered responsiveness to consumers, ingenuity, and bottom-line efficiency. Canadian critics of this trend cited evi-

dence from the United States that patient outcomes are actually worse in for-profit facilities.[18,19]

A second key issue was whether the financing of health care should be modified to change incentives or to allow more private money into the system. Some argued that the Medicare monopoly should be relaxed to allow private insurance for core medical and hospital services. Others advocated the introduction of user fees, deductibles, or medical savings accounts within Medicare.[20] None of these ideas drew much support from organized labor, organizations of health care providers, or academic policy analysts.

The third issue was whether the emphasis should be on higher levels of funding or tighter management of existing resources. Both sides agreed that simply increasing the level of funding would never satisfy providers and consumers without a substantial change in management.[7] But they differed on the questions of who should make those changes and whether a parallel private sector should be allowed to grow up alongside a tightly managed public system.

After a great deal of public discussion and anticipation, the two national reports were published in the fall of 2002, the Kirby Report[21] coming first, followed shortly by the Romanow Report.[2] The latter report recapitulated many of the key themes and arguments from Canadian health care reports during the past decade, such as the maintenance and expansion of universal public funding and health care delivery, the improvement of Canada's health information-technology infrastructure, the provision of better access to care for rural and remote communities, a strategy for enhancing the health of aboriginal populations, the expansion of coverage by the provincial health insurance plans into home-based health care services and prescription drugs, reform of primary care, and the targeting of federal funds with enhanced accountability for their use. The report also recommended the provision of an additional $15.32 billion over the next three years through a federal cash-transfer program designed to induce provinces to adopt these changes.

The Kirby Report supported many of the positions and recommendations of the Romanow Report. However, it contained a trenchant analysis of Canada's ability to sustain the single-tiered, publicly funded system. It paid much closer attention to the challenges facing physicians and hospitals, proposing clear reforms and targeted funding to buttress these "core services." Kirby's Senate committee also viewed academic health science centers as a national resource that deserves earmarked funding. More controversially, Kirby proposed expanding the role of the private sector within a single-tier, publicly funded system, allowing for more contracting out of services to investor-owned agencies and institutions, including private hospitals and clinics.

THE FIRST MINISTERS' HEALTH CARE RENEWAL ACCORD, 2003

After the release of the two reports, the federal and provincial governments met in early 2003 and hammered out an agreement to increase federal transfer funds over a five-year period by $30.9 billion more than the increase established in 2000 — a major reinvestment.[22] The cornerstone of the accord was the establishment of a special Health Reform Fund worth $16 billion over a five-year period, which was aimed at primary health care, home-based care, and catastrophic coverage for drugs.[22]

The accord ushered in a number of important reform initiatives that have been welcomed by the public and health care providers. These initiatives included a new fund for diagnostic and medical equipment, with monitoring to prevent misallocation; enhanced planning with regard to human resources for health care; a national institute of patient safety; more money to galvanize the creation of electronic patient records; a national immunization strategy; investments in the health of aboriginal populations; and the creation of a Health Council "to monitor and make annual public reports on the implementation of the Accord, particularly its accountability and transparency provisions."[22]

However, the language of the accord itself was an odd amalgam of firm commitments, impressive but nonspecific statements of principle, and treading around jurisdictional tensions. (Recall that the federal government cannot legislate or regulate matters related to health; it can only persuade provinces, with the use of financial incentives and penalties, to take certain actions.) These compromises in wording were most evident in the language surrounding the $16 billion increase in funding for the areas described above. Regarding the reform of primary care, the first ministers agreed "to make significant annual progress so that citizens routinely receive needed care from multi-disciplinary primary health care organizations or teams."[22] Countless group practices of family physicians making limited use of nonphysician providers could qualify under this

rubric. Similarly, the first ministers agreed "to the goal of ensuring that at least 50 percent of their residents have access to an appropriate health care provider, 24 hours a day, 7 days a week, as soon as possible." What exactly is an "appropriate" provider in this context? Does it mean a telephone help line or a walk-in clinic beside a hospital emergency room? Although the goals for home-based care were clearer, the plan for drug coverage called for "reasonable access to catastrophic drug coverage" by the end of the 2005–2006 fiscal year, again generating considerable scope for interpretive debate. Because provinces already varied in their progress toward these goals, they would be free to direct their residual share of these funds to other health-related purposes once the goals had been achieved.

More generally, the accord promised that the federal government would establish a new long-term Canada Health Transfer separate from the current combined transfer for health and social services. In an important concession, the federal government promised "predictable annual increases in health transfers" and, subject to "achieving the agreed-upon reforms," to roll the five-year Health Reform Fund into the ongoing transfers by early 2008.

THE FUTURE

As we noted above, 2003 will be heralded by some as a year of renewal for Canada's Medicare system. The Health Accord represents a welcome reinfusion of previously withdrawn federal funds and contains many useful reform initiatives. However, we also believe that the latest federal–provincial agreement is best interpreted as yet another temporizing compromise.

Constitutional constraints mean that fundamental reforms aimed at better alignment of incentives and integration of payment mechanisms have again been left to the discretion of each province. Yet at the provincial level, governments can ill afford to face the wrath of providers and the public with fundamental and potentially disruptive supply-side reforms. The pendulum in the United States has swung away from managed care, and we believe that Canadians would not find such a system palatable. They are accustomed to a health insurance card that allows them free choice of providers, and providers, in turn, have suffered relatively little micromanagement. Thus, the provincial capacity and appetite for change appear to be limited.

Compromise is also implicit in the position taken (or not taken) by the Health Accord on privatization. Notwithstanding the Romanow Report, the accord does nothing to eliminate the private provision of services within the framework of the public financing and administration of Medicare. And there will continue to be a blend of public and private financing for services outside the core of physician services and institutional care, including home-based care and "pharmacare."

One positive step taken by the accord is the expansion of the scope of insured services to include coverage of home-based care and prescription drugs. But in these areas, too, there is less change than there might appear to be. Most provinces had already implemented some public financing of home-based care services as they downsized their hospital sectors in the 1990s. Several provinces have catastrophic drug coverage, and all have provided coverage for the elderly and socially disadvantaged. Nothing in the previous federal transfers prevented funds from being directed to these ends.

Proposals for the reform of primary care involving a greater reliance on multidisciplinary teams and the elimination of fee-for-service payment have surfaced repeatedly in Canada since 1972, when Hastings[23] recommended such ideas in a landmark report for the federal, provincial, and territorial deputy health ministers. In Ontario, for example, the provincial government recently established the Primary Care Networks Program, an enterprise aimed at inducing physicians and other health care professionals to join primary care teams. A report published in October 2001 by a committee of the Ontario Ministry of Health and Long-Term Care that was convened to evaluate pilot programs for primary care reform reported that only 166 of the approximately 10,000 family physicians and general practitioners in Ontario had enrolled in the program.[24] Any reforms to the organization of and payment system for health care professionals in Canada require a negotiated agreement and cannot simply be imposed. Such agreements may prove to be very difficult to achieve.

In sum, the past decade in Canadian health care has been difficult for patients, providers, and governments alike. Canada's Medicare program has retained its iconic status during several years of intensive scrutiny. It is still defended as embodying our national values and is held out by some as a feature that differentiates us from our neighbors in the United States. The latest increments in funding and the reforms catalyzed by the new multigovern-

mental Health Accord should bring some stability to the system, but they appear unlikely to achieve a sustainable transformation in the organization, delivery, and financing of Canadian Medicare. We foresee continued turbulence as provinces cautiously pursue overdue reforms of their regional programs, as the federal government seeks to hold provinces to account for new funding, and as a growing proportion of Canadians lose patience with health care systems that they perceive as no longer delivering reasonable access to core services.

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