Reforming health care in Canada: Current issues*

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Abstract

This paper examines the current health care reform issues in Canada. The provincial health insurance plans of the 1960s and 1970s had the untoward effects of limiting the federal government's clout for cost control and of promoting a system centered on inpatient and medical care. Recently, several provincial commissions reported that the current governance structures and management processes are outmoded in light of new knowledge, new fiscal realities and the evolution of power among stake-holders. They recommend decentralized governance and restructuring for better management and more citizen participation. Although Canada's health care system remains committed to safeguarding its guiding principles, the balance of power may be shifting from providers to citizens and "technocrats". Also, all provinces are likely to increase their pressure on physicians by means of salary caps, by exploring payment methods such as capitation, limiting access to costly technology, and by demanding practice changes based on evidence of cost-effectiveness.

Key words: health care reform; consumer participation; Canada

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Resumen

Este artículo examina los temas más recientes en las reformas del sistema de atención a la salud en Canadá. Los planes de seguridad en el sector salud durante los años sesenta y setenta tuvieron efectos inapropiados en cuanto a que limitaron el poder del gobierno federal para controlar costos y promover un sistema centrado en la atención médico-hospitalaria. Recientemente, varias comisiones provinciales reportaron que las actuales estructuras de gobierno y gestión de los procesos no están actualizadas en términos del nuevo conocimiento, las nuevas realidades fiscales y la evolución en las formas de poder entre los grupos de interés. Sus recomendaciones incluyen formas descentralizadas de gobierno y mayor participación ciudadana. A pesar de que el sistema de atención a la salud en Canadá permanece comprometido a garantizar sus principios centrales, el balance de poder estaría cambiando de los proveedores a los ciudadanos y "tecnócratas". Al mismo tiempo, es probable que todas las provincias tiendan a aumentar sus presiones sobre los médicos mediante la imposición de topes en los salarios, métodos de pago tales como la "capitación", la limitación de acceso a tecnologías de alto costo y la demanda de cambios en las prácticas sobre la base de la costo-efectividad.

Palabras clave: reforma en atención a la salud; participación comunitaria; Canadá

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This paper intends to provide an overview of the current health care reform issues in Canada. First, I will present a few health and related indicators as a yardstick for comparing Canada to other countries, mainly to the US, so as to provide some indirect evidence as to the relative effectiveness and efficiency of the system. Second, I will very briefly describe the organization and financing of the health care system (HCS) with emphasis, when necessary, on differences amongst provinces. Lastly, I will present the current reform issues.

Socio-demographics and health

Canada is the world's second largest country, sparsely inhabited by some 29 million people mostly living along the US border in the south. Three-fourths of the population live in urban areas. While almost 75 percent of Canadians are English-speaking and 25 percent are French-speaking, the ethnic composition is much more complex with rather large minority groups of European, Asian and African-American descent living mostly in metropolitan areas. Canadians enjoy high standards of living; the United Nations Development Programme (UNDP) recently reported Canada to be the country with the highest human development index in the world.[1] The life expectancy at birth in Canada exceeds that in the US by more than 2 years for both sexes, mainly due to lower infant mortality, but also related to a lower homicide rate in the ages 15 to 24, and lower HIV infection, chronic liver disease and heart disease rates in the ages 25 and over.[2]

Health care organization and financing in Canada

The health care system in Canada constitutes the most popular publicly-funded service and enjoys a high level of public support.[3-5] The system aims at providing universal, equitable and high-quality health care to all its citizens. It is of interest to the reader to note two rather unique features of health care system in Canada. First, there is not a single Canadian HCS but rather ten provincial and two territorial systems (a total of 12 jurisdictions), each with its own peculiarities. Second, contrary to common belief, Canada does not have a "socialized health care system". The so-called Canadian health care system is, like many other institutions in Canada, a product of a compromise between European welfare idealism and North American penchant for individualism. Hence, health care financing in Canada is tax-based: both federal and provincial contributions are financed mainly through personal and corporate taxes, and sales and payroll taxes, respectively. Unlike Bismarckian health insurance systems in Germany, France and some other European countries, there are no statutory sickness funds financed through earmarked premiums or contributions for health care entitlements only. In Alberta and British Colombia, residents are required to pay an additional premium. However, the use of premiums is limited in scope as a supplementary source of revenue only and its payment does not constitute a pre-condition for access to health care. Entitlement includes all medically necessary ambulatory and hospital services for all residents of Canada, similar to the Beveridge model in the UK. However, unlike in the UK, health facilities are owned and run by not-for-profit foundations where physicians work as autonomous and private entrepreneurs in solo or in group practice.

Health care in Canada falls under the jurisdiction of provincial governments and territorial authorities. The role of the federal government is to define and enforce the basic principles through its financial contribution to provincial health plans and to provide health protection services for all Canadians and health care services to Indians on reserves and to military personnel. Aside from these areas, the role of the federal ministry of health, Health Canada, is limited to policy development in health and health care, to providing leadership and technical assistance in public health promotion and disease prevention programs, and to health-related research. However in reality, as recent history attests, the federal-provincial relationship over health and health care issues could more aptly be described as a tug-of-war between the federal government which uses its economic clout to dictate and enforce its own health policy to provinces while the latter, lured by the federal money, try nevertheless to have more control over the financing, organization and delivery of health care under their own jurisdictions.

Background to current reform issues

Although health insurance plans were successfully established under the federal leadership across all jurisdictions in the late 60s and 70s, ensuring equal access and universal coverage, they had two untoward effects: (i) the first, mostly financial, put the federal government in a reactive mode, in that it had to match provincial contributions while having little room for anticipating future costs and clout for budgetary control; (ii) the second, they had the undesired effect of

promoting a system centred on inpatient and medical care since federal contributions were directed to these services and this resulted in limited attention to less costly alternatives for care and to health promotion.[6]

Early attempts to reform the health care system

The federal government, provincial authorities and other stake holders –mostly physicians' representatives– spent the late 70s and early 80s debating these two important issues. For the purpose of this paper, it suffices to say that the federal government has managed to modify its financial obligation into a block fund transfer to be adjusted only based on population and Gross National Product (GNP) growth rates. Second, it has also managed to pass the much disputed *Canada Health Act* in 1984 –much to the dismay of physicians– which converted the five guiding principles of Canada's health care system namely, (i) *public administration of the provincial insurance plan*, that is, by a non-profit authority accountable to the provincial government; (ii) *comprehensiveness*, that is, coverage of all medically necessary inpatient services including all necessary drugs, supplies and diagnostic tests, and a broad range of outpatient services, and home and nursing care; (iii) *universality*, that is, coverage extended to all legal residents of the province; (iv) *accessibility*, that is, the provision of all medically necessary services without financial barriers and discrimination based on income, age and health status; and, (v) *portability*, that is, entitlement to coverage during temporary absence and after moving to another province, into conditions for eligibility for federal contributions and instituted severe financial penalties should provinces allow user fees, that is extra-billing by physicians and inpatient user charges. On the other hand, the new arrangement gave more flexibility to provincial governments to decide unilaterally to expand coverage to other services such as community health programs, prescription drugs for the elderly and dental care for children.

Despite continuous attempts by provinces and other stakeholders, the principles remain in force today. In practical terms, this means that provincial governments cannot devise co-payment mechanisms for cost-recovery such as user fees for services for which they receive federal money; and physicians, regardless of how specialized or well-known they are, cannot charge patients above the fee limits set forth through bilateral negotiations between provincial medical associations and representative of the provincial governments. This also means that private health insurance can be only supplementary to basic coverage and thus can cover relatively few goods and services such as dental care, some drugs and other medically not-so-necessary services such as private bed, etc. The debate, however, is far from being over.

Current reform issues

The HCS in Canada incorporates seemingly incompatible health care policy goals. On the one hand it strives to provide equitable and high quality services to the entire population through autonomous providers and independent institutions. On the other, health care financing is strictly controlled by the monopsony of provincial governments. The system was likened once by a critic to a "pressure cooker on a hot stove".[3] Indeed the cooker kept on building steam in the late 80s and early 90s as the economic recession and the resulting reduction in tax revenues and increased federal and provincial deficits substantially reduced federal transfer payments to provinces and thus increased the financial burden on the provincial budgets. In addition, the growth of the health care inflation rate over and above general inflation brought back on the front burner privatization, cost-containment and the touchy issue of revisiting the role of the federal government in light of its now reduced financial commitment. For instance, in 1994, Alberta's provincial government allowed the delivery of some medical care services in private settings for an additional fee above the fee schedule to cover the overhead costs, and therefore opening the way for a two-tiered system –one for the average citizen and another for the more affluent. While there have been previous unsuccessful efforts in this direction, extra-billing for example, such initiatives are taken seriously by the public and politicians alike and are generally unacceptable to the federal government –leading in many cases to federal-provincial conflict. After all, equity in access to health care is very dear to Canadians and is something of which they are very proud. Indeed, more elections in the past were won and lost over equity in access to health care than over other policy issues.

The future of medicare remains high on the Canadian political agenda today; right after the 1994 federal elections the new liberal government launched its own National Forum on Health (NFH) "to advise the federal government on innovative ways to improve our own health system and the health of Canada's people". After two years of extensive consultations, commissioned research and public hearings the NFH has recently made its reports public.[7] On the other hand, seven out of 10 provinces had set up their own com-

missions on the very same issues in the late 80s, albeit from their own provincial standpoints.

The conclusions reached by the provincial commissions were remarkably similar: they all concluded that the current system is too medically-oriented with emphasis on institutional care despite the dubious effectiveness of medical care in general; that there are allocative inefficiencies; that patient and citizen participation into decision-making is very limited; and that health care is but one of the determinants of population health and not necessarily the most important one. Most importantly perhaps, they claimed that the current governance structures and management processes are outmoded in light of new knowledge, new demands, new fiscal realities and the natural evolution of power among stake-holders. They pointed out that service delivery has become a function of payment method, practice organization and physician preferences instead of medical need only. In short, they all put forth arguments in favour of health care reform advocating decentralized governance and restructuring for better management and more citizen participation.[8]

Other reports also noted that significant savings could be made by reducing the number of acute care beds and the length of stay in hospitals and by promoting home care for the elderly instead of institutionalization. The recommendations included tighter control on physician supply and over physicians' compensation; more coordinated and integrated approach in personnel training and in identifying the right mix of professionals; broader use of generic drugs and improvement in effective drug prescribing practices; and, more cost-effectiveness research on new and existing expensive health care technologies before their introduction into the system.[9] Another focused more on physician supply and fee-for-service as the mode of payment: it recommended at least a 10 percent reduction in intake to medical schools; an increase in post-MD pre-licensure training to two years from one; a change in the specialty mix offered in academic centres so as to adapt it better to population needs; and the adoption of other less inflationary modes of payment such as capitation for general practitioners and family physicians, and sessional fees for physicians involved in training, education and administrative tasks.[10]

Current reform initiatives

Surprisingly enough, all provinces except for Ontario have decided to follow up on the commissions' recommendations and unveiled extensive reform plans in the early 90s. However, in a typical Canadian way, the solutions differed substantially across provinces: while most have created regional or district health boards, British Colombia, Manitoba and Nova Scotia went further by setting up a second tier of local boards. The scope of the services covered vary as well; some boards' jurisdiction is limited to hospital or institutional care (e.g., New Brunswick and Newfoundland) whereas others include all health and human services (e.g., Prince Edward Island). In terms of the functions they are responsible for and their decision-making power, some boards are the results of a genuine attempt to decentralize, such as in British Colombia, Saskatchewan and Nova Scotia, where they have the final word on allocation of funds, health and health services planning, limited revenue-raising, management. In other provinces the boards assume more of an advisory role, especially with regard to health planning.

Not surprisingly, all provinces kept funding centralized and linked the amount of transfers (global budgets) to boards to tangible criteria such as a fixed amount per capita, although in Saskatchewan they are experimenting with needs-based per capita funding and it is expected that others would eventually follow suit. Moreover, physician services and drugs have conveniently been kept at the provincial level beyond the grasp of health boards. Finally, almost all boards are appointed, except for Saskatchewan's 30 District Boards which are elected, albeit with varying compositions in terms of representativeness, eligibility and appointment procedures.[11] In Quebec, for instance, there are also regional assemblies in all 17 regions with the number of members varying between 60 to 150, which are responsible for, among other things, electing 20 of 25 members of their regional board every third year.[12]

Conclusion

Although Canada's health care system remains committed to safeguarding its guiding principles, considerable inroads have been made towards shifting the balance of power from providers to citizens and "technocrats". This is especially true in provinces like Quebec and Manitoba where efforts to decentralize governance and management have resulted in deconcentration and centralization, respectively. While physicians have been able to keep their own services out of the reach of boards, their power base seems to have been further eroded as many boards are responsible for human resources planning in their own jurisdictions. In practical terms, this means limiting practice

in case of surplus of providers. On the other hand, all provinces are likely to increase their pressure on physicians by means of salary caps, exploration of other payment methods such as capitation, introduction of practice guidelines, limiting access to costly technology, and demanding practice changes based on evidence of effectiveness and cost-effectiveness.

There is now a good understanding and explicit statement of the role of education and employment on health and concrete policy and strategic recommendations to invest in these areas with the hope that they will lead to a healthier society.[7] I think it would not be erroneous to say at this stage that Canada may again be leading the pack with its recognition of the importance of other determinants of health, by devolving management and service delivery to the local level where they count most, and by making the system citizen-centred as it should be.

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