Canada: the struggle over health care

Can a one-man Commission offer reforms to preserve the country's universal health insurance program?

BY *TIM STUTT*

Ask Canadians what makes their country different from the United States and you'll get the same answer: medicare – Canada's universal public health system. But rising costs, declining federal government financial support, growing shortages of health care workers and longer waiting lists for treatment cast a shadow on this cherished institution.

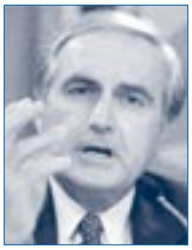
Canadians think their health care system is in danger, and this year their anxiety burst to the surface during public debate on medicare.

In April 2001, Prime Minister Jean Chrétien appointed Roy Romanow to chair a one-person Commission to investigate the sustainability of Canada's universal health care system. Few foresaw the response the former Saskatchewan Premier's inquiry would face: Thunderous applause, loud booing, marching protestors and the occasional heckler were all part of the agenda as the Romanow Commission on the Future of Health Care in Canada held public hearings across the land.

But the Canadian government did not put all its eggs in one basket. A parallel set of public hearings on "the state of the health care system in Canada" was commissioned by the Canadian Senate (an appointed body) in March 2001, under Senator Michael Kirby. Kirby chairs the Senate committee on social affairs, science and technology, which released its interim report on health care in April 2002, upstaging the interim report of the Romanow Commission.

The next report of Kirby's committee is set for October, also upstaging the Romanow Commission's final report in November. Controversy has plagued Kirby – journalists called for his resignation on grounds of conflict of interest, citing his involvement in Extendicare, an owner of nursing homes and other health care facilities.

Commissioner Romanow:



can he save the system?

Health Care: Priority No. 1

As Canadians await nervously the November 2002 release of the Romanow Commission's final report, opinion polls show attitudes towards their health care system have soured.

Canadians have a preoccupation with health care as an important public policy issue. A Communication Canada poll of more than five thousand Canadians conducted between April 25 and May 13, 2002 found that 93 per cent of those surveyed gave health care "high priority". This is the highest interest rating of any issue — ahead of national security in the wake of the September 11 terrorist attacks in the United States, unemployment, the state of the economy, taxation, public debt or any other problem.

Another Canadian preoccupation is equality of access to health care - regardless of ability to pay. A Conference Board of Canada analysis of Canadians' socio-economic values from 1981 to 2001 noted Canadians continue to support universality for health care. The same survey reported that 71 per cent of respondents said the quality of care they receive is good.

Yet the same Communication Canada survey demonstrates Canadians are more inclined to believe their health care system is in trouble. The poll says 64 per cent of Canadians believe the health care system is in poor shape overall, versus 30 per cent of respondents who say more money alone would solve its problems.

Federal influence via cash

Canadian health care does not form one national system –nor is it delivered exclusively by the public sector (*see Lazar in Federations, Special Triple Issue, Summer 2002, pg 35).*

Health care in Canada is predominantly financed by personal and corporate income taxes and is delivered primarily by private individuals and institutions.

The Canadian Constitution provides that the provinces are responsible for health. As a result, medicare is best described as an interlocking set of ten provincial and three territorial health insurance plans that provide access to universal, comprehensive coverage for medically necessary hospital, in-patient and out-patient physician services. Together these plans accounted for the largest share of a total of $82.5 billion CDN in health expenditures or 9.3 per cent of Canada's Gross Domestic Product in 1998.

Since the 1950s the federal government has influenced the evolution of health care in Canada via financial transfers to provincial and territorial governments. These transfers were intended to help the provinces and territories provide the same health coverage across Canada.

Five principles for the whole country

In 1984 the federal government adopted the *Canada Health Act*. This legislation specifies that provincial health insurance plans receiving federal funding must abide by five principles. Provincial plans must:

1) provide universal coverage
2) cover all "medically necessary" services
3) be publicly administered
4) provide portable coverage that can be used outside the province
5) not charge user fees or allow "extra-billing" by physicians

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At the same time the nature of federal transfers changed in a way that ensured tension between federal rules and provincial responsibility. During the 1950s and 1960s the federal government transferred conditional grants to the provinces and territories on a roughly fifty-fifty cost share basis for specified insured health services. In 1977 the federal government replaced these cost sharing arrangements with per capita transfers known as block funding.

From 1977 to 1996 the federal health care contribution was based on a uniform per capita entitlement that was adjusted annually according to changes in Canada's Gross National Product. Block funding transfers took the form of a tax transfer and cash payments.

Cuts in federal cash

With the arrival of block funding, federal health care transfers became conditional solely on provincial and territorial compliance to the principles of the *Canada Health Act*. Since they were no longer tied to spending on hospital and physician services, the provinces and territories had the flexibility to invest in other approaches to health care or to expand coverage for supplementary health benefits. However, block funding also left the provinces and territories vulnerable to changing federal priorities and growing financial pressures.

In response to economic uncertainties and a mounting federal deficit, the federal government unilaterally changed the formula used to calculate block funding on several occasions during the 1980s and 1990s. Lower total health care transfers to the provinces and territories provoked angry responses from their political leaders.

This trend continued during the 1996-97 fiscal year as the federal government consolidated its contribution to provincial and territorial health and social programs in a new single block transfer, the Canada Health and Social Transfer (CHST). Federal funding is transferred to the provinces and territories as a combination of cash contributions and tax points. Tax points represent reductions of federal taxes to give provinces more room to levy their own taxes.

New century, new squabbling

The signing of a Health Accord in September 2000 between the federal, provincial and territorial governments has not halted the squabbling over health care financing, even though the Accord provides a significant increase in funding to the provinces and territories from 2000 to 2004.

The federal government doubts that the provinces and territories devote all health care fiscal transfers to health care. Some federal politicians have even accused their provincial counterparts of using the transfers to help finance provincial tax reductions.

As for the provinces, they urge the federal government to go beyond the Health Accord to restore the health care transfers that it cut during the 1990s. They argue the federal share of total health care spending is now only 14 cents on the dollar, down from 50 cents in the 1960s. The federal government replies the 14-cent figure is lower than it actually is.

A fiscal necessity: reform

Health care continues to gobble up an ever-increasing share of provincial and territorial budgets. For example, last December the Canadian Institute for Health Information predicted the increase in provincial and territorial government spending on health care would total 7.9 per cent for 2001. And in their 2002-2003 budgets the provinces have budgeted from five to ten per cent more funding for the health care line item. In contrast the Canadian economy grew only by 1.5 per cent in 2001.

A recent report from the province of Alberta included a call to increase the role of private, for-profit health care delivery under certain circumstances. Alberta Premier Ralph Klein responded that the province would not wait for the release of the Romanow Commission's final report next November in order to start implementing his own report's recommendations.

Political posturing, public response

A June 2002 release of the results of a Romanow Commission public opinion focus groups study showed Canadians want increases in public funding for health care, not only by redirecting resources, but also from tax increases.

But the study also shows Canadians would place strict conditions on any tax increase. They want better accountability from governments, health care providers and users. They want greater transparency about where the money goes and its impact. And they want additional taxes to be earmarked for health care.

At the same time a Romanow Commission discussion paper released in September 2002 shows that citizens launching legal challenges under the Canadian Charter of Rights and Freedoms may play a crucial role in the future of the country's health care.

The paper says it may be possible to launch a charter case over the denial of access to private health care to ensure the right of timely treatment. Or the Charter of Rights could also be used to argue for an even broader public health system.

Finally, Prime Minister Chrétien's announcement in August that he will leave office in February 2004 has added a further element of intrigue to the mix. Since making his retirement plans public the Prime Minister has hinted that fixing Canada's health care system would be part of his political legacy. But his Finance Minister – and one of his potential successors – has indicated there may be little new federal funding for health care in the short term.

What new form for medicare?

The Romanow Commission is caught in a vice grip of high public expectations, mounting financial pressures, inter-governmental fighting and political intrigue.

In his February 2002 interim report Roy Romanow defined four approaches on what to do about health care:

- more public investment
- asking Canadians to bear more of the costs personally through user fees and other means
- increasing private sector involvement
- and reorganizing service delivery to provide integrated care

But with some pushing for greater private sector participation and others pulling to preserve the universal character of the system it doesn't look like a one-size-fits-all solution will be very easy, or even possible.

As Romanow himself put it:
"In reality, it is doubtful that any one perspective, however logical or persuasive, provides a complete solution for our health care system."