

HEALTH SERVICES IN CANADA: CHALLENGE AND CHANGE

- Draft speaking notes by Wayne Fritz, November 2002

Introduction

- Greetings
- Focus of presentation:
 - to provide a brief overview of how health services are organized and funded by the federal (national) and provincial governments within Canada; and
 - to highlight major changes that occurred during the 1990s in the organization and national funding of health services in Canada.

A Brief Look at Canada

- Canada has a land area of 3.84 million square miles, making it the second largest country in the world.
- The country has a population of approximately 31.4 million people, with 80% now living in urban areas and half of all Canadians living in 9 large metropolitan centres – Toronto, Montreal, Vancouver, Ottawa-Hull, Calgary, Edmonton, Quebec City, Winnipeg and Hamilton.
- In 1867, Canada's founding constitution established and defined the power and authority of the federal government and the five original founding provinces.
- Today, the government consists of a national government, ten provincial governments (British Columbia, Alberta, Saskatchewan, Manitoba, Ontario, Quebec, New Brunswick, Nova Scotia, Prince Edward Island, Newfoundland & Labrador), and three territorial governments (Yukon, Northwest Territories, Nunavut). (See map, below.)
- In 2001, Canada spent approximately \$89.5 (Cdn.) billion on the provision of health services, or roughly \$2,982 per capita.
 - 72.6% of this was publicly funded by the federal and provincial/territorial governments.
 - 27.4% was funded "out of pocket" by those individuals receiving the services.



Canada's Health System

Federal and Provincial Health Services

- In Canada, both the federal and provincial governments play key but different roles in the provision of health service.
- The 1867 Canadian Constitution did not clearly spell out what powers and responsibilities federal and provincial governments would have in the health field. At the time, health care was viewed primarily as the responsibility of individuals and religious or charitable organizations, with provincial governments having only broad responsibility for regulating such services. Constitutional rules were not established as to how health services would be organized or provided by different levels of government.
- Health service delivery in Canada has evolved over time in response to changing health needs, service innovations, intergovernmental funding agreements, and collaboration between federal and provincial governments at a national level.
- There is no single, integrated national health system in Canada. Rather, what is called the Canadian health system is really a collection of ten provincial and three territorial health systems. These separate systems share a number of common service features and are linked together by a web of joint federal and provincial funding, regulatory and administrative relationships, with broad public support for the idea of national health standards.

The Provincial Governments' Role

- Health services in Canada are primarily funded, organized and regulated by provincial/territorial governments. These governments commonly fund a wide range of health services including:
 - immunization, disease control, health promotion and public health inspection services;
 - public health nursing, pre- and post-natal services, and screening programs for children;
 - mental health and addiction services for children and adults;
 - hospital services;
 - physician services;
 - specialized rehabilitation services (e.g., speech and language pathology services, physiotherapy and occupational therapy services);
 - home care services;
 - residential long-term care services;
 - prescription drug services; and
 - ambulance services.
 - The majority of these services – immunizations, public health nursing, public health inspection, and mental health, addiction, hospital and physician services – are publicly funded through provincial/territorial government revenues and are provided to citizens on the basis of assessed need without any direct charge.
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- Other services such – such as prescription drugs, home care, long-term residential care, and ambulance services – are only partially funded from the public purse. Persons receiving these services are typically required to make some level of co-payment. Significant service and co-payment variations occur among the provincial governments.
- Health services are typically delivered by a range of regional health authorities, affiliated organizations and health professionals. Physicians are largely funded by provincial governments on a fee-for-service basis, while other health workers are employed predominately by health authorities through negotiated contracts with employee unions.
- Provincial health ministries are concerned with funding, regulating and working with third parties to ensure that health services are provided in ways that are effective, efficient and responsive to local health needs.

The Federal Government's Role

- The federal, or national, government exercises its role in the health system through the use of its spending powers, its criminal law powers, and its constitutional responsibilities for Status Indians and immigration. It also carries out a number of specialized service and coordinating functions.
- The federal government directly funds or provides health services for members of the Canadian Armed Forces, the Royal Canadian Mounted Police, federal penitentiary inmates and Canada's Status Indian population. In addition, it funds or provides health-related screening, quarantine and treatment services for immigrants or refugees before they enter Canada.
- Through its criminal law powers, the Government of Canada has the power to prohibit activities deemed to be morally reprehensible or a threat to national public health and safety (e.g., euthanasia, tobacco and prescription drug advertising).
- Through its ministry of health, the federal government sets national regulatory standards for the manufacture and sale of prescription drugs, food, cosmetics, medical devices, radiation emitting devices, drinking water devices, and the labelling of hazardous products. This ministry also works with other federal departments in the licensing of pesticides and the administration of the Canadian Environmental Protection Act. It also collaborates with provincial/territorial governments in managing a system of national health statistics and a national surveillance system for communicable and other diseases.
- The national government funds health research on a national scale and periodically provides funding to various organizations and community groups to pilot innovative health service approaches or provide health services to designated population groups.
- The federal government supports the provision of health services by providing annual funding to provincial/territorial governments, but reserves the right to withhold funding if provinces do

not adhere to those principles and requirements pertaining to hospital and physician services that are set out in the *Canada Health Act*. (See below.)

- Given that both the national and provincial governments play major roles in the Canadian health system, various intergovernmental structures and mechanisms have been established to facilitate communication, collaboration and conflict management. These include:
 - meetings of ministers and deputy ministers of health several times a year to discuss important policy issues;
 - standing and ad hoc intergovernmental committees to share information, co-ordinate intergovernmental activities and develop recommendations on matters of joint concern (e.g., standing advisory committees on population health, health services, health information, and health human resources);
 - both mandatory and voluntary sharing of information by provincial governments with the federal government; and
 - jointly created agencies to carry out specialized national tasks (e.g., Canadian Blood Services, Canadian Institute for Health Information, Canada Centre for Health Technology Assessment).

National Funding and the *Canada Health Act*

- The federal government began providing significant financial support to provinces for health services in the 1950s and 1960s through annual cost-sharing agreements. Through these agreements, the federal government covered approximately 50% of the costs incurred by the provinces to provide insured hospital and physician services within their respective jurisdictions.
- In 1977, these federal-provincial cost-sharing agreements were replaced by a system of block funding called Established Program Funding, or the “EPF,” which saw federal funding contributions de-linked from actual provincial program expenditures on insured hospital and physician services. Through this new block-funding program, the federal government made a commitment to initially maintain and subsequently increase health funding to the provinces based on the rate of growth in the national economy.
- Provinces, in turn, would no longer be required to spend the federal funding they received solely on the provision of insured hospital and physician services. The federal government obtained increased control and predictability over what it would provide to the provinces in support of health services, while the provinces gained greater flexibility to determine how that funding support could be spent.
- In the earlier annual cost-sharing agreements and subsequently in the “EPF” block-funding arrangement, the federal government had required the provinces to agree to a number of general principles in their delivery of insured hospital and physician services as a condition of receiving full funding. In 1984, those principles were entrenched in and expanded upon in a piece of federal legislation called the *Canada Health Act*.

- The principles of the *Canada Health Act* apply only to insured hospital and physician services. They can be summarized as follows:
 - Universality: Insured hospital and physician services should be provided under common rules to all persons eligible to receive those services.
 - Comprehensiveness: A comprehensive range of medically necessary hospital and physician services should be available.
 - Portability: Provinces should fund the cost of emergency hospital or physician services needed by their residents when in other provinces or countries at roughly the same level that those services would be funded in their home province.
 - Accessibility: Financial charges should not impede access to necessary services and there should be no extra billing or user charges for insured physician and hospital services.
 - Public administration: Insured hospital and physician services should be publicly administered.
- The federal government has legislatively reserved the right to penalize provinces by withholding cash transfers if provinces do not comply with the five *Canada Health Act* principles. The penalty for allowing extra-billing or user charges is the actual amount of the extra-billing by physicians or hospital user charges that occurred in the province. The penalty for any other contravention of the principles is an amount to be determined by the federal government as deemed "appropriate to the gravity of the default."
- The public widely supports the *Canada Health Act*'s five principles for providing insured hospital and physician services, and has generally come to view them as the ideal for how other publicly funded health services should be provided. To date, the federal government has been able to act as a national advocate for these principles without ever having to operationally define them or enforce them through financial penalties – except in a few cases where provinces allowed direct charges to be made for insured hospital and physician services. Provincial governments have few financial incentives to allow significant direct patient charges for these insured services, but maintain flexibility in determining how to organize and fund them to meet provincial health service needs.

Changes in the Organization and Funding of Health Services in Canada

Organizational Changes

- During the 1990s, 8 of the 10 provincial governments implemented major changes to the governance and organization of health services. Although differences occurred among the provinces in terms of the scope and pace of these “reform” initiatives, the organizational consolidation and integration of health services was a common objective.

- The province of Saskatchewan offers an illustrative case example of the organizational changes undertaken.
 - In 1990, with a population of approximately one million people, Saskatchewan had more than 400 separate and autonomous health boards, almost entirely funded by the provincial government, with responsibility for administering and providing hospital, ambulance, home care and long-term residential care services.
 - The provincial government negotiated budgets annually with each of the health agency boards.
 - The various health agencies coordinated services amongst themselves.
 - Five different health unions negotiated collective agreements on behalf of some 28,000 unionized health care workers through more than 500 separate bargaining units.
 - Public health, mental health and addiction services, and certain community-based therapy services were, for the most part, provided directly by employees of the provincial government.
 - The provincial government operated provincial pharmacare, cancer and “aids to independent living” programs.
 - Physician services were predominantly funded by the provincial government on a negotiated fee-for-service basis.
 - In 1993, the provincial government amalgamated most of the 400+ boards into 32 geographically based district health boards. (Boards of religious hospitals and privately owned long-term care homes were not required to amalgamate with the district boards, but they had to sign affiliation agreements with and get their funding through those boards.) The district boards became responsible for providing local hospital, ambulance and home care services, and for at least some long-term care homes.
 - In 1995, mental health, addiction and public health staff and service responsibilities were transferred from the provincial government to the district health boards.
 - New funding mechanisms were developed for the district boards to maintain revenue levels, recognize movement of patients from one region to another for services, and address the service needs of high risk population groups across the province.
 - In 1997, the provincial government legislated the restructuring and consolidation of health unions in the province to allow health districts to use their employees more flexibly and effectively. Union jurisdictions were altered to ensure that each health district now had no more than three unions representing its employees, and the number of bargaining units and collective agreements declined dramatically
 - In 2001, the Saskatchewan government further consolidated the organization of health services by amalgamating the 32 district health boards into 12 regional health authorities.

- The government continues to fund and directly manage the provincial cancer, pharmacare and aids to independent living programs. It also maintains control of funding for physician services.
- By 1997, all provinces other than Ontario and Quebec had implemented somewhat similar governance and organizational changes, although the extent, pace and “local” features of the changes varied to reflect provincial needs and priorities.
- By and large, the objective of provincial governments in reorganizing their health systems has been to develop new structural mechanisms to improve the integration and coordination of services. This being said, the drive to realize a more efficient and effective provincial health service delivery system has also been spurred, to varying degrees, by the efforts of provincial governments to reduce or constrain the growth of annual health expenditures.

Changes in National Funding for Provincial/Territorial Health Services

- In 1995-96, a part of an effort to deal with its own budget deficit, the federal government unilaterally announced changes in how and how much it would fund the provincial/territorial governments for the provision of health services.
- Beginning in 1996-97, the federal government consolidated all of its transfer payments to provincial governments for health, post-secondary education and social services into a new fund called the Canada Health and Social Transfer (CHST).
 - A key condition for provinces to obtain this funding was to continue to meet the 5 principles of the Canada Health Act concerning the provision of medically necessary hospital and physician services.
 - Of vital concern to the provincial governments was that the amount of the new CHST would represent a substantial decrease from the pre-existing 1995-96 base of \$18.4 billion:
 - to \$14.7 billion in 1996-97 (a 20% decrease); and
 - to \$12.5 billion for 1997-98, extending through 2000-01, a 32% decrease.
 - These unilateral changes by the federal government to the mechanism and amounts of funding for health and other services had immediate effects. Tensions developed between the national government and all provincial governments, and those health care tensions continue to this day.

- Provincial governments unanimously and very publicly argued the case that:
 - between 1977 (when the original EPF block funding for health services was implemented) and 1996-97, provincial/territorial government expenditures on health services had increased from \$11.1 billion to \$49.2 billion, a 343 % increase, with an average annual growth rate of 7% ; and
 - not only had the federal government's cash transfers to support health services not increased commensurately, but they had, in fact, decreased from 26.9% of overall provincial/territorial health expenditures in 1977-98 to 12.9% in 1996-97.
 - The provincial governments also strongly and publicly
 - challenged the federal government's level of commitment to the principles of the Canada Health Act, given the declining share of national funding support for health services in Canada;
 - questioned the feasibility of extending the principles of the Canada Health Act to other health services such as home care and pharmacare; and
 - called upon the federal government to support a larger share of provincial/territorial health service expenditures through the development of a new health service funding mechanism.
- In the face of such sustained political debate, improving government finances, and growing public concern about the adequacy of funding for health services in Canada, the federal government began to change its policy regarding funding to the provinces for health service provision.
 - Beginning in 1999-2000, the federal government began to increase its CHST cash transfers such that by 2000-01, its level of support for provincial/territorial health services was almost back to where it was in 1995-96.
 - In 2000, an accord called the Social Union Framework Agreement was reached between the federal and all provincial/territorial governments (except Quebec) specifying that future changes to federal transfer payments would not be made without prior intergovernmental consultation.
- Perhaps most importantly, in 2001, the federal government established an independent Royal Commission on the Future of Health Care in Canada. It gave the commission a broad mandate to consult with the public on the future of Canada's public health care system and charged it with making recommendations to ensure the sustainability of a universally accessible publicly funded health system that offers quality services and strikes an appropriate balance between investments in prevention and health maintenance and those directed to care and treatment.
 - The public release of the Royal Commission's final report and recommendations is expected in late November of this year.

- It is anticipated that the report will make interrelated recommendations to both the federal and provincial/territorial governments about a range of health funding and service issues, including:
 - the mechanism and future levels of funding from the federal government to support health services provided by the provinces/territories
 - how the principles of the Canada Health Act should be amended, operationally defined, enforced and adjudicated between governments;
 - whether other types of health services such as public health, vaccinations, mental health, home care and pharmacare should also be included as fully publicly funded services within the Canada Health Act; and
 - how the federal and provincial/territorial governments can collaborate more effectively in dealing with issues as health system accountability, health human resource training, managing the introduction of new health technologies, and assisting regional health authorities in providing health services more effectively and efficiently.