Commission on the Future of Health Care in Canada

Commission sur l'avenir des soins de santé au Canada

POLICY DIALOGUE NO.3

The Canada Health Act

University of Saskatchewan
Saskatoon, Saskatchewan

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The Commission on the Future of Health Care in Canada, in partnership with select Canadian universities, hosted 12 televised policy dialogues on key health care issues. At each session, a moderator guided a panel of leading health care experts in a discussion focussing on a priority health issue for Canadians. These sessions were based on Issue/Survey Papers developed for the Commission by the Canadian Health Services Research Foundation. This report is a synopsis of one of these 12 policy dialogues.

Chair:

Pamela Wallin

Participants:

Monique Begin,
Former Federal Minister of Health, Prof. Emeritus at University of Ottawa

Janice McKinnon,
Former Minister of Finance in Saskatchewan.

Dr. Peter Barrett,
Physician, Past President, Canadian Medical Association,
Clinical professor at University of Saskatchewan

Liz Harrison,
Director of School of Physical Therapy, University of Saskatchewan

Marelene Smadu,
Associate Dean of Nursing, University of Saskatchewan

Dr. William Orovan,
Former Head of Ontario Medical Association

Introduction

Panelist Monique Begin (Federal Minister of Health in 1984 when the Canada Health Act was passed) provided a brief historical introduction of how and why the Canada Health Act (CHA) was entered into legislation in 1984. In the late 1970s, some provinces had allowed the introduction of extra billing by specialists and user fees by some institutions. It was the first time since medicare had been introduced that patients were being asked to pay extra charges, and the government came under pressure to do something about practices that were felt to be"eroding" medicare.

One of the reasons these practices began, according to Mme. Begin, was a change in the transfer mechanism from the federal government to the provinces for health care. For the first 20 years of medicare in Canada, the federal government reimbursed the provinces 50 cents on the dollar for hospital and physician care. In 1977, this mechanism was abandoned in favour of block funding through a transfer of taxation capacity, as well as direct cash transfers. However the new block funding provided no mechanism for enforcing the rules of medicare. Voluntary approaches were attempted but proved unsuccessful. The CHA was therefore passed in order to ensure compliance by the provinces: for every dollar of extra charges a province allowed, one dollar would be deducted from the federal transfer. If the province got its house in order within the first three years of the Act, they would get that money back. The only principle added to the Act at that time was *accessibility*, which was meant to complement *universality*.

A short video presentation then provided a brief description of the CHA and introduced some of the key concerns expressed about the Act today:

"The CHA, in its simplest terms, is a social contract wherein health care is defined as a basic right for all Canadians. The Act was passed by parliament in 1984 and is one of the few pieces of legislation ever to receive unanimous approval. Basically it provides access to quality health care, without financial or other barriers, to all Canadians. To help ensure that access, the Act sets the standards that provincial insurance plans must meet in order to receive federal funding: they must provide equal coverage to all residents, they must pay for the medical care of their residents, even if that care is received in another province or territory, and medical services must be run publicly on a nonprofit basis.

For many years the assumption was that these standards were a sufficient guarantee that Canadians would have equal access to health care. But many people are now questioning whether the CHA can continue to protect medicare in a changing world. The Act says that the provinces must fund medically necessary hospital services and medically required physician services, yet fails to define those terms. Provincial health care plans may cover other forms of care, such as prescription drugs, immunization, long-term care, home care or rehabilitation services, yet CHA standards do not apply. There is growing concern that patients treated with home care or prescription drug therapy are not protected by the CHA, despite the fact that this care is medically necessary."

In preparation for the Policy Dialogue, the Canadian Health Services Research Foundation wrote a background paper on the Canada Health Act which focused on three possible course of action for changing the CHA. Each of these possibilities was discussed by panelists after which the discussion was opened to audience members.

Course of Action #1
Canada should modernize the Canada Health Act

The Canada Health Act is almost 20 years old, and reflects the Canadian healthcare system and the values of Canadians at the time it was drafted. The federal government should open up the Canada Health Act for debate, and allow amendments that reflect the fact that healthcare and the values of Canadians have changed. (From background paper)

Presentation by Monique Begin:

I believe the CHA should be reopened because legislation based solely on hospitals and doctors is not appropriate today and may even be detrimental to good health policy. I have not changed my principles and I still think the five conditions of the Act are key. Nor have I seen much proof that they impede innovation in the health system. What I would hope to accomplish by opening the Act is to engage a public debate that will preserve medicare.

We should look specifically at modifying the principles of *comprehensiveness* and *public administration* and perhaps add the principle of *accountability*. We knew even in 1984 that the Act omitted many valuable provisions of care by dwelling on hospital and physician services, but we could not risk opening it up at that time. Today, it seems, we have no choice.

Coverage must become much more comprehensive and integrated to include primary care, rehabilitation services, and the things people need in real life. Modernizing the CHA is going to cost more money because we cannot stop at hospital and doctor services. There is some money in the federal system to begin accomplishing this.

I am not necessarily advocating for a full pharmacare or even fully covered home care program, because I do not have the expertise to say whether that is economically feasible or desirable. The private sector is already involved in these areas, and people may be willing to pay relatively small sums out of their pockets for these services. However, coverage should be expanded quickly to include home care and pharmacare that are direct substitutions for hospital care. If someone is taking a drug instead of having surgery, that should be paid for publicly.

Presentation by Janice McKinnon:

My greatest concern is with the affordability of the current system. Costs are going up at a rate of 5% a year excluding inflation, and government revenues are going up at 3% a year. There is a gap here and we have to look at what the gap really means to Canadians. We have to open our minds to revising the principle of comprehensiveness, in terms of the basket of services that are covered, because the cost of the current system and the tradeoffs it requires are, in the long term, too great. I would also be very liberal in my interpretation of public administration. The role for government has to be defined, but it can be a limited role. We have to be open to alternatives and give the provinces the flexibility they need to deal with the system.

When costs are growing faster than revenues and 60 cents [sic] of every provincial tax dollar goes to pay for health care, it is obvious that the system is overburdened and trying to do too much with too little. This creates access problems for patients and a stressed workplace for professionals in the system. The overburdened workplace is especially worrisome because of the current and anticipated shortages of doctors, nurses and technicians.

Some say the solution is to get the federal government's contribution back up to 50% of the health care system, from a current 15%. That would mean tripling present funding levels, directing the lion's share of the federal money now into health care. What would happen to critical new areas that the federal government has moved into in the last five years, like research, which are key to our standard of living and our economic success?

The last chapter in my book is called "Health Care, Health Care, Only Health Care." The Federal budget of 1995 withdrew significant funding from health care. What did it do with that money? It brought in the innovation agenda, funding for research, the child benefit -- things that are essential to the future of our country. The federal government should be doing even more for infrastructure such as water and roads, and they will not be able to do that if they are pouring money back into health care. The debate about health care has to look at what tradeoffs we are making.

The Conference Board of Canada recently reported that five years ago the amount of government money going into education and health in Canada was about equal. Today, we have an $8 billion gap and the gap is growing. The US now spends about 50% more per capita on public advanced education than does Canada. Is this a wise tradeoff for Canada to be making, especially when we will face an acute shortage of skilled educated people as baby boomers retire in the next decade? Are higher tuition levels and caps on programmes really the way to entice people to get better educated to fill those gaps? More money needs to be spent on the conditions that lead to good health, such as alleviating poverty, providing affordable housing and clean water, and education

Health care is not a right/left issue in Canada. All governments are struggling with the same issues. So we need an absolutely open-minded debate about what is covered by medicare, about how it is paid for, and about who delivers services. We need to change our health care system to ensure that the services that are covered are high quality and accessible, to maintain the principle that nobody will be denied services because of lack of money, but also to have enough tax dollars left over for other priority areas. Medicare is important to Canada, but so is the idea that every child deserves to have a decent education and make the most of their abilities.

Panel and audience discussion:

While many participants welcomed the prospect of changing the CHA and the health care system, they acknowledged that unless there were some external factor to force a dramatic shift, such as devolving budgets completely to the regions, change would likely be incremental. "Many senior health administrators hoped that the 1995 cuts would at least force the system to tear down the silos that prevented real integration," said Mme. Begin, "but that did not happen." Dr. Barrett agreed that something had to happen to make change possible. "Canadians have stated they are ready for change and made health the number one issue in the last federal election, but still nothing happened. Canadians are looking for leadership on this issue."

Several panelists agreed that the two major reasons to change the CHA at this juncture were the need to have it reflect current treatment practices and the need to alleviate Canadian's uncertainty that the health care system will be there when needed. Some felt that accountability should be added to the Act, though others wondered at how accountability for quality or timeliness could be translated into concrete enforceable measures.

Most participants felt that change of any kind was unlikely unless the federal government increased spending significantly. Monique Begin felt that they should increase their contribution immediately to 25% of health care spending, and ideally move it eventually back up towards 50%. Dr. Barrett suggested earmarking the 3% deduction we have had on our federal income tax for healthcare, or look at tobacco taxes or the GST. "We should be prepared to look at other options as well, including user fees," he said, "if they are really for services at the margin of what is necessary, like private hospital rooms."

Course of Action #2:
Federal/provincial disputes over the interpretation of the Canada Health Act should be resolved through an arm's length mechanism that is both objective and binding

Presentation by Dr. Peter Barrett:

The Canadian Medical Association (CMA) has put forth a proposal entitled "A Prescription for Sustainability". The first component is a Canada Health Charter, which would articulate a shared vision of what Medicare should be. It would outline rights and responsibilities, and include some mechanism for accountability. The Charter could help put some certainty back in the system, as neither the CHA nor the Charter of Rights and Freedoms speaks specifically about standards for things like timely access to care.

Canadians consider waiting times the major problem in the health care system today and it is time that we agree on evidence-based benchmarks for waiting times and find ways of enforcing them. If someone cannot get access to care within these benchmark times, they should be able to go to another province, or even another country, and be covered at the rates paid for care in Canada.

The Charter would likely not have the force of law, but would act like an Auditor General of health to report on the system. We know that when the auditor general reports negatively on what government is doing, government tends to perk up and behave.

The second component of the CMA's proposal is the creation of a permanent Canadian Health Commission, made up by experts from the professions, from business, government and the patient community who would park their constituencies at the door, come together and make decisions. Different groups would nominate people who would be credible to Canadians and other players in the system, and the Commission would pick from among them. We need to somehow depoliticize the whole process of health system decision-making. The Commission would operate at the national level to advise Canadians, monitor compliance, perhaps accomplish the standards benchmarking, and work very closely with groups like the Canadian Institute for Health Information, and the Canadian Institutes for Health Research. The Health Commissioner would report annually to Canadians, much as the Auditor General does now, on the performance of the health care system.

The third component of the proposal involves legislative reform to amend the CHA to account for both the Charter and the Commission and provide for a regular review of the basket of core services covered by the CHA. Core services should extend beyond physician and hospital services. We used to treat ulcers surgically and that was covered. Now we treat ulcers with pills, which are not covered. We need to regularly update and review the basket of core covered services to keep up with advances in treatment. And if we find we cannot afford to cover everything, then we have a proper forum in which to discuss where to maintain first dollar coverage, and where shared coverage might be appropriate. We need to expand the CHA to areas that are not currently covered, such as pediatric dental care or insulin for diabetics, and if we agree that we cannot fund them fully, then let us at least agree that they would be provided under uniform terms and conditions right across Canada.

Deciding what to cover is certainly not an easy process, and must be done in a fair and transparent manner. Decisions cannot be made behind closed doors, and that is what we have seen for the past 10 years with the Federal, Provincial and Territorial Ministers conferences. No one hears or influences what goes on in that room and the result is questionable policies that providers have to implement and patients have to live with. The executive black box of federalism will not help in health care.

Presentation by Liz Harrison:

The Health Services Utilization Research Commission in Saskatchewan is now evolving into two organizations, one of which will be a quality council. Whether that kind of initiative ends up being housed at the federal level or integrated between provinces and the federal government still needs to be worked out, but the fact is we already know how to do the work of monitoring performance, ensuring accountability, and informing the public, and we know that it works to improve care.

Terminology like informed decision making, evidence-based practice, but also mechanisms such as quality councils and performance measures, need to be incorporated into the CHA. Health professionals and patients are already acting on evidence-based practice through clinical practice guidelines and the like. We also need to incorporate the elements of accountability and evaluation into administration and policy. The provinces are starting to show some leadership in coming up with innovative ways of designing mechanisms, and the CIHR is now encouraging multidisciplinary research that goes from the bench to the bedside in actually changing policy. What we need to do now is bring this work to the national level and apply it more broadly through the CHA.

Panel and audience discussion:

While some participants welcomed the idea of a non-political agency such as the CMA's proposed permanent Health Care Commission to monitor system performance, others questioned the need for yet another player. "Creating a Commission may just add another layer of bureaucracy to the system and make it more laborious and harder to deal with," said Marlene Smadu.

Those who favoured the idea welcomed the prospect of greater participation from non-political players who were intimately involved with the system, especially provider and patient groups who have been conspicuously absent from decision-making in health care over the past 10 years.

> ***The patient/taxpayer/citizen is the only group nowhere to be seen at any level of the health care system and that deprives the system of key input. — Monique Begin***

Some also felt it appropriate to have a mechanism other than elections for the Canadian public to express their views about the way health care was being managed. "Elections every four or five years are the wrong tool, because all they can do is get rid of an entire government," said Monique Begin.

Others, however, felt that the public expects its elected officials to deal with issues such as health care, and not pass them off onto other bodies. The other major objection to a national Commission was that it stepped into what is essentially a provincial jurisdiction. "There are provinces that have very strongly held views about health care that no federal government is going to change," said Janice McKinnon. Rather than playing at big brother gatekeeper, Ottawa and the provinces need to work out a real partnership.

Evident in all comments was tremendous dissatisfaction with the current federal-provincial relationship and especially with the Federal-Provincial-Territorial Conferences which, as Monique Begin stated, "are totally dysfunctional. They cost $23 billion, produce agreements that last for a week and then disintegrate." Panelists and audience members agreed on the need for better working relationships between levels of government, and a better combined federal and provincial system of providing health care.

Course of action #3

The Canada Health Act should be broadened so that it includes other important "medically necessary" services, not simply those provided by doctors and in hospitals.

Presentation by Marlene Smadu:

Despite the alarms that go off at the mention of more dollars, I support broadening the Canada Health Act. Health relates to quality of life as well as quality of care, so while physicians and hospitals are necessary to health, they are not sufficient. We know that interventions like smoking cessation, weight loss and physical activity programmes are key to preventing heart disease, but these programmes and those who provide them are not covered under the CHA, so they remain episodic and unevenly available.

When your condition deteriorates to the point that you require cardiac bypass surgery, you are assured hospital care and physician care, but does this provide you the best possible quality of life? No, because you now have heart disease that you will have to live with for the rest of your life. What government articulates is what people come to see as valuable, so we need to articulate that non-physician, non-hospital services are important

Broadening the CHA would send a valuable message from government to the people of Canada that health depends on more than just physicians and hospitals. We have told the public over the past 20 years that when you are not well we will have health services for you. We have not said you have a responsibility for being well, and making the appropriate support services available. Broadening the CHA would also promote the kind of seamless coverage we need to make sure everyone gets the right care at the right time. And we can expect significant savings down the road. There is ample literature telling us that when we invest our dollars correctly upstream in very early intervention, we will save dollars, for at least that group of clients, downstream.

Presentation by Bill Orovan:

In 1998, I said we suffered from a crisis of confidence in a system governed by an outmoded Canada Health Act. At that time, advocating for change and modernization of the CHA was not a particularly popular position to take. There is considerably more support for that idea today.

As just one example, there is an urgent challenge to improve coverage of pharmaceuticals. We are seeing an increase in drug expenditures of more than 10% a year going back now more than a decade. Drugs now consume more dollars per year than doctors services. And this is before we look at the new pharmaceuticals coming out of genomic and proteomic research, such as the genomic breast cancer screening test which costs $3000 a patient. We need to find a way to fund this and I do not think we will be able to do that simply by managing better and setting up more transparent rules and better processes.

Evidence-based practice does not provide us with a threshold below which we can confidently say we should not provide a service. It lays out a continuum and you make decisions along that, and at some point particular patients who might benefit from that treatment do not get it. Saying that something which is not publicly funded should not be available at all is offensive to the spirit of choice and options. We have to set up something that allows opportunities for those patients to have treatment too.

In addressing change to the CHA, we first need to put to rest this mythical idea that it is a symbol of what it means to be Canadian, that it defines the country. We cannot put that kind of mythical status onto a social program and then step back and have a nice debate about how we might change it.

Second, we need to address the issues around service delivery, through quality councils, better rules, evidence-based practice, some kind of public and private partnerships, although those have been difficult. We have seen in Alberta with Bill 11 how much anxiety was generated around including private delivery even though we had security of public funding.

Third, we need to look at funding. Mr. Mazankowski's report, Mr. Kirby's report, and even the preliminary report from Mr. Romanow said we need to broaden the funding base. We need more money. We have to ask very seriously whether we can get it exclusively from within the public domain or need to look beyond that. I do not believe that we can made the publicly funded health care system work by better management and better transparent processes.

Panel and audience discussion:

There was broad agreement among panelists that the major impediment to broadening the CHA to include services other than physician and hospital services was the idea that anything covered by the CHA had to be 100% publicly funded. There was significant support for user fees on at least some services, so long as they were imposed according to a person's ability to pay. "Surely, if we use the principle of ability to pay so poorer people are supported, we can identify some services that will be partially paid out-of-pocket or through private insurance," said Janice McKinnon.

> ***"If we want to start talking about introducing other aspects and broadening the act to include home care and pharmacare, and try to provide first dollar coverage, single source funding for all those services is not possible." — Bill Orovan***

While some participants felt that non-medical determinants of health should also be addressed under the CHA, there was no consensus on the evidence that upstream investments would bring downstream savings. "Once you get past childhood immunization, prevention of underweight babies by good maternal nutrition and counseling, and stopping smoking," said Bill Orovan, "the data on how much money would be saved through health promotion starts to get pretty iffy." Others felt the research supporting a multi-sectoral approach to problems such as physical inactivity was fairly strong.

Part of the dilemma in broadening the act to acknowledge the non-medical determinants of health was that this would require inter-departmental cooperation that could not exist in the current government set-up. "The policies to govern the determinants of our health need to come from a multi-sectoral approach," said Rick Bell from the Coalition for Active Living. However, as Monique Begin stated, the way government is now set up encourages competition among ministries for a limited pie, not cooperation. And, as Ron Labonte, Director of the Saskatchewan Population Health and Evaluation Research Unit, pointed out, health care is not the only sector in crisis at the moment; education, the environment and justice, among others, are also feeling the pinch. "One of the reasons behind these crises is the increased tax competition we see, between provinces and between countries, which erodes our ability to enrich the tax base," said Labonte.

Some participants questioned how other countries were able to offer public coverage of a broader range of services, combine public and private services, and use mechanisms such as co-payments much more easily than Canada. Monique Begin pointed to historical differences in the evolution of health systems as a major factor. "Canada is one of the few countries in the entire industrial world, if not the only one, that never had a private health care system," she said. "European countries all had private health care systems on top of which public health care systems were developed, some since Bismarck and more since the 2nd World War. Canada, with very few exceptions, had not-for-profit civic and religious order hospitals. So we do not come from the same tradition. When the system was developed here, it was a public system, and there was no private system behind it or parallel to it. The room we have for private contributions is in home care and pharmacare because these are already important roles played by the private sector."

There was considerable support for using the CHA to harmonize existing provincial efforts in areas such as pharmacare and home care as a way to even out access across the country without necessarily creating new national programs.

> ***"Many of my patients would prefer to have their pharmaceuticals paid for rather than coming to see me and I think the CHA should be opened up to cover not necessarily all physician services, but also some pharmaceutical coverage." — Stan Oleksum, Family Physician***

Conclusion:

Discussion of modernizing the CHA revolved primary around the prospect of broadening it beyond services provided by doctors or in hospitals. One hundred percent public administration and financing were regarded as impediments to extending the reach of the CHA to other services and service providers. Other reasons for changing the Act were the desire to force change on the system and regain Canadians' confidence.

Monique Begin advocated modifying the principles of public administration and comprehensiveness in order to expand the scope of public coverage to domains which, she acknowledged, would not necessarily be insured nor delivered 100% publicly. Janice McKinnon proposed reexamining the same two principles for quite different reasons. She felt that the very size of the health care portfolio and budget was making the CHA unworkable and threatening other important societal goals.

The Canadian Medical Association's proposed Health Care Commission provided a focus for discussing a mechanism for settling federal-provincial disputes. Concerns about black box decision-making, which many feel has defined health care for the past 10 years, were translated into call for mechanisms for public and expert input into more transparent decision-making at all levels. Many welcomed the prospect of de-politicizing health system management, but it was recognized that health remained a provincial jurisdiction and that cooperation between federal and provincial governments would always be required.

All participants supported broadening the CHA to include the non-hospital and non-physician services that have become essential components of health care. Most considered the 100% public coverage necessary under the Act as it now stands to be an impediment to this expansion. Premiums, public private partnerships and user fees were all suggested as ways to increase the funding base to allow a greater range of services. However, there was no clear direction as to how the CHA could be modified so that some services would be 100% publicly financed and others partially funded. There was also some support for bringing non-medical determinants of health into the CHA, but such a move would require inter-departmental cooperation that was difficult to imagine under the governmental structure.